Title

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Journal

New England Journal of Medicine, 379(20)

ISSN

0028-4793

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Publication Date

2018-11-15

DOI

10.1056/nejmp1811623

Peer reviewed

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

NOVEMBER 15, 2018

CASE STUDIES IN SOCIAL MEDICINE

Medicalization and Demedicalization — A Gravely Disabled Homeless Man with Psychiatric Illness

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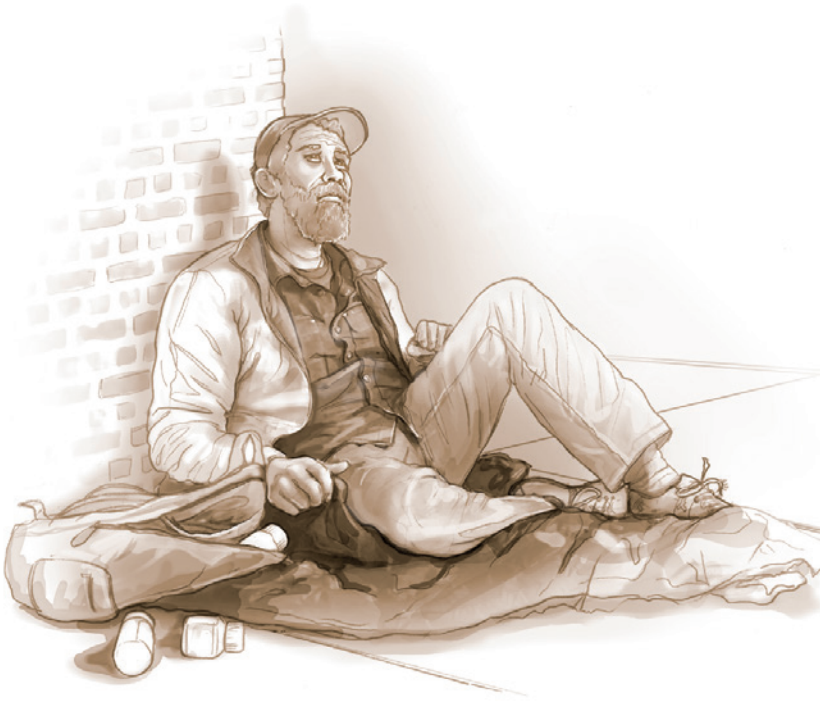
A 55-year-old man, Mr. N. presented to the UCLA emergency department (ED) reporting auditory hallucinations and thoughts of suicide. This was his sixth visit to the UCLA ED over a period of a few months; each visit was precipitated by his losing his medication and experiencing worsening psychotic symptoms and suicidal thoughts. During all but one of these visits, the examining physicians concluded that Mr. N. did not meet the criteria for psychiatric inpatient care. A typical note read, "He is only in the ER for food and shelter. . . . He has been homeless for many years. Given that he came to the ER to seek shelter, he has proven himself capable of making plans."

Mr. N., first diagnosed with schizophrenia about 30 years earlier, had had numerous hospitalizations. In keeping with trends in the United States toward shorter and less frequent inpatient psychiatric admissions, Mr. N.'s rate of hospitalization had diminished over recent years. The resident who evaluated him this time doubted that he would benefit from hospitalization. She explained to her attending physician that Mr. N. consistently stopped taking prescribed antipsychotics after discharge. She questioned the value of investing resources in an admission, since he would probably be back on the street in a few days, neither taking his medications nor following up on clinic referrals.



Suggesting that Mr. N. was more interested in escaping the streets than in psychiatric treatment, and feeling pressure to allocate beds to patients she saw as having more acute medical needs, the resident concluded, "We should give him 10 mg of Zyprexa [olanzapine] now, and he should be more coherent in a few hours so we can let him leave."

Like most states, California allows physicians to admit patients involuntarily if they are "gravely disabled" — lacking the ability to find food, clothing, or shelter because of mental illness. As the number of severely mentally ill homeless people in the United States has grown, this category has been eroded as a justification for inpatient care. This time, however, the attending argued that Mr. N.'s homelessness was as much a symptom of his psychosis as his hallucinations were and that the only way to genuinely treat his complex disease — a disease expressed in both the social register (homelessness, social isolation) and the psychiatric one (auditory hallucinations, suicidal ideation) — was to hospitalize him. At least temporarily, such care could address both social and psychiatric issues, whereas prescribing olanzapine and sending Mr. N. back to the streets was not therapeutic. So the resident placed him on a 72-hour hold for grave disability and ordered that he be admitted.

An hour later, a new psychiatric attending took over. Four hours later, still awaiting a bed in the overcrowded hospital, Mr. N. was evaluated by the second attending. Perhaps feeling the same pressure to discharge that the resident had initially articulated, this attending decided that the patient's condition was not in fact best managed with inpatient care. Mr. N. was discharged, and the attending wrote, "Pt is able to articulate a plan of care. Psych feels that he has a clear plan to see a psychiatrist as an outpatient and has resources . . . pt stable for d/c."

Social Analysis Concept: Medicalization and Demedicalization

Mr. N.'s case hinges on physicians' interpretations of whether his problems and their possible solutions are or are not medical in nature and therefore whether they are within the scope of practice of medical institutions. This tension can be understood using the paired concepts of medicalization and demedicalization, which social scientists outlined in the 1960s and 1970s (see box).[1] Grappling with an increasing number of critiques of medicine, sociologists, anthropologists, and historians developed the concept of medicalization to elucidate the processes by which certain behaviors and social problems are transformed into medical ills requiring medical interventions.[2,3] Researchers usually understood medicalization as a distorting process, in which the "true" social nature of certain behaviors and problems was obscured when they were deemed to be diseases. In such cases, medical intervention often served as a form of social control rather than alleviating underlying causes of suffering. The history of approaches to homosexuality illustrates the process of

Demedicalization is the transformation of problems formerly understood to be medical in nature into problems understood to be nonmedical.

Like its opposite, medicalization, demedicalization occurs at multiple levels, ranging from the conceptualization of etiology to the understanding of whether interventions for problems are appropriately medical or nonmedical.

medicalization beginning in the late 19th century and the process of demedicalization in the 1970s and 1980s — both of which were tied to powerful political and moral debates about the nature of deviance, difference, and disease.

Before the 18th century, madness was understood not as a medical malady but as a religious, social, or moral phenomenon. By the early 19th century, physicians had staked out madness as a range of medical diseases, requiring care and treatment in specialized "asylums," which were renamed "state hospitals" in the 20th century. These psychiatrists laid the medical foundation for the belief that people with psychotic symptoms who cannot successfully function within a wage-labor economy have a medical illness that requires not only appropriate medical interventions but also housing, occupational therapies, meaningful activities, and socialization.[4]

Popular perceptions notwithstanding, most state hospitals succeeded at their core medical functions — providing refuge, care, and meaning for people whose psychiatric illness made it impossible for them to survive without intensive care. Though some patients received aggressive treatments and conditions were sometimes poor, evidence suggests that state hospitals usually provided humane and comprehensive care. They rarely refused care because of a patient's inability to pay. Contrary to portrayals of prisonlike custodial bins for the unwanted, asylums often allowed patients to come and go at will, and patients as ill as Mr. N. would probably never have been forced back onto the streets. Food, clothing, and shelter were as integral as chlorpromazine, amitriptyline, and group psychotherapy to the medical treatment of psychiatric illness.

From the mid-1960s onward, fiscal crises, federal government policies, and ideological beliefs about community care propelled states to abandon state hospital care. Largely in response to these changes, psychiatrists came to view patients' social ills as outside their purview. Mr. N.'s life over the past 30 years illustrates the receding domain of psychiatric responsibility. His early hospitalizations lasted months, and when he wandered, homeless and psychotic, into emergency departments, physicians admitted him. But over time, his hospitalizations became shorter and less frequent, as homelessness became an increasingly permanent and normalized fate. Structural forces such as gentrification, sparse affordable housing, and an increasingly porous social safety net contributed to Mr. N.'s spiral into chronic homelessness.

Yet demedicalization of the social ravages of psychiatric disease — which enabled physicians to narrow the disease aspects for which they claimed responsibility — deserves equal blame for Mr. N.'s decline. Whereas homosexuality's demedicalization helped to reduce long-standing cultural and medical misunderstandings of sexuality, the demedicalization of chronic mental illness meant eliminating benefits that had improved people's lives. We have seen not only the abdication of medical responsibility for the life circumstances of severely psychotic people, but also a growing acceptance of homelessness and incarceration as legitimate fates for people whose psychotic behavior violates social norms.

Clinical Implications

Medicalization was conceived as a critique of medical power's overreach into everyday life. The concepts of medicalization and demedicalization can be useful in questioning our understanding of and care for diseases that blur arbitrary boundaries between the social and the medical. Social scientists generally consider demedicalization of a set of behaviors to be an advance and attribute the original medicalization to cultural ignorance. But demedicalization is not always liberatory and can result in reduced options for people whose suffering from illness is augmented in the

process.[5] We would highlight two key clinical implications:

1. *When a set of symptoms is demedicalized and physicians come to see the remedy as outside their realm of responsibility, the consequences for patients can be dire.* Patients like Mr. N. are often discharged to the streets not because physicians lack empathy, but because social conditions are considered to be beyond the scope of medical practice. Furthermore, demedicalization is itself a product of political and economic forces. In ways that warrant examination, medicine's diagnostic categories and physicians' sense of their responsibilities have been structured by policies that don't always serve patients' best interests.

2. *Physicians are critical to the reversal of inappropriate demedicalization.* The criminalization of mental illness that followed deinstitutionalization has resulted in a gradual transfer of many seriously mentally ill people from asylums to prisons. Physicians are uniquely equipped to point out the consequences of demedicalization and to devise solutions. Yet re-medicalization, or focusing in on biochemical causes and treatments, is not the only possible response. Physicians who recognize how demedicalization has narrowed medical responsibilities to the detriment of patient outcomes are better able to design and implement interventions to improve those outcomes. Such interventions may include changes in the purview of medical care, such as expansion of the use of California's "gravely disabled" criteria for involuntary commitment in order to temporarily shelter patients with serious mental illness who cannot care for themselves. Without structural changes, however, these interventions will inevitably have limited effectiveness. So physicians have also mobilized for "housing as health care." This movement, drawing on the well-supported link between certain models of permanent housing status and health outcomes, has won regulatory changes to allow for the use of Medicaid funds for supportive housing for homeless people with serious mental illness in some states.

Case Follow-up

Mr. N. never returned to the ED and is unlikely to do so for many years: in March, he was arrested and charged with a felony and now resides in Twin Towers Jail in Los Angeles, awaiting trial and with no hope of raising $100,000 for bail.

An audio interview with Dr. Braslow is available at NEJM.org

Meanwhile, a group of UCLA psychiatry residents has begun advocating against the classification of the social sequelae of psychiatric illness as outside their clinical purview (https://sites.google.com/view/uclacgp/home). They have organized clinical electives in the Los Angeles County Jail and are working to establish an intensive public mental health clinic for homeless people with serious mental illness, aiming ultimately to provide long-term housing and care.

The editors of the Case Studies in Social Medicine are Scott D. Stonington, M.D., Ph.D., Seth M. Holmes, Ph.D., M.D., Helena Hansen, M.D., Ph.D., Jeremy A. Greene, M.D., Ph.D., Keith A. Wailoo, Ph.D., Debra Malina, Ph.D., Stephen Morrissey, Ph.D., Paul E. Farmer, M.D., Ph.D., and Michael G. Marmot, M.B., B.S., Ph.D.

The patient's initial and some identifying characteristics have been changed to protect his privacy.

Disclosure forms provided by the authors are available at NEJM.org.

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DOI: 10.1056/NEJMp1811623