The Routledge Companion to Philosophy of Medicine

Miriam Solomon, Jeremy R. Simon, Harold Kincaid

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Publication details
Annemarie Jutel
Published online on: 25 Oct 2016

How to cite: Annemarie Jutel. 25 Oct 2016, Diagnostic Categories from: The Routledge Companion to Philosophy of Medicine Routledge
Accessed on: 09 Aug 2023

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DIAGNOSTIC CATEGORIES
Annemarie Jutel

Diagnosis is at the heart of Western medicine and plays an important role in structuring care for the individual patient as well as in creating priorities and measuring outcomes for public health. It is usually in the pursuit of diagnosis that the layperson enters the medical system. Dysfunction or distress, determined by the sufferer to be medical in nature, is brought to the doctor for explication, and that explication is most frequently couched in diagnosis. The diagnosis, both a process and a category (Blaxter, 1978), organizes the symptoms, provides a sense of direction to the patient, points (hopefully) to a treatment, describes the future (prognosis), allocates resources (e.g., sick leave, prescriptions, insurance reimbursement), and even designates a social role to the newly diagnosed patient (Balint, 1964, Leder, 1990, Jutel, 2011).

Diagnosis is a powerful tool as it simultaneously parcels out treatment and other social goods and functions. The diagnosis will determine what sub-specialty should be involved, what resources should be provided, and whether the outlook is bright or dim. It also is the conduit by which the patient assumes the “sick role” (Parsons, 1958), allowing the individual to withdraw from regular social expectations, like going to work or other duties, in exchange for compliance with medical orders. A diagnosis can also transform the identity of the diagnosed person. In the language of diagnosis, one “becomes” diabetic, hypertensive, psychotic. This is the linguistic troping by health professionals that Fleishman has described, where, via synecdoche, the patient becomes the ailment (Fleischman, 1999).

It is hard to imagine medicine without diagnostic categories. To develop evidence to determine the best practice, the most effective treatment, the likely outcomes, categories are essential. Without categories, generalization is not possible; without generalization, science cannot fulfill its roles. Statistical analysis is only possible with categories to represent outcomes and interventions.

Outside of medicine as well, we have difficulty speaking of dysfunction without diagnostic categories. As medicine’s authority expands, we increasingly use diagnostic language, swapping sadness for depression, distractibility for ADD, and shyness for social anxiety disorder or social phobia. Using the language of medicine adds credibility to suffering, absolves the sick person of many responsibilities, and gives a sense of hope as well: diseases have treatments. Self-diagnosis is also on the rise, with diagnostic apps and online checklists to help shape the experience of dysfunction in medical terms.

Despite the “realness” of disease and dysfunction, the process of categorizing and classifying disease states is one that relies heavily on the social and the political. In the pages that follow, I will describe how diagnostic categories function socially. Considering the social features of diagnostic categories as well as the pathophysiological nature of disease can adumbrate a number of clinical and public health challenges. It punctuates how diagnosis can be a point of tension between patient and physician rather than a point of agreement; how technology can
disappoint or trouble a diagnostic picture; and how culture and identity are both tools in, and obstacles to, medicine's success.

Is Nature Really Jointed?

Categories are about cutting nature up into useful packages, what Eviatar Zerubavel (1991) calls "islands of meaning." The question of whether nature comes pre-parceled, with natural categories ("jointed," as Plato suggested), or whether nature is categorizable in unlimited ways, is well known to philosophers. Thomas Arnold espoused the latter. He wrote:

We are not to suppose that there are only a certain number of divisions in any subject, and that unless we follow these, we shall divide it wrongly and unsuccessfully: on the contrary, every subject is, as it were all joints, it will divide wherever we choose to strike it, and therefore according to our particular object at different times we shall see fit to divide it very differently.

(Arnold, 1839)

When we name things as belonging to one group as opposed to another, we are imposing a structure on our environment that reflects our values, knowledge, and beliefs. Categories and classification thus are at the heart of how we understand the world.

In medicine, how we break up nature into manageable and explainable parts not only reflects the society or group that makes the divisions but also shapes how we will respond to our conditions. How we categorize says as much about who we are as it does about pathophysiology. Diagnoses are the categories we use to create order, sort through particular symptoms and presentations, place them together or apart, and do the work of medicine. The categories used in medicine reify, serve as heuristic and didactic structures, determine the treatment protocol, predict the outcome, and provide a sense of identity for laypeople and professionals. In the pages that follow, we will review the tradition of medical classification and diagnostic categories, explore how and why we classify disease as we do today, and develop an understanding of the consequences of diagnostic categorization.

Principles of Classification

Classification is based on notions of difference and similarity. It seeks to find items that have more in common with one another than phenomena belonging to another category (Zerubavel, 1996). To classify is to overlook some similarities in favor of others, and similarly to overlook some differences in favor of resemblances. The challenge of classification is to make useful the placing of particular items with one another rather than with something else, without as a result obfuscating important differences that would be better revealed. Occham’s Razor, dating from the 14th century, underlines this clearly. He postulated that “entities are not to be multiplied beyond necessity” (Leff, 1997).

We can see how Occham’s principle works by thinking about Skip the dog. One could see Skip quite pragmatically as a dog, or possibly as a “mixed-breed, collie-type, mature, male dog.” The former is probably all that matters for most cases. But, if we were to classify him as a four-legged, red-furred, long-haired, barking, 8-year-old, male creature named Skip, the reference could probably only be about one dog, as opposed to a class of dogs, which is not useful for categorizing dogs in general, even though it helps to identify Skip the dog from other dogs. By the same token, while classifying dogs, stopping at the level of “creatures” is hardly helpful, as it is so general a term as to include both spiders and Skip.
When discussing disease, the same rules apply. We can see each case of illness as unique, with associated comorbidities, personal circumstances, individual disease expression, and so forth. However, making generalizations about illness is useful. How would we undertake research, examine disease patterns, predict outcomes, without classifying? Classification organizes knowledge (Jacob, 1992); identifies clusterings and similarity (Fleiss et al., 1971); creates stable and predictive classes (Silvestri and Hill, 1964); and perhaps, above all, reduces a disorderly mass to an orderly whole (Richardson, 1901).

So, while categorizing, rather than seeing each case of illness as separate and unique, is certainly helpful in advancing the aims of medicine, as in the case of Skip the dog, categorizing obfuscates difference in the cause of generalization. A person categorized by diagnosis is nonetheless still an individual case, a point the clinician must bear in mind. At the same time, however, the purpose of classification is to generalize, rather than to individualize, with all the benefits that this can bring to understanding a particular situation. Classifying becomes thus a means of summarizing many cases of disease in a way that helps organize human illness in meaningful ways.

Classification Systems

The earliest surviving compilation of diagnostic categories is probably the Ebers Papyrus, which, written circa 1500 BCE, identified remedies for a range of conditions from abdominal obstruction to the “rose,” or what we would call herpes zoster today (Veith, 1982). The purpose of this papyrus was to list the remedies for each of these disorders. Treatments were linked to diagnosis in different ways than today, with the proper cure thought to be found in the inverse of the disease (Daly and Brater, 2000).

Another historical example of diagnostic categorization comes from what is often referred to today as the “Galenic tradition” (even though it was in fact initiated by Empedocles some 700 years prior in circa 500 BCE). This categorization saw disease based in the four humors: hot, cold, dry, and moist (Daly and Brater, 2000). Treatment hinged on rebalancing an excess of whichever humor accounted for the diseased state.

Diagnostic categories vary not only over time but also geographically. Traditional Chinese medicine positions the disharmony of yin and yang, qi, meridians, and more at the base of diagnosis, while Tibetan medicine links diagnosis to the three poisons, which give rise to three humors, linked in turn to earth, water, fire, air, and space (Janes, 1995).

The earliest classification of diseases to provide a model for the kinds of records we keep today for public health in Western medicine was likely John Graunt’s *Natural and Political Observations*, published in 1662 (Graunt, 1662a), which described the state of the kingdom, its strengths and its vulnerabilities, via the diseases that caused death. In his “Reflections on the Weekly Bills of Mortality” (Graunt, 1662b), Graunt mused about categories of disease, how they were arrived upon, and whether or not they were variable depending upon who used them.

Graunt discussed distinctions among different groups and which categories could be made more explicit. What number of years, he asked, should be called “aged”? Is it, as he suggested it should be, greater than 70? And what is an infant? Is it a child who cannot yet speak, or rather, one who is under two or three years of age? He identified the problems relating to the individuals who undertake classification, their status, and integrity. Can those who record the causes of deaths distinguish fairly between emaciation due to consumption, lung disease, hectic fever, or infection, he wondered, particularly after a glass of ale, or “the bribe of a two-groat fee” (Graunt, 1662b, p. 22)? Disease categories contained in Graunt’s analysis included such today-picturesque conditions as “French pox,” “purple fever,” “rising of the lights,” “stopping of the stomach,” or “made away themselves.”
Belief in an orderly arrangement of nature underpinned other disease classification theories, such as that devised by Thomas Sydenham, a 17th-century English physician (and John Graunts’ contemporary). A convinced empiricist, Sydenham wrote that “[a]ll diseases then ought to be reduc’d to certain and determinate kinds, with the same exactness as we see it done by botanic writers in their treatises of plants” and this with the view to “the improvement of physick” (Sydenham, 1742, p. iv–iv). This classification enables the doctor to “distinguish [a disease] from all other distempers” (p. xvi). He believed that the improvement of medicine depended on creating a collection of disease descriptions and their concordant “methods of cure” (p. ii). Such a collection was based on Sydenham’s unwavering belief in a natural world whose existence was available for discovery by the careful observer.

Later classification projects were organized to capture and understand rules of nature, and, as with all things, the presence of divine order. As one 19th-century mother wrote to her children about the study of classification:

> We have reviewed all the classes of beings from insects to man, and we have recognised the hand of God everywhere. We have seen everywhere order and harmony which force our admiration. It would be impossible for us in the face of all these marvels of nature, not to praise he who created all.

(Anon, 1840, p. 72)

Today

There are dozens of different disease classification systems in use today: general diagnostic systems such as Systematized Nomenclature of Medicine (SNOMED), International Classification of Diseases (ICD), Diagnostic and Statistical Manual of Mental Disorders (DSM), Read Codes, and so on; specific diagnostic systems such as international classification of headaches, sleep disorders, and cerebral palsy; and administrative diagnostic systems such as Diagnosis Related Groups and Major Diagnostic Groups. Different countries have nation-specific modifications (e.g., the ICD-10-AM/ACHI/ACS, which is the Australian modification of the ICD-10, and the AR-DRG, which is an “Australian Refined Diagnosis Related Groups” classification). Although these diagnostic systems have much in common, they also have many differences that are best understood in terms of social and political factors.

For example, there are differences between how ICD and DSM see particular (mental) disorders and between how different countries apply diagnostic criteria. Diagnoses can be clinical or administrative, and, particularly in countries where medicine is not socialized (and even in those where it is), an administrative disease category may be different than a clinical one. In many American practices, a clinical coder will come after a medical diagnosis is made to determine the most effective diagnostic code for obtaining advantageous reimbursement. Whether a person’s mental distress is classified as major depressive disorder, recurrent; major depressive disorder, single episode; or acute anxiety disorder will determine the number of therapy sessions offered, impact on future insurability, and guide the pharmacotherapeutic approach.

Even in countries where the insurance industry plays a smaller role, there are still competing diagnostic categories for many disorders. One example is ankylosing spondylitis, an inflammatory form of arthritis, which causes the vertebra to fuse. In the small country of New Zealand, for example, where limited public resources curtail access to treatment to particular therapeutics, doctors are required to satisfy a checklist of diagnostic criteria administered by the pharmaceutical management agency before they can prescribe some of the more expensive treatments (New Zealand Pharmaceutical Agency, 2010). This checklist includes sacroiliitis.
and elevated nonspecific clinical markers, which are not necessarily viewed by clinicians as the best means for categorizing the disease and its severity. It is the administrative disease definition that matters, however, because it is a precondition for treatment. Turner has referred to this as “the standardization of illness into phenomena which can be managed by bureaucratic agencies” (quoted in Filc, 2006).

Making Categories

The physical nature of a disorder or dysfunction must be considered when discussing diagnostic categories. However, interlaced with the pathophysiological nature of the problem, and often more easily dismissed, are the important social forces that shape how scientists, physicians, and laypeople talk about diagnosis. So, even while science and medical research play often very important roles in developing disease categories, we cannot overlook how the process of developing disease categories is based in politics, consensus, and pressure, and as we might surmise from the previous paragraph, money. As I wrote in the introduction, no matter how “real” a particular physical dysfunction may be, the process of recognizing it as a disease, deciding that it can be generalized about—so that future incidences of the disorder will be so recognized—creating particular categories into which the condition can be slotted, is done by people in a social setting, involving resources, debates, and consensus, as we will discuss in the paragraphs that follow.

Decisions about what groups of symptoms should receive disease status are often tasked to “expert consensus panels” (Aronowitz, 2001). However, the ultimate decisions of such groups typically conceal some of the factors that have driven the outcomes, and the interests of those who define diseases helps determine how scientific evidence will be used in the development of diagnostic classifications. For example, a consensus panel on Lyme disease ultimately rejected a symptom-based in favor of a laboratory-based diagnostic standard, restricting the diagnosis to the type of patient these doctors would prefer to treat (p. 807).

As this volume goes to press, an interesting debate is taking place about a disease category in-the-making. The fraught problem of chronic fatigue syndrome (CFS), a debilitating, medically unexplained state of extreme exhaustion, is under review. This syndrome is among those for which there is no generally accepted explanation, and Dumit referred to it as an “illness you have to fight to get.” By this he means that a patient’s receiving a diagnostic label of CFS does not confer legitimacy on the individual’s suffering, but instead, causes her suffering to be looked at askance, as if it were less “real” than other diagnosed conditions. It is a condition that lacks biological “facts” (explanations, such as laboratory tests and what might be considered “irrefutable” evidence) and as such, denies its sufferers legitimacy (Dumit, 2006). People with this condition experience extraordinary physical fatigue but often find their condition shrugged off by doctors and explained as psychosomatic in nature, as are so many disorders for which medicine does not have an explanation (Jutel, 2010b). There is thus a hierarchy of diagnoses, and those that rely upon patient description of suffering do not grant the same legitimacy as those that can be measured.

Two recent publications about CFS demonstrate how there are a range of potential avenues for any condition to be categorized and explained. On the one hand, researchers at Harvard have announced they have discovered alterations in the early immune profile of people suffering from CFS, which can be detected by laboratory assay (Hornig et al., 2015). On the other hand, the Institute of Medicine, in response to the frustration about finding root causes or biomarkers for CFS, has proposed symptom-based diagnostic criteria, which include duration of impairment (more than six months), post-exertional malaise, unrefreshing sleep, and either cognitive impairment or intolerance of standing (Institute of Medicine, 2015). Both groups
believe in the importance of cementing the disease category in a meaningful way in order to enable research, statistical analysis, and ultimately more effective treatment. Yet, we have here two different ways of creating the diagnostic category: immunological and functional. Which model will win out will be a matter for debate, consensus, politics, and future scientific inquiry. Once established, however, the diagnostic definition will reify the condition for years to come in one way as opposed to the other.

One powerful player in the construction of diagnostic categories is the pharmaceutical industry. The introduction into medical discourse of the diagnosis of female sexual interest/arousal disorder is an excellent example of industry influence in creating diagnoses. In the late 1990s, anticipating the immense commercial success of sildenafil (Viagra) and other drugs developed to treat erectile dysfunction, pharmaceutical companies were eager to bring to market a similar drug to treat sexual dysfunction in women, a “pink Viagra.” However, there was no established specific diagnosis for women looking for treatment, parallel to erectile dysfunction in men. Therefore, in order to have a disease for “pink Viagra” to treat, the pharmaceutical industry organized and financed an International Consensus Development Conference on Female Sexual Dysfunction in 1998. Delegates participated by invitation and consisted of a group equally balanced between pharmaceutical representatives and researchers either experienced with or interested in working collaboratively with the industry (Moynihan, 2003).

The consensus they produced lamented the lack of studies investigating female sexual dysfunction and the absence of diagnostic frameworks (Basson et al., 2000). The committee found that urgent investigation was required to develop new classifications and definitions of sexual dysfunction. Their work was supported by “educational grants” from Eli Lily, Pentech, Pfizer, Procter and Gamble, Schering-Lough, Solway Pharmaceuticals, TAP Pharmaceuticals, and Zonagen. Its 19 authors acknowledged financial or other relationships with 24 listed pharmaceutical companies.

Building on this report and its recommendations, a number of screening tools were developed to affirm, define, and reinforce the report’s assertions. Not surprisingly, much of the work was both funded and copyrighted by one pharmaceutical company that was at the time working on its own version of “the pink Viagra” (Jutel, 2010a). The need for the category and the means by which it is pinned down and made concrete are, in this case, owned by commercial interests. But, as Ian Hacking (2001) reminds us:

> the idea of nature has served as a way to disguise ideology, to appear to be perfectly neutral. No study of classification can escape the obligation to examine the roots of this idea . . . no study of the word “natural” can fail to touch on that other great ideological word, “real.”

(p. 7)

Hacking is pointing out that once a category is cemented, as it is in the case of female sexual dysfunction, the details of its development become opaque, as the category naturalizes the particular disorder as The Way Things Are.

Initially, the U.S. Food and Drug Administration (FDA) did not grant approval for a number of “pink Viagra” substances, but the pharmaceutical industry (Sprout Pharmaceuticals, as one powerful example) worked to create alliances around promoting the disease in order to create a perceived imperative for drug development (see: http://eventhescore.org/). The FDA held a second round of hearings on flibanserin, one of the “Pink viagras” in 2015, with arguments on all fronts, including those who promote the DSM-5 diagnosis and others (notably New View Campaign http://www.newviewcampaign.org) who challenge the premise that
sexuality should be medicalized at all. The result of the hearing was that the FDA approved Addyi (flibanserin) to treat acquired, generalized hypoactive sexual desire disorder (HSDD) in premenopausal women (United States Food and Drug Administration, 2015). Thus, the pharmaceutical industry shepherded a disease, female sexual dysfunction, from recognition as a diagnostic entity to treatable condition.

Although sexual dysfunction may seem to be a facile example of social, cultural, and commercial interference in disease categorization, disease categories are all subject to the same influences. In the next section, we turn to another diagnostic category to explore how its “joints” have been defined and how they emerge from a particular set of social circumstances. In this case, however, the diagnosis is physical, observable, and measurable.

Overweight

There is a common tendency to think that social forces and politics only come into play in particular categories of disease, notably those diagnosed by observation of behavior or subjective input. These might include psychiatric illness or other diseases for which laboratory tests or medical imaging technology cannot confirm their “realness.” However, even tangible and seemingly concrete conditions that can be measured and observed are subject to social forces and politics. I use the case of overweight and obesity as an example to demonstrate the social contingency of disease categories.

Let us start by thinking about how bodies are categorized. In the case of overweight and obesity, the categorization is based on body mass or size. Organizing people by categories of body weight will necessarily obfuscate some difference, one of the challenges presented by classification. Although people within the category of overweight may be very similar on some grounds (measured body mass index, or weight in kilograms divided by height in meters squared), they may vary greatly on others. They may be tall or short, muscular or flabby, blond or brunette. They may have different dietary intake, exercise patterns, general physical and mental health, blood pressure, blood glucose, and so on. Similarly, a number of other people of lower body mass index (BMI) may be more similar to some members of a group of fat people than is recognized when body weight is the criterion for classification. For example, a slender person may not exercise and may have poor dietary patterns. She will not be classified with heavy non-exercisers on the basis of a mass-based classification system.

Until well into the 20th century, weight was not used to establish the boundaries of a disease category. This is not to say that fatness was not seen as disease, but rather it was seen in qualitative terms. Herrick’s dictionary defined it as “increased bulk of the body, beyond what is sightly and healthy” (Herrick, 1889) and Thomas described “excessive development of the adipose tissue” (Thomas, 1891). Scales were not widely available and were too expensive for regular use. The “Reliance Weighing Machine” started marketing scales as a “useful adjunct to the consulting room” in the late part of the 19th century (“Reliance Weighing Machine,” p. 940). The importance of weighing undoubtedly grew with their availability.

With this increased availability of scales, the use of weight tables became feasible. In the early 20th century, the insurer Metropolitan Life developed actuarial tables based on weight. These tables were used to evaluate insurance risk. However, weight did not catch on quickly as a tool for diagnosing. In Europe, as in the United Kingdom and United States, doctors argued that weight could not be used to determine who was sick and who was well. Dr. Jean Leray, in France, reduced the various weight tables to “theoretical interest” only and rejected any benefit to their use. He chose rather to accept Leven’s definition of safe body weight as “[a person’s] average weight, maintained over a number of years, as long as the subject has been well” (in Leray, 1931, p. 7 [translation mine]). Meanwhile, William Christie (1927) warned
English-language readers in 1927 that “no weight table is sufficient by itself to base an estimate of the ideal state.” He continued to state that “standard tables which show the average for men and women of our race at any given age and height are fallacious, because no allowance is made for the distinctions of personal physique, nor consideration given to obvious rolls of fat” (p. 23).

However, as we can observe today, weight progressively became a diagnostic criterion. Measurement in general was supplementing, if not replacing, clinical judgment in the assessment of patient health. “Instruments of precision” (like scales):

\[\ldots \] promised to provide ways of describing disease that could be built into tight, seemingly objective pictures, useful in diagnosing and monitoring particular cases yet capable of being generalized into larger understandings.

(Rosenberg, 2002, p. 244)

Progressively, weight tables and calculations became mainstream, and today, weighing oneself and using weight as part of health assessment is commonplace. However, the way in which weight has been used to categorize healthy and non-healthy is not fixed and has been influenced by context and era. Between 1942 and 2000, there were over 17 different methods used for categorizing weight (Kuczmarski and Flegal, 2000). Not only were there different ways of measuring overweight (weight-for-height tables, weight-for-height indexes), but the desirable and undesirable ranges changed repeatedly over the course of the 20th century. When the BMI overweight cut-offs were shifted in 1995, from 27.8 for men and 27.3 for women to 25 for both, 35.4 million adults became overweight overnight (Kuczmarski and Flegal, 2000).

One important factor in the adoption of weight as a measure of illness was the ease of self-diagnosis. Categorizing overweight as a disease was simple in this context and could be undertaken by the individual; all it took was stepping on a scale. Weight seemed an easy proxy for health and disease. However, overweight presents a number of challenges as a disease category as it obfuscates so much salient difference.

Scales do not recognize ethnic difference or muscularity. Although weight often co-varies with health, and on this basis is used as a proxy, it doesn’t always co-vary, and slender people who have health risks get missed, in the same way as fat people without health risks are often presumed to be unwell. Considering overweight as disease creates a situation in which scientists/doctors stop interrogating the data. Rather than ask whether overweight is a disease, they simply ask how to get rid of it. Some data have shown that being overweight carries less risk than being normal weight (Flegal et al., 2005, Flegal et al., 2007, Orpana et al., 2009), and that it is not possible for people to change their weight categories durably anyway. Also, slender people may fail to get health advice on the basis of the assumptions about weight. Although many normal-weight individuals could benefit from weight and exercise advice, Ma et al. (2004) showed that patients were more than five times more likely to get advice about diet and exercise if they were obese than if they were of normal weight.

Numerous industries stand to gain when overweight is categorized as a disease. The pharmaceutical industry is indeed involved, but the gym, fashion, self-help, and diet industries are also actively engaged in the promotion of overweight as a disease. The self-diagnosability of weight that results from the availability of scale, and the public promotion of BMI tables push people towards potentially lucrative weight reduction diets, books, exercise programs, food supplements, and other dietary products.

BMI calculators are available on many public health websites, along with generic information about body weight. The National Heart, Lung and Blood Institute, for example, provides a calculator online and encourages people to calculate their BMI and monitor themselves for
symptoms of overweight. They describe clothes feeling tight and needing a larger size, or the scales showing weight gain, as symptoms of this disease (National Heart, 2014). The important point is that overweight has diagnostic tools and is monitored as a matter of national and international public concern (World Health Organization, 2014). Citizens engage in self-monitoring as part of good citizenship and adherence to social expectations.

Although diagnosis can legitimize abnormal behaviors, it can also stigmatize. As has been widely written elsewhere, regarding overweight as a disease results in stigma—making the fat body problematic and the fat person morally deficient. One of the important assumptions supporting fat stigma is the idea that weight is a factor we can independently control and that fatness reflects a failure to engage in healthy activity. This is what Carole Spitzak referred to as an “aesthetic of health,” the idea that the physical appearance of the individual speaks to their inner nature. The conception of fatness as a moral deficiency results in the pursuit of slenderness rather than the pursuit of health. Along with this pursuit is the neglect of the health needs of the thin, seeing their body size as virtuously healthy, even though weight loss and disease often go hand in hand.

Fat stigma also leads to discrimination against, and exploitation of, fat people. The discrimination can be enacted on the individual level but also at a population level. For example, in understudied populations, such as Pacific Island peoples, for whom population-specific statistics have not been developed, almost 70% have BMIs of 30 or greater (World Health Organization, 2009). These groups are identified as fat populations and subject to collective stigma associated with being fat. At the same time, an anti-fat industry based in pharmaceutical, diet, exercise, and self-help flourishes, surviving on widely accepted beliefs about, and fear of, being fat, as mentioned above.

If it were necessary to provide further illustration about how weight is socially negotiated as a disease category, the Obesity Society—an American-based association of clinicians focused on obesity advocacy and research—has prepared a white paper entitled “Obesity as Disease,” which does so powerfully (Allison et al., 2008). This society, whose stated mission is to “lead the charge in advancing the science-based understanding of the causes, consequences, prevention and treatment of obesity” commissioned a panel of experts to determine whether obesity should be considered a disease or not. The experts came from within its membership and must be considered a priori committed to the society’s goals. The point here is not to debate whether they were right or wrong in their assessment that the disease label “might have broad effects for a large portion of society for the greater good” (p. 1169). Rather it is to underline the social (and often conflicted) ways in which disease categories come to be recognized as such.

Overweight and obesity are useful examples of how disease categories are socially contingent. They demonstrate how even physical categories are framed by economics, politics, and social norms, with very real consequences for those thus categorized. However, while we note this, we can nonetheless see the important role played by disease categories in understanding health and illness scientifically.

### Using Categories

As I wrote above, diagnostic categories are the tools of medicine. They enable classification, which in turn serves as the mechanism by which medicine is enacted as a social process. Diagnosis cements the respective roles of patient and clinician, determines which specialist takes care of which problems and where a patient should turn, provides a language for discussing and reproducing health and disease, allocates resources, shapes research, and much more (Jutel, 2011).
Diagnosis has long served to cement the authority that is vested in the doctor. Hippocrates wrote that

\[
\text{if [the doctor] is able to tell his patients when he visits them not only about their past and present symptoms, but also to tell them what is going to happen, as well as to fill in the details they have omitted, he will increase his reputation as a medical practitioner and people will have no qualms in putting themselves under his care.}
\]

(Lloyd, 1983, p. 170)

The diagnosis is the starting point for determining a prognosis, variable though it may be, and conveys, as this quotation asserts, authority to the clinician who discloses it. Diagnosis does provide a sense of direction (prognosis) and an associated treatment, but it also explains and organizes as well as giving access to services, identity, and the sick role. The layperson cannot write her own sick note or prescription, nor can she access disability services or certain therapies without the diagnostic category afforded by the doctor. As Freidson (1972) pointed out, the doctor's ability to label sickness and health, normal and abnormal, is key to medical authority and prestige. Importantly, the labeling also enables a particular social behavior in the diagnosed individual.

The “sick role,” as described by Talcott Parsons (1958), is the temporary retirement from social responsibilities afforded to the individual who is diagnosed. Diagnosis allows one to stay in bed, for example, rather than go to work or look after the children. It also often excuses antisocial behavior, as in the case of a legal defense of insanity, or at a lower level, as in the case of attention deficit disorder. The sick role includes not only a shift in social roles, but it also includes an expectation that the diagnosed person will make every effort to submit to medical recommendations to become well.

Not only does diagnosis confirm power relations, it also serves an important didactic and heuristic role. A diagnosis is a kind of short-hand for encapsulating as much information as possible into a word or phrase. To return to the example of the “mixed-breed, collie-type, mature, male dog” above, we can see that within this not-so-short category, we may also be able to make assumptions about fur color and length, activity level, and proclivities. Diagnoses can describe a situation with similar concision. To identify a person with, for example, influenza, is to say that they have a systemic illness probably accompanied by fever and upper respiratory symptoms. Their affliction is contagious, and is generally self-limiting, although presents risks in some cases and in some circumstances. One word, in the case of influenza, captures thirty. But, at the same time, that one word, as with Skip the dog, does not capture the particular case presentation.

The power of diagnosis goes well beyond its use in the doctor's office or the hospital wards. A diagnosis can make a powerful statement about society and its unmaking. For example, to speak of the resurgence of polio in Syria, or of PTSD in post-tsunami Indonesia is to make a statement about social disarray with an intensity that other words cannot convey. Disease categories describes a situation with force and authority.

Diagnosis is also a powerful discourse for politicians, public and corporate figures. To express support of ethnic, national, or gendered groups via diagnostic categories is another powerful statement. By wearing a pink ribbon (symbol of the international breast cancer support charity), a politician positions himself or herself as a supporter of women. In New Zealand, placing prostate cancer screening as a plank in the National Party’s campaign platform attempted to demonstrate sensitivity towards male voters. The pharmaceutical industry does not need to peddle its potions as long as it promotes awareness of disease categories for which its therapies
are effective. Here, the power of the diagnostic category is in its ability to circumvent drug advertising in countries where direct-to-consumer advertising is not legal.

Conclusion

Diagnostic categories are more influential in daily life than is often acknowledged. On the one hand, they structure the way we practice and consume medicine in Western society. Diagnosis is one of medicine’s most important tools: the means by which we talk about, understand, explain, treat, and predict outcomes of disease. It would be hard to imagine a medicine that operated outside of diagnostic frameworks.

On the other hand, diagnoses do far more work than just organize medicine. As described above, from the identification of diagnostic categories to their application in the clinic, and the consequences they entail, diagnoses reflect and reproduce the societies in which they are generated. Recognizing the fluid nature of the diagnosis, challenging the putative perception of firm and naturalized diagnostic categories is important to understanding where power resides and how it operates. Diagnostic categories create social “truths” about the world, by virtue of the fact that they formalize certain parameters, or boundaries, within the continuum of nature. Because of the authority conferred by a diagnosis, the category it creates conceals previous debates, contests, and tensions. We can observe this in real time with the diagnosis-in-the-making chronic fatigue syndrome. If and when there is a shift in the diagnostic configuration of this disorder, one possible model will assimilate the others. This means that certain values (immunological, symptomatic) will be subsumed in favor of others. Each diagnostic category thus promotes certain perspectives and, in a way, puts halt to the debate.

This chapter should have helped to debunk the idea that diagnostic categories simply mark natural boundaries. Diagnostic boundaries are at the same time elusive and necessary (Jutel, 2013). The challenge for those who use diagnostic categories (most of us, as either patients or clinicians) is that while it behooves us to interrogate these categories and step back in order to obtain critical distance, it is difficult to do so from within the medical system in which we are deeply engaged. Mary Douglas makes the point clearly as she both acknowledges the importance of structural constraints and the difficulty of achieving critical distance: “How can an individual [in the grip of iron hard categories] turn round his own thought-process and contemplate its limitations?” (Douglas, 1966, p. 16). Raising our consciousness of the social operation of diagnostic categories is an important first step.

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Further Reading

