Two Concerns about the Medicalization of Love

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In their article "The Medicalization of Love," Brian D. Earp, Anders Sandberg, and Julian Savulescu question whether the possible development and use of pharmaceuticals and other emerging technological interventions could result in the medicalization of human love and heartache, and, if so, whether it would be a good or a bad thing.[1] They consider a number of possible reasons why the medicalization of love could be problematic but argue, on the whole, that it may not necessarily be as troublesome as is sometimes assumed, "because medicalization in general can be either good or bad, and which one it is, on balance, depends on a number of specific and even idiosyncratic factors."[2]

In all, there is a lot to praise in Earp et al.'s analysis, and despite being in broad agreement with their line of argument, I would like to examine two areas I believe deserve additional enquiry. Their analysis of the medicalization of love, relating to its ethical and social implications, is, in part, tenuous and requires a more comprehensive investigation. Such a complete undertaking is beyond the scope of my commentary here, but I nevertheless look at a couple of possible areas in which the use of neurotechnological interventions could have more damaging social consequences than Earp et al. seem to acknowledge in their article. One area is the role various pharmaceutical corporations play in society; the other is the effects that new biotechnological interventions could have on individuals situated in particular nondemocratic cultures.

The Medicalization of Love and the Pharmaceutical Industry

One possible worry Earp et al. consider is that the medicalization of love could create an opportunity for pharmaceutical companies to sell more drugs than is necessary. It is not inconceivable to imagine a scenario in which a large drugs company, with sizeable resources and influence, sets out to expand its power further by interfering in our lives. The fear is, it could be argued, that products could be heavily marketed by them to show that the new interventions are "necessary" for those who are concerned about their sexuality—particularly in cases in which more conventional methods would be more effective, or in which individuals were formerly at ease with their sexuality.

In response, Earp et al. claim that there is now an emerging public awareness and skepticism with regard to how drug companies operate. Furthermore, they refer to Kristina Gupta, who suggests that a number of guidelines could be implemented to ensure that pharmaceuticals are more socially responsible, as well as citing ways to offer better education on sexual diversity in medical health curriculums.[3] Earp et al. acknowledge that these kinds of measures would not completely rule out opportunities for misuse but, all the same, argue that they could go a long way to hinder it. Unfortunately, though, they do not discuss the point much further and, on the whole, merely gloss over the issue. I believe more can be said on this issue.

Cambridge Quarterly of Healthcare Ethics (2015), **24**, 490–492.
© Cambridge University Press 2015.
doi:10.1017/S0963180115000158

https://doi.org/10.1017/S0963180115000158 Published online by Cambridge University Press

Indeed, we should bear in mind that companies within the pharmaceutical industry in the United States have gained substantial political power since the 1980s. Marcia Angell said, in a criticism of pharmaceutical policy, for instance, that those in the industry "have the largest lobby in Washington, and they give copiously to political campaigns. Legislators are now so beholden to the pharmaceutical industry that it will be exceedingly difficult to break its lock on them."[4] Large companies, worryingly, have also grasped ways to make very large profits with drugs that do not greatly improve public health and are at times not safe or are prescribed without real necessity.[5]

Here, Earp et al. have largely ignored some key ethical issues associated with present-day technologies and the scale of bargaining power that drug companies seem to have over their internal and external stakeholders, though it seems there are some good reasons to believe the emergence of biotechnologies to promote individual and couple well-being could also be outweighed, in at least some respects, by large corporate interests. That is to say, advanced biotechnologies for love and relationship needs may not emerge in a more ideal realm, at least not in the beginning anyway.[6] Earp et al., for the most part, have not offered any substantial reason why we should assume otherwise.

The Medicalization of Love and Non-Western Cultures

Earp et al.'s ethical framework might work well within the bounds of liberal democracy, in which individual rights and autonomy are generally respected. And even if we assume that the damaging influence of large corporations can be largely averted, we still have to think about the prospect of abuse cropping up in more paternalistic cultures, where medical practices are different from contemporary Western ones, and where strong prejudices against certain sexual minorities would exist. Earp et al. have not really given any thought to ways in which emerging technological interventions could be used for nonprogressive purposes in societies that are less tolerant of sexual diversity.

Same-sex sexual activity, for instance, is still illegal in almost 80 countries around the world, and according to the International Lesbian and Gay Association (ILGA), about 2.7 billion people reside in countries where being gay is punishable by imprisonment, lashes, or death.[7] We therefore could envisage a grim scenario of enforced high-tech "conversion" therapy (an intervention Earp et al. discuss elsewhere[8]) being used to alter the sexual desires and behavior of LGBT individuals in some of these cultures. Any form of sexual identity that does not conform to the social norms, or is deemed to be a mental illness, could then be viewed as something that could be "cured" with advanced technological interventions by authorities. This undoubtedly would further oppress marginalized individuals. On the other hand, it might also be possible to imagine some individuals using neurotechnological interventions as a form of recourse. Someone might, for example, find it difficult to freely abstain from same-sex sexual activity, but if he or she risked imprisonment, or even death, he or she could use them as a form of refuge in an unsafe environment. Living in a country with draconian antihomosexual laws would be fearsome, and some might welcome this option as a way to avoid harsh punishment or even death. It is unlikely that this possibility would appeal to everyone—especially those who would be reluctant to alter something they deem to be an important part of their

https://doi.org/10.1017/S0963180115000158 Published online by Cambridge University Press

identity, even when it reduces the chance of punishment—and it would not do much, if indeed anything, to transform homophobic attitudes in that environment.

If we are to carefully consider the wider social consequences of "love-enhancing" and "love-diminishing" technologies, I see no reason why we should limit the analysis to mostly liberal democratic countries, as Earp et al. do here. I believe it is important to also evaluate the effect neurotechnological interventions relating to love and sexuality could have on individuals living somewhere that presently has discriminatory policies against specific sexual minorities. Seeing that we live in a globalized, networked world, it is important to realize that our actions in one place can result in significant events occurring somewhere else on the planet.[9]

In summary, despite observing some shortcomings in Earp et al.'s analysis, I am not suggesting that neurotechnological interventions should be prohibited. In fact, there are good reasons to believe the medicalization of love could be rewarding for both the individual and society. As Allen Buchanan points out, to raise a concern about something does not necessarily constitute an argument against it. We can have concerns about the democratic political process, he claims, but it does not necessarily follow that this in itself would be an argument against democracy.[10] Along these lines, the considerations in favor of neurotechnological interventions may outweigh the concerns. At the same time, I think the concerns I have raised here should make neuroscientists and ethicists reflect more on, and discuss, the wider ramifications of new advanced technological interventions being used for nonprogressive purposes.

Notes

1. Earp BD, Sandberg A, Savulescu J. The medicalization of love. *Cambridge Quarterly of Healthcare Ethics* 2015;24:323–36.
2. See note 1, Earp et al. 2015, at 331.
3. Gupta K. Protecting sexual diversity: Rethinking the use of neurotechnological interventions to alter sexuality. *AJOB: Neuroscience* 2012;3(3):4.
4. Angell M. The truth about the drug companies. *New York Review of Books* 2004 July 15; available at http://www.nybooks.com/articles/archives/2004/jul/15/the-truth-about-the-drug-companies/ (last accessed 14 Aug 2014).
5. Jorgensen PD. Pharmaceuticals, political money, and public policy: A theoretical and empirical agenda. *Journal of Law, Medicine and Ethics* 2013;14(3):562.
6. In considering initial prospects for change, Jorgensen, for example, has proposed "an agenda that would provide (a) a theoretical framework . . . with which to view pharmaceutical political power and (b) two empirical projects to document links between political money and pharmaceutical policy"; see note 5, Jorgensen 2013, at 565.
7. Cage F, Herman T, Good N. Lesbian, gay, bisexual and transgender rights around the world. *The Guardian* 2014 May 17; available at http://www.theguardian.com/world/ng-interactive/2014/may/-sp-gay-rights-world-lesbian-bisexual-transgender (last accessed 19 Aug 2014).
8. Earp BD, Sandberg A, Savulescu J. Brave new love: The threat of high-tech "conversion" therapy and the bio-oppression of sexual minorities. *AJOB: Neuroscience* 2014;5(1):4–12.
9. Singer P. *One World: The Ethics of Globalization*. New Haven, CT: Yale University Press; 2002.
10. Buchanan A. *Better than Human: The Promise and Perils of Enhancing Ourselves*. Oxford, New York: Oxford University Press; 2011, at 144.

https://doi.org/10.1017/S0963180115000158 Published online by Cambridge University Press