

The Consumer culture or “McDonaldization” of Dentistry: Dental Practice from a Socio-cultural Perspective

Masahiko Fukagawa

1. Introduction

Health care is closely intertwined with social changes. There have been some dramatic changes in health care in Japanese and American dentistry, including the emergence of the medical advertisement and the increase in the number of medical lawsuits reflecting a change in the relationship between the patient and the doctor. Moreover, in the present consumer society, patients as consumers ask the doctors not only for conventional medical procedures for the purpose of restoring health but for a new type of procedures which create beauty. Thus, health care is viewed as a “commodity” and individuals are defined as health care “consumers” in contemporary societies.

There are several different models that have been used to describe the doctor-patient relationship. It is believed that the relationship was traditionally paternalist, but this has changed in recent years to an autonomous one. Health care service has shifted from provider-oriented to consumer-oriented in contemporary society. Thus the doctor-patient relationship has become the one between “provider” and “consumer” in consumer society. In particular, patients have changed from passive recipients of paternalistic care

into active partners with shared authority over decision-making in their treatment.

Moreover, a new type of illnesses emerged in recent years. For example, young women pursue a slim body, and this leads to anorexia nervosa, which is a typical postmodern disorder (Morris, 1998, pp.156-158). In addition, in the contemporary society people consume their own body as if it is consumer goods and tradable. Although a large number of researchers have investigated the characteristics and practices of “consumer society”, there have been relatively few analyses of consumerism specifically addressing dental health care. This paper examines the metamorphosis of the doctor-patient relationship and discusses the relationship between contemporary health care, especially dentistry, and consumer society from a socio-cultural perspective.

2. Metamorphosis of the doctor-patient relationship

There are different models that have been used to describe the doctor-patient relationship. The relationship of the doctor and the patient has changed in recent years from a paternalistic to an autonomous model.

2-1. Analysis of the metamorphosis of the doctor-patient relationship

The doctor-patient relationship was traditionally believed to be paternalist, based on that of the father to his son. In this relationship, patients are subordinates and doctors are dominants. Christine Hogg explains the traditional model of paternalism as follows:

‘professionals are deemed to know best and patients are required to trust them’ (Hogg, 1999, p.5). This form of the doctor-patient relationship is well described by Talcott Parsons, who introduced the concept of the “sick role”. Tony Bilton explains the definition of four features of the sick role as follows:

Sick people are legitimately exempted from normal social responsibilities associated with work and the family.

Sick people cannot make themselves better—they need professional help.

Sick people are obliged to want to get better—being sick is only tolerated if there is a desire to return to health.

Sick people are therefore expected to seek professional treatment.

(Bilton et al., 2002, p.359)

Parsons (1951) proposes the notion of the sick role to describe the patterns of behaviour of a sick person. Parsons’ concept of the sick role helps us to understand the doctor-patient relationship. Parsons believes an illness to be a deviance from the normal condition and can be seen as the result of physical causes beyond patient’s control. The sick person is therefore not responsible for his or her condition. The role of medicine is to regulate and control those who the doctor defines as sick so that they can return to their normal tasks and responsibilities. Parsons’ sick role model is based upon the idea

of paternalism. In Parsons' view the patient gains two rights and two obligations when they have fallen ill. One of the duties is: 'The sick person should seek technically competent help and cooperate with the physician' (Cockerham, 2001, p.161). Thus the patient is expected to follow the doctor's orders in seeking to recover from his illness. This obligation means that physicians have the overall initiative in the patient's medical treatment. This ultimately means that the doctor monopolises authority over the whole situation of medical treatment.

With a chronic disease, the patient is able to play his usual social role, which makes the rights of Parsons' sick role inapplicable. Szasz and Hollender show how the doctor-patient relationship is affected by the severity of the patient's symptoms, and propose three alternatives to Parsons' concept of the sick role. These concepts were based on the various degree of control of each participant in the doctor-patient interaction: activity-passivity, guidance-cooperation, and mutual participation models. Let us consider these models. The first Szasz and Hollender call the "model of activity-passivity", where decision-making and the power balance are on the side of the expert professional. The activity-passivity model applies when the patient is the submissive and contributes little or nothing to the interaction, for example when he is in a state of relative helplessness because of a severe injury or a comatose patient. The second they term the "model of guidance-cooperation". In this model, the patient is

expected to cooperate and acquiesce to the extent that they agree with the doctor. This kind of situation arises most often when the patient has an acute or infectious illness, for instance, the flu or measles. The patient knows what is going on and takes an active role in the relationship by cooperating with the doctor, but the physician makes the final decisions. The third model is the “model of mutual participation”, in which the patient works with the doctor as a full participant in controlling the disease. Szasz and Hollender note that this model applies to the management of chronic illness such as diabetes or heart disease (Cockerham, 2000, pp.180-181).

By the late 1960s, infectious diseases had almost been conquered in the industrial countries. This resulted in a major change in the pattern of diseases as chronic illnesses became the major threats to health. Chronic diseases, such as cancer, heart disease, and strokes have increased and become more influential in contemporary society. Acute diseases are often accompanied by a sharp pain, and the pain dramatically disappears with the doctor’s treatment, which results in the patient’s respect and gratitude to the doctor, which in turn leads to the doctor gaining power. In the case of chronic diseases, however, conditions do not change so dramatically or rapidly and efforts and cooperation on the part of the patient are an essential part of the way to recovery.

2-2. The doctor-patient relationship in contemporary society

The structural shift in medicine in which chronic rather than acute diseases have become dominant has significantly decreased the authority of physicians. Furthermore, other factors, including growing consumerism and advancements in information technology, have exerted a strong influence on the contemporary doctor-patient relationship.

2-2-1. Different models of the doctor-patient relationship

Hogg argues that three perspectives on the doctor-patient relationship have been added to the paternalist model since Parsons formulated his concept of the sick role. There are three different models: partnership, autonomy, and consumerism. Different models proposed to replace paternalism are summarized by Hogg's definition in Figure 1 (Hogg, 1999, pp.46-47). According to Hogg, 'Partnership recognizes that people should be encouraged to be as involved and take as much responsibility for their treatment and care as they want...Both parties have knowledge and must cooperate to provide effective health care' (Hogg, 1999, p.48). The partnership model sees the giving and receiving of health care as a negotiation, agreed between the parties. Patients are not necessarily autonomous or dominant.

	Paternalism	Consumerism	Partnership	Autonomy
Values	Principles of good medical care override individual treatment preferences and values. Concern for patient overrides efficiency.	The patient's health care values dominate. Efficiency and effectiveness are considerations.	Values of professional and patient are negotiated and agreed. It is recognized that some patients are disadvantaged in access to services. Efficiency and effectiveness are considerations.	The different perspectives of patient and professional are recognized. but the patient's health care values dominate. It is recognized that some patients are disadvantaged in access to services. Patients and capers may demand treatments against the evidence.
Goals	Doctor and patient have common goals to promote patient's health. Doctor retains power and has high status.	Doctor and patient have divergent goals. the patient wants good health as he or she defines it the doctor wants appropriate treatment for the patient, as he or she defines it, in addition to money and status.	Doctor and patient have common goals based on joint assessment agreed during the consultation.	Doctor and patient have common goals negotiated during the consultation, but patient's preferences prevail.
Relationships	Doctor has obligations and patient has needs. Enduring relationship between patient and doctor. The patient does not complain.	The patient has rights: the relationship is equal or patient may have greater power. The patient shops around for services, while doctors market their services. The patient will complain or seek redress if dissatisfied.	The patient has rights and responsibilities. The inequality between patient and professional is recognized as well as the need for advocacy. Patients can complain, but this may lead to a breakdown of the partnership.	The patient has rights and responsibilities. The inequality between patient and professional is recognized as well as the need for advocacy. Patients can complain and this is accepted as a right.
Decision making	Doctor has more expertise and power and makes the decisions.	The doctor gives information and the patient makes the decision.	The doctor gives information and the decision is made by the patient jointly with the doctor.	The doctor gives information and the decision is made by the patient. The doctor respects the patient's right not to follow professional advice.
Accountability	Self-regulation is a professional matter. Patient does not hold doctor responsible for bad outcomes and mistakes. Third party intervention is inappropriate.	Legal accountability for medical errors, which may lead to more defensive medicine. External regulation and policing may be required as consumer protection.	Clinical standards are audited and reviewed according to national standards. Regulation involves professional and lay people.	Clinical standards are audited and reviewed according to national standards. Procedures for independent investigation and regulation to protect patients. Redress available for victims of medical accidents.

Figure 1. The doctor-patient relationship – different models

Source: Hogg, C., (1999) *Patients, Power & Politics*.

Hogg defines autonomy as the individual's freedom to decide his or her own goals and to act according to those goals. Hogg states, 'Professionals respect each individual even if they disagree with their views or actions' (Hogg, 1999, p.48). This autonomy undermines the doctor's monopolised authority as the sole decision-maker in treatment.

Consumerism sees the individual as a consumer in the marketplace. It is useful first to define "consumer society", which is inevitably related to the doctor-patient relationship.

Juliet Schor (1998) defines consumer society as:

'a society in which discretionary consumption has become a mass phenomenon, not just the province of the rich or even the middle classes. Thus, while consumerism as a way of life and an ideology began very early in some places (the Dutch golden age, late Ming China, Georgian England), consumerism as a mass phenomenon started in the United States in the 1920s' (1998, p.217).

A consumer is generally defined as the person who pays for and uses certain goods and services. The consumer looks for the best deal and may not feel loyalty to a particular

“brand”. Consumerism does not take account of the complexity or intimacy of the professional-patient relationship and the importance of trust in that relationship (Hogg, 1999, p.48). Hogg argues that consumerism goes to the other extreme from the model of paternalism. Consumers are in charge of getting the “best buy” for their own health care and they cannot take the trustworthiness of professionals for granted (Hogg, 1999, p.5). There has also been a change in terminology to describe the individuals from “patients” to “consumers”, reflecting the emergence of the new consumer society. Consumer models, however, raise problems.

2-2-2. The right of decision-making and informed consent

Decision-making in health care used to be overwhelmingly dominated by physicians rather than by patients. However, patients gradually want to participate and have more say in deciding their own treatment. Physicians who used to enjoy absolute power over the medical decision-making are now feeling frustrated by the influence of informed consent. Physicians deemed it to be a signal of distrust and responded to the movement as if it were a threat to their professional autonomy.

The initiative in decision-making over treatments has shifted from the physician to the patient. This transfer of the right of decision-making leads to the physician losing his overall initiative on health care and weakening of the physician’s power. One of the

causes of the physician's weakened power is that the patient has increasingly been able to collect medical information through the media prior to and in the process of visiting the doctor. The patient is able to choose the suitable medical treatment and the physician for themselves on the basis of the information and knowledge thus collected. Thus the patient becomes an autonomous participant and decision-maker in medical care. This means that the doctor should respect the patient's choice even if their views disagree with respect to the treatment scheme. This should be viewed as a positive step towards empowering the patient. In this way, the patient changes from passive recipient of paternalistic care into active partner.

At the patients' request doctors are required to fully explain their prospective medical procedures. This is called informed consent. This notion was produced by the judgment at the Nuremberg trials after the Second World War and was later extended to clinical practice (Hogg, 1999, p.11). Informed consent is the most important legal doctrine in the doctor-patient relationship. George Annas explains the basic concept of informed consent as follows: 'a doctor cannot touch or treat a patient until the doctor has given the patient some basic information about what the doctor proposes to do, and the patient has agreed to the proposed treatment or procedure' (1989, p.83). Informed consent is the process to make sure that the patient gains appropriate information relevant to exercising their decision-making rights when necessary. Patient's rights and informed

consent have been advocated from the 1960s, and the patient's choice has become more respected in health care. Caroline Faulder (1985) has outlined five elements that underlie informed consent: Autonomy, Veracity, Justice, No Harm, Best Interests. Autonomy is the right that patients have to choose treatment plans which the physician disagrees with, to decide his or her own goals and to act according to those goals. Veracity is the duty to tell the truth. Veracity means the transfer of information from the doctor to the patient in an honest manner and the necessity of helping the patient understand the information about his or her treatment. Health care must be based on the honesty of doctor. Justice refers to fairness in the distribution of resources in regard to health care delivery and also means that both the doctor and the patient have a duty to treat each other justly, whether the doctor-patient relationship is seen as a contract, covenant or a partnership. No Harm is the expectation that treatment will do no harm. No Harm means the protection of patients' health from needless harm or injury such as medical mistakes. Best Interest means that the doctor has a duty to respect and act in the best interests of the patient.

The principles of informed consent recognize that it is the patient that has the right to make a decision over his or her treatments, on the basis of all the necessary information available. Decision-making power is increasingly seen as something to be shared between equal partners in the doctor-patient relationship. The widespread influence of

the principle of informed consent has helped transform the doctor-patient relationship.

Informed consent is the process, not just a form, by which fully informed patients can participate in choices about their treatment and its goal is to ensure that the patient has an opportunity to be an informed participant in their medical decisions. Medical information must be presented to enable the patient to voluntarily decide whether or not to accept the procedures. However, most medical information is technically complex and so not easily understood by a layman. Informed consent requires the doctor to reduce the patient's disadvantage in terms of information and knowledge available. Informed consent is not a device to have the patient accept the physician's medical plan but a means of sharing medical information between the physician and the patient. Thus, informed consent gives the patient more power over treatment and thus undermines the physician's domination.

2-2-3. McDonaldized health care

The concept of "McDonaldization" is rapidly taking over both the American and Japanese societies and also spreading into health care. "McDonaldization" is an expansion of Max Weber's theory, which focuses on rationalization. Rationalization is a way of thinking regulated by reason and based upon clear, objective ideas, which can be demonstrated and understood by other intelligent human beings (Bilton et al., 2002,

p.483). For Weber, science and modern capitalism were both part of the rationalization process. George Ritzer outlines four main features of “McDonaldization”: efficiency, calculability, predictability and control. Ritzer defines “McDonaldization” as ‘the process by which the principles of the fast-food restaurant are coming to dominate more and more sectors of American society as well as of the rest of the world’ (2000, p.1). This is not, Ritzer demonstrates, limited to fast-food industries, but applies to a wide range of social aspects, including medical care.

We will now examine more closely the first dimension of “McDonaldization”, efficiency, which has deep relevance to health care and the doctor-patient relationship. Efficiency can be important in modern capitalist society. Ritzer describes efficiency as, ‘the optimum method for getting from one point to another’ (2000, p.12). Ritzer argues that efficiency means the choosing of the best available way to reach the purpose with the least amount of cost or effort. In fast-food restaurants, for example, the customers take an empty plate and have to load the vegetable at a salad bar. This is very efficient for the restaurant. Customers perform many more unpaid tasks compared with those who have dinner at full-service restaurants.

In health-care provision, medical service producers seek efficiency. One remarkable feature of modern health care is to put patients to work. For example, anyone can buy

medicines and health products over-the-counter in a pharmacist or a supermarket, without a prescription. People can also buy medical test kits, e.g., for pregnancy, also without a prescription, and patients can use them on their own. We can safely say that these are forms of “McDonaldization”.

On the other hand, the consumer also pursues efficiency. Ritzer describes an efficiency-seeking aspect of medical practice as follows: ‘Perhaps the best example of the increasing efficiency of medical practice in the United States is the growth of walk-in/walk-out surgical or emergency centers. “McDoctors” or “McDentists” serve patients who want medical problems handled with maximum efficiency. Each center handles only a limited number of minor problems but with great dispatch’ (2000, p.51). McDonaldization’s model offers an efficient method for satisfying consumers’ needs. From the consumer’s point of view, people are able to get medical services far more conveniently. “McDentists” and “McDoctors” meaning ‘drive-in clinics designed to deal quickly and efficiently with minor dental and medical problems’ have emerged in the United States (Ritzer, 2000 p.10). “McDentists” are only sufficient for simple dental procedures. McDoctors may be more efficient than private doctors’ offices when people have minor complaints. It may be convenient for the patients to see the doctor without an appointment. As highlighted by Ritzer, the demand for quicker health care provision with less effort on the part of the patient has led to the “McDonaldization” of the system.

Health care has been McDonaldized by pursuing efficiency and rationalization in consumer society, emphasizing the commodity aspect of health care services.

The second dimension of “McDonaldization” is calculability, which emphasizes quantification. Ritzer argues that calculability is ‘an emphasis on the quantitative aspects of products sold and services offered’ (Ritzer, 2000, p.12). All medical organizations tend to push health care in the direction of quantification. Ritzer states as follows: ‘limiting time with each patient and maximizing the number of patients seen in a day allows the corporation to reduce costs and increase profits... Profits can also be increased by pushing doctors to spend less time with each patient, to see more patients, to turn down patients who probably can’t pay the bills, and to see only patients who have the kinds of diseases whose treatment is likely to yield large profits’ (2000, p.70).

The third dimension of “McDonaldization” is predictability. Predictability is ‘the assurance that products and services will be the same over and in all locales’ (Ritzer, 2000, p.13). Ritzer believes that ‘[i]n a rationalized society, people prefer to know what to expect in most settings and at most times’ (2000, p.83). People do not want surprises. Consumers need predictability because it gives them peace of mind. In order to achieve predictability, people must have ‘discipline, order, systemization, formalization, routine, consistency and methodical operation’ (2000, p.83). Predictability is also important in

health care. For example, health insurance can be viewed as a device to increase predictability, both in the bill to be paid by the patient and in the kinds of treatments he or she will get. With insurance, one can be fairly certain in advance that the bill will be within a limit. Also, since insurance usually covers the limited kinds of procedures, one will be saved the worry that one might receive an extraordinary (and sometimes experimental) procedure.

The fourth dimension of “McDonaldization” is control. Ritzer states, ‘The people who work in McDonaldized organizations are also controlled to a high degree, usually more blatantly and directly than customers. They are trained to do a limited number of things in precisely the way they are told to do them. Health care is controlled by various rules and bureaucracies’ (2000, p.14). Ritzer shows an example of control in health care as follows:

‘These and other developments in modern medicine demonstrate increasing external control over the medical profession by third-party payers, employing organizations, for-profit hospitals, health maintenance organizations (HMOs), the federal government, and “McDoctors”-like organizations. Even in its heyday the medical profession was not free of external control, but now the nature and extent of the control is changing

and its degree and extent is increasing greatly. Instead of decisions being made by the mostly autonomous doctor in private practice, they are more likely to conform to bureaucratic rules and regulations. In bureaucracies, employees are controlled by their superiors. Physicians' superiors are increasingly likely to be professional managers and not other doctors' (2000, p.109).

McDonald's also controls employees by threatening to use technology to replace human workers (2000, p.14). Replacement of human by nonhuman technology is often oriented towards greater control. Similarly, health care is already under the control of computers. Physicians frequently depend on computer programs in order to diagnose disease. Ritzer concludes that the situation in which doctors are under the control of computers is the result of 'the growing importance of bureaucratic rules and controls and the growth of modern medical machinery' (2000, p.108). Health care is controlled by various rules and bureaucracies, which are designed to control both the patient and the doctor. HMOs use control through nonhuman technology by keeping track of the physicians. Physicians are forced to conform to bureaucratic standards.

Ritzer adds one more dimension, the irrationality of rationality, to the discussion of the four fundamental characteristics of "McDonaldization". Ritzer argues about rational

systems that ‘[T]he basic idea here is that rational systems inevitably spawn irrational consequences. Another way of saying this is that rational systems serve to deny human reason; rational systems are often unreasonable’ (2000, p.16). The irrationality of rationality leads to dehumanization. An example of this is the growth of modern medical machinery. It enables people to get diagnoses or the computer to diagnose illness. As Ritzer demonstrates, this phenomenon, a process of rationalization, carries with it a series of dehumanizing consequences for the physician. In the past, private practitioners had a large degree of control over their work. From the patient’s viewpoint, the rationalization of medicine causes a number of irrationalities. The patients also lose out, as the need for efficiency creates a feeling as if being on an assembly line, causing discontentment with the system, as well as losing important doctor-patient relationships. Patients can even cut out the doctor altogether by diagnosing themselves with a automated test. Ritzer concludes the influence of “McDonaldization” as follows;

‘The ultimate irrationality of this rationalization would be the unanticipated consequences of a decline in the quality of medical practice and a deterioration in the health of patients. Increasingly rational medical systems, with their focus on lowering costs and increasing profits, may reduce the quality of health care, especially for the poorest members of society. At least some people may become sicker, and perhaps even die,

because of the rationalization of medicine. Health in general may even decline' (2000, p.144).

Although there have been many benefits and conveniences that are related to rational systems, these rational systems tend to lead to irrational outcomes since some parts of medicine have moved away from human toward nonhuman technologies.

2-2-4. Marketing of health care

As the market mechanism is introduced to health care, physicians have begun to approach patients actively. In contemporary society, physicians increasingly use advertisements through various media as a means of patient acquisition. Patients who want to know more about their medical needs are now gaining easy access to medical knowledge by TV programs, magazine articles, and Web pages. Marketing, especially in the form of advertisements, also has come to play an important role in a prospective patient getting necessary information when they seek health care services. When discussing marketing, the definition by Philip Kotler is often quoted: marketing is 'a social and managerial process by which individuals and groups obtain what they need and want through creating, offering and exchanging products of value with others' (Kotler, 1999, p.8). Kotler (1999) argues that marketing is a human activity directed at satisfying needs and wants. Kotler explains the terms needs, wants, and demands as

follows:

'The marketer must try to understand the target market's needs, wants, and demands. Needs describe basic human requirements. People need food, air, water, clothing, and shelter to survive. People also have strong needs for recreation, education, and entertainment. These needs become wants when they are directed to specific objects that might satisfy the need. An American needs food but wants a hamburger, French fries, and a soft drink. A person in Mauritius needs food but wants a mango, rice, lentils, and beans. Wants are shaped by one's society. Demands are wants for specific products backed by an ability to pay. Many people want a Mercedes; only a few are able and willing to buy one. Companies must measure not only how many people want their product but also how many would actually be willing and able to buy it. These distinctions shed light on the frequent criticism that "marketers create needs" or "marketers get people to buy things they don't want". Marketers do not create needs: Needs preexist marketers. Marketers, along with other societal influences, influence wants. Marketers might promote the idea that a Mercedes would satisfy a person's need for social status. They do not, however, create the need for social status' (Kotler, 1999, p.11).

Marketing focuses on the satisfaction of customer needs and wants. Needs are totally rational while wants are purely emotional. Marketing is the process by which producers satisfy customer wants and needs. The marketing approach in health care actualizes the characteristics of the “consumers” who have needs, wants, and desires. Consumption is associated with the satisfaction of needs and wants (du Gay, 1997, p.86). The aim of marketing is to actualize the needs which are not visible and to change needs into desires.

One of the roles of marketing is creating demand. The provider of medical services uses media actively and tries to create new demands for their services. John Galbraith argues that direct links between production and wants are provided by the institutions of modern advertising and salesmanship (1958, p.127). Galbraith calls this “the Dependence Effect,” which he explains as follows: ‘As a society becomes increasingly affluent, wants are increasingly created by the process by which they are satisfied. This may operate passively. Increases in consumption, the counterpart of increases in production, act by suggestion or emulation to create wants. Expectation rises with attainment. Or producers may proceed actively to create wants through advertising and salesmanship. Wants thus come to depend on output’ (1958, p.129). The producers create the wants by stimulating consumers’ desire. They approach consumers in order to

make them consume more. Advertising is creating the very consumer demands that the products satisfy in modern society.

In the process of globalization, a marketing principle is also being introduced into dentistry health care in Japan for the purpose of increasing medical demands and in the pursuit of rationality. OCA of the U.S. which adopts the marketing technique and aims at patient acquisition has entered into the Japanese dental health care. The company used the media in order to get the new patients. For example, the average orthodontist in the U. S. starts about at 260 new patient cases per year. The average OCA orthodontist in the United States, all of whom market in some fashion, starts about 520 new patient cases per year. OCA thinks that the advertising for dental services needs to dispel the myth that orthodontics and implants are very expensive and not affordable. OCA uses such marketing techniques as the consultation hours considered at a patient's convenience, structuring a comfortable environment, the price set of medical treatment, etc., in order to raise a profit. These marketing methods are consumer-oriented. It can be said that marketing has a huge influence on the future of health care.

3. Power in the Doctor - Patient relationship

The power element in the doctor-patient relationship is particularly important when a patient makes a decision about his or her own care plan. Power is generally defined as

the ability to compel behavior from another, regardless of the other's wishes (Haug, 1983, p.10). The doctor-patient relationship has gradually been changing, as stated above. In the transformation of the doctor-patient relationship from the paternalistic to the consumer model, patient's action has also changed. Annas describes the physicians' attitude toward the patient as follows:

'The major trend in medical in the past two decades has been toward the transformation of the physicians' primary goal from treating patients in the best way they know how to the goal of treating patients in a way that minimizes their potential exposure to a medical malpractice suit' (1989, p.239).

Physicians in the U. S. are keenly aware of the change of the doctor-patient relationship highlighted with the increase of law suits. Many of them feel that the medical profession has lost control over the patient, as expressed by Patch Adams, 'Fear of being sued for malpractice is one of the greatest tragedies of modern medicine' (1998, p.43). The increase in the number of law suits which patients file against physicians clearly indicates the change of patients' attitude. In this chapter, we will devote some space to the discussion of power which works in the doctor-patient interaction.

3-1. professional dominance

Physicians dominated its relationship with patients and possessed absolute power over patients' decision-making for a long time. In other words, patients were a subordinate group and doctors were dominants. How did medicine become so powerful? The position of the physicians can be seen as 'a result of the socially institutionalised power to define the experience of being "ill" and decide what treatment is required' (Bilton et al., 2002, p.358). The physician through their power declares the patient as "ill" and, therefore, patient has to obey the physician's orders; if he doesn't the patient will be labeled as a "difficult patient".

Also, physicians sought to establish a monopoly over its practice. This was 'done by limiting entry to those with certain qualifications and claiming that those who lack these qualifications do not possess the requisite expertise' (2002, p.546). In analyzing the features of the profession's interaction with its patients, it is necessary to distinguish between the medical profession and the general prestigious groups called profession. Medical professions have an overwhelming specialized knowledge and good training. The professionalisation of medicine justifies the power of the medical profession to control the patient and an asymmetrical distribution of power. Eliot Freidson calls the monopoly of medical establishment by physicians "professional dominance". The physician is the most prominent among members of the generally recognized

professions (Freidson, 1970, p.81). Freidson goes on to say:

‘In the medical organization the medical profession is dominant. This means that all the work done by other occupations and related to the service of the patient is subject to the order of the physician. The profession alone is held competent to diagnose illness, treat or direct the treatment of illness, and evaluate the service. Without medical authorization little can be done for the patient by paraprofessional workers...The dominant professional, then, is jealous of his prerogative to diagnose and forecast illness, holding it tightly to himself’ (1970, p.141).

Physicians used to enjoy absolute power over the treatment decision. Furthermore, Freidson argues that the profession’s strength is based on a legally supported monopoly of power. Freidson states that ‘[t]his monopoly operates through a system of licensing that bears on the privilege to hospitalize patients and the right to prescribe drugs and order laboratory procedures that are otherwise virtually inaccessible’ (1970, p.83). Physicians tend to be responsible for the determination of the course of medical procedures and to be free to control the patient. The formation of professional dominance includes the dominance in medical knowledge and the medical decision-making. Freidson discusses the medical profession using the term of

“autonomy”. Freidson claims that autonomy apparently refers most of all to control over the content and the terms of work in the case of medical professions (1970, p.134). Medical knowledge is too complex for a patient to be able to understand. The patient, lacking professional training, is too ignorant to be able to comprehend what information he gets and that he is too upset at being ill to be able to use the information he does get in a manner that is rational and responsible (Freidson, 1970, p.142). The patient often accepted without question the treatment suggested by the physician. This power-relation that exists between the physician and the patient results in the patient’s autonomy becoming victim to the “professional dominance”. Freidson concludes that physicians will maintain a place of privilege and “authority” by virtue of their expertise quite independently of bureaucratic office, and patients will hold a place of subordination by virtue of their helplessness and ignorance so long as the goal of therapy is maintained and physicians are held to know how to achieve it (1970, p.176).

The doctor-patient relationship in those days is well expressed by Patch Adams in his work *Gesundhett!*, ‘[M]any of my professors were all arrogant, and devoid of any vision of a humane health care system. The emphasis was on the patient as a passive recipient of wisdom, which demigods handed down from a temple of technology’ (1993, p.10). In the mid-twentieth century, the American medical profession was at the height of its professional power and prestige, which included public trust. It was at this time that

Freidson (1970) devised his “professional dominance” theory highlighting the level of control the doctor had over health care. The physician controls the patient through diagnosis and medical treatment based on their knowledge. William Cockerham argues, ‘The physician has the dominant role because he or she is the one invested with medical knowledge and expertise, while the patient holds a subordinate position oriented toward accepting, rejecting, or negotiating the recommendation for procedures being offered’ (2001, p.179). Medical specialists possess “expert knowledge”. Physicians have all the authority about diagnosis and medical treatment. Health care is carried out with physicians holding initiative and it is accepted as a matter of course.

Over time, the profession’s monopoly has changed and the professional dominance seems to be in decline at the beginning of the twenty-first century. Physicians are no longer keeping the unilateral decision power over their patients.

3-2. Medicalisation

The doctor seems to be trying to gain power in the relationship by expanding the scope of medical treatment, redefining the concept of illness itself. This is achieved through what we know as “medicalisation,” which means making what have previously been nothing but “trouble” into “an illness” which can and should be medically treated. Bilton argues that the power of the profession can be understood by considering the

medicalisation of lay forms of coping with illness and natural physical processes, such as ageing, previously handled within the community (2002, p.369). “Medicalisation” is promoted by the medical profession. Bilton defines the “Medicalisation” as ‘[i]ncreasing medical intervention in and control over areas that hitherto have been outside the medical domain’ (2002, p.149). According to Anthony Giddens, ‘The application of science to medical diagnosis and cure is one of the major features of the development of modern health care systems’ (2001, p.154). Specialized knowledge, thus expanded by medicalisation, justifies the doctor’s gained power over the patient.

Bilton discusses several forms of medicalisation. The first is ‘incorporating and redefining lay approaches to illness and physical processes so that they fall under the “medical gaze”—that is, they are redefined as a form of illness open to medical intervention’ (2002, p.369). For example, mental illnesses were medicalised in this way in the late eighteenth century. Bilton discusses mental illnesses as ‘Deviant or unusual mental states that had been seen in communities as signs of witchcraft or possession (divine as well as evil) were gradually redefined as psychiatric conditions, with religion gradually ceding territory to the newly established psychiatric profession’ (2002, p.369).

Michel Foucault uses concept of the “medical gaze” with regard to the concept of the domination which works between physicians and patients. Medical gaze means the power of modern medicine to define the human body. The medical physician’s gaze at

the patient's body is characterized by power and diagnostic intent. In order to restore the body to health, the cause of the disease must be isolated and specifically attacked. This leads to the notion that the mind and the body, and specific body parts, can be treated separately. As Foucault illustrates, the doctor in the eighteenth century asked his patient, 'What is the matter with you?' but this form of questioning was later replaced by 'Where does it hurt?' This change of attitude, Foucault argues, is due to the emergence of new gaze (1973, p.xviii). Medical specialists adopt a medical gaze, a detached approach in viewing and treating the sick patient (Giddens, 2001, p.154). Foucault compares the power which is held over individual bodies as a form of discipline that can be found in the restrictive Victorian fashion of corsets which squeezes ladies' waists. David Morris states that we regiment our behavior and even our flesh to conform with the dictates of culture. Medicine is implicated among the cultural forces of discipline by virtue of what Foucault calls a clinical "gaze". The medical gaze has brought considerable power and prestige to the physicians. Moreover, Foucault offers an explanation of the concept of power. According to Foucault, 'power is everywhere; not because it embraces everywhere, but because it comes from everywhere'. Foucault also states that power is not an institution but comes from below (Foucault, 1978, p.93). He explains that individuals exert power on each other in their everyday lives. That is, power exists as a relationship between individuals. What he means by the term "power" is that someone tries to control others' courses of action and at the same time he refuses

or chooses to be controlled by them. Foucault's theory concentrates on the dominant medical discourse, which has constructed definitions of normality (health) and deviance (sickness). This discourse provides subjects in modern societies with the vocabulary through which their medical needs and remedies are defined. The source and beneficiary of this discourse is the medical profession (Bilton et al., 2002, p.358).

The second element of medicalisation, which Bilton terms the benefit of scientific medicine, is the claimed efficacy of scientific medicine. Bilton goes on to say, 'Better drugs, surgical techniques, therapies, anti-viral agents and antibiotics are heralded as proof of the scientific progress of medical research and clinical practice' (2002, p.370). However, the benefit of scientific medicine is challenged by the growing incidence of iatrogenic illness. Iatrogenic illness is a disability caused by medical treatment. It is since the 1960s that the voices of criticism have been raised against health care in medical sociology. The well-known criticism in this connection is the argument by Ivan Illich. Illich criticizes the medical establishment as a major threat to health and he states, 'The disabling impact of professional control over medicine has reached the proportions of an epidemic' (1976, p.3). First, he argues that clinical iatrogenesis (doctor-induced disease) is increasing and modern medicine itself is a problem. Illich discusses that the layman and not the physician has the potential perspective and effective power to stop the current iatrogenic epidemic (1976, p.4). Progress of medical technology has enabled

some patients to either live longer or more satisfying lives despite having a serious disease. But in the end they suffer from the therapy they receive in the biomedical framework rather than the disease itself, and they become victims of iatrogenic disease. Illich believes that most medical treatments do not work and are not necessary, and attacks the notion that only doctors know what constitutes sickness, who is sick, and what shall be done to the sick. Physicians control patients through diagnosis and medical treatment. It can be reversed only through a recovery of will to self-care among the layman, which will impose limits upon the monopoly of physicians. Illich have suggested that modern medicine has actually done more harm than good.

3-3. The Rise of Consumerism in Health Care

We have traced the sources of the power monopolized in medicine. Specialized knowledge justified physician's power over patients. Although the physician once had overwhelming power, the patient is increasingly gaining power in the process of consumerization of health care. Marie Haug describes three typical patterns of the distribution of power: the power is asymmetrically distributed, resting entirely in the hands of the physician; the power is at least partially shared, as in a meeting between equals; and the patient alone commands power in the relationship (Haug, 1983, p.10). In the paternalistic model, the patient obeys the physician's medical treatment plan. However, patients have come to demand more say in a decision-making about medical

procedures they receive. A physician is obliged to accept a patient's autonomy and respect a patients' intention in medical decision-making. As a result, patients change from passive recipients of paternalistic care into active partners of medical treatments as cooperative processes. People have different attitudes to health in their life style and expect different things of health care. Some people may even willingly accept the "sick role". Others do not take professional advice because they have a different belief about solutions from that of physicians and they look for alterative ways of living with their illness. Illness is determined by agreement between the doctor and the patient. Therefore, the cure becomes chosen in a negotiated agreement between the doctor and the patient, making the latter an active participant who has the right to choose between alternative conceptions of, and treatments for, the condition he is in. Choice is at the heart of consumerism. With no choice, we would have to accept whatever was offered, which would leave no room for consumerism.

Saras Henderson and Alan Petersen explain the characteristics of consumer society as follows, '[P]eople consume not only goods, but also human services and therefore human relationship. Indeed, virtually everything becomes an object of consumption. Consumption has become a way of thinking and a way of life, and provides the very basis for our concept of self, or identity' (2002, p.2). In this context, health is even viewed as a "commodity" and individuals are defined as health care "consumers". Pasi

Falk argues that the body acts as expressions of social and personal identity, but at the same time as creators of identity (Falk, 1994, p.54). Falk argues that the sense of the self in contemporary society is profoundly connected with the idea of unlimited personal consumption of signs and goods. Now, consumers are in charge of getting the “best buy” for their own health care in contemporary societies. This attitude has a great influence on healthcare service and the doctor patient relationship.

John Tomlinson argues that a large proportion of cultural practices in modernity have become commodified—turned into things which are bought and sold (1999, p.85). Even the consumer’s body has become an object of consumption. Jean Baudrillard discusses that the body is the finest consumer object and states, ‘[I]n advertising, fashion and mass culture; the hygienic, dietetic, therapeutic cult which surrounds it, the obsession with youth, elegance, virility/femininity, treatments and regimes, and the sacrificial practices attaching to it all bear witness to the fact that body has today become an *object of salvation* (1998, p.129). Moreover, in the present consumer society, patients as consumers ask the doctors not only for conventional medical procedures for the purpose of restoring health but new type of procedures which create beauty. Some forms of health care, such as whitening, adult orthodontics, plastic and cosmetic surgery, have become a commodity in consumer society. Baudrillard explains people’s behavior of consuming in consumer society with a sign. Kathryn Woodward states that the body has

become a form of physical capital—a possessor of power, status and distinctive symbolic forms central to the accumulation of various resources (1997, p.88).

Consumerism has become pervasive in health care, reflecting a changed and still changing relationship between the doctor and the patient. In consumer society, patients have come to strongly display the character as consumers, autonomous agents. An example of consumerism in health care is in optical care. Apart from the fashion aspect to design choice for spectacles, there is also now the choice in contact lenses which extends to those that can alter the iris colour to the wearer's preference. Clearly the high street optician may choose to indulge consumer choice in this area too - and the ideal of blonde hair and blue eyes might have attractions for some people. So apart from dentistry and cosmetic surgery, the eyes offer another aspect of consumer gratification. Now everything becomes an object of consumption and consumer can choose the medical services. Consumers must accept, as much as is possible, responsibility for their own health.

4. Dentistry in the 21st Century: Socio-cultural Effects of Consumerism on Dental Practice

Although a large number of researchers have investigated the characteristics and practices of a “consumer society”, there have been relatively few analyses of an aspect

of consumption as applied specifically to dental health care. Ours is an age in which every item around us is viewed as a constituent of culture and assigned a “cultural” value depending on its position in the whole web of culture. Cultural items in this sense, and ultimately the cultural values themselves, are increasingly becoming objects of consumption. In the case of dentistry, one of the typical objects of consumption is the color of teeth, which can now be changed as the patients as a consumer likes. Below, we will look at how tooth color is assigned a certain value as a cultural item, and how this cultural object is “bought” and “sold”.

4-1. Tooth color as culture

Over the years tooth color has become evaluated not only for health-related reasons but for its cultural value. There was a time in Japan when people considered that blacken tooth was beautiful. However, today many people prefer to have white tooth. The taste for tooth color has changed with the times, depending on its customs and cultural preferences, both of which are instances of culture. The color of tooth which is regarded as “beautiful” reflects culture of the times. White tooth may be thought of as a fashion in that it is a way someone choose to be a member of a group of those who are viewed as “healthy” or “young” in the present-day Japanese society (Fukagawa, 2002, 97-102). They desire to make their tooth white to give the impressions of purity, health, beauty, and youth. Tooth whitening is perceived to be the fastest and easiest way to satisfy the

desire to obtain a beautiful smile. In other words, white teeth are taken to represent positive values in today's culture, which, according to John Tomlinson, 'can be understood as the order of life in which human beings construct meaning through practices of symbolic representation' (1999, p.41). Tooth whitening is a cultural act because it has been constituted by society through a range of meanings and practices. It is part of culture because we have constituted it as a meaningful object and it connects with social practices which are specific to our culture or way of life.



Figure 2. “ohaguro”

Historically, in Japan, there was a custom of dyeing white tooth black, which is called “ohaguro”, (black tooth) (Figure 2). We will now examine the rise and fall of the fashion of “ohaguro”, because it may be helpful to consider how the aesthetic sense of tooth color has been affected by the culture of the times. According to Mitumasa Hara, black was an aesthetic symbol from ancient times in Japan (Hara, 1994, p.190). In the

Heian Era (794-1192), “ohaguro” became popular among males, especially among court nobles and commanders (Hara, 1994, p.131). Hara (1994) interprets the custom of “ohaguro” among samurais as a proof of loyalty, that a samurai does not serve two masters within a lifetime. This is because, in the Buddhist faith, black is the “unchanging” color which cannot be dyed with another. It was believed to represent “robustness” and “dignity” from its visual weightiness, and thus the high ranking Samurais were fond of using it. In the case of men, the custom is said to have ended around the Muromachi Era (1558-1572) (Nagasaki, 1990, p.234). Then, the practice came to be followed only by young women, who first blackened their tooth as a way of enhancing their appearance when they were ready to find a husband. The custom of “ohaguro” spread all over the country especially during the Edo Era (1603-1867). From this time, “ohaguro” became the symbol of married women. It was thought that black tooth made a woman look beautiful (Hara, 1994, p.190). Furthermore, “ohaguro” has another meaning that a woman became obedient as a subordinate to her husband because black cannot be dyed with other colors. It is clear that black has a deep connection with the idea of fidelity (Hara, pp.97-98).

In Junichiro Tanizaki’s *Ineiraisan*, one of whose themes is the traditional Japanese aesthetic senses, a married woman’s wearing “ohaguro” is explained as a means to emphasize “oshiroi” (white powder). During the Edo Era, women of the middle class

lived in a dark house, whose rooms were only lit by candles. The room was dark, a woman's kimono was also dark, as well as her tooth. And women applied "oshiroi" to their faces in order not to show their expression (Tanizaki, 2001, pp.46-48). It is thought that "ohaguro" is effective in making the face the more expressionless. The black of "ohaguro" was in sharp contrast with the face white with "oshiroi" and had the effect of emphasizing it. We see from Figure 2 that the figure shows the results of a women's face after makeup has been applied. By shaving her eyebrows and dyeing the tooth black, the changes of feeling do not appear in her expression. Thus expression is extinguished. That is, one may say that "ohaguro" is the culture of hiding women's expression, which was thought to be one of the elements of a beauty.

This aesthetic sense of tooth changed from "black" to its opposite, "white". The custom of "ohaguro" declined in the late 1800s, when Japan went through a profound change in terms of culture. Japan adopted not only science but ways of life as well in that period, thus losing some of its identity. The custom of "ohaguro", which was one of the characteristics of the Japanese society then, became out of date as a result of Japan's westernization, a form of globalization, which Giddens defines as 'the process in which human activities are integrated and being shared to the extent that the planet is becoming "one world"' (1990, p.77).

4-2. White Tooth As a Consumer Good

As we have seen, which color of teeth is viewed as “beautiful” depends on the cultural values current in a given society. Today, the color is white, and the desire to have white teeth has goal to an extreme: they are no longer satisfied with “naturally” white teeth but want to have them even brighter. In this process, the patient became a “consumer”, increasingly asking the doctor not only for appropriate medical procedures but for a new type of procedures to create and enhance beauty, one of which is tooth whitening. This attitude on the part of the patient-consumer, and the reaction to it on the part of dentistry, are well illustrated by the photograph below (Figure 3).

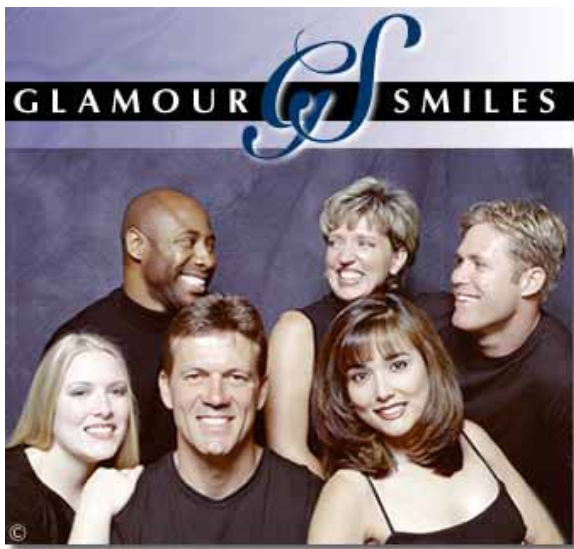


Figure 3. (<http://www.glamoursmiles.com/>)

First, let us look at how this photograph acts on the patient-consumer. The cultural text

of whitening is put into the minds of people unconsciously through an advertisement containing this photograph. What has to be noticed is that all the models are smiling, showing their white tooth. What do their white teeth represent? Their tooth is the emphasized part; it is the face with the white tooth. Their white teeth represent purity, health, beauty, and youth. Most modern people would prefer to have dazzling white tooth like those of these young models. Consumers see the models in the advertisement and think, 'I want to be like them'. Consumers unconsciously try to identify themselves with young models in advertisements by making their tooth white. Since the models in the photograph already have a kind of value, which now we will call "image", such as purity, health, beauty, and youth, they can be used for the advertisement of whitening. In the code system it is the image that their faces (perfectly beautiful) represent, not their actual faces, that is important.

The purpose of advertisers is to stimulate the consumer's desire using certain images which appear in the advertisement rather than to inform people of the product itself. It can be said that white tooth are a "sign" in a semiological sense and thus the providers of whitening emphasize cultural images of white tooth, such as purity, health, beauty, and youth, in advertisements of whitening. A sign can be a word, a color, a tooth, a face, a gesture. The sign has been divided into its constituent parts, the signifier and the signified. According to Judith Williamson, 'the Signifier is the material object, and the

Signified is its meaning' (1996, p.17). Through advertising, white teeth are represented as a signifier for purity, health, beauty, and young people.

Behind the mechanism of advertisement discussed above is a shift in the ways people are motivated to be dental clients. Patients show their character as a consumer more strongly, in that they decide to visit a dentist's office not because of such external causes as a pain or an inconvenience but in order to have what they want. For example, a discolored tooth is not accompanied by an ache, and there is almost no trouble with it in living everyday lives; it is not urgent. Thus, a physician's dominance over patients, which used to characterize a paternalistic medical setting, has become weaker because it is not the doctor but patients who determine whether to start their treatment or not. This situation is part of the fact that dentistry is becoming "consumerized" and that white teeth are assigned certain cultural values, represent something to be identified, and thus become what consumers are willing to pay for. Whitening embodies consumers' desire to display such traits as purity, health, beauty, and youth. Advertisements represent whitening as a device for satisfying this desire.

In consumer society, even one's body is an object of consumption. The patient-consumer asks the doctor to manipulate a certain part of the body (e.g., to whiten the teeth) in order to look young and beautiful. It is as if he or she buys a new

part as a means of making the whole body perfect. The act of making teeth white is to fill one of the eternal desires of the human being to have a good looking face. At the moment white teeth is the fashion for consumers who want to look beautiful so many practices have been created and commercialized, that is, sold. White teeth have thus turned into something that is bought and sold, namely as consumer goods through the act of whitening.

5. Modernity or Postmodernity?

5-1. A Postmodern Aspect of Dental Practice: Simulation in Dentistry

Part of dental practice seems to be undergoing a series of major transformations which can be labelled postmodern and displaying postmodern aspects. One of them is an increase in simulation. As Alex Callinicos demonstrates, ‘postmodernity is characterized by “simulation”’ (1989, p.145). For example, the procedure of implanting a tooth is ordinarily carried out in Japanese dentistry. Dental implants are artificial tooth root analogues, which are inserted into the bone. The implant tooth is not real but “simulacra”, the concept Baudrillard formulated to analyze the postmodern consumer society. New forms of technology, such as TV and movies, help a shift from a productive social order to a reproductive social order in which simulation constitute the world. Let us now take some examples to illustrate the feature of postmodernity, simulation and reality. According to Baudrillard, simulation is ‘the generation by

models of a real without origin or reality: a hyperreal' (Baudrillard, 1994, p.1). In *Simulacra and Simulations*, Baudrillard summarizes the situation of the "real" in the postmodern world. The "real" transformed into the "hyperreal" and it has disappeared completely into the process of a simulation. For Baudrillard, hyperrealism is a characteristic feature of postmodernity. Baudrillard uses the term simulacrum in almost the same sense as a "sign" in semiology. He argues that the distinction between simulated objects and their simulating representations has disappeared as the quantity of signs and images has increased. He further claims that we are living in a world of "simulation", where media-generated images function independently of any reality external to them. For Baudrillard the postmodern world is a world of simulacra, where we can no longer differentiate between reality and simulation. Therefore, in postmodern society, a thing turns into a sign and people consume a thing according to the principle of difference. The simulation society is the world where simulacra become real. Simulation blurs the difference between the "true" and the "false", the "real" and the "imaginary".

The implant tooth is a simulacra, which blurs the distinctions between true and false. This technology suggests that people can have artificial tooth without originals. Distinctions between objects and their representations dissolved, and only simulacra are left. This is the feature of a postmodern society.

Consumption in the postmodern information society is characterized by simulacra. Baudrillard argues that we have moved from the industrial era to new era in which the sign and simulacra predominates. In consumer society commodities are the sign and simulacra. We unconsciously consume them in everyday lives. Ritzer argues that signs control our behavior in this means of consumption (1998, p.129). It is necessary to keep in mind that this means of consumption spread not only American society but also the world of health care including Japanese dental healthcare. The desire of consumption creates new commodities which enable people to do things they could not do before. It is natural that the means of consumption exerts a strong influence on dental health care and the implant tooth was created.

5-2. Remnants of Modernity

Although we face changes in dental health care and the changes can be interpreted as postmodern phenomena, we also see the evidence of modernity here. In the postmodern world, progress of such technologies as information technology has altered health care including the doctor-patient relationship. However, health care does not shift to the postmodern completely. “Discipline”, to borrow Foucault phrase, of a patient still remains at the clinical place. A patient is required to obey the physician’s instruction. The patient has remained to be the body obedient to a physician. It is thought that the

contemporary health care has both elements of postmodern and modern and has continuity. We can adopt the two approaches to analyzing contemporary consumer phenomena. We have seen that many postmodern characteristics are concurrent with modern elements in the system and procedures of contemporary health care, including the doctor-patient relationship. Therefore, we can say that modernity and postmodernity coexist within the field of dental health care.

Zygmunt Bauman argues that in modern society producers set health as the standard which its members ought to meet. In modern society, in which people's lives were organized around the producer's role, health was important. On the contrary, he goes on say that in postmodern society, in which people's lives are organized around consumption, the importance is lost. According to Bauman, 'Health, like all other normative concepts of the society of producers, draws and guards the boundary between "norm" and "abnormality"' (Bauman, 2000, p.77).

“Health” is the proper and desirable state of the human body and spirit — a state which (at least in principle) can be more or less exactly described and once described also precisely measured. It refers to a bodily and psychological condition which allows the satisfaction of the demands of the socially designed and assigned role — and those demands tend to be

constant and steady. “To be healthy” means in most cases to be “employable”: to be able to perform properly on the factory floor, to “carry the load” with which the work may routinely burden the employee’s physical and psychical endurance’ (Bauman, 2000, p.77).

Health defined by its standards and armed with a clear distinction between “norm” and “abnormality”. However, the norm of health has been severely shaken and become fragile under the aegis of “liquid” modernity. Bauman goes on to describe,

‘What yesterday was considered normal and thus satisfactory may today be found worrying, or even pathological and calling for remedy. First, ever-new states of the body become legitimate reasons for medical intervention - and the medical therapies on offer do not stay put either. Second, the idea of “disease”, once clearly circumscribed, becomes ever more blurred and misty. Rather than perceived as an exceptional one-off event with a beginning and an end, it tends to be seen as a permanent accompaniment of health, its “other side” and always present threat: it calls for never-lapsing vigilance and needs to be fought and repelled day and night, seven days a week’ (2000, p.79).

Thus, present health care does not necessarily lend itself to the framework of conventional biomedical health care. According to Morris, 'postmodern illness is fundamentally biocultural — always biological and always cultural — situated at the crossroads of biology and culture' (1998, p.71). Morris goes on to say that postmodern illness is an outlook that understands a specific malady, whatever its particular causes, as created in the convergences between biology and culture (1998, p.76). A postmodern patient adds changes to his or her body continuously in search of the perfect body. In contemporary society, the scope of consumption is expanding to include not only commodities but health care like the dental procedures of tooth whitening and tooth implant and also the human body.

6. Conclusion

So far we have discussed the features of consumer under the influence of both “McDonaldization” and consumerism in health care. With all said, what is a consumer? An active decision-maker who makes a choice between alternatives, as depicted in the socio-medical literature? Or, someone who seeks as much efficiency and predictability as possible, which is the typical image of a consumer in the framework of “McDonaldization”? The former is a postmodern conception of a consumer, who consumers mainly in order to show the difference from others clearly, because the choice they make represents “what he is”. People express their social status through the

goods they own as a result of consumption. Du Gay discusses that consumption practices always tend to have “identity” value (1997, p.96). Identity is defined by difference. Identities are frequently constructed in terms of oppositions. That is, identity depends more on what it is not than what it is. People have the desire to be different from others: That is, they want to be conspicuous. In the context of dentistry, the patient-consumer wants to have, for example, white teeth to look more beautiful than others, to be distinct from others. On the other hand, this desire for identity will, paradoxically, result in homogenization. This is because, as we have seen, identity requires a model to be identified with, to be imitated. In a case we have discussed, the models in the advertisement photograph is the source of the desire for identity; but at the same time, this desire is realized by identifying with the models, which causes those who want beauty as part of their identity to want to look like them. The stronger and widespread this desire, the more alike people will look.

The latter is a modern conception of a consumer. Many features of “McDonaldization” can be categorized as modern. A “McDonaldized” consumer derives comfort from rationality. For example, a modern consumer in McDonaldized medicine demands a quicker health care provision with less effort on the part of the patient, which reinforces the tendency toward the “McDonaldization” of the system. Health care has been increasingly McDonaldized by pursuing efficiency and rationalization, thus

emphasizing the commodity aspect of health care services. This type of consumers also want predictability because it gives them peace of mind. However, rational systems inevitably spawn irrational consequences, which phenomenon Ritzer call “irrationality of rationality”. Irrationality of rationality leads to dehumanization. The process of rationalization carries with it a series of dehumanizing consequences for health care provision. Although there have been many benefits and conveniences that are related to rational systems, these rational systems tend to lead to irrational outcomes since some parts of medicine have moved away from human toward nonhuman technologies. This dehumanization process will also lead to homogenization, because, in search for rationality, the competition centers around price and efficiency.

This leads us to a rather paradoxical view of the consumer in today’s society. Modern and postmodern features of the consumer, which at first sight appears incompatible to one another, paradoxically leads to the same effect: homogenization of consumption. However, the implication of this process of homogenization for medical service provision is really twofold. One aspect is medical services for those who can afford luxury: an example of this in the context of dental health care is tooth whitening for beauty and identity. The other is the service provision those with limited time and resources: McDentists are an example of this. In other words, the process of homogenization leads to two extremes, which fits the kind of stratifying trend of today’s

society that Bauman illustrates, when he says, ‘the postmodern, consumer society is a stratified one. But it is possible to tell one kind of society from another by the dimensions along which it stratifies its members. The dimension along which those “high up” and “low down” are plotted in a society of consumers, is their *degree of mobility*—their freedom to choose where to be’ (1998, p.86, italics in the original). What is interesting with Bauman’s point here is that the stratification cited in this passage is not the one directly based on the possession of material goods and resources, but, obviously, it is ultimately related to material well-being, resulting from increased freedom of choice. Postmodernity has changed the framework in which people view and live in the world, and health care is no exception.

References

- Adams, P., (1993) *Gesundheit!*, Rochester, Vermont: Healing Arts Press.
- Annas, G., (1989) *The Rights of Patients*: Southern Illinois University Press.
- Baudrillard, J., (1979) *The Consumer Society*, London: Sage Publications.
- (1994) *Simulacra and Simulation*: The University of Michigan Press.
- Bauman, Z., (2000) *Liquid Modernity*, Cambridge: Polity.
- (1998) *Globalizatio*, the human consequences, Cambridge: Polity.
- Bilton, T., (2002) *Introductory Sociology*, 4th edition, Palgrave Macmillan.
- Callinicos, A., (1989) *Against Postmodernism*, New York: St. Martin’s Press.

- Cockerham, W. C., (2000) *Medical Sociology*, New Jersey: Prentice Hall.
- Du Gay, P., et al., (1997) *Doing Cultural Studies: The Story of the Sony Walkman*,
London: Sage Publications.
- Falk, P., (1994) *The Consuming Body*, London: Sage Publications.
- Faulder, C., (1985) *Whose Body Is It? The Troubling Issue of Informed Consent*.
London: Virago.
- Foucault, M., (1973) *The Birth of the Clinic: An Archaeology of Medical Perception*,
New York: Vintage Books.
- (1978) *The History of Sexuality*, New York: Vintage Books.
- Freidson, E., (1970) *Professional Dominance*, Chicago: Aldine Publishing Company.
- Fukagawa, M., (2002) 'Tooth Color in Japan: A Cultural Study', *The Journal of
Cosmetic Dentistry* 18:97-102.
- Galbraith, J. K., (1958) *The Affluent Society*, New York: Mariner Books.
- Giddens, A., (1990) *The Consequences of Modernity*, California: Stanford Univ. Press.
- (2001) *Sociology* 4th edition, Cambridge, Polity.
- Hara, M., (1994) *A study of 'ohaguro'*, Tokyo: Ningennokagakusya..
- Haug, M., (1983) *Consumerism in Medicine: Challenging Physician Authority*, London:
Sage Publications.
- Henderson, S. and Petersen, A., (2002) *Consuming Health*, London: Routledge.
- Hogg, C., (1999) *Patients, Power & Politics*, London: Sage Publications.

Illich, I., (1977) *Medical Nemesis*, Harmondsworth New York : Penguin.

Kotler, P., (1999) *Marketing Management*, New Jersey: Prentice Hall.

Morris, D., (1998) *Illness and Culture in the Postmodern Age*, California: University of California Press.

Nagasaki, S., (1990) *Iro shikisai no nihonshi*, Kyoto: Tankosya,.

Parsons, T., (1951) *The Social System*, London: Routledge.

Ritzer, G., (1998) *The McDonaldization Thesis*, London: Sage Publications.

(2000) *The McDonaldization of Society*, California: Pine Forge Press.

Schor, J., (1998) *Overspent American*, New York: Harper Perennial.

Tanizaki, J., (2001) *Ineiraisan*, Tokyo: Tyuokoronsinsya.

Tomlinson, J., (1999) *Globalization and Culture*, London: The University of Chicago Press.

Williamson, J., (1978) *Decoding Advertisements*, London: Marion Boyars.

Woodward, K., (1997) *Identity and Difference*. London: Sage Publications.

[\(http://www.glamoursmiles.com/\)](http://www.glamoursmiles.com/)