



Rethinking the Medicalization of Milder Symptoms in Sri Lanka: An Evidence-Based Approach to Rational Health Practices

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Medicalisation is the process by which non-medical issues are defined and treated as medical problems, often described in terms of illnesses or disorders [1]. As Parsons [2] argued, healthcare systems often expand their remit to manage conditions previously considered normal, reinforcing the cultural norm of seeking medical intervention. The medicalisation of health has evolved into a global phenomenon, encompassing even minor, self-limiting conditions, such as coughs, colds, fevers, day-to-day aches and pains, and diarrhoea. Traditionally managed through self-care or often requiring no medical intervention, these conditions frequently receive unnecessary medical attention, including consultations, diagnostic testing, and pharmaceutical prescriptions. Such practices overburden healthcare systems, inflate costs, and redefine natural health variations as medical concerns [3].

In Sri Lanka, these symptoms contribute to the majority of consultations in primary care [4]. Most of these clinical presentations have been found to be of minor severity [5]. In a study of childhood illnesses in Sri Lanka, 79.6% of the 637 acute respiratory infection episodes reported were classified as very low risk, and even for these low-risk symptoms, care seeking was relatively high [6]. Research from Sri Lanka highlights that cultural expectations often drive early and frequent healthcare-seeking behaviours, even for mild symptoms.

Studies have demonstrated that even in high-income countries, such as the United States and the United Kingdom, consultations for upper respiratory infections account for a significant portion of primary care visits, despite evidence suggesting that most upper respiratory infections resolve without medical intervention [7]. In Sweden, a survey revealed that 30% of the antibiotics

prescribed for respiratory infections were unnecessary, directly contributing to antimicrobial resistance [8]. Overuse of antibiotics for self-limiting conditions, such as sore throats, of which only 5–10% are bacterial, is a significant driver of antimicrobial resistance globally [9]. A European study found that 40% of patients expect antibiotics for common colds, despite campaigns to educate the public on viral vs. bacterial infections [10]. Similar trends have been observed in China and India, where increased access to private healthcare and pharmaceutical advertising has reinforced a culture of seeking medical solutions for minor ailments [11]. This overmedicalization amplifies health anxiety and reduces reliance on natural coping mechanisms. Patients who frequently seek medical care for minor conditions are more likely to develop dependency on medications, undermining long-term health resilience [8].

In Sri Lanka, linguistic factors significantly influence healthcare-seeking behaviours, particularly among mothers caring for young children. Many patients and their caregivers have limited proficiency in English, which restricts their ability to access and comprehend health information rooted in Western medicine. Conversely, those who know English are often exposed to an overwhelming amount of unfiltered health information, much of which can be confusing or misleading. This dichotomy leads both groups to rely on healthcare providers for even minor concerns, either due to insufficient understanding of medical concepts or over-reliance on potentially inaccurate information that may not align with evidence-based practices [12].

As Conrad [1] describes, medicalisation stems from social and cultural shifts that redefine normal health

experiences as needing medical intervention. In Sri Lanka, traditional beliefs, such as those rooted in Ayurveda, further contribute to this phenomenon. For instance, Ayurveda identifies phlegm as a manifestation of an imbalance in Kapha dosha, which must be addressed and balanced to restore health. [13]. Such cultural frameworks often prompt mothers to seek medical care for conditions perceived as harmful even when they are self-limiting. Moreover, heightened public health literacy, often derived from incomplete or misinterpreted information, drives this trend. Gale et al. [14] emphasised that even when patients are provided with detailed information on risks and benefits, their decisions often align with cultural preferences for medical intervention rather than natural recovery. This is particularly true in communities where seeking immediate medical attention is seen as a responsible and proactive choice, reinforcing dependency on healthcare systems and contributing to resource overutilisation [15].

The role of media in promoting medicalisation through biomedical narratives has been highlighted globally, influencing care-seeking behaviours and framing medical intervention as necessary for most conditions [16]. Public health and medical media campaigns frequently promote the idea that individuals should “consult their doctors,” encouraging healthcare-seeking, reinforcing the cultural norm of seeking medical intervention, as Parsons has argued.. However, this message is delivered in a vacuum, with a notable lack of accessible materials from professional associations or health regulators to support the public in self-managing minor health issues, highlighting a broader gap in promoting health literacy. This gap contributes to unnecessary healthcare consultations and medication use, as individuals often lack the resources to confidently manage self-limiting conditions. Patients are generally unaware that medications, such as steroids and antibiotics, can cause significant side effects and may believe that all medicines are inherently beneficial. Furthermore, the public is not always aware that doctors are not strictly bound by regulations regarding the medications they prescribe in specific situations, and in many cases, they have the discretion to issue and dispense drugs directly, which can contribute to the overuse or misuse of medications. Compounding this issue, the presence of unqualified practitioners, or “quacks”, adds another layer of risk,

as many individuals are unable to distinguish between licenced professionals and fraudulent providers. Consequently, the prevailing advice to “go to the doctor” can inadvertently perpetuate these problems by overlooking systemic issues in healthcare regulation and public awareness.

Meanwhile, the weak regulatory mechanisms in Sri Lanka further complicate this situation. Limited structures ensure accountability in medical practice, which can lead to variability in the quality and appropriateness of care provided. For instance, general practitioners in Sri Lanka can issue medicines directly to patients without writing a prescription, leaving patients unaware of what these medications are or why they are being given. Patients often take these medications without questioning, assuming them to be necessary, which undermines informed decision making and rational healthcare. This practice is neither rational nor humane as it disregards the patient’s right to understand and actively participate in their own care, perpetuating a cycle of dependency and potential harm [17].

Furthermore, in Sri Lanka, the tendency to bypass smaller healthcare institutions, sometimes even for minor conditions, is a significant concern. Heightened anxiety regarding medical conditions, combined with perceptions of higher-quality care at tertiary institutions, often drives patients to seek treatment at larger hospitals. A study conducted at General Hospital Kalutara revealed that 44.6% of patients bypassed smaller institutions, opting for the hospital despite the availability of appropriate care at peripheral facilities [18]. This behavior exacerbates congestion in tertiary care facilities, contributing to overburdened outpatient departments (OPDs) and stretching limited healthcare resources.

The impact of such overutilization on the quality of care is profound. Research conducted at the National Hospital of Sri Lanka (NHSL) indicates that due to the overwhelming demand, OPD consultation times are restricted to an average of just 1.6 minutes per patient [19]. Such brief consultations significantly limit the ability of healthcare providers to offer thorough evaluations, accurate diagnoses, and personalized care. This not only compromises the quality of care but also reinforces the cycle of dependency on repeated healthcare visits for unresolved issues.

In addressing these challenges, Sri Lanka has the opportunity to build a more rational, equitable, and sustainable healthcare system. By fostering culturally appropriate health literacy, strengthening regulatory frameworks, and leveraging digital tools to guide self-care and ensure access to reliable medical advice, the healthcare system can reduce overmedicalisation and misuse of resources. Collaborative efforts involving policymakers, healthcare professionals, community

leaders, and traditional practitioners can promote trust and evidence-based practices while respecting cultural values. Enforcing accountability and curbing unregulated practices will further enhance the quality and efficiency of care. With these strategies, Sri Lanka can create a resilient, patient-centered healthcare model that prioritizes self-care, rational service utilization, and equitable access, ultimately ensuring the well-being of its population.

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