▲ The use of herbal therapies is a form of alternative medicine that is increasing in popularity in the United States. How does this approach to health care differ from a more traditional medical approach?

Sociological Perspectives on Health and Medicine

Functionalist, conflict, symbolic interactionist, and postmodernist perspectives focus on different aspects of health and medicine; each provides us with significant insights on the problems associated with these pressing social concerns.

A Functionalist Perspective: The Sick Role

According to the functionalist approach, if society is to function as a stable system, it is important for people to be healthy and to contribute to their society. Consequently, sickness is viewed as a form of deviant behavior that must be controlled by society. This view was initially set forth by the sociologist Talcott Parsons (1951) in his concept of the ***sick role*—the set of patterned expectations that defines the norms and values appropriate for individuals who are sick and for those who interact with them**. According to Parsons, the sick role has four primary characteristics:

1. People who are sick are not responsible for their condition. It is assumed that being sick is not a deliberate and knowing choice of the sick person.
2. People who assume the sick role are temporarily exempt from their normal roles and obligations. For example, people with illnesses are typically not expected to go to school or work.
3. People who are sick must want to get well. The sick role is considered to be a temporary one that people must relinquish as soon as their condition improves sufficiently. Those who do not return to their regular activities in a timely fashion may be labeled as hypochondriacs or malingerers.
4. People who are sick must seek competent help from a medical professional to hasten their recovery.

- **Sociological Imagination:** After you have covered the functional perspective, ask students to write for ten minutes on the meaning of the sick role and how it functions in our society.
- **For Discussion:** Ask students about the fundamental premises of the functionalist perspective on health in the United States.
- **Historical Perspective:** "Parsons used ideas from Freud's psychoanalytic theories as well as from functionalism and from Max Weber's work on authority to create an 'ideal type' that could be used to shed light on the social forces involved in episodes of sickness" (Andrew Roberts, Middlesex University).
- **ASA Task Force Recommendation:** #6 Empirical and Theoretical Analysis

As these characteristics show, Parsons believed that illness is dysfunctional for both individuals and the larger society. Those who assume the sick role are unable to fulfill their necessary social roles, such as being parents or employees. Similarly, people who are ill lose days from their productive roles in society, thus weakening the ability of groups and organizations to fulfill their functions.

According to Parsons, it is important for the society to maintain social control over people who enter the sick role. Physicians are empowered to determine who may enter this role and when patients are ready to exit it. Because physicians spend many years in training and have specialized knowledge about illness and its treatment, they are certified by the society to be "gatekeepers" of the sick role. When patients seek the advice of a physician, they enter into the patient–physician relationship, which does not contain equal power for both parties. The patient is expected to follow the "doctor's orders" by adhering to a treatment regime, recovering from the malady, and returning to a normal routine as soon as possible.

What are the major strengths and weaknesses of Parsons's model and, more generally, of the functionalist view of health and illness? Parsons's analysis of the sick role was pathbreaking when it was introduced. Some social analysts believe that Parsons made a major contribution to our knowledge of how society explains illness-related behavior and how physicians have attained their gatekeeper status. In contrast, other analysts believe that the sick-role model does not take into account racial–ethnic, class, and gender variations in the ways that people view illness and interpret this role. For example, this model does not take into account the fact that many individuals in the working class may choose not to accept the sick role unless they are seriously ill—because they cannot afford to miss time from work and lose a portion of their earnings. Moreover, people without health insurance may not have the option of assuming the sick role.

A Conflict Perspective: Inequalities in Health and Health Care

Unlike the functionalist approach, conflict theory emphasizes the political, economic, and social forces that affect health and the health care delivery system. Among the issues of concern to conflict theorists are the ability of all people to obtain health care; how race, class, and gender inequalities affect health and health care; power relationships between doctors and other health care workers; the dominance of the medical model of health care; and the role of profit in the health care system.

© Sean Justice/Photonica/Getty Images

▲ According to the functionalist perspective, the sick role exempts the patient from routine activities for a period of time but assumes that the individual will seek appropriate medical attention and get well as soon as possible.

Who is responsible for problems in the U.S. health care system? According to many conflict theorists, problems in U.S. health care delivery are rooted in the capitalist economy, which views medicine as a commodity that is produced and sold by the medical–industrial complex. The ***medical–industrial complex*** **encompasses local physicians and hospitals as well**

holistic medicine an approach to health care that focuses on prevention of illness and disease and is aimed at treating the whole person—body and mind—rather than just the part or parts in which symptoms occur.

sick role the set of patterned expectations that defines the norms and values appropriate for individuals who are sick and for those who interact with them.

medical–industrial complex local physicians, local hospitals, and global health-related industries such as insurance companies and pharmaceutical and medical supply companies that deliver health care today.

- **ASA Task Force Recommendation:** #7 Sociological Literacy
- **Active Learning:** Ask the class to outline the key points of the conflict theory on health and health care. They should identify differences and similarities between this perspective and functionalism.
- **ASA Task Force Recommendation:** #6 Empirical and Theoretical Analysis

as global health-related industries such as insurance companies and pharmaceutical and medical supply companies (Relman, 1992).

The United States is one of the few industrialized nations that has relied almost exclusively on the medical–industrial complex for health care delivery and has not had any form of universal health coverage to provide some level of access to medical treatment for all people. Consequently, access to high-quality medical care has been linked to people's ability to pay and to their position within the class structure. Those who are affluent or have good medical insurance may receive high-quality, state-of-the-art care in the medical–industrial complex because of its elaborate technologies and treatments. However, people below the poverty level and those just above it have greater difficulty gaining access to medical care. Referred to as the *medically indigent,* these individuals do not earn enough to afford private medical care but earn just enough money to keep them from qualifying for Medicaid (Weiss and Lonnquist, 2009). In the profit-oriented capitalist economy, these individuals are said to "fall between the cracks" in the health care system.

Who benefits from the existing structure of medicine? According to conflict theorists, physicians—who hold a legal monopoly over medicine—benefit from the existing structure because they can charge inflated fees. Similarly, clinics, pharmacies, laboratories, hospitals, supply manufacturers, insurance companies, and many other corporations derive excessive profits from the existing system of payment in medicine. In recent years, large drug companies and profit-making hospital corporations have come to occupy a larger and larger part of health care delivery. As a result, medical costs have risen rapidly, and the federal government and many insurance companies have placed pressure for cost containment on other players in the medical–industrial complex (Tilly and Tilly, 1998).

Conflict theorists increase our awareness of inequalities of race, class, and gender as these statuses influence people's access to health care. They also inform us about the problems associated with health care becoming "big business." However, some analysts believe that the conflict approach is unduly pessimistic about the gains that have been made in health status and longevity—gains that are at least partially due to large investments in research and treatment by the medical–industrial complex.

A Symbolic Interactionist Perspective: The Social Construction of Illness

Symbolic interactionists attempt to understand the specific meanings and causes that we attribute to particular events. In studying health, symbolic interactionists focus on the meanings that social actors give their illness or disease and how these affect people's self-concept and relationships with others. According to symbolic interactionists, we socially construct "health" and "illness" and how both should be treated. For example, some people explain disease by blaming it on those who are ill. If we attribute cancer to the acts of a person, we can assume that we will be immune to that disease if we do not engage in the same behavior. Nonsmokers who learn that a lung cancer victim had a two-pack-a-day habit feel comforted that they are unlikely to suffer the same fate. Similarly, victims of AIDS are often blamed for promiscuous sexual conduct or intravenous drug use, regardless of how they contracted HIV. In this case, the social definition of the illness leads to the stigmatization of individuals who suffer from the disease.

Although biological characteristics provide objective criteria for determining medical conditions such as heart disease, tuberculosis, or cancer, there is also a subjective component to how illness is defined. This subjective component is very important when we look at conditions such as childhood hyperactivity, mental illness, alcoholism, drug abuse, cigarette smoking, and overeating, all of which have been medicalized. The term ***medicalization*** **refers to the process whereby nonmedical problems become defined and treated as illnesses or disorders.** Medicalization may occur on three levels: (1) the conceptual level (e.g., the use of medical terminology to define the problem), (2) the institutional level (e.g., physicians are supervisors of treatment and gatekeepers to applying for benefits), and (3) the interactional level (e.g., when physicians treat patients' conditions as medical problems). For example, the sociologists Deborah Findlay and Leslie Miller (1994: 277) explain how gambling has been medicalized:

> Habitual gambling . . . has been regarded by a minority as a sin, and by most as a leisure pursuit—perhaps wasteful but a pastime nevertheless. Lately, however, we have seen gambling described as a psychological illness—"compulsive gambling." It is in the process of being medicalized. The consequences of this shift

- **For Discussion:** Lead a class discussion based on the following questions: How does the symbolic interactionist perspective on health care compare with other perspectives? What unique contribution can it make to our understanding?
- **ASA Task Force Recommendation:** #7 Sociological Literacy
- **For Discussion:** What is meant by the social construction of illness? Ask students to talk about the ways that illness has been described and experienced in their family. Call attention to the wide variety of experiences of the same phenomenon, such as having a cold.
- **Recent Events:** "An independent panel convened this week by the National Institutes of Health found that it is important that menopause not be viewed as a disease. The tendency among women and their healthcare providers in the U.S. to medicalize menopause concerned the panel because the tendency can lead to overuse of

in discourse (that is, in the way of thinking and talking) about gambling are considerable for doctors, who now have in gamblers a new market for their services or "treatment"; perhaps for gambling halls, which may find themselves subject to new regulations, insofar as they are deemed to contribute to the "disease"; and not least, for gamblers themselves, who are no longer treated as sinners or wastrels, but as patients, with claims on our sympathy, and to our medical insurance plans as well.

Sociologists often refer to this form of medicalization as the *medicalization of deviance* because it gives physicians and other medical professionals greater authority to determine what should be considered "normal" and "acceptable" behavior and to establish the appropriate mechanisms for controlling "deviant behaviors."

According to symbolic interactionists, medicalization is a two-way process: Just as conditions can be medicalized, so can they be demedicalized. ***Demedicalization* refers to the process whereby a problem ceases to be defined as an illness or a disorder.** Examples include the removal of certain behaviors (such as homosexuality) from the list of mental disorders compiled by the American Psychiatric Association and the deinstitutionalization of mental health patients. The process of demedicalization also continues in women's health as advocates seek to redefine childbirth and menopause as natural processes rather than as illnesses (Conrad, 1996).

© Comstock (RF)/Jupiter Images

▲ Is gambling a moral issue or a medical one? According to sociologists, the recent trend toward viewing compulsive gambling as a health care issue is an example of the medicalization of deviance.

In addition to how health and illness are defined, symbolic interactionists examine how doctors and patients interact in health care settings (see "Sociology Works!"). Some physicians may hesitate to communicate certain kinds of medical information to patients, such as why they are prescribing certain medications or what side effects or drug interactions may occur (Kendall, 2004).

Symbolic interactionist perspectives on health and health care provide us with new insights on the social construction of illness and how health and illness cannot be strictly determined by medical criteria. Symbolic interactionists also make us aware of the importance of communication between physicians and patients, including factors that may reduce effective medical treatment for some individuals. However, these approaches have been criticized for suggesting that few objective medical criteria exist for many illnesses and for overemphasizing microlevel issues without giving adequate recognition to macrolevel issues such as the effects on health care of managed care, health maintenance organizations, and for-profit hospital chains.

A Postmodernist Perspective: The Clinical Gaze

In *The Birth of the Clinic* (1994/1963), postmodern theorist Michel Foucault questioned existing assumptions about medical knowledge and the power that doctors have gained over other medical personnel and everyday people. Foucault asserted that truth in medicine—as in all other areas of life—is a social construction, in this instance one that doctors have created. Foucault believed that doctors gain power through the *clinical* (or "observing") *gaze,* which they use to gather information. Doctors develop the clinical gaze through their observation of patients; as the doctors begin to diagnose and treat medical conditions, they also start to speak

medicalization the process whereby nonmedical problems become defined and treated as illnesses or disorders.

demedicalization the process whereby a problem ceases to be defined as an illness or a disorder.

treatment approaches that are known to carry serious risks, or whose safety is as yet unclear" (National Institutes of Health, 3/2005).

- **ASA Task Force Recommendation:** #6 Empirical and Theoretical Analysis
- **Extra Examples:** "How can the free gaze that medicine, and, through it, the government, must turn upon the citizens be equipped and competent without being embroiled in the esotericism of knowledge and the rigidity of social privilege?" (Michel Foucault). Have students try to rephrase this statement in their own words.
- **For Discussion:** "The people of modernity thought that with this powerful gaze the physician could penetrate illusion and see through to the underlying reality, that the physician had the power

sociology works!

Sociology Sheds Light on the Physician–Patient Relationship

DOCTOR: What's the problem?

(Chair noise).

PATIENT: . . . had since last Monday evening so it's a week of sore throat.

DOCTOR: . . . hm . . . hm . . .

PATIENT: . . . which turned into a cold . . . and then a cough.

DOCTOR: A cold you mean what? Stuffy nose?

PATIENT: uh stuffy nose yeah not a chest . . . cold . . .

DOCTOR: . . . hm . . . hm . . . And a cough.

PATIENT: And a cough . . . which is the most irritating aspect. . . .

DOCTOR: Okay. Uh, any fever?

PATIENT: Not that I know of . . . I took it a couple of times in the beginning but haven't felt like—

DOCTOR: How bout your ears? . . . (Mishler, 2005: 322)

In this brief excerpt from the transcript of a discussion between a doctor and patient, the patient responds to the doctor's request for information by telling him what her symptoms are and how they began to change when her illness "turned into a cold . . . and then a cough." According to sociologists who study the social organization of health care, this transcript indicates that the physician wants the patient to continue speaking when he makes sounds such as "hm . . . hm," but he also wants to remain in control of the conversation. When the patient mentions that she has a "cold," for example, the doctor asks for further clarification of her specific symptoms so that he can determine, efficiently and in a short period of time, what kind of cold she has and what the treatment plan should be (Mishler, 2005). This is one brief passage from many pages of medical transcripts that researchers have used to study what they refer to as the struggle between the voice of medicine and the voice of the lifeworld (Mishler, 1984, 2005).

What are the voices of medicine and of the lifeworld? In this context, the voice of medicine refers to the technical, "wisely" about everything. As a result, other people start to believe that doctors can "penetrate illusion and see . . . the hidden truth" (Shawver, 1998).

According to Foucault, the prestige of the medical establishment was further enhanced when it became possible to categorize all illnesses within a definitive network of disease classification under which physicians can claim that they know why patients are sick. Moreover, the invention of new tests made it necessary for physicians to gaze upon the naked body, to listen to the human heart with an instrument, and to run tests on the patient's body fluids. Patients who objected were criticized by doctors for their "false modesty" and "excessive restraint" (Foucault, 1994/1963: 163). As the new rules allowed for the patient to be touched and prodded, the myth of the doctor's diagnostic wisdom was further enhanced, and "medical gestures, words, gazes took on a philosophical density that had formerly belonged only to mathematical thought" (Foucault, 1994/1963: 199). For Foucault, the formation of clinical medicine was merely one of the more-visible ways in which the fundamental structures of human experience have changed throughout history.

Foucault's work provides new insights on medical dominance, but it has been criticized for its lack of attention to alternative viewpoints. Among these is the possibility that medical breakthroughs and new technologies actually help physicians become wiser and more scientific in their endeavors. Another criticism is that Foucault's approach is based upon the false assumption that people are passive individuals who simply comply with doctors' orders—he does not take into account that people (either consciously or unconsciously) may resist the myth of the "wise doctor" and not follow "doctors' orders" (Lupton, 1997).

Foucault's analysis (1988/1961) was not limited to doctors who treat bodily illness; he also critiqued psychiatrists and the treatment of insanity.

The Concept Quick Review summarizes the major sociological perspectives on health and medicine.

to see the hidden truth" (Lois Shawver, notes on reading *The Birth of the Clinic*).

- **For Discussion:** "As a medical doctor, it is my duty to evaluate the situation with as much data as I can gather and as much expertise as I have and as much experience as I have to determine whether or not the wish of the patient is medically justified" (Jack Kevorkian). Have students examine this statement in the context of Kevorkian's controversial work with assisted suicide.
- **ASA Task Force Recommendation:** #10 Intellectual Connections Between Sociology and Other Fields
- **Extra Examples:** "More and more Americans feel disconnected from their doctors, especially compared to a generation ago. And they certainly have less confidence in the profession as a whole. In

scientific attitude adopted by many doctors in their communication with patients. This type of discourse is generally abstract, neutral, and somewhat distant. By contrast, the voice of the lifeworld refers to the natural, everyday attitudes that are expressed by patients when they talk to their physician in the hope of gaining additional insight on their medical condition. Some sociologists believe that a constant struggle exists between these two "voices" in the doctor–patient relationship and that this struggle affects the outcome of each medical encounter. The voice of medicine makes it difficult for patients to believe that their concerns are being heard when the physician is visibly in a hurry, does not listen, interrupts frequently, and/or talks down to the patient.

To minimize the voice of medicine, some sociologists advocate *therapeutic communication* between doctors and patients. In therapeutic communication (1) the physician engages in full and open communication with the patient and feels free to ask questions about psychosocial as well as physical conditions, (2) the patient provides full and open information to the physician and feels free to ask questions and seek clarifications, and (3) a genuine rapport develops between physician and patient (Weiss and Lonnquist, 2009).

According to some social analysts, it takes a doctor no additional time to use a positive communication style that conveys friendliness, empathy, genuineness, candor, an openness to conversation, and a nonjudgmental attitude toward the patient. Such a communication style certainly helps physicians establish positive relationships with their patients. Of course, patients should also try to communicate in a positive manner with physicians, people whom the patients hope will be able to help them remain healthy or help them resolve an existing medical problem (Weiss and Lonnquist, 2009).

reflect & analyze

Sociologists who study the social organization of medicine will continue to look for new insights on the physician–patient relationship in the future. What other sociological perspectives do you believe might be useful in explaining the dynamics of doctor–patient communications or other social interactions (such as between physicians and other health professionals) that routinely take place within the health care system?

[concept quick review 14.1]

Sociological Perspectives on Health and Medicine

A Functionalist Perspective: The Sick Role	People who are sick are temporarily exempt from normal obligations but must want to get well and seek competent help.
A Conflict Perspective: Inequalities in Health and Health Care	Problems in health care are rooted in the capitalist system, exemplified by the medical–industrial complex.
A Symbolic Interactionist Perspective: The Social Construction of Illness	People socially construct both "health" and "illness," and how both should be treated.
A Postmodernist Perspective: The Clinical Gaze	Doctors gain power through observing patients to gather information, thus appearing to speak "wisely."

1966, a Harris Poll found that almost three-quarters of Americans had 'a great deal' of confidence in their health care leaders. That number has steadily dropped over the last four decades, so that today only slightly more than a third feel the same way, the same poll shows" (Pauline W. Chen, *New York Times,* 9/2008).

- **Active Learning:** Have students analyze doctor–patient interactions, using examples from their own experience or those of their friends and family. Ask them to apply one of the major sociological perspectives to the interaction and to draw conclusions about the different styles of communication involved.
- **Box Note:** When your students respond to the "Reflect & Analyze" question here, encourage them to think about their own interactions with their physicians as they were growing up.