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Second Edition

The Sociology of Medicine and Illness

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Preface

It is a sociological truism that cultures change. Nowhere is this better demonstrated than in the U.S. health care institution. Consequently, the health of the population and the system of caring for the ill have changed in important ways since the first edition of this book was published. To keep up with changes, and to keep the medical sociology perspective current, this book revision was necessary.

The most significant change in health in the United States since the first edition was published was the advent of acquired immune deficiency syndrome, or AIDS, as a disease of major concern. No one in the early 1980s could have predicted the powerful impact this condition would have on the nation and its health care system. Until a cure for AIDS or its underlying infection (human immunodeficiency virus, or HIV) is found, AIDS is bound to increasingly dominate worries within the society, particularly because of fears that the disease-causing virus will spill over into the heterosexual population in a major way. Epidemiological aspects of AIDS, and society's reactions to the condition, are incorporated into this second edition.

In another change, large numbers of medical professionals are leaving solo, fee-for-service practices and are joining with other health professionals in group practice, Health Maintenance Organizations, and corporate medicine. Similar changes have affected the entire health care system, especially hospitals, which are also in a transition toward a corporate structure. As an antecedent to, or a consequence of, these changes, the authority of the physician is increasingly being questioned.

At the same time, the question of whether some sort of universal health insurance system should be established in the United States has become less controversial. For the first time, both the business community and the medical profession have recognized the need for a national system and have endorsed the idea of universal health insurance coverage. The United States is at the beginning of a debate that will eventually be settled within the political system. But, given the continuing dominance of the medical profession in the health care delivery system, the politicians will not be effective without the approval of organized medicine. Therefore, from a sociological point of view, understanding the value context of the debate is

important. A discussion of viewpoints and alternatives is included in this edition of the book.

While incorporating these changes, we maintained the general format of the first edition with some modifications. For one, we reduced the number of chapters from thirteen to twelve by combining the previously separate discussions of the medical profession and the medical school. This reflects our view that the practice of medicine should be discussed in the same context as the process of becoming a physician. For another, we revised our presentation of social epidemiology by eliminating discussion of some technical aspects and by adding an extensive discussion of AIDS and HIV infection. Third, the People's Republic of China was added to our discussion of the health care systems of other countries. Finally, in recognition of the growing debate about problems in the U.S. health care institution, we recast our previous evaluation of the system into a final chapter that looks at the health care system of the United States as a social problem.

During the revision process, we attempted to keep in mind the nature of our audience—those interested in how the sociological perspective is used to interpret health, illness, and the system that has been established in response to the perceived health needs of society. Our intended readers are students taking sociology courses, students taking courses in other disciplines for whom the sociological perspective would be new and enlightening, practitioners in the health occupations and professions, and social commentators interested in social aspects of this response.

Several colleagues contributed to our approach to the subject matter of the book, particularly during the early stages of writing; we are pleased to acknowledge their contributions. Among these colleagues are Carole A. Campbell, California State University, Long Beach; Pamela D. Elkind, Eastern Washington University, Cheney; Frederic W. Hafferty, University of Minnesota, Duluth; and Marilyn Schmit, Cardinal Stritch College, Milwaukee.

We once again acknowledge the contributions of Patricia Kurtz to our thinking and writing. Her friendly comments and veiled threats added immeasurably to the organization and readability of the book.

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Basic Sociological Concepts

INTRODUCTION

Like the other social sciences, sociology has developed by first broadening its perspectives and then by refining newly emerged interests. As the discipline of sociology developed, areas of scientific concern expanded and theories and research were extended. New interests led to new subdisciplines. Many of these now have an academic following, and many have received official recognition by sociologists and practitioners of other disciplines. In this progression, the concepts of sociology were applied to the special phenomena of new interest areas. As part of the historical development process, theoretical and methodological questions were raised, additions were made to college curricula, and research was conducted focusing on phenomena of the specialized interest. Special professional journals were founded to serve as a forum for discussion and as a means for sharing research findings, special sections of devotees were created in the national association, and, inevitably, textbooks were written to collate and explain the theories and findings of the specialty.

Within this context, sociology has broadened its perspective in the direction of medical sociology. Although a precise date of initiation is difficult to pinpoint, the mid-to-late 1800s is a convenient date to identify as the beginning of the idea for such a subdiscipline, because Virchow suggested in 1851 that medicine itself is a social science, and McIntire used the term *medical sociology* in a publication in 1894. But modern medical sociology, that is, medical sociology as we now know it, developed during the 1930s, when it was recognized that sociological insights could, and should, be applied to medicine. Particularly important were a 1927 work by Stern, who discussed social factors in medical progress, and a 1935 article by Davis, who called for research in the economic and social aspects of medicine. The first research that can truly be labeled medical sociology was undertaken in the 1930s and 1940s, when several sociologists turned their attention to health and medical phenomena (Hollingshead, 1973).

Several developments led to interest in medical sociology during the late 1940s. Significant to this development was financial and social support by such funds and foundations as Milbank Memorial, Russell Sage, Commonwealth, and Carnegie (see, for example, Freeman and Levine, 1989) along with the postwar strengthening of the National Institutes of Health and the National Institute of Mental Health. Stimuli for development came from several directions at once; the most important were the initiating of professional communication between sociologists themselves, communication between social and medical scientists, and the planning and executing of research studies. Sociology departments, colleges of medicine, and schools of public health participated in these activities.

As they moved into the new area of interest, most sociologists used their traditional academic departments as bases, but others took positions in medical and public health schools. This dual entry into what, for sociologists, was a new field is best described by Straus (1957), who refers to both the sociology *of* medicine and sociology *in* medicine. The sociology *of* medicine is an interest area within the sociology departments of arts and sciences colleges. Its emphasis is on how health phenomena fit into the wider context of society as a whole, on health and the health

care system as dimensions of society; its approach to understanding health phenomena is from the society to health phenomena. Given this location, the sociology *of* medicine is academic in nature. Sociology *in* medicine, in comparison, is usually an interest area in colleges of medicine, schools of public health, nursing schools, hospitals, and local health departments. Given these locations, sociology in medicine is often practical in nature, with focus on such problems as social factors in etiology, the ways society copes with medical problems, and reactions to illness; often, the approach is from health phenomena to the society. In either case, the medical sociologists' contribution is a new perspective, a different way of interpreting health phenomena. This distinction between *of* and *in* has become less relevant as medical sociology developed and its contributions became increasingly valuable (Freeman and Levine, 1989). The sociology *of* medicine now produces results applicable to medical practice, and sociology *in* medicine has contributed to the development of sociological theory.

The sociologists' approach provided new insights and helped explain how health-relevant occurrences and behavior were influenced by social factors. The new perspective accomplished two essential tasks simultaneously: It provided more meaningful interpretations of health events, and it pointed to previously neglected factors that must be recognized for health institutions to function effectively. Mechanic and Aiken (1986) suggest that the most significant contribution of the field has been research results that have affected how intelligent laypersons and decision makers conceptualize medicine and health policy.

Actually, the philosophical context for medical sociology had been around for many years. Although the idea for such a discipline was recognized by people like Virchow as far back as 1851, the approach lacked an acceptable means of providing the right type of recognition; the idea was without a base or a methodology that would command the respect of those functioning in the health enterprise. The new approach needed the acceptance and legitimation finally provided by sociologists who applied their increasingly accepted theoretical and methodological approaches to health phenomena in a context that has come to be known as the social system perspective (Mercer, 1972).

Medical sociology has grown considerably since its earliest days. According to Freeman and Levine (1989), this occurred because all areas of knowledge are significantly affected by the social milieu. Further, they note, dramatic changes in all facets of health care make the sociological perspective more relevant. Such changes include a commitment to provide all in need with appropriate health care, the changing demographics straining U.S. resources, the development of complex equipment, the increasing specialization among physicians, and rapidly increasing health care costs.

Medical sociology is similar to all other interest areas of the discipline. In sociological terminology, the family, education, the political system, and the economy are all social institutions; they are socially developed means, structures, and personnel for meeting the basic needs of the people. From the sociological perspective, the health system is a social institution developed to meet the health needs of the population. Thus, medical sociologists focus their efforts on the health institution,

just as the family sociologist focuses on the family as an institution, and those in other specialties focus on other social institutions. From a broader sociological perspective, all converge, since society consists of interdependent institutions.

In addition, medical sociologists share a particular perspective and a series of particular concepts with the members of all other sociological subspecialties. They emphasize the *social* and *cultural* nature of human behavior and the social processes and structures comprising society. People are seen as sociocultural beings who have been socialized to function in their particular groups and in society as a whole. This book emphasizes the behavioral patterns of U.S. society that are particularly important to the health institution.

Sociologists offered the medical sociology perspective as an alternative, or supplement, to the tradition-bound, medically based clinical approach of medical scientists. A description of the two perspectives will help us understand the differences.

TWO APPROACHES: THE CLINICAL AND THE SOCIAL SYSTEM

Clinical Approach

In the traditional approach, clinical practitioners focus on individual pathology or abnormality. Clinicians are educated and trained to be therapists who intervene so individuals can return to a normal (that is, nonpathological) health state. Most focus their attention on the biological organism and seek physiological explanations for malfunction. They rely on measurable attributes (such as a blood count) and on judgments of what is abnormal. Illness is thus individual pathology that can be diagnosed by objective means (although the art of the clinician is recognized, and even honored); a treatment regimen can then be instituted with the intent of bringing about a cure.

Social System Approach

In contrast to the emphasis on individual pathology, the social system perspective focuses on group phenomena and on what the group has defined as normal behavior. This is a widening of horizons, for emphasis is shifted to the total health system, to its everyday functions, and to the health behavior of people in groups.

When a distinction is drawn between the two perspectives, the most significant factor is the emphasis on what is normal rather than on what is abnormal. As a corollary, therapy and intervention give way to understanding and meaning. Focus is on the social rather than the biological. In this context, illness becomes a social condition. Questions about the antecedents and consequences of disease are questions about the social environment's contributions to the disease and the social effects of the condition. Since illness has a social meaning, social explanations and consequences make sense. For example, illness is defined as being important to the patient, the patient's groups, the doctor, the hospital staff, and society as a whole. To

accompany this perspective, the sociologist offers health practitioners methods that can be used to collect information about the nature and functions of the health institution.

To set the stage for an elaboration of this perspective, we present and define several sociological concepts and discuss how each helps us understand some aspects of health and illness in the United States.

SOME BASIC SOCIOLOGICAL CONCEPTS

This section reviews the sociological concepts relevant to the study of health and medicine. It is limited to the seven most significant for understanding social aspects of health and illness: (1) culture and subculture; (2) groups and categories; (3) values, norms, beliefs, knowledges, and symbols; (4) deviant behavior; (5) status and role; (6) social institutions; and (7) social stratification.

Culture and Subculture

The Concepts. The broadest of all sociological (and anthropological, we may add) concepts is that of *culture*, which is often defined as "the way of life of a people." This definition is easily understood, but it is too general; it leaves so much of the essential nature of the concept unstated that it is inadequate for all but the most casual understanding. *Culture* does refer to the way of life of a people or a society in a general sense, but the definition as stated does not indicate that people following this pattern of living develop both material and nonmaterial products. People carry on their ways of life within social contexts, not within vacuums. And when they are acting or behaving according to their ways, they develop preferences, notions of expected behavior, beliefs, knowledges, and symbols (some of the nonmaterial elements of culture); they also produce buildings, automobiles, stethoscopes, telephones, television sets, scalpels, photocopiers, sphygmomanometers, printing presses, X-ray machines, and blackboards (some of the material aspects of culture). Both nonmaterial and material products of human behavior are part of the culture; they are shared, in different degrees and in different ways, by those following a particular way of life.

Culture is taught and learned. Sociologists refer to this teaching and learning experience as the *socialization process*. During socialization, people are taught the ways of the society and of particular groups within the society; the biological person also becomes the social person.

When teaching and learning are mentioned, the usual thought is of a school system with its organized program of classes in which teachers impart knowledge to pupils. But the school system is not the only societal unit within which culture is transmitted. Most obvious, and certainly most powerful in the early years of life, is the family unit, the social institution that overtly and covertly transmits conceptions of the society and correct behavior within it. Another significant socializing group is the peer group, where people learn from equals. Also, the mass communications