HOWARD D. SCHWARTZ

Dominant Issues in Medical Sociology

THIRD EDITION

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PREFACE

As with the prefaces for each of the previous editions, I would begin by pointing out, once again, the very strong hold that *Dominant Issues* has on my heart. The material for the first edition was largely gathered at night in the Yale University Medical School library at the time my mother was dying of cancer in a room across the street. From this great loss, I was able to create something which has turned out to be quite enduring. As I have also mentioned before, the fact that the book has evoked such strong loyalties and has become something of an "institution" is an extra bonus.

The third edition appears at what seems to be a very auspicious time for U.S. health and health care. Discoveries from genetic research are certain to provide answers to many of our chronic illnesses. In response to public concern, a new administration in Washington has pledged itself to guaranteeing some form of health care for all Americans. For those of you who have remained loyal to *Dominant Issues,* and there are many, it will come as no surprise that the current edition takes note of these and other very contemporary events. Being up to date has always been one of *Dominant Issues'* strong suits.

As is also true of this third edition, just as things change, so they also stay the same. The first edition of the book published exactly fifteen years ago was the first of a new generation of readers in the field. Those aspects which so many of you have indicated should be retained, and which have been so critical to the longevity of *Dominant Issues,* will be found here. One of these is the emergent levels format which still seems to me, and you, to be the most effective mechanism

for distinguishing between the micro and macro levels of analysis in medical sociology.

Symbolic of the meshing of the tried and true with the new, adopters of previous editions will find many of the familiar sociological themes. These are embedded, however, in a collection of articles more than two-thirds of which are new to this edition. Given the rapid changes in both the U.S. health-care system and medical sociology itself, the publishing rule of thumb for readers—that successive editions should retain well over a majority of the earlier articles—does not seem to have the applicability here that it may have for some other academic areas.

As in the past, a central feature of *Dominant Issues* has been its versatility. The traditional format means that *Dominant Issues* is very compatible with the organization of the typical text, and can easily be used as a companion to it. However, for those who wish to use *Dominant Issues* as the main resource for a course, as a large number have done in the past, the volume's comprehensiveness easily permits such use.

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Howard D. Schwartz

INTRODUCTION

Perhaps the most telling point about *Dominant Issues in Medical Sociology,* and I reiterate this with each new edition, is the degree to which it has been structured around the needs of a particular audience. *Dominant Issues* has always been, and continues to be, directed to introductory students in medical sociology. The largest number of these are, of course, undergraduates representing a wide variety of academic interests. Nevertheless, it is truly gratifying to me that *Dominant Issues* has also found a permanent home in graduate seminars throughout the country.

Up to this point, *Dominant Issues in Medical Sociology* has been the mechanism through which three generations of students have been introduced to the field. In my mind, its continuing appeal can be traced to four enduring and essential characteristics. Like the earlier editions, this third one is distinctive in the degree to which it is *comprehensive, current, integrated,* and *accessible.*

Stephen Wallace, in a recent review of current medical sociology readers in *Teaching Sociology,* has commented on a hallmark of *Dominant Issues* with his observation that it is the only one using reprinted material which contains articles on mental illness. While Wallace finds this noteworthy, it is also symptomatic of a more general truth concerning the book's broad range. *Dominant Issues* is nothing if not comprehensive. Within its pages can be found examples of *micro* and *macro* medical sociology, the "sociology of medicine," and the "sociology in medicine" and a wide-ranging array of perspectives including the *feminist, Marxist, constructionist,* and *interactionist* ones as well as the so-called critical approach which cuts across most of these.

The micro issues, essentially social psychological and interpersonal in nature, were the earliest focus of the field and are found here in the first five chapters. Initially, the interest of medical sociologists was toward what was perceived to be a basically cooperative professional-patient relationship. Lately, medical sociologists have begun to look at what they perceive as the growing disjuncture between professional and patient, a view represented here by articles by Zola and Kleinman in Chapter 4 which look at strains in the doctor-patient relationship. Micro medical sociology has also moved out from the patient-professional interaction to consideration of relationships between laypersons themselves. The Corbin and Strauss reading in Chapter 3, for example, looks at the critical role of spouses in the case of chronic disease, while in the preceding chapter Boutté explores the interplay between family members when offspring are at risk for a genetically linked disease.

Macro issues, those concerned with health policy and other broad societal health and health-care concerns, are dealt with in the second half of *Dominant Issues*. The consequences of such important dynamics as the deepening exclusionary character of the U.S. health-care delivery system, a potential countervailing force in the reaffirmation of health care as a right by a new administration in Washington, the seemingly contradictory emphasis on a strong marketplace competition and increased government regulation, the escalation of corporate tendencies in the health-care sector, and the movement of the locus of much health care to outside the walls of hospitals, including the home, can all be found among the readings.

From the beginning, *Dominant Issues* has not only featured a focus on both micro and macro issues but, just as importantly, the connection between the two. And so it is this time. In this third edition, some of the more explicit and obvious linkages between micro and macro analysis relate to readings on genetics and health, AIDS, mental illness, and home care.

Another aspect of comprehensiveness is the inclusion of articles representing virtually all the major theoretical perspectives presently employed by medical sociologists. Articles by Riessman on the medicalization of women's problems and Glazer on the disproportionate burden of home care borne by women are written from a feminist perspective. Glazer's article also has a Marxist focus which it shares with Navarro's contribution to Chapter 10. In this regard, both authors see inequities in health care in the United States as part of the more general oppression along class lines found in advanced capitalist society. Because of its current popularity and prominence in medical sociology, social constructionism, with its central concern being the medicalization of numerous facets of everyday life, is very much on view in the third edition. Social constructionism is critical of the biomedical understanding of what constitutes disease and looks at how social factors influence the way diseases are defined, classified, and

"constructed." Fortunately, I have found that constructionist analysis evokes the strongest amount of interest from my medical sociology students. And if the responses of my students are to be trusted, Chapter 6 includes two of the most compelling articles of this genre. These are Wikler and Wikler's argument as to why artificial insemination should be demedicalized and Werth's description of the very recent medicalization of normal shortness in children. Perhaps because of the growing incidence of depression in the United States, there has developed, of late, a very large body of work surrounding the construction of a diagnosis of neurasthenia. This "disease" was so prevalent about a century ago in this country that, as one recent analyst put it, anyone who was anybody was diagnosed as neurasthenic. Through Kleinman's cross-cultural look at the legacy of neurasthenia, this edition of *Dominant Issues* presents, what I believe, is among the clearest articulations of the interface between very broad macro variables and the construction of disease. As a final example, another well-represented perspective, symbolic interaction, underlies discussions of the doctor-patient relationship and the way in which patients cope with illness in their own lives. Most explicit, in this regard, are Zola's articles on "structural constraints" impeding communication between doctor and patient, found in Chapter 4 and articles in Chapter 3 dealing with the ways in which spouses of the chronically ill cope and AIDS patients maintain a sense of self.

One of the early distinctions in medical sociology, and one that persists today, is that between the sociology of medicine and the sociology in medicine. The major difference is, as one sociologist has put it, that the former is driven primarily by the theoretical concerns of sociologists, the latter by the more applied concerns of those in the health field. Viewed, first and foremost, as a treatise on the professionalization process, an article in Chapter 7 dealing with current attempts of nursing to upgrade its professional standing would exemplify the sociology of medicine. On the other hand, the majority of readings in Chapter 10, which deals with social epidemiological research, would classify as sociology in medicine. Having said this, I would observe that the distinction between the sociology of and in medicine seems less tenable today than it has been in the past. With more and more medical sociology being practiced outside academic institutions, there has been, to my mind, a gradual merging of the pure and applied. This may be indicative of a desire on the part of medical sociologists to achieve a relevance in the larger health-care arena which has been largely missing. This time around, *Dominant Issues* also includes articles representing this blending of the two emphases. While Lawton Burns uses the sociological distinction between organizations and institutions to frame his discussion, his key article in Chapter 8, is at the same time, a very applied analysis of the functioning of the present-day community hospital which includes a prescription for the future. In the

same chapter, Judith Levy shows how the development of the hospice idea in the United States fits the criteria for a social movement while also identifying significant and very real problems that the movement will have to face to remain an innovative force.

I must say something here about the so-called critical perspective in medical sociology and point out that *Dominant Issues* gave a prominent place to this approach well before the term "critical" became the vogue. For example, in an article written for the last edition, I showed how the health-care system in the United States was irrational in that it served the needs of providers more than it served the needs of the public. As a sort of sequel to that piece, the third edition contains that same argument within the context of the debate over whether or not the United States should embark on rationing as a matter of public policy.

In addition to comprehensiveness, currency marks this edition even more so than it has previous ones. At the micro level, for example, the mix of articles on the patient status reflects a burst of interest in the meaning of illness for the patient. As far as the macro level is concerned, the second edition of *Dominant Issues* was the first volume of readings to focus on diagnostic-related groups (DRGs) and rationing. This edition provides detailed updates on both of these very significant issues. It also takes stock of new initiatives which will soon come forth from a new administration in Washington concerning the right of all citizens to some level of health care. The student will also find current data on the uninsured and underserved in the United States. In addition to all this and to maintain an up to date book, I have greatly enlarged the role of the "editorial comments." Representative of this effort is a discussion of the reemergence of tuberculosis in the United States which, in the last chapter, follows an article by Leavitt and Numbers about the often-overlooked contribution that public health has made to the decrease in killer infectious diseases over the last hundred years.

Dominant Issues has always placed a high premium on being an integrated set of readings. Just as I make greater use of editorial comments for the sake of currency in this edition, so I make more liberal use of addenda as way of explicating links between articles. In the case of Chapter 11, the readings are transformed into a coherent whole by using the lead article to frame those which follow.

This edition continues a tradition of accessibility which is so critical given that, for many readers, *Dominant Issues* will be the first exposure to the field of medical sociology. This tone is set, from the first, by Phil Brown's nontechnical, easy-to-comprehend overview of the field. *Dominant Issues* was the first to include some articles from such nontraditional sources as the mass media and popular sociology. In this regard, Susan Agee's description, taken from the *New York Times,* of

the anguish faced by a woman who is tested for Huntington's disease and two pieces from Pulitzer prize-winning journalist Walt Bogdanich's acclaimed investigation of the U.S. hospital system immediately come to mind. In addition, I have tried to select, where options were available, highly readable articles on a given topic. The contributions of Arthur Kleinman on the contrasting perspectives of doctor and patient and Leavitt and Numbers on the role of public health in disease prevention are cases in point.

Finally, something must be said about my retaining the term medical sociology in the title as opposed to using a variation like the "sociology of health," "the sociology of health and medicine," or "the sociology of health and illness." Any of these would have been just as appropriate for this volume of readings—that is, appropriate except for the fact that medical sociology remains the officially designated name for the field. Moreover, it is the designation still most commonly used, by far, by those working in the field.

CONTENTS

CHAPTER 1

Introduction to Medical Sociology

The development of contemporary medical sociology has had a decidedly American flavor. A German medical sociologist writing in the mid-1970s stated that all publication and research in medical sociology came from the United States. Although the United States still dominates the field, an increasing amount of important work is being done abroad. An international journal entitled *Social Science and Medicine* consistently publishes interesting and significant articles written by sociologists from around the world. With the advent of national health insurance in Canada, a great deal of work in medical sociology has been coming from, among others, a small group of researchers at the University of Toronto.

The field of medical sociology is very young as far as recognition within sociology is concerned. It was not until 1955 that an informal Committee on Medical Sociology was started within the American Sociological Association (ASA). A formal section was chartered within the ASA four years later. However, it wasn't until 1965 that the field gained a journal of its own, the *Journal of Health and Social Behavior*, which is now its official journal.

Since its founding in 1959, the section on medical sociology has grown by leaps and bounds. By 1980, its membership had grown to 1000, making it the ASA's largest and most active section.

Medical sociology has grown rapidly not just in numbers but also in domain. In the beginning, medical sociologists focused almost exclusively on microsociology—sociology at the social psychological (i.e., interpersonal) level. Although the doctor-patient relationship, the socialization and training of health professionals, and the like remain central issues, a great deal of interest in macro issues, relating to the health of Americans and the provisions of health-care services to the nation as a whole, has developed within the field. Sociologists like Eli Ginzburg, David Mechanic, and Donald Light have become important and prolific writers on a variety of health-policy issues at the national level.

Reflecting medical sociology's ever-enlarging parameters, there has been, in recent years, considerable discussion about changing the name of the field. While such titles as the sociology of "health," "health and illness," or "medicine and illness" are now attached to a considerable number of texts and courses, "medical sociology" remains the official name.

There is a consensus among medical sociologists that the future holds enormous opportunities for the field. Among those issues mentioned as fertile areas for exploration are the impact on health and health care of the increasing number of elderly; the dramatic growth in the percentage of women physicians in the United States; the push for a greater professionalization in nursing; ethical concerns related to such topics as euthanasia, rationing, and genetic research; the process through which medical research is carried out; the effect of social support on mortality and morbidity; and the interfacing of U.S. culture with a new system of health care which is likely to place limits on health-care choices as never before.

In Reading 1, a succinct but comprehensive introduction to the field entitled "Themes in Medical Sociology," Phil Brown describes medical sociology's early, and limited, focus which centered on doctors and patients within the medical setting and the field's astonishing growth since then. Among the recent developments are those resulting from feminist concerns and the women's health movement, a growing interest in health-policy issues, and a critical posture toward the increasing medicalization of so many facets of everyday life.

Reading 1

Themes in Medical Sociology

Phil Brown

The largest section of the American Sociological Association (ASA) for at least two decades has been Medical Sociology. Approximately 1,100 medical sociologists, making up 11 percent of the ASA membership, work in sociology departments, public health schools, medical schools, hospitals, state and federal health agencies, and population and family planning programs. What kinds of work do they do? What theoretical foundations do they share? What is the nature of their discipline?

I present here a sketch of the field of medical sociology (frequently called the sociology of health and illness. . . . It is not meant to be a thorough survey but a selective discussion of key elements, issues, and debates that represents my own orientation to the field.[1] I deal almost exclusively with American medical sociology, even though by doing so we lose sight of, for instance, the vibrant British medical sociology. British sociologists are largely qualitative, concentrating on doctor-patient interaction, the experience of illness, and, increasingly, the narrative approach to illness experience.

SCOPE OF THE FIELD

Medical sociology centers on the social construction of health and illness—that is, a construction shaped by the many elements of the social order and often independent from biomedical phenomena. In this perspective, medical sociology links together and makes sense of the varied manifestations of health and illness: biomedical data, professional practice, institutional structures, social policy, economics and financing, the social epidemiology of disease and death, and the individual experience of health, illness, and medical care. The discipline links the micro-level (self-awareness, individual action, and interpersonal communication), meso-level (hospitals, medical education), and macro-level (the nation's health status, the structure and political economy of the health care system, national health policy). This linkage ensures that individual entities are not studied in isolation from their surroundings. For example, an ethnic group's particular set of attitudes to health is related to the ways the members understand health-related processes, seek medical care, and interact with providers. At the same time, we must understand the ethnic group as a whole, in light of its history of immigration and acculturation, its standing in the hierarchies of status, power, and wealth, and the attitudes of the professions and the public toward the group.

For another example, if we want to understand what goes on in the interaction between client and health provider, we cannot simply analyze the language, information exchange, and power relationships in that encounter. After all, the encounter is influenced by the larger context—including professional, institutional, sociocultural, political, and economic factors. Likewise, if we want to examine the effects of diagnosis-related groups (DRGs), we cannot look only at aggregate data on a patient's length of stay in hospital. We must also explore the impacts of DRGs on particular interchanges between providers and consumers, such as discussions between doctor and patient about a hospital discharge that may be premature.

In studying health and illness in the social context, medical sociology is concerned with the distinction between disease and illness. *Disease* is a more biomedical phenomenon, though strongly affected by social forces. The distribution of disease and death differs on the basis of class, race, sex, ethnicity, education, and other

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