MEDICAL SOCIOLOGY
Topics

1. Introduction to Sociology
2. Introduction to Medical Sociology
3. Social Inequalities and Health
4. The Sociology of Medical Knowledge
5. Health
6. Medicalization
7. Social Aspects of Doctor-Patient relationship
1. INTRODUCTION TO SOCIOLOGY
Definition of sociology

• a definition of Sociology depends on the conceptual framework in operation
• there are as many definitions of Sociology as many theories of Sociology we have
• SOCIETY is not an empirical fact of Natural Science
• SOCIETY is a *phenomenon* of one of the Social Sciences, namely Sociology
Two illuminating analogies

1. season – life choices

2. the puppet theatre – our own positions in the society
   (Peter Berger)
Social world – life choices

- the social world guides all our life choices in much the same way the seasons influence our choice of clothing
"A more adequate representation of social reality now would be the puppet theatre, with the curtain rising on the little puppets jumping about on the ends of their invisible strings, cheerfully acting out the little parts that have been assigned to them..."
... We locate ourselves in society and thus recognize our own positions as we hang from its subtle strings. For a moment we see ourselves as puppets indeed. But then we grasp a decisive difference between the puppet theatre and our own drama.
Unlike the puppets, we have the possibility of stopping in our movements, looking up and perceiving the machinery by which we have been moved. In this act lies the first step towards freedom.”

Berger, P. (1963)  Invitation to Sociology: A Humanistic Perspective
Sociology

Sociology: the systematic study of human society

Sociological perspective:
the special point of view of sociology that sees
general patterns of society in the lives of
particular people

/seeing the general in the particular – Peter. B./
To see the world sociologically

We begin to see the world sociologically by realizing how

the general categories into which we fall shape our particular life experiences.

(Macionis, JJ. Sociology 2012. 2.)
Sociological Knowledge - change

Just as social change encourages sociological thinking, sociological thinking can bring about social change.

↑

The more we learn about how „the system” operates, the more we may want to change it in some way.
Sociology and personal growth

The sociological perspective:

1. Helps us assess the truth of “common sense”
2. Helps us see the opportunities and constraints in our lives.

3. Empowers us to be active participants in our society.

4. Helps us live in a diverse world.
Sociological theory

The desire to translate observations into understanding brings us to the important aspect of sociology known as **theory**.

**Theory**: a statement of how and why specific facts are related

The job of sociological theory is to explain **social behaviour** in the real world.
The 2 basic questions

What should we study?
How should we connect the facts?

↓

In the process of answering these questions, sociologists look to one or more theoretical approaches as „road maps.”
THEORETICAL APPROACHES

I. The Structural-Functional Approach
II. The Social Conflict Approach
III. The Symbolic-Interaction Approach
The structural-functional approach

- sees society as a **complex system** whose parts work together to promote **solidarity** and **stability**
- points to **social structure**, any relatively **stable pattern of social behavior**
- looks for **social pattern** for the operation of society as a whole
- all social structures function to keep society going (at least in its present form)
The social conflict approach

• sees society as an arena for *inequality* that generates *conflict* and *change*
• highlights inequality and change
The symbolic-interaction approach

- uses a micro-level orientation: a close-up focus on social interaction in specific situations
- sees society as the product of everyday interactions of individuals
- society is the shared reality that people construct for themselves as they interact with one another
- we create reality as we define our surroundings, decide what we think of others, and shape our own identities
Some key topics

Social Identities

Socialization, Identity, and Interaction
Sex and gender
Racial and ethnic identities
Deviant and conformist identities
Body, health and medicine
Social Structures

Education
Communication and the media
Religion, belief and meaning
Family and household
City and community
Globalization
Work, employment and leisure
Inequality, poverty, and wealth
Stratification, class, and status
Organization, management, and control
Politics, power, and protest
The state, social policy, and welfare
2. INTRODUCTION TO MEDICAL SOCIOLOGY
Medical Sociology

Def.:

is the study of social causes and consequences of health and illness


is the study of society in so far as it concerns health and disease

(Hannay, D.R. Lecture Notes on Medical Sociology. Blackwell 1988. 35.)
multidisciplinarity
Connections with other fields /multidisciplinarity/

- Epidemiology
- Social Medicine
- Preventive Medicine
- Public Health
- Philosophy
- History

etc.
Fields of Medical Sociology

A. SOCIOLOGY OF MEDICINE

B. SOCIOLOGY IN MEDICINE

C. SOCIOLOGY OF HEALTH
A. SOCIOLOGY OF MEDICINE

Examples:

→ Social Construction of Medical Knowledge
→ Medicalization
→ Sociology/Social Functions of Medical Institutions (eg. Hospitals)
B. SOCIOLOGY IN MEDICINE

Examples:

→ Compliance and Concordance
→ Doctor-Patient Relationships
→ Illness Behaviour, The Sick Role
→ Lay Knowledge
→ Professional Socialization
→ Medical Autonomy
C. SOCIOLOGY OF HEALTH

focuses on prevention (more specifically: primary prevention)

Examples:

→ Social Stratification and Health
→ Health Promotion
→ Social Problems and Health
A survey of medical sociology

What are the *key areas* and *key concepts* of medical sociology?

(Key Concepts → Jonathan GABE, Mike BURY and Mary Ann ELSTON: Key Concepts in Medical Sociology, SAGE 2004)
Key areas

- Social Epidemiology
- Sociocultural Responses to Health and Illness
- Patient-Practitioner Relationships
- The Sociology of the Hospital
- The Organization of Medical Care
- Health Services Utilization
- The Sociology of Medical Education
• Class/Ethnicity/Gender and Health
• Health Inequalities
• The Sociology of Stress and Coping Behaviour
• The Sociology of Health Occupations
• Social Psychiatry and Mental Health
• Medicalization
• Social Policy and Health Care
• Sociology of the Body: Chronic Illness and Disability
• Ageing and Health
• Death and Dying
• Places of Care
• Social History of Health and Healing
Key concepts (1 of 5)

Social patterning of health

Social Class
Gender
Ethnicity
Age
Place
Health and Development
Material and Cultural Factors
Psycho-social Factors
Social Support
Life Events
Lifecourse
Key concepts (2 of 5)
experience of illness

Medicalization
Illness Behaviour
Stigma
Embodiment
Chronic Illness and Disability
Illness Narratives
Risk
The Sick Role
Practitioner–Client Relationships
Uncertainty
Compliance and Concordance
Quality of Life
Dying Trajectories
Key concepts (3 of 5)
health, knowledge and practice

Medical Model
Social Constructionism
Lay Knowledge
Reproduction
Medical Technologies
Geneticization
Surveillance and Health Promotion
Key concepts (4 of 5)
health work and the division of labour

Professions and Professionalization
Professional Socialization
Medical Autonomy and Medical Dominance
Decline of Medical Autonomy
Medical Pluralism
Negotiated Order
Emotional Labour
Informal Care
Key concepts (5 of 5)

health care organization and policy

Hospitals and Health Care Organizations
Privatization
Managerialism
Consumerism
Social Movements and Health
Social Problems and Health
The New Public Health
Medicines Regulation
Citizenship and Health
Evaluation
Malpractice
An example:

Social factors and health/disease
MEASURING THE HEALTH OF the POPULATION AT RISK

/Preliminary tasks/

What is health? ➔ We need an operational definition of health.

To measure health in a negative way:

What diseases we have? ➔ We need a nosology.

To measure disease frequency in the population at risk?

We need (a) measure(s).
## Leading causes of death

**Change:**

<table>
<thead>
<tr>
<th>PAST</th>
<th>→</th>
<th>PRESENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epidemics</td>
<td></td>
<td>Civilisation Illnesses</td>
</tr>
</tbody>
</table>

**Example:**

leading causes of death - EU-27,2009
Civilisation illness

- illness of which the development is strongly associated with the general lifestyle in the so called civilized countries
Civilisation Illnesses

Two key terms here:

→ multifactoriality
→ biopsychosocial model
Medical sociology

- focuses on the **social determinants and consequences** of health and disease, which are forming a subgroup of the environmental factors

- it, however, has more other general topics to discuss, which are not forming parts of social epidemiology
Epidemiology and medical sociology
some shared common basic terms
**measuring health and disease**

- Mortality
- Morbidity
- Incidence
- Prevalence
- Life Expectancy
MORTALITY, MORBIDITY

Health can be measured in a variety of ways.

Two of these measures are of particular importance:

**Mortality**: the fact and cause of death

**Morbidity**: sickness
Death rate/Crude mortality rate

From the knowledge of the number of deaths and the size of the population, it is possible to calculate what is known as the crude death rate

\[
\text{Crude mortality rate} = \frac{\text{Number of deaths in a specified period}}{\text{Average total population during that period}} \times 10^n
\]
Death rates

It may sometimes be important to identify death-rates within particular age groups.

\[ \downarrow \]

Age-specific death rates are often calculated.

2 of them are of special importance:

* stillbirth rate
* infant mortality rate
Morbidity

• death rates are particularly useful for investigating diseases with a high case-fatality
• however, many diseases have low case-fatality (e.g. most mental illnesses, chickenpox)

↓

in this case data on morbidity (illness) are more useful than mortality rates
Incidence, Prevalence

**Incidence:** the number of **new** cases of a disease during a specified period of time

**Prevalence:** the number of **existing** cases of a disease at a specific point in time
rates

incidence and prevalence are normally presented as rates as both are more useful if converted into rates

↓

Incidence Rate,

Prevalence Rate
Incidence rate

\[
I = \frac{\text{Number of new events in a specified period}}{\text{Number of persons exposed to risk during this period \times 10^7}}
\]
Prevalence rate

\[ P = \frac{\text{Number of people with the disease or condition at a specified time}}{\text{Number of people in the population at risk at the specified time}} \times 10^n \]
Risk

• is the probability that a person becomes diseased during the time of observation

\[
\text{risk} = \frac{\text{number of persons who become diseased during a time period}}{\text{number of persons at the beginning of time period}}
\]
Population at risk

Def.: that part of the population which is susceptible to a disease

→ the calculation of measures of disease frequency depends on correct estimates of the number of people under consideration

→ ideally these figures should include only people who are potentially susceptible to the diseases studied
Life expectancy

Def.: the average number of years an individual of a given age is expected to live if current mortality rates continue
3. SOCIAL INEQUALITIES AND HEALTH
Moral Equality

Def.:

people who are *similarly* situated in morally relevant respects should be *treated similarly*

↓

Questions:
1. What kinds of similarity count as relevant?
2. What constitutes similar treatment?
The principle of moral equality

everyone is morally equal

(each person has the same moral worth)
NATURAL HUMAN HIERARCHY  

one group is inherently superior to another

EGALITARIAN PLATEOU

each person has the same moral worth
The principle of moral equality

everyone is morally equal

↓

we all enjoy the same basic freedoms

- notice: the term „moral equality” is defined
Basic freedoms

European Convention: fundamental freedoms

John Rawls: „citizens of a just society are to have the same basic rights”

(Rawls 1999:61.)
synonyms

the same *moral worth* =

the same *basic freedoms* =

the same *fundamental freedoms* =

the same *basic rights*
The „equality of what?” question

BUT:

people disagree about the form that these basic freedoms should take
The „equality of what?” question

What needs to be equally distributed to make a society just?

(Sen 1980.)

What it is that is to be equalised?

(Sen 2004:22)
inequality

consists in the differences between individuals or groups in the possession of what is desirable or undesirable
Two influential answers

JOHN RAWLS
A Theory of Justice (1971)

AMARTYA SEN
JOHN RAWLS

primary social goods would be equalised

AMARTYA SEN

they need to be backed up with equality in substantive freedoms (capabilities)

Example:

the individual with impairments may require a higher income to secure the same life chances as one without impairments
The value of health in sen’s account of core capabilities

„Health is among the most important conditions of human life and a critically significant constituent of human capabilities which we have reason to value. Any conception of social justice that accepts the need for a fair distribution ... of human capabilities cannot ignore the role of health in human life and the opportunities that people respectively have to...
... achieve good health – free from escapable illness, avoidable afflictions and premature mortality. Equity in the achievement and distribution of health gets, thus, incorporated and embedded in a larger understanding of justice.”

Equality/Inequality can be interpreted from different perspectives.

Some examples:
- equality in rights
- equality before the law
- equality of political power
- gender equality
- racial equality
- social equality
SOCIAL EQUALITY/SOCIAL INEQUALITY
Social equality

Def.: is a social state of affairs in which all people within a specific society or isolated group have the same status in a certain respect

* equal rights under the law
* economic equity, i.e. access to education, health care and other social securities
Social inequality

Def.:

refers to a situation in which individual groups in a society do not have equal social status in a certain respect
How to define individual groups?

What characteristics need to be taken into account in defining a group?
STARTIFICATION
→ a number of different classschemes have been proposed, each giving a slightly different picture of the class structure
example

United Kingdom:

Registrar-General’S Occupational Social Class (RG)

- the classification of social classes that has been used in many official statistics
Characteristics of rg I.

- revolves around 3 basic social classes:

  1. The upper and the middle classes,
  2. Skilled workers,
  3. Unskilled labourers

(to which are added 2 intermediate categories to cover those who do not fit neatly into the 3 principal social classes)
Characteristics of rg II.

- the resulting 5 social classes are numbered in Roman figures from I to V
Registrar-general’s occupational social class

(I) Professional
(II) Intermediate
(IIIN) Skilled non-manual
(IIIM) Skilled manual
(IV) Semi-skilled manual
(V) Unskilled manual
Socio-economic positions

• societally determined and individually generated positions (fashioned by individuals making their way in societies whose major institutions continuously stratify them)

• valuable resources are not confined to economic assets – like well-paid job, financial investments and property -, various types of cultural capital also matter
Socio-economic positions

• constituted along a range of dimensions

SOCIAL CLASS = SOCIO-ECONOMIC POSITION

(Remark: it is a stipulative definition)
Social inequality

a multidimensional continuum

those with more of the resources which their society values will occupy positions towards the end of a continuum, while those with less will be concentrated at its lower end
Areas of **social inequality** include

* income, education, occupation
* access to social goods and services (eg. access to health care)
* family life, **neighborhood life**
* job satisfaction etc.
Health inequality or health inequalities

- ‘health inequality’ and ‘health inequalities’ tend to be used interchangeably in national and international policy debates
- the plural usage is more common
Health inequality and health inequities

**Health inequality**: describes patterns of health

(descriptive term; simply describing what is, it makes no moral judgements about what should be)

**Health inequity**: refers to health inequalities which are ‘politically, socially and economically unacceptable’

(WHO 1978. 1.)

(normative term)
The meanings of health inequalities

A. Health differences between individuals

B. Health differences between population groups

C. Health differences between groups occupying positions in society
Explanation of health inequalities

1. Artefact explanations.
2. Theories of natural or social selection.
3. Materialist or structuralist explanations.
4. THE SOCIOLOGY OF MEDICAL KNOWLEDGE
The development of modern medicine

• ‘the Enlightenment’ (as a body of thoughts)
  reason ↔ belief, superstition, religious thought
  scientific method

• growing secularization of society
BIOMEDICINE

is the principal way of understanding health illness in western culture

(widely accepted not just by medical profession but also by the lay (non-professional) population)
The medical model of explanation

1. Mind-body dualism
2. Mechanical metaphor
3. Technological imperative
4. Reductionist
5. The doctrine of specific aetiology
1. Mind-body dualism

Monism/Dualism
I. monism

there is one ultimate substance that constitutes the world

Its ontology:

A. Physicalism/Materialism
B. Idealism
C. Neutral monism
Ontology of monism

A. Physicalism/Materialism

the ultimate substance is matter and its attendand manifestation of energy and the forces that interact among and on material entities
Ontology of monism

B. Idealism

mind or spirit is the ultimate substance of the world

C. Neutral monism

the ultimate substance is neither matter nor mind or spirit but a third substance
II. dualism

there are two separate entities that capture reality

Its ontology:

*the more traditional position:

René Descartes (1596-1650)
Types of dualism

• **Interactionism**: mind and body can interact with one another

• **Epiphenomenalism**: the body affects the mind but the mind does not affect the body
Types of dualism

- **Parallelism**: the mind and body are two comparable, non-reducible realities or entities that do not interact.

- **Dual aspect theory**: body and mind are not two separate realities per se, but two separate properties of the same reality or entity.
2. Mechanical metaphor

- the patient as mechanical body
The patient as mechanical body

sources for the mechanization of the human body:

* René Descartes

* physicians motivated By Isaac Newton (1643-1728) and his mechanical philosophy

↓

after Newton IATROMECHANISM became the dominant approach to medical practice and increasingly influenced its practice until the present
The result of mechanization

1. The Fragmented Body: the division of body into individual, isolated parts

2. The Standardized Body: the generic body to which the patient’s body qua clinical data is compared
3. **The Transparent Body**: medical technology allows physicians to peer into the inner reaches of the patient’s body

4. **The Estranged Body**: the alienation of the patient’s body from the self and lived context and from other people
“to view the human being as an assemblage of bodily parts and processes is to deprive the patient of every moral as well as social dimension”

Who’s definition of health

Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.
paradigm

refers to a mode of thought, a particular way of seeing the world,
that sets boundaries to

- what we see
- how we might measure and record that information and
- which factors are significant and which are not
LUDWIG FLECK → thought collectives

THOMAS KUHN → paradigms

Paradigm shift: a change in the basic assumptions within the ruling theory of science
(The Structure of Scientific Revolutions, 1962)

MICHEL FOUCAULT → episteme
The dynamic nature of medical knowledge

1. Medical knowledge has changed and developed over time
2. Medical knowledge has become increasingly specialized

3. Each paradigm shift in thought has entailed a shift in the nature of the relationship between the practitioner and the patient
Foucault and the clinical gaze

Michel Foucault (1926-1984)

Madness and Civilization (1967)
The Order of Things (1970)
The Birth of the Clinic (1973)
Discipline and Punish (1979)
The Birth of the Clinic.
An Archeology of Medical Perception

(1973)
Clinical gaze

• a specific way of conceptualizing the body
• the **corpse** became the source of knowledge about the body
• to interpret the body and its workings requires a ‘guide’
Clinical autonomy

the freedom of clinicians to make decisions on the basis of their professional judgement and specialist knowledge

challenges to this degree of clinical freedom:
1. patients
2. alternative practitioners
3. health managers
Clinical judgements

A. Positive developments in medicine
   = bring about positive changes in the patient

B. Harm resulting from health care
   = lead to negative effects on the patient

IATROGENESIS = medical harm
A. Positive developments in medicine

O ------------------------------- O

minor ailments
life can be saved

can be eliminated
and prolonged
B. IATROGENESIS (medical harm)

- **Clinical iatrogenesis**: „doctor-caused illness”, harm would not have been caused *without* the medical intervention

- **Cultural iatrogenesis**: dependence on medicine to cure and care for; people no longer take responsibility for their own health problems

5. HEALTH
DEFINING HEALTH
„Why should we be interested in defining health? Because if health is the goal of healthcare and research, we need to know what it looks like and how to measure it.”

(Machteld Huber et al. ‘How should we define health?’ BMJ 30 July 2011 Vol 343 235-7.)
Defining health

There are many ways of defining health, but generally speaking these can be divided into 2 broad types:

1. Official definitions
2. Lay beliefs
1. Official definitions

the views of health professionals

2. Lay beliefs

the views of those who are not professionally involved in health issues
1. Official definitions: the views of health professionals are of 2 main types:

1.A. those which define health *negatively* the absence of certain qualities such as *disease* and *illness*

1.B. those which adopt a *more positive stance* the presence of certain qualities
WHO’s definition of health

Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.
WHO’s definition of health

→ health is not merely the absence of negative traits
   (such as illness, or injury), but

→ requires the presence of positive traits
   (such as feelings of well-being),
   traits which are social and psychological as well as physical
WHO’s definition of health

Problems

1. It unintentionally contributes to medicalization of society
WHO’s definition of health Problems

2. Since 1948 the demography of populations and the nature of disease have changed considerably
WHO’s definition of health Problems

3. ‘Complete’ is neither operational nor measurable.
A new proposal?

• two day meeting in the Netherlands in December 2009

Invitational Conference 'Is health a state or an ability? Towards a dynamic concept of health'. December 10-11, 2009.

(Report of the meeting was published in May 2010, http://www.gezondheidsraad.nl/sites/default/files/bijlage%20A1004_1.pdf)
A new definition of health?

„the ability to adopt and to self manage”

(In. Machteld Huber et al. ’How should we define health?,’ BMJ 30 July 2011 Vol 343 235-7.)
MEASURING HEALTH
**Society (Social indicators)**

- measurements of health are used to indicate the major health problems confronting society

**Individual**

- many indicators of the health of individuals have been developed
„the onion principle”

as the numerator becomes smaller, it also becomes less representative as an indicator of the health of the broader population

↓

the resolution of one type of health problem reveals a new layer of concerns
example

Health problems:

- Infant Mortality Rates declines
- low birth weight

- life expectancy increases in industrial societies
- disability
Types of health measurements

There are several ways to classify health measurements:

A. Function (the purpose of the method)

B. Descriptive classifications (focus on the scope)

C. Methodological classifications (consider technical aspects)
Reliability and validity

**Reliability**: consistency of a measure; is a matter of whether a particular technique, applied repeatedly to the same object, yields the same result each time

**Validity**: refers to the extent to which an empirical measure adequately reflects the real meaning of the concept under consideration
MEASURING SOCIAL HEALTH
Social health

A. as a characteristic of the society
B. as a characteristic of an individual
A. The concept of the social health of society

This regards social health as a characteristic of society rather than of individuals:

„A society is healthy when there is equal opportunity for all and access by all to the goods and services essential to full functioning as a citizen”

B. The concept of the social health of individuals

„that dimension of an individual’s well-being that concerns how ge gets along with other people, how other people react to him, and how he interacts with social institutions and societal mores”

Measuring social health

What scales do we have?
And what they are good for?

I. Adjustment Scales
II. Social Support Scales
I. Adjustment Scales

Key Question:

Does the individual function adequately in personal relationships?

(social adjustment)
I. Adjustment Scales

*social adjustment*: definable in terms of the interplay between the individual and her social environment and her success in chosen social roles

- social adjustment may be measured by
  A. considering a person’s satisfaction with his relationships /affective resp./ or
  B. by studying his performance of various social roles
II. Social Support Scales

• **social support**: generally definable in terms of the availability of people whom the individual trusts, on whom we can rely, and who make him feel cared for and valued as a person.
The Social Relationship Scale
(Allan H. McFarlan, 1981)

Conceptual basis:

„social bonds” are considered necessary for the individual to cope with adverse events
The Social Relationship Scale

• was developed to measure the extent of an individual’s network of social relationships and its perceived helpfulness in cushioning the effects of life stresses on health

• was intended primarily as a research instrument for use in studies of life events in general population samples
Three scores may be calculated:

1. The **quality of the network**
2. The **extent of the network**
3. The **degree of reciprocity**
6. MEDICALIZATION
Medicalization

Definition:

A process by which non-medical problems become defined and treated as medical problems, usually in terms of illnesses or disorders.

Problems: non-medical / medical

? : How does a problem become a medical problem?
Examples

Non-medical context

Sexual attraction or behaviour between members of the same sex or gender

Persistent pattern of inattention and/or hyperactivity-impulsivity

Medical context

Homosexuality (DSM I.; 1952)

ADHD (Attention-Deficit/Hyperactivity Disorder)
Non-medical context

Normal Sorrow/Sadness

Contested Illnesses

Medical context

Depressive Disorder
FEATURES OF MEDICALIZATION

1. bidirectional

2. need not be total

3. medical categories can shift on the continuum toward or away from more complete medicalization

4. is a form of collective action
FEATURES OF MEDICALIZATION

5. focuses the source of the problem in the individual rather than in the social environment

6. calls for individual medical interventions rather than more collective or social solutions

7. increases the amount of medical social control over human behavior
„From a sociological perspective, case studies of medicalization have created a new understanding of the social process involved in the cultural production of medical categories or knowledge; however, these investigations do not necessarily contain a mandate as to how the categories and knowledge are to be evaluated.”

(Peter Conrad. 2007. The Medicalization of Society. 10.)
SOCIAL CONSTRUCTIONISM

A disease does not exist until the social institution of medicine creates a representative diagnostic category.

(Brown 1995.; Freidson 1971.)
Classification systems

- **DSM:** Diagnostic and Statistic Manual of Mental Disorders

- **ICD:** International Statistic Classification of Diseases and Related Health Problems
CONTESTED ILLNESSES
Examples of CONTESTED ILLNESSES

• chronic fatigue syndrome (CFS)/myalgic encephalomyelitis (ME)
• fibromyalgia syndrome
• irritable bowel syndrome
• urologic chronic pelvic pain syndrome
• temporomandibular dysfunction (TMJ)
• tension headache
• multiple sensitivity disorder
• Gulf War syndrome
• sick building syndrome etc.
CONTESTED ILLNESSES

DEFINITION

conditions in which sufferers and their advocates struggle to have medically unexplainable symptoms recognized in biomedical terms, despite resistance from medical researchers, practitioners, and institutions
• the subjective **experience of these illnesses** stand in sharp contrast to the **medical uncertainty** surrounding them

„*uncertainty*“: lack of medical consensus concerning the biological nature of these illnesses

„*contested*“: A. clash between medical knowledge and patient experience
B. these illnesses exist somewhere between entirely discredited and fully legitimate diseases
• conditions for which individual patients and patient groups demand medicalization (explanation and remedy)

→ given the gulf between distress and negative medical tests, sufferers sometimes begin to **doubt their own grip on reality**
→ „the pilgrimage“: many individuals doggedly continue their search for a biological explanation in an effort to prove to medical professionals, their families, and themselves that they really are ill
DIAGNOSIS

• doctor-patient encounters favor diagnosing
diagnosis: effectively legitimizes both parties and the doctor-patient relationship itself

for the **physician**: diagnosis represents codified knowledge about a patient’s experience and indicates a treatment protocol

for the **patient**: diagnosis gives meaning and legitimacy to worrying symptoms
• “decision rule”/”diagnostic imperative”:

  tendency within medicine to favor assigning illness over health
  physician prefer to diagnose illness rather then health

  (the diagnosing behavior)
„Under the weight of the decision rule, even physicians who are sceptical about contested illnesses are inclined to diagnose them.”

(Barker 2010. 156.)
• contested illnesses are "interactive kinds of things" (Hacking 1999)

individuals reorient their symptoms and sense of self in relationship to that disease designation

Diagnosis
→ contributes to the creation of an illness identity
→ launches a particular illness career
→ makes possible affiliations with an illness community
DEVIANCE
SOCIAL NORMS

- Pluralist society ➔ no universal metaphysics
- Pluralist ethics ➔ no universal ethical norms
Theories of DEVIANCE

I. POSITIVIST approach

deviance exists in the objective experience of the people who commit deviant act and those who respond to them

I. INTERACTIONIST approach

actions or conditions that are defined as inappropriate to or in violation of certain powerful groups’ conventions
FEATURES OF DEVIANCE

1. Social definition
2. Universal
3. Contextual
4. Social groups make rules and enforce their definitions on members through judgement and social sanction
5. Defining and sanctioning deviance involves power
Labeling theory

The so-called „labeling theory” provides the framework for understanding the interactive processes of stigmatization.

Labeling theory says:

once a person is defined, or labeled, by other people in a certain way, others will respond to him or her in accordance with the label
THE CONTROL OF DEVIANCE

Medicalization is

often associated with the control of deviance
and
the ways in which deviant behaviours that were
once defined as immoral, sinful or criminal have
been given medical meaning.

deviance – control (power relations);
deviant behaviour - medical meaning
SOCIAL CONTROL

• *wider meaning*: the processes societies develop for regulating themselves

  (eg. Edward A. Ross (1901.))

• *narrower meaning*: the control of deviance and the promotion of conformity

  (eg. Talcott Parsons (1951))
7. SOCIAL ASPECTS OF DOCTOR-PATIENT RELATIONSHIP
Illness

• Illness: a type of deviation from a set of norms representing health or normality

→ the concept of illness is inherently evaluational: medicine is a moral enterprise seeking to uncover and control things that its considers undesirable
Two kinds of imputed deviance

1. step: Moral designation of deviance: singling out something bad or undesirable (it is generally moral, therefore social)
   ↓
2. step: Illness can be analyzed as biological deviance or social deviance
   ↓
   1. **biological deviance**: the armamentarium of medicine is appropriate
   2. **social deviance**: sociology is appropriate
Illness as biological deviance

Assumptions:

→ deviant signs are independent of the vagaries of human culture (objectivity)

→ deviant signs are successfully manageable by the same scientific medical techniques everywhere (universality)

→ medicine’s tasks:
  1. to explain the cause of an illness
  2. to discover proper treatment(s) for an illness
The STATE

The MEANING OF A STATE

PROBLEM

RESEARCH

• The etiology of the state

  (the contribution of social variables to the etiology and management of disease)

• The etiology of the meaning of a state

  (requires explanation of the cause and consequences of the meaning attached to behavior)
Research questions

- How does a state come to be considered deviant?

- How does it come to be considered one kind of deviance rather than another?

- Is there patterning in the way deviance tends to be imputed?

- What does the imputation of a particular kind of deviance do to the organization of the interaction between interested parties?
„The basic point of the distinction between primary and secondary deviation is that significant deviance is a function of others’ responses to an individual’s characteristics or an individual’s response to himself. The characteristics themselves are of less importance to producing and forming deviance than are the social responses to them, the labeling that gives them meaning.”

(Medicine as Profession 219.)
Talcott Parsons: The Social System

Talcott Parsons – „the sick role“
„Certainly by almost any definition health is included in the functional needs of the individual member of the society so that from the point of view of functioning of the social system, too low a general level of health, too high an incidence of illness, is dysfunctional. This is in the first instance because illness incapacitates for the effective performance of social roles. It could of course be that this incidence was completely uncontrollable by social action, an independently given condition of social life. But in so far as it is controllable, through rational action or otherwise, it is clear that there is a functional interest of the society in its control, broadly in the minimization of illness.”

(Talcott Parsons. 1951. The Social System 430.)
The 4 basic aspects of the parsionian sick role

1. The exemption of the sick individual from normal social role responsibilities
2. The nonresponsibility of the individual for his or her condition
3. The recognition that being sick is undesirable and one should want to get well
4. The obligation to seek out competent help
The role of the practitioner

- just like the sick concept, the patient-practitioner relationship is an institutionalized role-set in contemporary Western societies

- the practitioner is to function as the social control agent for society in situations where the deviant individual is not held responsible for his or her inability to perform normal task and role obligations
the practitioner

1. Technical specificity
2. Functional specificity
3. Affective neutrality
4. Universalism
Criticism of Parsons’ patient-practitioner relationship

1. It does not apply to all illnesses

2. There are social and also cultural barriers to communication

3. There is a growing number of nonphysician practitioners

4. The provision of health care is becoming more and more of a team effort
Criticism of Parson’s patient-practitioner relationship

5. We are seeing an increase in the involvement of the patient’s family in the treatment process and an increase of familial efforts concerning the patient’s life space and health care.

6. There is the expansion of our conception of health and illness beyond strictly physiological criteria.
THE END