3

Theoretical Contours

The major theoretical frameworks of structural functionalism, symbolic interactionism, and conflict theory have competed for influence within the field of medical sociology over the past 60 years. Different approaches have dominated at different times; for example, as we will see below, the structural functionalist medical sociology of Parsons was most influential in the 1950s. It subsequently gave way to research more closely aligned with symbolic interactionism in the 1960s. In the past 15 years, a medical sociology inspired by a cluster of approaches that are often grouped together and characterized broadly as "conflict theory" has focused on inequality as a social determinant of health and has fostered links with theoretical and empirical research in political economy and at the same time nurtured discussion between researchers employing positivist, interpretivist, and critical realist epistemologies. Research tied to the theoretical tradition of symbolic interactionism was central to some of the pioneering work in medical sociology of the 1960s, and continues to flourish.

My analysis of how these traditions have influenced the development of medical sociology highlights the notion that theories should not be seen as discrete models; they often interact and sometimes clash, and in doing so, change the fundamental nature of the field. Theories act as lenses through which we investigate the social world; some bring to our attention problems of inequity, while others bring forth issues of lived experience. In other words, theories enable researchers to view questions of health and illness from different perspectives and help us to identify a wide range of issues that influence patterns of health in society. The discussion below traces the general theoretical contours of the field by asking: What are the major theoretical perspectives of sociology that have influenced medical sociology, what roles have they played, and what influence do they currently have?

The Sick Role: Parsons and Structural Functionalism

The major theoretical perspectives are distinguished by the way they view or define society. The structural functionalist perspective, with its roots in the works of Auguste Comte (1798–1857), Herbert Spencer (1820–1903), and Emile Durkheim (1858–1917), is based on the notions of equilibrium and consensus. It sees society as a system of inter-related parts, and seeks to identify the functions (both manifest and latent) that these parts carry out (Craib, 1997).

Structural functionalist analysis rests on the idea of *functional necessity*. This was most clearly elaborated in Kingsley Davis and Wilbert Moore's (1945) analysis of the functional necessity of stratification, where they argued that differential rewards are required by society. Under this approach, a system of differential rewards (in other words, inequality in resources and prestige) is needed for the proper functioning of a social system, a notion with deep Parsonian roots. Their analysis begins with the observation that stratification is universal; no society is "classless" or unstratified. They then attempt to explain the universality of stratification with its functional necessity:

> As a functioning mechanism a society must somehow distribute its members in social positions and induce them to perform the duties of these positions. It must thus concern itself with motivation at two different levels: to instill in the proper individuals the desire to fill certain positions, and, once in these positions, the desire to perform the duties attached to them . . . Inevitably, then, a society must have, first, some kind of rewards that it can use as inducements, and, second, some way of distributing these rewards differentially according to positions. The rewards and their distribution become a part of the social order, and thus give rise to stratification.
>
> (1945: 242–243)

For Davis and Moore, stratification therefore serves a vital societal function. They conclude

> Social inequality is thus an unconsciously evolved device by which societies insure that the most important positions are conscientiously filled by the most qualified persons. Hence every society, no matter how simple or complex, must differentiate persons in terms of both prestige and esteem, and must therefore possess a certain amount of institutionalized inequality.
>
> (1945: 243)

Their theory of stratification has been heavily criticized for ignoring factors such as inherited wealth, inter-generational family status, and class structure (Tumin, 1953; Waters, 1994), and is not widely accepted today. However, their work remains a classic example of the logic underlying the structural functionalist approach insofar as it relies on the concept of

functional necessity and seeks to understand how a social system achieves equilibrium.

Along these lines, structural functionalism sees health as requirement of a properly functioning system; it is prerequisite for proper role performance. For instance, illness is *dysfunctional* in the sense that it interferes with people's capacity to carry out their prescribed social roles and obligations; as such, without some mechanism for legitimization, illness is deviance. It is the role of the medical system (or more precisely, the medical profession) to regulate this dysfunction by treating, curing, or preventing disease that may otherwise interfere with expected social actions and norms (Cockerham, 2004). For Gerhardt, "illness represents a threat to the social structure and its fabric of roles. It reverses the repression of emotional needs which produces role conformity, and it allows passivity and dependency which jeopardize 'healthy' competition in the labour market" (1979: 230–231). This theoretical lens therefore gives primacy to issues of social roles and mechanisms that shape those roles.

The American sociologist Talcott Parsons developed structural functionalism as a leading theory in sociology (Holton, 2008). Indeed, Parsons' publication of *The Social System* in 1951 was a landmark in the development of medical sociology as a theoretical subdiscipline. In *The Social System*, he developed a novel model of society, one where "social order and harmony are preserved by people acting in certain defined roles and performing certain functions" (Lupton, 2003: 7). For Parsons, illness is dysfunctional and therefore "deviant", as it interferes with the performance of normative roles. Indeed, he defined deviance as "behaviour which is defined in sociological terms as failing in some way to fulfill the institutionally defined expectations of one or more of the roles in which the individual is implicated in society" (1951: 610).

Consider an office clerk who misses work, or a student who fails to attend a final exam. Both are examples of individuals failing to perform their expected roles; on a basic level, both cases are examples of deviant behaviour. But what happens if their behaviour is a result of an illness of reasonable severity? Most of us would excuse the clerk and the student from their expected roles; the clerk may stay at home without fear of losing pay and the student may rightfully expect to be able to write a makeup exam. The structural functionalist position

> is to view illness as a potential state of 'deviance'; that is, failure to conform to societal expectations and norms in some way. Illness is considered an unnatural state of the human body, causing both physical and social dysfunction, and therefore a state which must be alleviated as soon as possible.
>
> (Lupton, 2003: 7)

To account for this potential problem, Parsons theorized the *sick role* – a normative social role with accompanying rights and obligations that sick people follow to legitimate their condition.

Parsons (1951) argued that there are four components to the sick role: (1) the sick person is exempt from "normal" social roles; (2) the sick person is absolved of personal responsibility; she or he is not to blame for their condition; (3) the sick person should try to get well; and (4) the sick person should seek technically competent help and co-operate with a physician. The first two components describe rights which the sick person is entitled to under the sick role. In the example that I described above, the sick role offers the office clerk and the student an exemption from their normal duties and they are not held culpable for their illness. The second two components describe obligations that accompany those rights; both the clerk and the student are expected to do all they can to get better and see a medical professional if their condition requires it.

With these four components of the sick role, Parsons believed he had discovered how society legitimates certain conditions as illness. If a person falls ill, they enter the medical system and they can fulfill the sick role – if they do not, their behaviour begins to verge on deviancy and falls outside of the medical system. Notice that the four components of the sick role act as a sort of self-adjusting mechanism; if the clerk and the student who fall ill do not try to get better (i.e., if they actively do things that lead to deterioration in their condition, or if they fail to seek and comply with a physician's instructions), the rights that accompany the sick role would be void, and the clerk or student would be seen as deviant, rather than ill. At its core, the sick role emphasizes the social context of illness. Holton notes that "[f]or Parsons, sickness was not only a biological state, but also a matter of social significance. One did not become sick independent of the social system, rather one was socially defined as sick" (2008: 143). This notion foreshadows later developments in medical sociology on the social construction of disease.

This approach also theorized about the social relationships related to health and illness. Parsons' notion of the sick role is above all concerned with the doctor–patient relationship and reflects a continuation of his work on the sociology of the professions (Gallagher, 1976). Lupton argues that under Parsons' sick role, the patient is placed

> ... in the role of the socially vulnerable supplicant, seeking official verification from the doctor that she or he is not "malingering". The role of the doctor is seen as socially beneficent, and the doctor–patient relationship as inherently harmonious and consensual even though it is characterized by an unequal power relationship.
>
> (2003: 7)

In Chapters 6 and 7, I will examine how Parsons' views of the medical profession and the medical encounter have shaped subsequent research in these areas. Partly based on his conceptualization of the sick role, Parsons has been criticized for having an uncritical view of physicians and a simplistic understanding of the medical encounter.

It is important to note that Parsons' formulation of the sick role was primarily a theoretical construct; it was not based on extensive empirical investigation (Clarke, 2004). That is not to suggest that his work in this area is not valid; indeed, most medical sociologists – even if they disagree with the basic assumptions of structural functionalism – acknowledge the importance of the concept to the development of medical sociology. They would also acknowledge the theoretical importance of Parsons' work. For Pflanz and Rohde, "the foundation of our sociological understanding of illness has been laid by Talcott Parsons, no matter to which specific theoretical approach we may have subscribed" (1970: 645). Along these lines, Cockerham notes that

> Parsons' concept of the sick role is a clear and straightforward statement of four basic propositions outlining the normative pattern of physician utilization by the sick and their respective social roles. Parsons not only constructed the first theoretical concept directly applicable to medical sociology, but by utilizing the work of Durkheim and Weber, he did so within the parameters of classical social theory.
>
> (2001: 6)

Indeed, Parsons' sick role is essentially a Weberian *ideal type*; one informed by Durkheim's work on the function of moral authority (with doctors yielding the power of social control traditionally associated with priests) and by Freud's psychoanalytic theory. For example, Parsons was concerned with patients' motivation to recover from an illness and perhaps their conscious or unconscious desire to accrue "secondary gain" (Cockerham, 2004), what psychoanalysts label the "holding on" to illness because of real or perceived advantages (van Egmond, 2003). However, despite this strong theoretical lineage, the concept of the sick role needed empirical verification in order to have long-term utility in medical sociology.

Whilst Parsons himself did not test the sick role in an empirical manner, other researchers soon did. For example, Kassebaum and Baumann (1965) developed the *Dimensions of the Sick Role Scale*, a battery of twenty Likert-type statements that aimed to test the applicability of Parsons' concept among samples of sick people (see Text Box 3.1).

Text Box 3.1: Likert Scales

One of the most common ways of measuring attitudes in survey studies involves the use of Likert or Likert-type scales. Likert scales present the respondent with a statement, and the respondent is then asked to indicate their level of agreement to that statement using pre-set categories that usually range from 1 = "strongly disagree" to 5 = "strongly agree". Likert-type scales are similar in format, but instead of presenting statements, they can pose questions. For example, many surveys in medical sociology include Likert-type items to measure self-rated health. These may ask respondents: "In general, would you say your health is: 1 = excellent, 2 = very good, 3 = good, 4 = fair, or 5 = poor?" or "Compared to one year ago, how would you say your health is now? 1 = much better than one year ago, 2 = somewhat better now than one year ago, 3 = about the same, 4 = somewhat worse now than one year ago, or 5 = much worse now than one year ago". Scales such as these can be used quite effectively with large samples and can be used to identify differences between groups (Bryman and Teevan, 2005). Self-reported health status is widely used in medical sociology and social epidemiology, and has been found to be highly predictive of actual health status, including subsequent morbidity (Kennedy et al., 1998) and mortality (Idler and Benyamini, 1997). Although some researchers have raised questions regarding the validity (De Maio, 2007a; Sen, 2002) and reliability (Crossley and Kennedy, 2002) of self-reported health status measures in some settings, they remain an important and useful part of a sociologist's methodological toolbox.

More specifically, Kassebaum and Baumann (1965) sought to relate differences in the *Sick Role Scale* to differences in age, sex, ethnicity, socioeconomic status, and clinical diagnosis. For Kassebaum and Baumann, "... the sick role, as described by Parsons, although a useful conceptual model for organizing normative expectations, may vary among different types of *patients*, that is, among persons occupying different positions in the social structure" (1965: 26). To test this notion, they enrolled a sample of 201 patients from an out-patient clinic of an urban teaching hospital in the United States. The patients ranged in age from 14 to 91 years; some had no formal schooling, whilst others had college degrees. Most were diagnosed with heart disease, diabetes, or psychoneurosis (a set of mental disorders typically not requiring hospitalization). Slightly more than half of the sample had been born in the United States. All of the patients had low to moderate incomes, one criterion for eligibility in the out-patient clinic.

They used factor analysis, a statistical technique for identifying groupings of items made by respondents, rather than *a priori* groupings made by the investigators, to collapse their 20 statements into the four clusters listed in Figure 3.1 – dependence, reciprocity, role-performance, and denial. In other words, factor analysis enabled the identification of latent concepts underlying the data.

Factor 1 – Dependence

Illness makes a person a burden on other folks around him.
The trouble with being ill is that you have to depend on other people.
There is some truth to the saying that illness is a punishment for sins.
The most important thing for a sick person to understand is that he needs outside help because he cannot help himself.
Sick people deserve more consideration than they usually get.
Most sick people are difficult to get along with.

Factor 2 – Reciprocity

People in general realize it is not the patient's fault that he is ill.
In general, people make allowances for the fact that a sick person isn't able to carry out his normal social responsibilities.
While a woman is sick, people don't blame her for not managing the home the way she normally does.
People in general are usually very kind and considerate to a person who is ill.
Most people do not blame a person for being sick.

Factor 3 – Role-Performance

People who are sick have a right to expect that others will help them.
In general, people demand too much from a person who is ill.
Often the only rest a busy person gets is when he is sick.
When a person is sick, he usually isn't expected to hold a job.

Factor 4 – Denial

Many people act sicker than they are just in order to get sympathy.
Most sickness is due to careless and wrong living habits.
How fast a sick person gets well is due more to his own efforts than to any particular medicine he is taking.
A person's health is his own responsibility just like any other part of his life.
Most people do not understand the problems a sick person has in his life.

Figure 3.1 The dimensions of the sick role scale

Source: Adapted from Kassebaum, G. G. and Baumann, B. O. (1965). Dimensions of the sick role in chronic illness. *Journal of Health and Human Behavior*, 6(1), 16–27.

Kassebaum and Baumann found that a respondents' score on these items (representing their agreement with the statement) was related to their age, sex, ethnicity, education, occupational category, and diagnosis. For example, "the tendency to score high on *Dependence* was most characteristic of older respondents, of men, of foreign-born patients, of those with low educational attainment, of those in blue-collar occupations, and of patients with psychoneurosis" (1965: 26). In addition, blue-collar respondents responded with greater agreement to *Role-Performance* items, suggesting that "different positions in the social structure are associated with different sick role expectations" (1965: 23). The results of the study

suggested that low educational attainment – a measure of low social class – was perhaps associated with willingness to adopt sick role expectations.

The results held implications for the concept of the sick role and its use *in* medicine. As Kassebaum and Baumann point out,

> ...any attempt to describe sick role expectations in terms of behavior alone, without specifying a context, is necessarily inadequate.... [However] a systematic investigation of the relationship between sick role expectations and response to different types of therapeutic programs would be of considerable utility to persons engaged in providing medical care...
>
> (1965: 27)

Overall, this empirical study developed Parsons' concept of the sick role in important ways; no longer was it a universal norm, but something that – along with health – was socially patterned. The empirical finding that willingness to adopt sick role behavioural expectations depended on social factors was arguably relevant for treatment regimens and patient education programs.

Twaddle (1969) and Berkanovic (1972) published qualitative studies which led to further criticism and refinement of the Parsonian sick role. Twaddle begins his report with an acknowledgement of the importance of Parsons' work, noting that "the study of illness behavior from a sociological perspective began in earnest with Parsons' formulation of the sick role" (1969: 105). He further noted that whilst the concept had been critically discussed by some (including Freidson (1970a)), it had yet to be adequately investigated using qualitative methods that asked participants to describe their experience of illness in their own terms. Twaddle conducted a series of 29 interviews with a subsample of males enrolled in a larger health study. The interviews focused on normative behaviour among individuals defined as "ill". With respect to the sick role, Twaddle observed that "in this sample, Parsons' formulation of the sick role successfully described the modal pattern of expectations and behavior for older, married, urban males *when each component was treated separately*. It was further found, however, that the *combined configuration described the response of only a minority*" (1969: 110, emphasis in original). In other words, support was observed for each of the four sick role components when they were analyzed in isolation; the complete sick role, with all four components, actually fit only a minority of the sample's experiences. Among his sample of men, Twaddle observed that the most contested component of the sick role was the exemption from normal roles, and that the least contested component was responsibility for the illness. In fact, Twaddle's qualitative study helped to generate seven possible configurations of the sick role (see Figure 3.2).

Exemption from normal roles	Responsibility for onset or continuation of illness	Cooperation with a treatment agent	Number of respondents
–	–	+	1
+	–	+	2
–	+	+	10
+	+	–	4
+	+	+	5
+	–	–	1
–	+	–	3

Figure 3.2 Expanded sick role configurations, based on Twaddle's empirical study

Notes: A "plus" (+) indicates a response consistent with Parsons' conceptualization, and a minus (–) reflects a response inconsistent with Parsons' conceptualization.

Source: Adapted from Twaddle, A.C. (1969). Health decisions and sick role variations: an exploration. *Journal of Health and Social Behavior*, 10(2), 105–115.

All of Twaddle's interviewees agreed with the third component of Parsons' formulation (being ill is undesirable and the patient has an obligation to want to get well). However, the other components of the sick role could be seen in myriad combinations; for example, one respondent disagreed with the sick role's components of exemption from normal roles and responsibility for onset or continuation of illness and agreed with the component dealing with cooperation with a treatment agent, such as a physician (see Figure 3.2). Twaddle did acknowledge that his small sample inhibited generalization, noting that "one can only wonder to what extent the findings reported here would apply to the wider population" (1969: 113). But despite this limitation, he argued that – instead of Parsons' *one* sick role, there are *many different* sick roles; that is, different people enact different patterns of behaviour in the face of an illness. This may, for example, depend on particular life circumstances and/or a range of sociological characteristics, including socio-economic position. This is an interesting example of empirical findings being used to redefine a theoretical construct.

Studies published in the 1970s continued the attempt to examine Parsons' sick role empirically and systematically. Empirical research in this case played a very important role in the development of the concept; above all, it enabled a critical analysis of its universality (Berkanovic, 1972). Segall notes that "the general tendency has been to accept uncritically the

assumption that the pattern of expected behaviour described by Parsons is the same for all members of society" (1976b: 47). However, the early work of Kassebaum and Baumann summarized above suggested that the sick role may not have universal applicability.

Building on this notion, Segall (1976a, 1976b) and then Arluke et al. (1979) sought to empirically test socio-cultural variations in the perception of and willingness to adopt the sick role. Segall developed two additional Likert-type instruments – the *Perception of the Sick Role Scale* and the *Willingness to Adopt the Sick Role Scale* – and found little support for the overall sick role concept among a sample of 70 hospital patients from Toronto. Indeed, the majority of responses documented by Segall indicate a sense of anomie, or uncertainty regarding the rights and obligations of a sick person. Fully 69 per cent of participants in his study were uncertain about their agreement with the sick role's notion that the sick person should be exempt from responsibility for their incapacity to fulfill their regular obligations, and 53 per cent indicated being uncertain whether it was the sick person's obligation to seek medically competent help. The only dimension of the sick role that received strong support in Segall's (1976b) study was the sick person's obligation to try to get well, with 84 per cent of respondents in agreement. Segall hypothesized that Anglo-Saxon and Jewish respondents would differ in their perceptions of the sick role and their willingness to adopt sick role behaviour; however, his data revealed no statistically significant differences between these groups. He concluded the study with a call for methodological and theoretical refinement of ethnicity as a concept in social science research, and supporting the earlier findings of Kassebaum and Baumann, affirmed that "the evidence seems to indicate that the sick role (as conceived by Parsons) is not a unitary concept and empirically, the ideal model of the sick role is often not fully realized" (1976b: 50).

As part of a larger study of hospital volunteers, Arluke et al. explored the notion that Parsons failed to adequately account for "the empirical variety of expectations that people bring to the illness situation" (1979: 30) by collecting survey data from 490 recently discharged patients from two large New York City hospitals. Their self-administered postal survey used Segall's *Perception of the Sick Role Scale*, a Likert-type scale. They also collected information on a range of demographic and socio-economic factors, including sex, age, employment status, education, income, marital status, and religion. Their correlation and regression analyses (see Text Box 3.2) indicated interesting patterns; for example, education, sex, employment status, marital status, and religion did not influence levels of agreement with the sick role. But respondents with lower levels of income were most likely to agree to the second component of the sick role – that the sick person is not to blame for their condition. For Arluke et al., "these data all suggest that the class patterns we find in accepting the notion that illness

Text Box 3.2: Regression Analysis

Statistical research in medical sociology often involves regression analysis. Studies employing this technique usually have one "outcome" or "dependent" variable (e.g., an individual's probability of being in poor health, or a country's life expectancy) and attempt to model that outcome with a set of "explanatory" or "independent" variables. There are many different types of regression analysis, and they differ in that some are more appropriate than others for certain types of data, often depending on the level of measurement of the data. For example, logistic regression is used when the outcome measure is a dichotomy (e.g., 0 = respondent is not taking an antidepressant, 1 = respondent is taking an antidepressant), whereas ordinary least squares regression is used when the outcome measure is continuous (e.g., life expectancy at birth, measured in years). This type of analysis is most closely associated with positivism; yet as Olsen and Morgan (2005) and Porpora (2001) argue, regression analysis can be used quite effectively under a critical realist epistemology as well.

is not the responsibility of the sick person might be related to broader class differences in imputation of responsibility" (1979: 33–34). Research like this extended Parsons' theoretical concept; given the findings described above, the sick role could no longer be seen only from the perspective of social psychology (focused on individual beliefs and action) and instead, began to be seen as a normative behaviour shaped by divisions within society itself.

Parsons' sick role has been criticized from a variety of perspectives. Critiques have focused largely on the issue of responsibility. The second component of the sick role asserts that "the sick person is not responsible for his or her condition"; yet a well-known effect of the health promotion community's emphasis on *healthy lifestyles* is that of blaming the victim. In this view, *we know what it takes to be healthy*: don't smoke, don't overeat or indulge in unhealthy foods, don't consume too much alcohol, practice safe sex, and exercise. Indeed, the current emphasis on healthy living as a result of personal choices suggests that the second component of the sick role may not hold true in contemporary society. Instead of absolving the sick person from responsibility for their illness, we may instead think about illness as a stigma (Goffman, 1963; Scambler, 2004).

The sick role has also been criticized for being irrelevant to the experiences of those with chronic illnesses (e.g., cancer, asthma, and cardiovascular heart disease) (Cockerham, 2004). These conditions often require

lifelong treatment and may even be asymptomatic – the sick role, with its focus on a temporary exemption from "normal" duties, says little about illness experience for chronic or re-occurring conditions. A recent empirical study on this issue examines how chronic back pain sufferers frame the delegitimation of their condition as an inability to achieve the sick role (Glenton, 2003). By focusing on a "contested" illness without a clear physiological cause (like back pain), the study extends our understanding of how the sick role works in everyday life, and importantly, how in some cases, individuals have to strive to *achieve* the sick role and gain its benefits. For Glenton,

> individuals who experience bodily suffering but who fail to gain acceptance for this suffering find themselves with illness but without sickness and can be described as inhabiting a liminal space, being both well and sick, and being neither... To achieve the sick role is to achieve recognition of one's suffering and is also a license to be exempt from particular duties for a given period of time. This exemption requires legitimation... [usually from a medical doctor].
>
> (2003: 2244)

Above all, this speaks of the importance we attach to the legitimation of illness experience by authority.

The methodology in the study was quite innovative. Glenton used qualitative content analysis of almost 500 contributions to an online discussion list where visitors wrote about their experience with chronic back pain. These data were supplemented by open ended, in-depth interviews with 19 back pain sufferers. In general, respondents lamented the lack of a clear diagnosis. The data emphasize the role of medical diagnoses as "proof of suffering"; an entry point to the benefits of the sick role. Respondents lamented the lack of clear diagnosis for chronic back pain. When a physical origin was detected, respondents reported a sense of relief – "proof to one's doctor and to one's social surroundings that one truly is in pain" (Glenton, 2003: 2246). The data also reflect patients' efforts to comply with sick role obligations; Glenton notes that several of the respondents expressed fear that the lack of available treatment could be seen as a sign that they were not serious about getting back to work, that they were malingering and not committed to their obligations.

Central to the responses was the struggle back pain sufferers endured to *achieve* sick role status. Glenton notes that

> while other patient groups may meet the identification of a disease with dismay, and many try to negotiate for another alternative, either because the disease in question has serious implications for the person's health or because it is associated with social stigma, back pain sufferers in this study and elsewhere often

> welcome and encourage positive diagnostic tests and diagnoses, describing them in terms of relief, as vindication and as "proof" of their suffering.
> (2003: 2249–2250)

Glenton concludes that "while the expectations and demands of the sick role are indeed ill-suited for people living with chronic back pain, the sick role concept appears to reflect the social obligations and expectations that are present in the minds of health professionals, colleagues, family members, and back pain sufferers themselves" (2003: 2245). Thus, whilst the sick role as a theoretical construct may be criticized, empirical studies have shown that the role very much exists and structures the health care encounter.

Lastly, Parsons' sick role has been criticized, along with the structural functionalist perspective in general, for neglecting issues of power and conflict. As the guardian of the sick role, the medical profession serves as an institution of social control, "using its power to distinguish between normality and 'deviance' " (Lupton, 2003: 7). In the years following the publication of *The Social System*, medical sociologists began to examine this notion under the concept of "medicalization" (see Chapter 6); however, it was not something that Parsons considered when writing on the sick role. It is also unclear how alternative approaches to health care are handled under the sick role – again, an issue of power and territoriality. Parsons, true to his structural functionalist perspective, also modeled the doctor–patient relationship as one of consensus and harmony. Critics, on the other hand, assert that the relationship is often a struggle for power, a contested relationship where organizational constraints (the time that a doctor has available to see a particular patient), patient history (previous experience with the medical system), and other factors (illness under consideration, insurance/cost considerations) influence the negotiation of the sick role. Indeed, Parsons' sick role pays no attention to differences in health care or doctor–patient communication based on age, gender, class, or ethnicity (Williams, 2005). Interestingly, the basis of all of these criticisms lies in the empirical world.

Parsons' work on the sick role in the 1950s reflects the historical dominance of the structural functionalist perspective in North American sociology. Despite criticism leveled against it, the concept has been at the centre of medical sociological research for the past 50 years, and continues to be used today. For example, the concept is used by researchers trying to better understand why some people dutifully comply with the instructions of their doctors and others do not, an issue with particular relevance in research on prescription medication non-adherence or non-compliance (Becker et al., 1974; Coambs et al., 1999; Conrad, 1985; Wilson et al., 2002). There remain important dimensions of the sick role open to empirical research, for example, in terms of the psychological benefits that

accrue from it (Hamilton et al., 2003). In recent reviews, Shilling (2002), Cockerham (2004), and Williams (2005) argue that, despite criticisms against it, the Parsonian legacy in medical sociology is timely and relevant.

The development of the sick role was undoubtedly an important landmark in the development of medical sociology. It signaled the growth of the subdiscipline as a distinct area within academic sociology. At a theoretical level, it reflected the dominance that structural functionalism enjoyed across the discipline. Holton notes that

> ... in Parsons' discussion of the sick role, we see both his general theoretical ambitions and his concern for concrete interactions of daily life at work. At one and the same time, he is challenging the idea that "the invading microbe" is the root cause of all sickness, while claiming for sociology a part in the fine-grained analysis of health and illness, within – not outside – society.
> (2008: 144)

However, with the exception of Merton's structural functionalist account of the socialization of medical students in *The Student Physician* (Merton, 1957b), no other major structural functionalist works were published in medical sociology during this period (Johnson, 1975). Overall, structural functionalism quickly lost support. For Cockerham, "structural-functionalism, with its emphasis on value consensus, social order, stability, and functional processes at the macro-level of society, had a short-lived period as the leading theoretical paradigm in medical sociology" (2001: 6). The perspective seems detached from the revolutionary changes which societies around the globe experienced in the 1960s; as a theoretical perspective, it was soon replaced by symbolic interactionism and conflict theory.

Medical Sociology's Expanding Theoretical Base

As we saw in the discussion above, Parsons' conceptualization of the sick role claimed new territory for medical sociology by bringing the particular roles enacted by patients and medical professionals within the research gaze of social scientists. However, his analysis, rooted in structural functionalism, was not without limitations, and researchers utilizing different theoretical positions soon rose in prominence in medical sociology. In particular, symbolic interactionism offered medical sociology an important new perspective on health and illness; research guided by symbolic interaction has influenced our understanding of the very meaning of these concepts. For example, symbolic interactionism has generated the idea that *disease* refers to particular pathologies of the body, whilst *illness* is the social meaning given to that pathology (and thus has opened extensive

possibilities for cross-cultural and longitudinal research). As Schneider and Conrad, in *Having Epilepsy: The Experience and Control of Illness*, have pointed out: "We cannot understand illness experiences by studying disease alone, for disease refers merely to the undesirable changes in the body. Illness, however, is primarily about social meanings, experiences, relationships, and conduct" (1983: 205). Similarly for Freidson, it is clear "... that what is social about illness is analytically independent of what is biophysical. In its social form, illness is a meaning assigned to behaviour by the actor or those around him, and illness behaviour is ordered by that meaning" (1970a: 224). A focus on "understanding illness experiences" is central to the symbolic interactionist approach to medical sociology, and is often perceived as a fundamental break with the Parsonian approach to health. I hope to show, however, that there are good grounds for thinking that whilst the focus of the two approaches differs, they are ultimately overlapping and compatible.

At its core, the symbolic interactionist approach to medical sociology builds from Max Weber's (1864–1920) *verstehen* (subjective meaning, empathy, or "to understand") and his definition of sociology as "... a science which attempts the interpretive understanding of social action" (Weber, 1947 [1922]: 88). Craib's (1997) overview of Weber's sociology offers insight into these points. When applied to health issues, the symbolic interactionist framework gives primacy to particular questions, primarily those which accentuate people's understanding of their situation, and focuses on the notion that social reality is constructed on an everyday basis through the interaction of individuals (see Plummer, 1991). Methodologically, this tradition of sociological research has been most closely associated with qualitative research designs, particularly those relying on participant observation as a means of data collection.

This tradition influenced two of the major early medical sociologists: Anselm Strauss and Erving Goffman, whose works dominated post-Parsonsian medical sociology. Strauss, now most closely associated with *grounded theory analysis* (Charmaz, 1983), co-authored the classic study of medical school socialization *Boys in White* (Becker et al., 1961) with Howard Becker, the author of *Outsiders* (Becker, 1963) and leading thinker behind *labeling theory*. That theory posits that deviant behaviour is not a characteristic of the act in question, but rather the consequence of its definition as deviant by others. This framework has been particularly useful in medical sociology and influenced Thomas Scheff's classic *Being Mentally Ill* (1966), where he defined psychiatric symptoms as "residual rule-breaking" – that is, behaviour that violated social norms that did not fit existing culturally recognizable categories of violations. In this light, madness (much of Scheff's work is focused on schizophrenia) is a social construction; for Scheff, "mental illness in general – and schizophrenia in particular – are not neutral, value-free scientifically precise terms but are,

for the most part, the leading edge of an ideology embedded in the historical and cultural present of the white middle class of Western societies" (1975: 6–7). Strauss also made important contributions to the sociology of death and dying, and examined the "negotiated order" of hospital work (see Cockerham, 2001).

Goffman began his research career in medical sociology, but he did not continue to work much in the area after the publication of his landmark books *Asylums* (1961) and *Stigma* (1963). Both works contributed important concepts to sociology's theoretical stock, including "total institutions", "moral career", "betrayal funnel", and "impression management". Methodologically, he developed the dramaturgical approach to sociology, which views the social world as theatre and people as if they were actors on the stage.

Asylums is a collection of essays based on Goffman's fieldwork at St. Elizabeth's Hospital, a Washington, D.C. institution housing 7,000 patients. The work is best understood in context; a period of revolutionary change in the field of mental heath. This was a period of deinstitutionalization, where the mental hospital lost much of its legitimacy. Goffman's observations and subsequent analysis did much to portray mental hospitalization as a dehumanizing experience. Kesey's (1962) *One Flew Over the Cuckoo's Nest* and Szasz's (1961) *The Myth of Mental Illness* were published around the same time.

Johnson describes Goffman's *Asylums* as a "methodological breakthrough which had important theoretical implications, at the same time as providing enough insights and hypotheses to keep an army of empiricists in ceaseless activity" (1975: 229). Indeed, Goffman's sociology was very much an integrated empirical and theoretical endeavour, and drew from qualitative methods in particular. Interestingly, quantitative survey-based research in the late 1960s through to the 1980s attempted to "test" Goffman's analysis. Mechanic notes that

> ... none of these studies has the theoretical brilliance of Goffman's work or the quality of his insight, but they consistently fail to replicate his view of the patient's experience. Most patients did not report feeling betrayed; many reported being helped by hospitalization, and viewed the hospital as a refuge from impossible problems and stresses. Moreover, some patients from disadvantaged backgrounds viewed the hospital experience as less coercive and less depriving than their usual life situation. The studies do provide evidence of stigma associated with mental illness but negate the profoundly negative conception of the experience depicted by Goffman.
>
> (1989: 148)

Goffman's analysis – like Parsons' – is particularly interested in social roles, and the rules that underlie them. However, Goffman's roots in symbolic interactionism centres his research gaze on the performance and

negotiation of meaning that is embedded in interaction, a focus quite distinct from that of Parsons' structural functionalism, which above all, focused on consensus and system integration.

A very interesting interplay between theory and empirical data is evident in the dissonance between Goffman's observations and the patient survey studies that have subsequently been published in this area. For Mechanic, the issue "is not simply one of deciding whether the studies based on patient interviews and questionnaires support or disconfirm Goffman. It becomes necessary to inquire more deeply whether this type of evidence invalidates the theoretical 'ideal type' of mental hospitalization that Goffman developed" (1989: 148). Furthermore,

> Goffman's observations appear credible despite disconfirmation by surveys, because readers of his analysis find his depiction meaningful and convincing when they view themselves as the hypothetical patient in the context he describes. Thus Goffman conveys a certain kind of "truth" that cannot be dismissed easily. This type of contextual credibility is often persuasive, having the quality of *verstehen* embodied in the methodology of Max Weber.
>
> (Mechanic, 1989: 150)

In other words, Goffman's analysis of mental institutions created a Weberian ideal type – an analytical construct, which according to Weber: "... is formed by the one-sided accentuation of one or more of points of view, and by the synthesis of a great many diffuse, discrete more or less present and occasionally absent concrete individual phenomena ... In its conceptual purity, this mental construct cannot be found anywhere in reality" (Weber, quoted in Craib, 1997: 50). Studies relying on patient surveys and usually working with a positivist epistemology are arguably ill-suited for "testing" the validity of Goffman's analysis of the dehumanizing elements of institutional life, their fixed-response categories and hypotheses perhaps not appropriate for the context. Arguably, the asylum is a place where quantitative survey methods reach a limit; whilst they may continue to be used, the knowledge that is generated through these methods in that context may not be congruent with the knowledge that is generated through other methods and under different epistemologies. The validity or credibility of any of these approaches is an open question.

The subjectivity inherent in Goffman's participant observation methodology is important. It is something that must be acknowledged and understood if we are to make sense of his work. Later in life, Goffman himself lived through an episode of mental illness involving a person close to him; he is reported to have said that if he had written *Asylums* after this experience, his analysis would be quite different (Mechanic, 1989). What we have in *Asylums* is the interpretation of a mental hospital from the viewpoint of an independent-minded, middle-class university professor; a person who strongly valued the personal autonomy that was compromised by the strict routines of hospitalization (Mechanic, 1989).

Goffman's influence on medical sociology can also be implicitly seen in research on the medical encounter. This area of research owes a great deal to Goffman's work on "interaction order"; that is, "environments in which two or more individuals are physically in one another's response presence" (Goffman, 1983: 2). Goffman argued that this should be a central area of sociological research, noting that "it is a fact of our human condition that, for most of us, our daily life is spent in the immediate presence of others" (1983: 2). For Goffman, sociology ought to be concerned with identifying and understanding the rules and norms which govern any interaction order, be it in an asylum, a classroom, or at home. Based on this notion, medical sociologists have studied the interaction between medical doctors and patients, noting the structure of medical communication, and importantly, examining efforts by patients to challenge the authority of medical professionals in face-to-face interaction. From this perspective, we may pose the following question: what roles do individuals enact, and what scripts do they follow? How are scripts constructed, and what happens when actors deviate from them?

Along with Strauss and Goffman, Eliot Freidson's books *Profession of Medicine* (1970a) and *Professional Dominance* (1970b) are central works in the canon of medical sociology and represent significant contributions based on symbolic interactionism. Freidson's books made contributions to several important areas of medical sociology, including the analysis of medical doctors as a professional force and the illness experience, where he significantly extended Parsons' sick role. His analysis of professional power is discussed in Chapter 5. Here, I would like to briefly examine Freidson's writings on the sick role. He begins by noting that Parsons' formulation is "a penetrating and apt analysis of sickness from a distinctly sociological point of view" (1970a: 228). However, Freidson soon thereafter takes issue with Parsons' discussion; incorporating insights into stigma and identity from Goffman, Freidson develops an expanded classification of illness behaviour (see Figure 3.3).

Freidson explains that his classification is "based on the meanings that people impute to physical attributes or concrete facts whether or not the imputation is, in the professional view of doctors and judges, 'correct' " (1970a: 225), a clear signal of his ties to the tradition of symbolic interactionism. His framework distinguishes six different varieties of illness.[1] They differ by their ascribed legitimacy and the severity of the condition itself. According to Freidson, legitimacy can take one of three forms: (1) *conditional legitimacy*, where the person is temporarily exempted from normal obligations (this applies to acute health conditions, where a person can be expected to fully recover after treatment); (2) *unconditional legitimacy*, where the person is granted long-term or even permanent

Imputed seriousness	Illegitimate (stigmatised)	Conditionally legitimate	Unconditionally legitimate
Minor deviation	Cell 1: "Stammer" Partial suspension of some ordinary obligations; few or no new privileges; adoption of a few new obligations.	Cell 2: "A cold" Temporary suspension of few ordinary obligations; temporary enhancement of ordinary privileges. Obligation to get well.	Cell 3: "Pockmarks/Acne scars" No special change in obligations or privileges.
Serious deviation	Cell 4: "Epilepsy" Suspension of some ordinary obligations; adoption of new obligations; few or no new privileges.	Cell 5: "Pneumonia" Temporary release from ordinary obligations; addition to ordinary privileges. Obligation to cooperate and seek help in treatment.	Cell 6: "Cancer" Permanent suspension of ordinary obligations; marked addition to privileges.

Figure 3.3 Freidson's typology of illness

Source: Adapted from Freidson, E. (1970a). *Profession of Medicine: a Study of the Sociology of Applied Knowledge*. New York: Dodd, Mead. Reproduced with the permission of the University of Chicago Press.

exemption from normal obligations (this applies to chronic conditions and long-term disabilities); and (3) *illegitimacy*, where the person is not held accountable for their condition (and thus not culpable), but at the same time, is awarded few or no privileges. This is a situation of *stigma*; the person gains few, if any, privileges and concurrently takes up burdensome obligations. Freidson argued that such experiences were common for people with epilepsy.

For Freidson, "the *sick role*, as Parsons defines it, is only to be found in cell 5 of the table" (1970a: 239) (see Figure 3.3). This is where the condition is awarded legitimacy by the medical profession (i.e., it is something within the medical sphere) *and* it is a condition from which the patient may recover in the short-term. Freidson points out that the Parsonian sick role does not fit very well in the case of debilitating chronic illnesses (cell 6 in Figure 3.3), where a patient's exemption from normative roles may be permanent, writing that

> ... a chronically ill or permanently impaired person who "expects too much" or "makes too many demands" is likely to be rejected by others. In that case, legitimacy is not conditional on seeking help as it is for illness believed to be acute and curable. Rather, legitimacy is conditional on limiting demands for privileges to what others consider appropriate.
>
> (1970a: 235)

Freidson's writing on the sick role has interesting theoretical implications – it is a case where symbolic interactionism refines a structural functionalist concept. Here, the sick role is significantly modified by the reaction of other social actors; illness can only be understood as social interaction, and the sick role varies by ascribed legitimacy and the severity of the condition.

The rise of symbolic interactionist research in medical sociology – an area previously dominated by Parsons and structural functionalism – meant that the subdiscipline became a focal point of debate between two of sociology's major theoretical perspectives (Cockerham, 2001). Conflict theory soon entered the fray as well and moved us from a focus on individuals to a focus on populations.

Sick People or Sick Societies?

Thinking broadly about conflict theorizing, we can identify several varieties under this general framework. At the heart of this approach is, of course, Karl Marx (1818–1883) – who did not explicitly write about health, although much of his work has influenced contemporary research on health inequities and the political economy of health and illness. Along with Marx, the tradition of conflict theory brings into focus the diverse works of Ralf Dahrendorf, Lewis Coser, Randall Collins, David Lockwood, and Jürgen Habermas and the Frankfurt School (Stones, 2008; Turner, 1991). Interestingly, questions of health and illness featured in none of the major works by these theorists – perhaps reflecting sociology's hesitation to enter the realm of medicine and the early dominance of sociology-in-medicine in the field. Indeed, whilst conflict theories have been particularly important in the development of social theory, their role in medical sociology has been questioned (Cockerham, 2001).

My own perspective is that researchers working within the conflict theory perspective – particularly approaches with Marxist roots – have been very influential in medical sociology. Indeed, much of today's research on health inequities traces its lineage, at least implicitly, to Engels and his classic treatise on the *Condition of the Working Class in England*. As discussed in Chapter 2, Engels and his contemporary Virchow developed a perspective on health that identified societal factors as determinants of disease, a notion that is at the crux of contemporary research on health inequities. It is worth noting that this is an aspect of health that is temporally prior to the moments focused on by symbolic interactionists when they analyze the differences between disease and the social meaning given to the pathology; in this sense, symbolic interactionist and conflict approaches to health and illness bring our attention to different phases of a health – disease spectrum.

Marxist models of class division have greatly shaped research on the political economy of health. In *Medicine Under Capitalism* (1976) and *Crisis, Health and Medicine: A Social Critique* (1986), Vicente Navarro examined how the fundamental pursuit of profit by the capitalist system *produces* disease – for example, people suffer due to chemical, biological, or physical agents in the workplace or indirectly, through stress and alienation. Today, much of the research published in the *International Journal of Health Services* continues to examine these issues (Navarro is the editor of the journal). Navarro continues to publish regularly in the field of medical sociology, and his more recent writings have focused on the political context of health inequities (Navarro, 2002b; Navarro et al., 2003; Navarro and Shi, 2002), a critique of the concept of social capital (Navarro, 2002a), and more widely, globalization (Navarro, 1999).

Most recently, Richard Wilkinson – in numerous publications, including *Unhealthy Societies: The Afflictions of Inequality* (1996), *Mind the Gap* (2000), and *The Impact of Inequality* (2005) as well as articles in *Social Science & Medicine*, the *British Medical Journal*, and the *American Journal of Public Health* – has outlined a hypothesis linking a society's level of income inequality to its level of population health. The hypothesis claims that an individual's health is influenced not only by their own level of income, but by the level of inequality in the area in which they live. As discussed in the following chapter, this hypothesis has important underlying (yet often unacknowledged) links to social theory, including Durkheimian notions of social integration and social cohesion as well as a conflict theory perspective on status, power, and class. Coburn (2004) has explored Wilkinson's income inequality hypothesis from the perspective of political economy, and in doing so, has generated significant debates between the (neo-) positivism of Wilkinson and social epidemiology with the critical realism espoused by contemporary writers on globalization and neo-liberalism. Similarly, Muntaner (2003) has provided thoughtful discussion on how Wilkinson's analysis could be strengthened by a renewed focus on not just income inequality, but on Marxist notions of class exploitation as well. The debates embedded within the literature on Wilkinson's income inequality hypothesis provide us with important lessons about the nature of empirical/theoretical connections in medical sociology in general and, in particular, how a researcher's decision to include or exclude variables from an analysis (a decision always based on both theoretical and empirical grounds) can significantly alter the kinds of messages that arise from the work. Debates surrounding Wilkinson's hypothesis also clearly signal the influence of the importance of conflict theories in medical sociology.

In contrast, Cockerham, in a recent analysis of the relationship between medical sociology and sociological theory, argues that conflict theory "has failed to date to establish a major foothold in medical sociology" (2001: 9). Aside from a brief acknowledgement that conflict theory can be brought

to bear on questions of politics and health care reform, Cockerham argues that

> there are inherent limitations in the use of conflict theory in medical sociology. While some health situations are affected by conflict-related conditions, others are not. People may maintain their health or become sick and these outcomes can have little or nothing to do with conflicts, politics, interest-group competition, class struggles, and the like.
>
> (2001: 10)

He goes on to claim that the "greatest potential of conflict theory for medical sociology thus lies in its non-Marxist aspects, as interest-group competition in welfare states proves more relevant for health concerns than class struggle" (2001: 11). This is a controversial assessment; and indeed, not one shared by other writers who have analyzed the link between medical sociology and social theory (Bourgeault, 2006; Gerhardt, 1989; Lupton, 2003). Indeed, the medical sociological literature is replete with research informed or inspired by conflict theory; along with Vicente Navarro and Richard Wilkinson (who is ignored altogether by Cokerham), we have, for example, Ivan Illich.

Illich's *Limits to Medicine* offers a devastating critique of contemporary medical practice in general and the process of medicalization in particular. His analysis begins with the position that "the medical establishment has become a major threat to health" (1976: 3) and he famously noted, as we saw in Chapter 1, that "medicine is but a device to convince those who are sick and tired of society that it is they who are ill, impotent, and in need of technical repair" (1976: 9). For Illich, medicine, as practiced in industrialized countries, only obscures the political conditions that cause sickness. Central to his analysis is the concept that medical practice is *iatrogenic* – that is, it actually creates disease and illness through its normal operation. Illich identified three types of iatrogenesis

> [It is] clinical, when pain, sickness, and death result from the provision of medical care; it is social, when health policies reinforce an industrial organization which generates dependency and ill health; and it is structural, when medically sponsored behaviour and delusions restrict the vital autonomy of people by undermining their competence in growing up, caring for each other and aging.
>
> (1976: 270–271)

His analysis has significant contemporary echo; indeed, clinical iatrogenesis is widespread, for example, as demonstrated in the current debates surrounding the efficacy and effectiveness of pharmacological treatments for mood disorders (Blech, 2006; Moynihan and Cassels, 2005).

Illich's analysis is fundamentally a lament over the health effects of life in industrialized, highly bureaucratic societies – a concern that he shared

with Weber. Illich saw the process of medicalization as one that disempowered people, and that leads to a decline in personal freedom. Illich warns: "[o]nce a society is so organized that medicine can transform people into patients because they are unborn, newborn, menopausal, or at some other 'age of risk,' the population inevitably loses some of its autonomy..." (1976: 78). This concern is shared with other researchers engaged with conflict theory. However, where Illich and other conflict theorists such as Navarro (1975) diverge is with respect to strategies for change. For Illich, the only way to combat medicalization is to de-bureaucratize and de-professionalize the practice of medicine; his is a radical (anarchist) position which sees efforts to reduce unequal access to medical treatment by ensuring universal access to health care as *regressive* and *counter-productive*.

Conflict theory – particularly of the Marxist variety – has made a profound contribution to our understanding of global health issues, health inequities, the power of the pharmaceutical industry, and health care reform. Conflict theory has been particularly useful in the analysis of health care as a private commodity, something to be purchased under market mechanisms rather than a public good, guaranteed by citizenship or human rights. However, its contribution has at times been more implicit than explicit, and some commentators have noted that conflict theory's use in medical sociology has at times also been contradictory. For example, Lupton notes that under the conflict theory perspective, "medicine is typically criticized for being both overly expansionist and exclusionist (of the underprivileged), and illness is seen as being caused by both deprivation and medical domination" (2003: 10).

The political economy branch of medical sociology has also been criticized for failing to recognize or acknowledge the significant improvements to living conditions, life expectancy, infant mortality rates, and medical treatment that most countries – even those low on the United Nations' Human Development Index – have experienced over the past 100 years (Lupton, 2003). However, I would suggest that this is an unfair criticism. Working within a political economy-based conflict perspective, Raphael et al. (2004) acknowledge that significant improvements in health status have occurred in all industrialized nations since 1900. Indeed, profound improvements in health status have occurred in most places in the globe since 1900 (with some significant exceptions in recent decades, particularly as a result of HIV/AIDS in sub-Saharan Africa (Mathers and Loncar, 2006)). Whilst much of this improvement is attributable to factors outside of the health care system (and instead, can be traced to improvements in sanitation, housing, nutrition, and access to potable water), health care services are by no means devoid of importance among conflict theorists (with a notable exception, as noted earlier, being Illich, who focused on its iatrogenic effects). Disagreement clearly exists about the status and prestige

that should be awarded to medical services; these debates show that conflict theories can be both critical of the expansionist/iatrogenic properties of modern biomedicine and at the same time be used to highlight issues of inequitable access to effective treatments. Conflict theorists can emphasize the point of overall improvements in health status – because it is precisely those improvements that make the remaining (and in some places and cases, growing) inequities so problematic. Farmer, a first-hand witness to the effectiveness of treatments for tuberculosis and HIV, has expressed this most clearly: "... one can be impressed by the power of modern medicine and yet dejected by our failure to deliver it equitably" (1999: 264–265).

The statistics on health inequities are indeed striking. At a global level, life expectancy data indicate that the richest nations have life expectancies of about 80 years. Yet people born in the poorest nations in the world experience life expectancies of half that amount – about 40–45 years (Coburn, 2006), with life expectancies in some African countries now dipping below 40 (UNDP, 2007). It is this global pattern of inequity that has at the same time outraged and inspired researchers working under a conflict theory paradigm. Much like Virchow and Engels (and Marx), conflict theorists attempt to identify underlying structural forces that result in these disparate statistics, and engage with policy issues. For example, Coburn writes: "degrees of inequality are clearly influenced by international, national and local political policies which are amenable to change. We can either ignore these processes or seek to understand and begin to change them" (2000: 144). This reflects (following Marx's dictum) an underlying commitment to not only describe the world, but to change it.

Much feminist social theory has conflict theory roots, and like other conflict theories such as Marxism, has informed the development of medical sociology. A notable example of this tradition is Doyal's (1995) *What Makes Women Sick: Gender and the Political Economy of Health*. Feminist medical sociology has contributed in significant ways to research on medicalization, with a landmark study published by Oakley (1984) on pregnancy. Her work developed a feminist analysis of childbirth and examined mechanisms that establish and expand medical dominance over women (also see Barker, 1998). In other words, this work frames much of Western medical practice as a patriarchal force interested in extending control over women's bodies (Ballard and Elston, 2005). Additionally, as shown in Chapter 7, feminist notions of gender as performance (with an implicit link to Goffman's dramaturgical sociology) have made significant contributions to how we understand the medical encounter.

This is not only seen in relation to pregnancy, but also with the menopause (McCrea, 1983), which in the past 30 years has also been "medicalized". Ballard and Elston note: "... as a result of medical definitions of the menopause as a 'deficiency disease', many women came to feel morally obliged to accept medical intervention in order to prevent future

ill-health" (2005: 232). Their comment reveals important links between feminist-inspired medical sociology and insight derived from the writings of Michel Foucault, particularly his work on surveillance and more recent writings on risk (see Chapters 6 and 7).

Refocusing: From Roles and Populations to Discourse

The philosopher Michel Foucault has had a profound influence in the development of medical sociology and is the last of the major theorists that I would like to introduce in this chapter. His work has generated insight into the relationship between knowledge and power, and how these are embedded within the language and thoughts of individuals (Cowley et al., 2004). In Foucault's analysis, knowledge and power are positioned as being so closely connected that an extension of one means an expansion of the other; Foucault used the term "power–knowledge" to express this unity. For Foucault

> We should admit rather that power produces knowledge... that power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations. These "power-knowledge relations" are to be analysed, therefore, not on the basis of a subject of knowledge who is or is not free in relation to the power system, but, on the contrary, the subject who knows, the objects to be known and the modalities of knowledge must be regarded as so many effects of these fundamental implications of power-knowledge and their historical transformations.
>
> (1977: 27–28)

Above all, Foucault's account of power–knowledge brings our attention to discourse, and how it reflects power–knowledge relations. He gives us an important example of this in his landmark book *The Birth of the Clinic*, where Foucault (1994 [1973]) distinguished "medicine of the species" and "medicine of social spaces". The former refers to classification, diagnosis, and treatment of disease and defines the human body as an object of study, whilst the latter characterizes preventive public health measures. In doing so, Foucault conceptualized medicine as a type of perception (the "clinical gaze") which gave ontological primacy to the body and its parts, at the expense of the person. He describes the medical gaze: "In order to know the truth of the pathological fact, the doctor must abstract the patient... in relation to that which he is suffering from, the patient is only an external fact; the medical reading must take him into account only to place him in parentheses" (1994 [1973]: 8). This gaze not only describes the interaction

between physician and patient, but it also establishes power – a power that produces authority as well as knowledge. Samson notes that observations derived from the clinical gaze

> eventually form the basis for the medical categorization of illness, [and] ignore the individual patient as a person. As soon as definitions, categories and taxonomies are formalized in texts and taken to be sources of authority, medical power is expressed in the routines, rituals and bureaucracies of hospitals and clinics.
>
> (1999: 9)

Foucault's analysis of the clinical gaze shows how biomedicine became established as the authoritative "truth" on matters of health and illness; how we think about disease is shaped by the clinical gaze. In this way, the clinical gaze is both a consequence and a driver of what we now call biomedicine – an approach to healing firmly rooted in mechanistic models of the body which relies on scientific reason to identify how pathogens influence bodily systems to produce disease. As we saw in Chapter 2, this atomistic model of medicine is also one of Virchow's legacies.

Similarly, in his book *Madness and Civilization*, Foucault (1965) used historical analysis (which he defines elsewhere as a "genealogy" or an "archaeological method") to examine how medical discourse surrounding madness led to the development of psychiatry as a system of knowledge and a way to exert disciplinary power over populations. He noted that whilst how society treats "lunatics" has changed dramatically over time, "modern" systems of treatment may best be understood as ever-more powerful techniques of surveillance, based on the internalization of societal norms and subtle, indirect ways of regulating individuals (Turner, 1995). For example, Foucault's analysis examines how the surveillance of human sexuality subjected intimate bodily activities to institutional monitoring and control and is at the root of extensive literatures on so-called surveillance medicine and, more recently, the sociology of the body.

Foucault referred to this notion of regulation as "panopticism" (after the Panopticom, a type of prison designed by Jeremy Bentham which allowed observers to see all prisoners but kept the prisoners from knowing when they were being watched). From this perspective, medicine is but one of many mechanisms through which control manifests. In *Discipline and Punish*, Foucault writes of "disciplinary projects" that began to come together in the nineteenth century and situates these projects "in the psychiatric asylum, the penitentiary, the reformatory, the approved school and, to some extent, the hospital" (1977: 199) and questions: "Is it surprising that prisons resemble factories, schools, barracks, hospitals, which all resemble prisons?" (1977: 228).

Foucault's notion of knowledge/power has greatly influenced work on medicalization, particularly the writing of Deborah Lupton (see Chapter 6), who sees in Foucault's theorizing both an anchor and a critique of the concept. And in Chapter 7, I examine the work of Nicholas Fox, who has developed a post-structuralist ethnographic study of the medical encounter. Building from the work of Foucault (and other post-structuralist/post-modern theorists), Fox notes that "post-structuralism has led to a radical re-thinking within social theory of the nature of power" (1993: 17–18); this re-thinking has involved a shift of attention towards the concept of *discourse*. His writing on this notion is very instructive and is worth quoting at length:

> The distinctive character of such an approach is perhaps worth exploring. Structuralist, both functionalist and marxist, perspectives reify "organisations" as things, treating the structures they uncover as *sui generic* realities. For the post-structuralist, so to do is to confuse the model or method of social analysis with organization itself: if you look for a system, you will find one. Interactionist and phenomenological perspectives on organization have explored how the social world becomes routinised in practice through actors' taken-for-granted assumptions about their environment, while ethnomethodologists seek to show how actors use organizational rules to validate their activities. These perspectives have this in common with postmodern social theory: they reject the notion of organizational structure as reality. But whereas for traditional idealist approaches rules and routines reflect consensus, negotiation and shared world-views, in the postmodern study of organization, routine is not the outcome of a shared world-view, but the opposite: the imposition of control and constraint by the empowered, through techniques of power mediated by discourse.
>
> (1993: 18)

This is a powerful development of Foucault's writings on discourse. Fox's analysis is based on ethnographic data and conversation excerpts and focuses on the discourse that takes places between surgeons and their patients shortly after the operation has taken place. Following Foucault, Fox is particularly concerned with how discursive structures dominate interaction between surgeons and patients, and how surgeons shape and control post-operative discourse in such a way that their claim to be healers is privileged. This hegemonic discourse – central to the medical encounter – is, for Fox, best analyzed through post-structuralist "deconstruction", wherein "the ideological claims of text are exposed, the very things which the author of discourse would deny come to be seen as the bedrock without which the discourse would founder" (1993: 38). This analysis of "micropolitics" owes much to the Foucauldian framework of knowledge/power. In Chapter 7, I examine the differences between this approach to the medical encounter and the approach espoused by Parsons.

Conclusion

Medical sociology has developed over the past 60 years into an arena of rich theoretical debate. As we saw in Chapter 2, the origins of the field can be traced to the pioneering work of Engels and Virchow – writers who saw the social seeds of disease and analyzed health issues through the prism of social inequality. That perspective still holds significant influence, particularly in contemporary research on health inequities, as we will see in the next chapter. This chapter traced the major theoretical contours of the discipline, centring our gaze primarily on the work of Parsons on the sick role – in many ways, medical sociology's core theoretical construct.

Arguably, it is debate over the merit and limitations of Parsons' sick role that has allowed medical sociology to develop a rich mix of theoretical positions. As we saw in this chapter, Freidson's symbolic interactionist critique of Parsons yielded a major development for the field, and enabled us to see the sick role from a different perspective. Goffman's work in *Asylums* and *Stigma* also center on sick roles – and therefore may be seen as an extension of Parsons' original framework (and clearly Goffman's work on stigma influenced Freidson's typology of illness). Conflict theorists, and their focus on health inequities, arguably are also centred on the sick role – but in most cases, the emphasis moves from sick people to sick populations. And Foucault's analysis of knowledge/power shows how the very ways we think about disease are intertwined with regimes of social control.