Health and Medicine

13

Learning Objectives

After having read chapter 13, you will be able to

- describe the core characteristics of medical sociology.
- define the "sick role" and briefly describe expectations associated with it, drawing on examples.
- compare and contrast biomedicine and alternative medicine.
- critically discuss the shortcoming of the biomedical model.
- define medicalization using examples.
- distinguish between three types of iatrogenesis.
- discuss the impact of class, gender, and "race" and ethnicity on health and health care.

Chapter Summary

Medical sociology is based on the view that medical practices and beliefs are intensely social. Healing, for example, is a social process shaped by a person's age, gender, ethnic background, "race," and social class. Much of medical sociology is rooted in **policy sociology**, which seeks to generate sociological data to help governments and medical professionals develop healthcare policies and thereby improve healthcare delivery in Canada. Medical sociology also draws on **critical sociology** to investigate the practices of multinational companies (Big Farm and **Big Pharma**), medical schools, hospitals, and for-profit clinics.

The first medical sociological term may have been coined by structural functionalist Talcott Parsons (1902–1979) when he developed the concept of the sick, or patient, role in 1951. The **sick role** includes two social expectations that ill people are expected to fulfill (try to get well and seek the help of a qualified health professional) and two that society around the ill person is expected to fulfill (exempt the patient from "normal social responsibilities" and take care of the patient). The sick role allows an individual to be temporarily "deviant." However, structural functionalism problematically presumes uniformity of individuals' experiences. A critique of the universality of Parsons's theory came first from Earl Koos (1954), who argued that the ability to play the sick role is class-based because people in lower classes have less luxury to play it. Other critiques looked at how gender, "race," and ethnicity shape individuals' ability to play the sick role. Most recently, Ivan Emke noted that the model of the sick roles changes over time. He suggested that, due to changes in the new economy of the twenty-first century and neoliberalism, there were new expectations of the sick role. Most importantly, people are more responsible for their illness

and illness is frequently attributed to individual choices, such as smoking or not eating healthy. Secondly, people are increasingly expected to only put limited demands on the health care system, which is rooted in concerns over the presumed unnecessary utilization and abuse of the health care system.

Conventional medicine understands diseases in terms of their natural course of development: get ill, experience symptoms, use medicine to alleviate symptoms, get well (or sicker). However, a disease also goes through a **social course**, which refers to social interactions that a person goes through in the process of being treated and that is shaped by social factors.

Sometimes known as "conventional medicine," **biomedicine** applies the standard principles of Western scientific disciplines in the diagnosis and treatment of symptoms of illness. Biomedicine has been criticized as looking at health from a **reductionist** perspective. The biomedical model attributes medical conditions to a single factor treatable with single remedies, tends to ignore contextual factors of disease and healing, and has been criticized for being **absolutist** by failing to recognize that there are different **cultures of medicine** that have different ways of practising medicine. Other approaches to medicine used to treat patients are known as **alternative**, or **complementary**, **medicine** (e.g., acupuncture, massage therapy, etc.). These approaches are based on the notion that a person's psychological state affects his or her ability to fight diseases. Recent research in **psychoneuroimmunology** has shown links between a person's emotional and mental health on their abilities to fight diseases.

Medicalization, according to Change and Christakis (2002), is the "process by which certain behaviours or conditions are defined as medical problems . . . and medical intervention becomes the focus of remedy and social control." This process entails defining certain behaviours or conditions as medical problems, not social problems. Medical interventions become the focus of remedy and social control. An example of medicalization is viewing obesity as a personal failing (overeating, weak willpower) instead of as a result of environmental factors such as the increased availability of fast food and the sedentary aspect of many jobs. Medicalization promotes the **commodification** of healthcare by identifying certain (normal) conditions as diseases that are treatable with "commodity cures." For example, a relatively normal age-related issues such as male baldness or erectile "dysfunction" in aging men is treated as "deviant" and patients are offered "cures" for them. **Posttraumatic stress disorder** (PTSD) is another condition that has recently been medicalized.

A pioneer in the criticism of medicalization, Ivan Illich argued that "[t]he medical establishment has become a major threat to health." Illich identified three forms of what he called **iatrogenesis**, which refers to "doctor-generated epidemics." It averts people from preventing and treating their own illness and criticizing industrial society for making people sick. The three forms are **clinical** (diagnosis and cure are worse than illness), **social** (hidden conditions that make society unhealthy), and **cultural iatrogenesis** (doctors are the experts and patients are given no credit in their recovery). Critics of medicalization will point to the commercial interests of "Big Pharma," which profit from developing, manufacturing, and marketing drugs.

Medicine intersects with several social factors. For example, the connection between healthcare and "race" and ethnicity is evident in the doctor shortage that exists in many Canadian communities. Four major parts of this problem are that immigrant doctors face many obstacles in being able to practise medicine here; rural communities are underserved because most doctors prefer to live and practise in urban centres; the **brain drain**, which involves medical professionals leaving their country of origin; and doctors' associations that allow Canadian-trained doctors to maintain their own power by restricting the ability of internationally trained doctors to practise.

Another example is the large numbers of Filipino nurses in Canada while Canada accepted very few other health professionals (such as doctors) from the Philippines.

"Race" and medicine are further linked by the **racialization** of disease, which occurs when a disease becomes strongly associated with people of a particular ethnic background. An example of racialization is the SARS outbreak in Toronto in March 2003. Due to its origins in China, the disease was racialized by portraying mainly Asians as carriers of the disease and the media thus propagated a great deal of fear-mongering. This situation led to discrimination against Canadians of Asian descent.

Gender and medicine also interconnect. In 1959, only 6 per cent of medical school graduates in Canada were women compared to 62.2 per cent in 2011. Today, there are more women than men in medical school. However, men and women specialize in different fields and practise medicine differently. For example, women are more likely to become family doctors and less likely to become surgeons than men, are more likely to screen patients for preventable illnesses and less likely to be sued for malpractice. At the same time, nursing is a female-dominated medical field. In 2011, only 9 per cent of all Registered Nurses were men, almost half of whom worked in Quebec. Gender and race often intersect in medicine. For example, male nurses are recruited predominantly from visible minority groups and Indigenous men and women are underrepresented among health care practitioners.

Finally, social class and medicine intersect. In 1971, Dr. Julian Tudor Hart introduced the idea of the **inverse care law**—the stipulation that people with the greatest need for good medical care have the least access to it. Poor communities, where need for medical care is often highest, we are more likely to see doctor shortages, overworked doctors, and obsolete facilities and equipment. Another area where social class comes into play is in the social class locations of medical students in Canada. In a recent Ontario study comparing first- and fourth-year medical students, first-year students were more likely to be from homes with lower family incomes, to be graduating with higher debt loads, to consider finances in their decision to enter medical school, and to be stressed out by their financial situations. Ontario was chosen for the study because tuition rates had increased the most in that province at that time. There were no such social class differences reported between student cohorts in provinces without major tuition hikes.

Study Questions

1. What is medical sociology? What are its principal goals? Describe in which ways it draws on principles of political and critical sociology.

2. What are the four expectations attached to Talcott Parson's sick role? What are the critiques of and additions to Parsons's sick role?

3. What are the differences between biomedicine and alternative medicine? Give examples of both.

4. Define medicalization and outline its central characteristics.

5. What are some major drawbacks of medicalization? Draw on the work of Illich and the example of Big Pharma in your answer.

6. Briefly describe the four major factors shaping the shortage of doctors in Canada?

7. What does racializing a disease entail? Provide an examples of a racialized diseases.

8. Describe the processes through which a condition such as obesity or PTSD become commodified?

9. How is access to the jobs in medical professions gendered? Think of both doctors and nurses. Next discuss how gender and "race" and ethnicity intersect here.

10. How does social class affect health and healthcare, both in terms of access to medical care and access to medical professions?

Exploration and Discussion Exercises

1. Visit the World Health Organization's page on Canada at www.who.int/countries/can/en/ and read about the nation's health concerns. Then choose a few other countries from the site's home page and read about instances of outbreaks, crises, mortality, burden of disease, health service coverage, risk factors, and health systems. If you're interested in helping people and want to volunteer or work abroad, check out these organizations:
   - Habitat for Humanity Canada www.habitat.ca/
   - Reach Out to Humanity www.reachouttohumanity.org/
   - GoAbroad.com http://www.goabroad.com/
   - SWAP Working Holidays www.swap.ca/

2. Why is there resistance from some of the public and certain politicians to nationalizing healthcare in the United States? What factors account for this resistance? You can begin your research by watching news broadcasts and reading the articles at the following URLS:
   - www.telegraph.co.uk/news/worldnews/northamerica/usa/barackobama/5859382/Barack-Obamas-British-health-critics-are-shocked-to-be-caught-up-in-US-ad-campaign.html
   - www.balancedpolitics.org/universal_health_care.htm
   - www.amsa.org/AMSA/Libraries/Committee_Docs/CaseForUHC.sflb.ashx

Further Readings

Fuller, C. (1998). *Caring for profit: How corporations are taking over Canada's health care system*. Vancouver: New Star.
This book takes a critical look at the privatization and commodification of Canada's health care system.

Nakhaie, R. and R. Arnold (2010). A four year (1996–2000) analysis of social capital and health status of Canadians: The difference that love makes. *Social Science and Medicine 71*(5): 1037–1044.
This article examines social determinant of health.

Association for Size Diversity and Health:
https://www.sizediversityandhealth.org/Index.asp
This website provides some useful information pertaining to the discrimination based on body weight and the consequences when oppressed communities are marginalized by the medical system and its practitioners.

Canadian Alliance on Mental Illness and Mental Health: http://www.camimh.ca/
This alliance of mental health organizations provides information, support and resources pertaining to mental illness and mental health.

Health Canada website: http://www.hc-sc.gc.ca/index-eng.php
A useful hub of information pertaining to health in Canada

Health Canada website: http://www.hc-sc.gc.ca/fniah-spnia/index-eng.php
A source of information about health issues in First Nations and Inuit communities

World Health Organization: http://www.who.int/en/
This websites provides resources pertaining to global health issues.

Doctors Without Residency: **https://www.nfb.ca/film/doctors_without_residency/**
This short documentary illustrates the challenges of foreign-trained doctors face when trying to practise medicine in Canada.

Doctor Woman: The Life and Times of Dr. Elizabeth Bagshaw
https://www.nfb.ca/film/doctor_woman_the_life_and_times_of_dr_elizabeth/
This documentary provides a portray of Dr. Bagshaw, who was a women's rights activists and one of Canada's first female doctors. She talks about the bias and discrimination against women in medicine

***Medicine Under the Influence*:** https://www.nfb.ca/film/medicine_under_influence/
This controversial documentary raises the question of the benefits of biomedicine, which can sustain lives, but can't always guarantee quality of life.