CENGAGE

Eighth Edition

The Sociology of Health, Illness, and Health Care

A Critical Approach

Rose Weitz

The Sociology of Health, Illness, and Health Care

A Critical Approach

The Sociology of Health, Illness, and Health Care

A Critical Approach

EIGHTH EDITION

ROSE WEITZ
Arizona State University

CENGAGE

Australia • Brazil • Mexico • Singapore • United Kingdom • United States

This is an electronic version of the print textbook. Due to electronic rights restrictions, some third party content may be suppressed. Editorial review has deemed that any suppressed content does not materially affect the overall learning experience. The publisher reserves the right to remove content from this title at any time if subsequent rights restrictions require it. For valuable information on pricing, previous editions, changes to current editions, and alternate formats, please visit www.cengage.com/highered to search by ISBN#, author, title, or keyword for materials in your areas of interest.

Important Notice: Media content referenced within the product description or the product text may not be available in the eBook version.

CENGAGE

The Sociology of Health, Illness, and Health Care: A Critical Approach, Eighth Edition
Rose Weitz

Product Director: Thais Alencar

Product Manager: Ava Fruin

Project Manager: Julie Dierig

Content Manager: Wendy Huska, MPS Limited

Product Assistant: Emily Wiener

Marketing Manager: Tricia Salata

Photo and Text Researcher: Lumina Datamatics Ltd.

Copyeditor:
Steven M. Summerlight

Art and Production Management, and Composition: MPS Limited

Cover Designer: Marissa Falco

Cover Image: iStock.com/ Wavebreakmedia; iStock.com/ FatCamera

Printed in the United States of America
Print Number: 01   Print Year: 2019

In memory of my mother, Lilly Weitz, with love

Brief Contents

Contents

vii

Chapter 13   Issues in Bioethics   303

Preface

The sociology of health, illness, and health care has changed dramatically over the past few decades. The field was started primarily by sociologists who worked closely with doctors, taking doctors' assumptions about health and health care for granted and primarily asking questions that doctors deemed important. By the 1970s, however, the field had begun shifting toward a decidedly different set of questions. Some of these new questions challenged doctors' assumptions, whereas others focused on issues that lay outside most doctors' areas of interest or expertise such as how poverty affects health or how individuals develop meaningful lives despite chronic illness.

I entered graduate school during this shift, drawn by the opportunity to study how health and illness are socially created and defined and how gender, ethnicity, social class, and power affect both the health care system and individual experiences of health and illness. As a result, over the years I have researched such topics as how medical values affect doctors' use of genetic testing, how midwives and doctors have battled for control over childbirth, and how social ideas about AIDS affect the lives of those who live with this disease.

Although I had no trouble incorporating this new vision of the sociology of health, illness, and health care into my research, I consistently found myself frustrated by the lack of a textbook that would help me incorporate it into my teaching. Instead, most textbooks still seemed to reflect older ideas about the field and to take for granted medical definitions of the situation. Most basically, the books assumed that doctors define illness according to objective biological criteria, so they failed to question whether political and social forces underlie the process of defining illnesses. Similarly, most textbooks ignored existing power relationships rather than investigating the sources, nature, and health consequences of those relationships. For example, the textbooks gave relatively little attention to how doctors gained control over health care or how the power of the more developed nations has affected health in less developed nations. As a result, these textbooks used sociology primarily to answer questions posed by those working in the health

xvi

care field, such as what social factors lead to heart disease and why patients might ignore their doctors' orders. Consequently, these textbooks often seemed to offer a surprisingly unsociological perspective with their coverage of some topics differing little from coverage of those topics in health education textbooks.

Because the textbooks available when I first began working on this book often avoided critical questions about health, illness, and health care, they seemed unlikely to encourage students to engage with the materials and to question either the presented materials or their own assumptions such as the belief that the United States has the world's best health care system, that medical advances explain the modern rise in life expectancy, or that all Americans receive the same quality of health care regardless of their ethnicity, gender, or social class. Instead, the textbooks primarily gave students already-processed information to memorize.

My purpose in writing this textbook was to fill these gaps by presenting a critical approach to the sociology of health, illness, and health care. This did not mean presenting research findings in a biased fashion or presenting only research that supported my preexisting assumptions, but it did mean using critical skills to interpret the available research and to pull it together into a coherent "story" in each chapter. In addition, I hoped to tell these stories in a manner that would engage students—whether in sociology classes, medical schools, or nursing schools—and encourage them to learn actively and think independently. These remain the primary goals of this eighth edition. Both of these goals led me to decide against trying to please all sides or cover all topics because I believe such a strategy leads to a grab-bag approach that makes textbooks hard to follow and to an intellectual homogenization that makes them seem lifeless.

THE CRITICAL APPROACH

The critical approach, as I have defined it, means using the "sociological imagination" to question taken-for-granted aspects of social life. For example, most of the available textbooks in the sociology of health, illness, and health care still view patients who do not comply with prescribed medical regimens essentially through doctors' eyes, starting from the assumption that patients should comply. More broadly, previous textbooks have highlighted the concept of a sick role—a concept that embodies medical and social assumptions regarding "proper" illnesses and "proper" patients and downplays all aspects of individuals' lives other than the time they spend as patients.

In contrast, I emphasize recent research that questions such assumptions. For example, I discuss patient compliance by examining how patients view medical regimens and compliance, why doctors sometimes have promoted medical treatments (such as hormone therapy for menopausal women) that later proved dangerous and how doctors' tendency to cut short patients' questions can foster patient noncompliance. Similarly, this textbook explains the concept of a sick role but pays more attention to the broader experience of illness—a topic that has generated far more sociological research than the sick role has over the past 20 years.

CHAPTER ORGANIZATION

This textbook demonstrates the breadth of topics included in the sociology of health, illness, and health care. Part I discusses the role that social factors play in fostering illness and in determining which social groups experience which illnesses. Chapter 1 offers an introduction to the field, the sociological approach, and the history of disease. Chapter 2 describes the major causes of preventable deaths in the United States, demonstrating how social as well as biological factors affect health and illness. Building on this basis, Chapter 3 describes how age, sex, gender, social class, race, and ethnicity affect the likelihood, nature, and consequences of illness in the United States. Finally, Chapter 4 explores the nature and sources of illness in the poorer countries of Asia, Africa, and Latin America.

Part II analyzes the meaning and experience of illness and disability in the United States. Chapter 5 explores the social meanings of illness and social explanations for illness as well as the social consequences of defining behaviors and conditions as illnesses. With this as a basis, Chapter 6 first explores the meaning of disability and then offers a sociological overview of the experience of living with chronic pain, chronic illness, or disability, including the experience of seeking care from both medical doctors and alternative health care providers. Finally, Chapter 7 provides a parallel assessment of mental illness.

Part III moves the analysis to the macro level. Chapter 8 describes the U.S. health care system, the battles surrounding the 2010 Patient Protection and Affordable Care Act, and the continuing crises in health care costs and accessibility. Chapter 9 offers some basic measures for evaluating health care systems and then uses these measures to evaluate the systems found in Canada, Great Britain, Germany, the People's Republic of China, Mexico, and the Democratic Republic of Congo. Finally, Chapter 10 examines four common health care settings—hospitals, hospices, nursing homes, and family homes—and provides a social analysis of the technologies used in those settings.

Part IV shifts the focus from the health care system to health care providers. Chapter 11 analyzes the nature and source of doctors' professional status as well as the threats to that status. The chapter also describes the process of becoming a doctor, the values embedded in medical culture, and the impact of those values on doctor–patient relationships. Chapter 12 describes the history and social position of various health care occupations, including dentistry, nursing, osteopathy, and acupuncture. Finally, Chapter 13 presents a sociological overview of bioethics.

COVERAGE

Although I have tried in this book to present a coherent critical view, I have not sacrificed coverage of topics that professors have come to expect. Consequently, this book covers essentially all the topics that have become standard over the years, including doctor–patient relationships, the nature of the U.S. health care system,

and the social distribution of illness. In addition, I include several topics that until recently received relatively little coverage in other textbooks in the field, including bioethics, mental illness, the medical value system, the experience of illness and disability, and the social sources of illness in both more and less developed nations. As a result, this text includes more materials than most teachers can cover effectively in a semester. To assist those who choose to skip some chapters, each important term is printed in bold the first time it appears in *each* chapter, alerting students that they can find a definition in the book's Glossary. (Each term is both printed in bold and defined the first time it appears in the book.)

In addition, reflecting my belief that sociology neither can nor should exist in isolation but must be informed by and in turn inform other related fields, several chapters begin with historical overviews. For example, the chapter on health care institutions discusses the political and social forces that led to the development of the modern hospital, and the chapter on medicine as a profession discusses how and why the status of medicine grew so dramatically after 1850. These discussions provide a context to help students better understand the current situation.

CHANGES IN THE EIGHTH EDITION

Throughout the textbook, I have worked to update statistics as well as reviews of topical issues and theoretical issues. Two-thirds of references in this new edition are from the last 10 years, and fewer than 10% are from books or articles written before 1990—a level of timeliness that significantly surpasses that of most textbooks. The reader can thus safely assume that, wherever possible, the statistics, policy summaries, and legal information are the latest available.

New and Updated Chapter Topics

Chapter 2
- E-cigarettes
- Distracted driving and rise in automobile fatalities and distracted driving
- The opioid epidemic
- Updated discussion of premature causes of death

Chapter 3
- Climate change, poverty, and ill health
- Transgender health
- Mass incarceration and health

Chapter 4
- Neglected tropical disease
- Zika virus

Chapter 7
- Recent challenges to psychiatric diagnosis
- Mental health and the Affordable Care Act

Chapter 8
- The impact of the ACA
- The ACA under attack

Chapter 9
- Updated statistics and descriptions of health care in five nations

Chapter 10
- Technology, terrorism and public health
- Updated statistics on hospice care, hospitals, nursing homes, and home care

Chapter 11
- "Boutique medicine"

Chapter 12
- Updated statistics on each health care occupation

Chapter 13
- CRISPR technologies

New or Revised Tables and Figures
- Map 2.1 Overdose Deaths Per 100,000 Persons, United States
- Table 2.1 Main Causes of Deaths, 1900 and 2016
- Table 2.2 Underlying Causes of Premature Death in the United States, 2010
- Figure 3.1 Life Expectancy by Race and Ethnicity and Sex
- Table 3.1 Infant Mortality Rates in Different Nations and U.S. Ethnic Groups
- Table 3.2 Top Causes of Death by Ethnicity
- Table 4.1 Life Expectancy and Infant Mortality by Development Level
- Table 4.2 Leading Causes of Death around the World
- Table 6.1 Percentage of Americans with Basic Activity Limitations
- Table 7.1 Sex, Ethnicity, and Social Class Groups with the *Highest* Lifetime Risks of Specific Mental Illnesses
- Figure 7.1 Antidepressant Use in the Past 30 Days, United States
- Figure 8.1 Health Expenses and Inpatient Days in Acute Care Hospitals in 30 Nations
- Figure 8.2 Health Expenses and Number of Doctor Visits in 30 Nations
- Figure 8.3 Health Expenses and Life Expectancy in 30 Nations
- Table 9.1 Characteristics of Health Care Systems in Seven Countries
- Figure 11.1 Median Salaries by Percentage Women in Specialty

PEDAGOGICAL FEATURES FOR STUDENTS

Learning Objectives

Each chapter opens with a list of learning objectives matched to the chapter's main sections. These objectives help students focus their studying by alerting them to the chapter's main themes. The objectives also can help students demonstrate their ability to apply what they have learned and can help both students and faculty assess students' understanding.

Chapter Openings

Unfortunately, many students take courses only to fill a requirement. As a result, the first problem professors face is interesting students in the topic. For this reason, the main text of each chapter begins with a vignette taken from a sociological or literary source that is chosen to spark students' interest by demonstrating that the topic has real consequences for real people—that, for example, stigma is not simply an abstract concept but something that can cost ill persons their friends, jobs, and social standing.

Chapter "Road Maps"

To help orient students to the chapters, each chapter's introductory section ends with a brief overview of what is to come.

Contemporary Issues

To further raise student interest and add to their knowledge, most chapters include a boxed discussion of a relevant topic taken from recent news reports. Topics include the debate over full-body computed tomography scans and the decline of primary care. These boxes should spark student interest while helping them make connections between textbook topics and the world around them.

Ethical Debates

To teach students that ethical dilemmas pervade health care, most chapters include a discussion of a relevant ethical debate. The debates are complex enough that students must use critical thinking skills to assess them; teachers can use these debates for classroom discussions, group exercises, or written assignments.

Key Concepts

To help students understand particularly important and complex topics, such as the difference between the sociological and medical models of illness or the strengths and weaknesses of the sick role model, I have included Key Concepts tables or boxes in several chapters.

Implications Essays

Each chapter ends with a brief essay that discusses the implications of the chapter and points the reader toward new questions and issues. These essays should stimulate critical thinking and can serve as the basis for class discussions.

Chapter Summaries

Each chapter ends with a detailed, bulleted summary that will help students to review the material and identify key points.

Review Questions and Critical Thinking Questions

Each chapter includes both Review Questions that take students through the main points of the chapter and Critical Thinking Questions that push students to extrapolate from the chapter to other issues or to think more deeply about issues discussed within the chapter.

Glossary

The book includes an extensive Glossary that defines all important terms used in the book. Each Glossary term is printed in bold and defined the first time it appears in the text. In addition, each term is also printed in bold the first time it appears in *each* chapter, so students will know that they can find a definition in the Glossary.

SUPPLEMENTAL AND PEDAGOGICAL FEATURES FOR FACULTY

Instructor's Manual with Test Bank

For each chapter, the *Instructor's Manual* contains a detailed summary, a set of multiple-choice questions, and a list of relevant books, narrative films, and documentaries. In addition, the *Instructor's Manual* includes several questions for each chapter that require critical-thinking skills to answer and that teachers can use for essay exams, written assignments, in-class discussions, or group projects. The manual also includes for each chapter a set of Internet exercises designed both to familiarize students with materials available on the Web and to facilitate critical reading and use of those materials. Finally, the manual lists for each chapter a few relevant nonprofit organizations. Organizations listed in the manual can serve as sources for more information or as sites for out-of-class assignments.

The Test Bank contains up to 20 multiple-choice questions, five true/false questions, and five essay questions per chapter, all fully updated according to match the eighth edition's content.

To guarantee the quality of the *Instructor's Manual with Test Bank*, I wrote everything in it rather than relying on student assistants. The manual is available for downloading at http://login.cengage.com.

PowerPoint Lectures

PowerPoint lectures for each chapter, including all tables and figures, can be downloaded from http://login.cengage.com. These lectures should prove useful both for new adopters and for past users who would like to incorporate more visual materials into their classrooms. As with the *Instructor's Manual*, I put these lectures together myself to ensure their quality.

Critical Thinking

In this textbook, I have aimed not only to present a large body of data in a coherent fashion but also to create an intellectually rigorous textbook that will stimulate students to think critically. I have tried to keep this purpose in mind in writing each chapter. Debates discussed within the chapters, as well as the various chapter features, all encourage students to use critical thinking, and all serve as resources that teachers can use in building their class sessions.

ACKNOWLEDGMENTS

In writing this textbook, I have benefited enormously from the generous assistance of my colleagues. I am fortunate to have had several exceptional scholars as colleagues over the years—Victor Agadjanian, Jill Fisher, Verna Keith, Bradford Kirkman-Liff, Jennie Jacobs Kronenfeld, and Deborah Sullivan—who shared my interest in health issues and helped me improve various chapters. I am also exceptionally fortunate to have had the assistance of several research assistants—Natasha McLain, Allex Raines, Ashley Fenzl, Allison Hickey, Ann Jensby, Melinda Konicke, Christopher Lisowski, Stephanie Mayer, Leslie Padrnos, Zina Schwartz, Diane Sicotte, Lisa Tichavsky, Caroleena Von Trapp, and especially Karl Bryant, Lisa Comer, and Amy Weinberg, who worked on the first edition.

Because, of necessity, this textbook covers a wealth of topics that range far beyond my own areas of expertise, I have had to rely heavily on the kindness of strangers in writing it. One of the most rewarding aspects of writing this book has been the pleasure of receiving information, ideas, critiques, and references from individuals I did not previously know. This edition was undoubtedly improved by suggestions from Ellen Annandale (University of York), Maria Dolores Corona (Universidad Autónoma de Nuevo León), Georgiann Davis (University of Nevada, Las Vegas), Victoria Fan (University of Hawai`i at Mānoa), Siegfried Geyer (Hannover Medical School), Lei Jin (Chinese University of Hong Kong), Tey Meadow (Harvard University), Melissa A. Milkie (University of Toronto), Jiong Tu (Sun Yat-sen University), Carla A. Pfeffer (University of

South Carolina), Helen Rosenberg (University of Wisconsin-Parkside), Ian Shaw (University of Nottingham), Lisa Strohschein (University of Alberta), and Diane Kholos Wysocki (formerly of University of Nebraska–Kearney).

In addition, I would like to once again thank those who gave me the benefit of their expert advice on previous editions: Astrid Eich-Krohm (University Hospital Magdeburg), Krista Hodges (University of Hawaii), Michael Polgar (Penn State University), Jennifer Schumann, Ian Shaw (University of Nottingham), Julia Stumkat, and Wei Zhang (University of Hawaii), Emily Abel (University of California–Los Angeles); James Akré (World Health Organization); Ellen Annandale (University of Leicester); Ofra Anson (Ben Gurion University of the Negev); Judy Aulette (University of North Carolina; Charlotte); Miriam Axelrod; James Bachman (Valparaiso University); Kristin Barker (University of New Mexico); Paul Basch (Stanford University); Phil Brown (Brown University); Peter Conrad (Brandeis University); Timothy Diamond (California State University–Los Angeles); Luis Durán (Mexican Institute of Social Security); Elizabeth Ettorre (University of Liverpool); Michael Farrall (Creighton University); Kitty Felker; Arthur Frank (University of Alberta); María Hilda García-Pérez (Arizona State University); Alya Guseva (Boston University); Frederic W. Hafferty (University of Minnesota–Duluth); Harlan Hahn (University of Southern California); Ida Hellander (Physicians for a National Health Program); Paul Higgins (University of South Carolina); Allan Horwitz (Rutgers University); David J. Hunter (University of Durham); Joseph Inungu (Central Michigan University); Michael Johnston (University of California–Los Angeles); Stephen J. Kunitz (University of Rochester); Donald W. Light (University of Medicine and Dentistry of New Jersey); Judith Lorber (City University of New York); William Magee (University of Toronto); Judy Mayo; Peggy McDonough (University of Toronto); Jack Meyer (Economic & Social Research Institute); Cindy Miller; Jeanine Mount (University of Wisconsin); Marilynn M. Rosenthal (University of Michigan); Beth Rushing (Kent State University); C. J. Schumaker (Walden University); Wendy Simonds (Georgia State University); Teresa Scheid (University of North Carolina at Charlotte); Clemencia Vargas (Centers for Disease Control and Prevention); Olaf von dem Knesebeck (University of Hamburg); Robert Weaver and his students, especially Cheryl Kratzer (Youngstown State University); Daniel Whitaker; David R. Williams (University of Michigan); Irving Kenneth Zola (Brandeis University); and Robert Zussman (University of Massachusetts–Amherst). This book undoubtedly would have been better if I had paid closer attention to their comments. I apologize sincerely if I have left anyone off this list.

Similarly, I am deeply grateful for the advice received from reviewers of this edition: Andrew Bedrous (Kansas Wesleyan University), DeAnna Gore (University of South Carolina, Aiken), Muhammad Haque (McNeese State University), Caroline Hartnett (University of South Carolina), Marta Jankowska (San Diego State University), Yushi Li (Northern Kentucky University), Elgin Mannion (Western Illinois University), Jewrell Rivers (Abraham Baldwin Agricultural College), Sharon Sassler (Cornell University), and Paul Sutton (University of Denver).

I also remain grateful for the suggestions from reviewers on previous editions: Jennifer Bulanda (Miami University), Benjamin Drury (Indiana University at Columbus), Jamie Gusrang (Community College of Philadelphia), David Mullins (University of Saint Francis), Claire Norris (Xavier University of Louisiana), Michael Polgar (Penn State University), Richard Scotch (University of Texas at Dallas), Nicole Vadino (Community College of Philadelphia, Thomas Allen (University of South Dakota), Karen Bettez (Boston College), Linda Liska Belgrave (University of Miami), Pamela Cooper-Porter (Santa Monica College), Karen Frederick (St. Anselm College), Stephen Glazier (University of Nebraska), Linda Grant (University of Georgia), Janet Hankin (Wayne State University), Heather Hartley (Portland State University), Alan Henderson (California State University–Long Beach), Simona Hill (Susquehanna University), Frances Hoffman (University of Missouri), Joseph Kotarba (University of Houston), Lilly M. Langer (Florida International University), Christine Malcom (Roosevelt University), Keith Mann (Cardinal Stritch University), Phylis Martinelli (St. Mary's College of California), Dan Morgan (Hawaii Pacific University), Larry R. Ridener (Pfeiffer University), Susan Smith (Walla Walla University), Kathy Stolley (Virginia Wesleyan College), Deborah Sullivan (Arizona State University), Gary Tiedman (Oregon State University), Diana Torrez (University of North Texas), Linda Treiber (Kennesaw State University), Robert Weaver (Youngstown State University), and Diane Zablotsky (University of North Carolina–Charlotte).

Finally, I would like to express my appreciation to the current and former Cengage staff who made the process of revising this book for its eighth edition as smooth as possible: Sharib Asrar, Mike Bailey, Julie Dierig, Deanna Ettinger, Ava Fruin, Jayne Stein, Wendy Huska, and Jenny Ziegler.

About the Author

Rose Weitz received her doctoral degree in sociology from Yale University in 1978. Since then, she has carved an exceptional record as both a scholar and a teacher. She is the author of numerous scholarly articles, the book *Life with AIDS*, and the book *Rapunzel's Daughters: What Women's Hair Tells Us About Women's Lives*. She also is coauthor of *Labor Pains: Modern Midwives and Home Birth* and coeditor of *The Politics of Women's Bodies: Appearance, Sexuality, and Behavior*.

Professor Weitz has won several teaching awards (including the Pacific Sociological Association's Distinguished Contributions to Teaching Award, the ASU Last Lecture Award, and the ASU College of Liberal Arts and Sciences Outstanding Teaching Award) and has served as director of ASU's graduate and undergraduate sociology and gender studies programs. In addition, she has served as president of Sociologists for Women in Society, as chair of the Sociologists AIDS Network, and as chair of the Medical Sociology Section of the American Sociological Association.

PART
I

Social Factors and Illness

Illness is a fact of life. Everyone experiences illness sooner or later, and everyone eventually must cope with illness among close friends and relatives.

To the ill individual, illness can seem a purely internal and personal experience. But illness is also a social phenomenon with social roots and social consequences. In this first part, we look at the role that social factors play in fostering illness within societies and in determining which groups in a given society will experience which illnesses with which consequences.

Chapter 1 introduces the sociological perspective and illustrates how sociology can help us understand issues related to health, illness, and health care. The chapter also provides a brief history of disease in the Western world, which highlights how social factors can foster disease. In the subsequent chapters, we explore the role social forces play in causing disease and in determining who gets ill in the modern world. In Chapter 2, we review the basic concepts needed to discuss diseases and look at modern patterns of disease. After that, we look at the social sources of illness in the contemporary United States and at some social factors that help predict individual health and illness. In Chapter 3, we investigate how four social factors—age, sex and gender, social class, and race or ethnicity—affect the

1

distribution of illness in the United States and explore why some social groups bear a greater burden of illness than others. Finally, in Chapter 4, we analyze the very different pattern of illnesses found in poorer countries and explain how social forces—from the low status of women to the rise of migrant labor—can foster illness in these countries.

The Sociology of Health, Illness, and Health Care

David Hanover/Getty Images

LEARNING OBJECTIVES

After reading this chapter, students should be able to:

- Describe the sociological perspective.
- Identify the difference between sociology *in* medicine and sociology *of* medicine.
- Understand how social changes have historically affected the health of populations.
- Evaluate research methods and sources.

Shortly before her 46th birthday, my friend Lara found a lump in her breast. A mammogram (a type of x-ray) soon identified the lump as potentially cancerous, and so a surgeon removed part of the lump for further testing. A few days later, Lara learned that she did indeed have breast cancer. That week, she got her affairs in order and signed a "living will," specifying the circumstances in which she would want all treatment stopped, and a "medical power of attorney" giving me legal authority to make medical decisions for her if she could not do so herself. These two documents, she hoped, would protect her from aggressive medical treatments that might prolong her suffering without improving her quality of life or chances of survival.

Two weeks after the initial tests, her surgeon removed the rest of the lump as well as the lymph nodes under her arm (where breast cancer most often spreads). The surgery went well, but the subsequent laboratory tests showed that the cancer had spread to her nodes.

Yet in many ways, Lara was fortunate. Her breast cancer was detected at an early stage, improving her odds of surviving. Although she had neither husband nor children to turn to, her friends proved uniformly supportive. She received health insurance through her employer and had no fears of losing either her job or her insurance.

Nevertheless, cancer changed Lara's life irrevocably, making it, at times, a nightmare. Having breast cancer shook Lara's faith in her body and changed her sense of her physical self. At the same time, her illness threatened her relationships with others. Despite the supportive responses she received from friends and coworkers, she feared that they would drift away as her illness continued or that she would chase them away with her all-too-reasonable complaints, worries, and needs.

Meanwhile, even though she had better health insurance than many Americans have, her debts for items not covered by insurance mounted. In addition, she had to spend hours fighting her insurance company to obtain relaxation training and expensive but effective anti-nausea drugs to cope with chemotherapy's side effects. Without the drugs, chemotherapy made her so

ill that she could barely function, let alone fight her insurance company. In addition, chemotherapy proved so toxic that it damaged her veins with each painful intravenous treatment. As a result, her doctors suggested inserting a semi-permanent plastic tube into her chest wall so they could instead administer the chemotherapy through the tube. Although doing so would have reduced her pain, Lara rejected the suggestion because she felt that, with this sign of her illness physically attached to her body, cancer would become part of her very self rather than merely one aspect of her life.

After a year of surgery, chemotherapy, and radiation, Lara's physical traumas ended, although it took another year before she regained her former energy.

Lara's story demonstrates the diverse ways that illness affects individuals' lives, as well as the diverse range of topics that sociologists of health, illness, and health care can study. This chapter opens with an overview of those topics, the sociological perspective, and the critical approach within sociology. We then look briefly at the history of disease, which helps put sociological research on health into context, before exploring the research sources used by sociologists.

THE SOCIOLOGY OF HEALTH, ILLNESS, AND HEALTH CARE: AN OVERVIEW

Sociologists' research into health, illness, and health care falls into three main categories. First, some sociologists study how social forces promote health and illness and why some social groups suffer more illness than others. For example, researchers have explored whether working conditions in U.S. factories help explain why poorer Americans get certain cancers more often than wealthier Americans. Similarly, sociologists can study how historical changes in social life can explain changes in patterns of illness. To understand why rates of breast cancer have increased, for example, researchers have studied the possible impact of environmental pollution, increased meat consumption, and women's changing work lives.

Second, instead of studying broad patterns of illness, sociologists can study the experiences of people like Lara who live with illness each day—exploring, for example, how illness affects individuals' sense of identity, relationships with family, or ideas about what causes illness. Similarly, sociologists can study the experiences of health care providers. Some sociologists have analyzed how doctors' status and power have shifted over time, and others have investigated how power affects interactions among doctors, nurses, and other health care workers. Still others have examined interactions between health care workers and patients, asking, for example, how doctors maintain control over patients or whether doctors treat male and female patients differently.

Third, sociologists can analyze the health care system as a whole. Sociologists have examined how health care systems have developed, compared the strengths and weaknesses of different systems, and explored how systems can be improved.

For example, some have studied how U.S. health insurance companies can make it difficult for people like Lara to get needed care, explored why European countries do better than the United States at providing health care to all who need it, and examined whether European health care policies could work in the United States.

The topics researched by sociologists of health, illness, and health care overlap in many ways with those studied by health psychologists, medical anthropologists, public health workers, and others. What most clearly differentiates sociologists from these other researchers is the *sociological perspective*. The next section describes that perspective.

THE SOCIOLOGICAL PERSPECTIVE

The **sociological perspective** is a view of the world that focuses on *social patterns* rather than *individual behaviors*. Whereas a psychologist might help a battered wife develop a greater sense of her own self-worth so she might eventually leave her abusive husband, a sociologist likely would consider therapy a useful but inefficient means of addressing the root causes of wife abuse. Most battered wives, after all, don't have the time, money, or freedom to get help from psychologists. Moreover, even when therapy helps, it takes place only after the women have experienced physical and emotional damage. The sociologist would not deny that individual personalities play a role in wife battering but would find it more useful to explore whether social forces can explain why wife battering is much more common than husband battering or why battered wives so often remain with abusive husbands. Consequently, whereas the psychologist hopes to enable the individual battered wife eventually to leave her husband, the sociologist hopes to uncover the knowledge needed by legislators, social workers, activists, and others to prevent wife abuse in the first place.

As this example demonstrates, using the sociological perspective means framing problems as *public issues* rather than as simply *personal troubles*. According to C. Wright Mills (1959:8–9), the sociologist who first drew attention to this dichotomy:

> [*Personal*] *troubles* occur within the character of the individual and within the range of his immediate relations with others; they have to do with his self and with those limited areas of social life of which he is directly and personally aware. Accordingly, the statements and the resolutions of troubles properly lie within the individual as a biographical entity and within the scope of his immediate milieu.…
> [In contrast, *public*] *issues* have to do with matters that transcend these local environments of the individual and the range of his inner life. They have to do with the organization of many such milieus into the institutions of an historical society as a whole.

For example, whenever a child is diagnosed with severe brain damage, it is a tragedy and personal trouble for the child's family. If, on the other hand, several

children in a neighborhood receive the same diagnosis during the same year, it could suggest a broader public issue such as a contaminated water system—as happened in Flint, Michigan, in 2016. A sociologist would be likely to look for such a pattern and explore why, for example, polluting industries are more likely to build factories in poor, minority neighborhoods than in affluent, white neighborhoods. The sociological perspective, then, departs radically from the popular American belief that individuals create their own fates and that anyone can succeed if he or she tries hard enough.

The sociological perspective can help us identify critical research questions that might otherwise go unasked. For example, in the book *Forgive and Remember: Managing Medical Failure*, sociologist Charles Bosk (2003:62–63) described a situation he observed one day on rounds, the time each day when recently graduated doctors (known as *residents*) and more senior doctors jointly examine the patients on a service or ward:

> Dr. Arthur [the senior doctor] was examining the incision [surgical cut] of Mrs. Anders, a young woman who had just received her second mastectomy. After reassuring her that everything was fine, everyone left her room.
>
> We walked a bit down the hall and Arthur exploded: "That wound looks like a walking piece of dogshit. We don't close wounds with continuous suture on this service. We worked for hours giving this lady the best possible operation and then you screw it up on the closure. That's not how we close wounds on this service, do you understand? These are the fine points that separate good surgeons from butchers, and that's what you are here to learn. I never want to see another wound closed like that. Never!"
>
> Arthur then was silent, he walked a few feet, and then he began speaking again: "I don't give a shit how Dr. Henry [another senior doctor] does it on the Charlie Service or how Dr. Gray does it on Dogface: When you're on my service, you'll do it the way I want."

Dr. Arthur and the residents he supervised undoubtedly viewed this situation as a personal trouble requiring a personal solution—the residents seeking to appease Dr. Arthur, and Dr. Arthur seeking to intimidate and shame the residents into doing things the way he considered best. Similarly, depending on their viewpoint, most observers probably would view this as a story about either careless residents or an autocratic senior doctor. Sociologists, however, would first ask whether residents and senior doctors *typically* interact like this. If they do, sociologists then would look for the social patterns underlying such interactions rather than focus on the personalities of these particular individuals. So, for example, based on his observations in this and other cases, Bosk discovered that cultural expectations within the medical world regarding authority, medical errors, and the importance of personal, surgical experience gave Dr. Arthur and the other supervising doctors power and allowed them to humiliate residents publicly and to set policies based more on personal preferences than on scientific data.

Whereas Charles Bosk studied relations among doctors, sociologist Kristin Barker (2008) looked at interactions among individuals who believe they have fibromyalgia. Fibromyalgia is a relatively new disease label given to individuals who experience a wide variety of disabling symptoms. Because there are no biological tests for fibromyalgia, many doctors doubt whether it should be considered a disease.

To explore what it means to live with fibromyalgia, Barker looked at posts to an online fibromyalgia support group. In a typical post, a woman named Sarah wrote:

> My new doctor appointment was today. Was not good!! First of all she is four months out of medical school. She looked over my chart and immediately wanted to change all medications that I am taking.… [Then she said,] "Now about your fibromyalgia, I will not prescribe pain killers for fibro." I sat there with my mouth open. She went on to tell me the fresh-out-of-med-school approach to fibro is exercise, diet. I said what about the pain? She proceeded to tell me the pain was "ALL IN MY HEAD, THERE IS NO PAIN, YOU JUST IMAGINE THERE IS." My first thought was [to] jump up out of this chair and slap the B——!! Instead I said "You are an idiot"!! Then I walked out.

Depending on one's perspective, Sarah's post suggests either an ignorant and insensitive doctor or a rude patient with delusions of grandeur. To a sociologist, however, this post raises several questions that go beyond these individuals and therefore requires looking at the surrounding culture and social structure. Barker, for example, explored how the online support group increased patients' power to negotiate with their doctors, how the broader social structure nevertheless allowed doctors to control most interactions with patients, and how these struggles between doctors and patients reflected wider social questions regarding what constitutes an illness.

In sum, the sociological perspective shifts our focus from individuals to social groups and institutions. One effect of this shift is to highlight the role of power. **Power** refers to the ability to get others to do what one wants, whether willingly or unwillingly. Power is what allowed Dr. Arthur to treat his residents so rudely and what allowed Sarah to reject her doctor's advice. Because sociologists study groups rather than individuals, the sociological analysis of power focuses on why some social groups have more power than others, how groups use their power, and the consequences of **differential** (that is, unequal) access to power rather than on how specific individuals get or use power. For example, sociologists have examined how doctors use their power in negotiations with hospitals over working conditions and how *lack* of power exposes poor persons to unhealthy living conditions.

A CRITICAL APPROACH

Although the concept of power underlies the sociological perspective, sociologists don't necessarily emphasize power in their research and writing. For example, some sociologists have researched unhealthy eating patterns among poor people

without exploring how a lack of power may force individuals to work two jobs and leave them without enough time to prepare healthy meals.

Those sociologists, on the other hand, who focus on the sources, nature, and consequences of power relationships can be said to use a *critical* approach. Critical sociologists recognize that, regardless of how power is measured, men typically have more power than do women, adults more power than children, whites more power than African Americans, heterosexuals more power than those who are not heterosexual, and so on. Critical sociologists who study health, illness, and health care have raised issues such as how differing levels of power affects individuals' access to health care and healthy living conditions.

Critical sociologists also emphasize how social institutions and popular beliefs can reflect or reinforce the existing distribution of power. For example, many researchers who study the U.S. health care system have looked simply for ways to improve access to care within that system such as by providing subsidies to doctors who practice in low-income neighborhoods. Those who use a critical approach have asked instead whether we could provide better care to more people if we changed the basic structure of the system such as by removing the profit motive from health care to reduce the costs of care for everyone.

Similarly, critical sociologists have drawn attention to how doctors' power enables them to shape our ideas about health, illness, and health care. Most basically, these sociologists have questioned the very terms *health, illness*, and *disability* and have explored how these terms can reflect social values as well as physical characteristics.

In any sociological field, therefore, those who adopt a critical approach will ask quite different research questions than will others. Within the sociology of health, illness, and health care, this approach translates largely to whether sociologists limit their research to questions about social life that doctors consider useful—a strategy referred to as **sociology *in* medicine**—or design their research to answer questions of interest to sociologists in general—a strategy referred to as the **sociology *of* medicine** (Straus, 1957). Research using the latter strategy often challenges both medical views of the world and existing power relationships within health care.

To understand the difference between sociology *in* medicine and sociology *of* medicine, consider the sociological literature on patients who don't follow their doctors' advice. Reflecting doctors' views of such patients as problematic, many sociologists (practicing sociology *in* medicine) have explored ways to encourage patients to comply with medical advice. In contrast, sociologists *of* medicine have looked at the issue of compliance through patients' eyes. As a result, they have learned that patients sometimes ignore medical advice not out of foolishness but because their doctors did not clearly explain the prescribed regimens or because the emotional or financial costs of following that advice seem to outweigh the potential benefits. Similarly, whereas those practicing sociology in medicine have studied the experience of *patienthood*, those practicing sociology *of* medicine instead have studied the broader experience of *illness*, which includes but is not limited to the experience of patienthood. The growing emphasis on sociology of medicine and on the critical approach has led to a proliferation of research on the