Why should this choice be forbidden to individuals simply because they cannot, either physically or emotionally, carry it out themselves? And why should we allow individuals to choose death only through passive euthanasia, leaving them to languish in pain while awaiting death, if instead they could be killed quickly and painlessly?

Opponents of this view argue that the duty to preserve life overrides any other values and that euthanasia is merely a nice word for suicide or murder. They question whether Elizabeth Bouvia would have wanted to die if she still had the resources she needed to live independently, and they wonder whether euthanasia gives society a way to avoid responsibility for relieving the burdens imposed by illness and disability. Opponents who have studied the Netherlands suggest that Dutch doctors sometimes end patients' lives without consent and without first attempting to make patients' lives worth living (Hendlin, Rutenfrans, and Zylicz, 1997). In addition, opponents question whether Dutch acceptance of euthanasia explains why, compared with the rest of Europe, the Netherlands has fewer hospices and fewer doctors trained in pain relief.

In sum, the use of euthanasia, whether active or passive, raises numerous difficult questions: What are the consequences of, in effect, declaring it reasonable for disabled people to choose death? What pressures does this place on individuals to end their own lives rather than burdening others? What responsibilities does this remove from society to make these individuals' lives less burdensome? Finally, given that social factors, such as age, gender, and social class, affect our perceptions of individuals' worth, how do we ensure that society will not more willingly grant a right to die to women, minorities, or other socially disvalued groups?

Sociological Questions

1. What social views and values about medicine, society, and the body are reflected in the debate over a right to die? Whose views are these?
2. Which social groups are in conflict over this issue? Whose interests do the different sides of this issue serve?
3. Which of these groups has more power to enforce its view? What kinds of power do they have?
4. What are the intended consequences of recognizing a right to die? What are the potential *unintended* social, economic, political, and health consequences of doing so?

Both women and whites use hospice care more often than do others. In addition, most hospice clients are older than age 65. Not surprisingly given this age distribution, most hospice clients rely on Medicare to pay the costs (National Hospice and Palliative Care Organization, 2010).

Because Medicare only pays for hospice care for 6 months, hospices lose money if their clients survive beyond that time period. As a result, hospices disproportionately serve individuals with cancer, whose life expectancies can be fairly accurately predicted. In 2009, 40% of hospice clients had cancer (National

Hospice and Palliative Care Organization, 2010). Conversely, the greatest unmet needs are found among dying patients who do *not* have cancer.

Outcomes of Hospice Care

Research suggests that hospice care saves Medicare more than $2,000 per person and that even more could be saved if individuals entered hospice care sooner (Taylor et al., 2007). To understand the full economic impact of hospice care, however, we must take into account that 40% of hospice users now die in their homes (National Hospice and Palliative Care Organization, 2010). In these circumstances, family members provide most care. To do so, they often must take time off from work or drop out of the labor market altogether. Consequently, hospice care might not reduce the costs of caring as much as it shifts the costs from hospitals and insurers to families.

The health benefits of hospice care are more clear. One study using a large-scale **random sample** of terminally ill Medicare recipients found that hospice clients survive an average of one month *longer* than those who receive ordinary medical care instead (Connor et al., 2007). Moreover, another study, which randomly assigned patients recently diagnosed with a terminal illness to either hospice or regular medical care, found that the hospice patients reported a *higher* quality of life, experienced *less* depression, and survived almost *three months* longer than those who continued with medical care (Temel et al., 2010). These individuals may have benefitted both from the supportive care of hospice and from avoiding the traumatic surgeries and chemotherapies typically given to terminally ill patients.

HOME CARE

As the discussion of hospices suggested, most individuals who experience chronic or acute health problems—whether children, working-age adults, or elderly, and whether the problems are physical or mental—receive most of their care at home. This is even truer now than in the recent past because of technical, demographic, and policy changes. Because of technological advances, babies born prematurely or with birth defects and persons who have experienced severe trauma are increasingly likely to survive, although often with severe disabilities that require lifelong assistance. Much of this care is now given by family members in the home. In addition, technological advances also have made it possible for families to provide treatments at home that previously were available only in hospitals, such as chemotherapy or kidney dialysis.

At the same time, the rise in the numbers of frail elderly, many of whom have both multiple physical problems and cognitive impairments, has increased the number receiving care at home. In addition, the movement begun in the 1960s (and described in Chapters 6 and 7) to deinstitutionalize people with disabilities and mental illnesses, combined with the lack of community supports for such individuals after deinstitutionalization, have shifted much of the burden of care from state institutions to the home. Finally, as described earlier, policy changes now encourage

hospitals to discharge patients to their homes "sicker and quicker," in essence replacing paid hospital workers with unpaid family caregivers (Glazer, 1993).

Because of limited public or private insurance coverage for home care, most who need long-term supportive care receive services only from family members and, less often, friends. Existing data suggest that home care has little impact on the overall costs of care or the mental or physical health of those receiving care but can produce small improvements in individuals' satisfaction with life (Arno, Bonuck, and Padgug, 1995; Weissert, 1991).

The Nature of Family Caregiving

A survey conducted for the nonprofit organizations National Alliance for Caregiving and AARP (2009) found that 29% of U.S. adults—66 million people—provide care for elderly, ill, or disabled family members (or, less often friends). About two-thirds of these caregivers are women. Ethnic minorities and poorer persons also are more likely to become caregivers, probably because these groups experience higher rates of illness and disability and have less access to formal services.

Those who care for the health needs of family members typically do so out of love and often reap substantial psychological rewards. Nevertheless, caregiving by family members should not be romanticized, nor should the financial, physical, social, or psychological costs of caregiving be underestimated (Arras and Dubler, 1995; National Alliance for Caregiving and AARP, 2009; Reinhard and Horwitz, 1996; Tessler and Gamache, 1994).

The financial costs of caregiving are substantial. The demands of caregiving force many to shift to part-time work or even abandon paid employment. In addition, caregivers must purchase, often out of pocket, both expensive drugs and technologies and many everyday items such as diapers and bandages. In addition, caregivers typically are responsible for purchasing a variety of services and therapies from a range of companies and health care workers.

The physical costs also can be high. Caregiving often includes strenuous tasks which can result in back injuries or exhaustion, such as lifting a physically disabled person into a bed. The time burdens of caregiving also can become physically draining. The typical caregiver spends 20 hours per week on caregiving, does so for more than 4 years, and holds at least a part-time job as well. Moreover, many are simultaneously responsible for more than one relative, such as a child with a disability and a parent with Alzheimer's disease. Not surprisingly, the more hours individuals spend each day in caregiving and the more months (or years) they spend in this way, the greater the toll on caregivers' health (National Alliance for Caregiving and AARP, 2009).

Taken together, the financial and physical burdens of caregiving often leave individuals with little time, energy, or money for social relationships. Caregivers often report that their relationships with both family and friends have suffered because of their responsibilities (National Alliance for Caregiving and AARP, 2009). For example, a mother who spends hours each day caring for an ill child might regret that she has so little time for her other children, and those children might resent the attention given to their ill sibling. Problems are particularly

acute when the person receiving care is mentally ill and throws family routines into chaos, embarrasses other family members, or physically threatens their safety (Reinhard and Horwitz, 1996; Tessler and Gamache, 1994).

Family life also can suffer when caregiving requires the use of high technology within the home. John D. Arras and Nancy Neveloff Dubler suggest that this

> invasion of the home by high-tech medical procedures, mechanisms, and supporting personnel exerts a cost in terms of important values associated with the notion of home. How can someone be truly "at home," truly at ease, for example, when his or her living room has been transformed into a miniature intensive care unit? ... Rooms occupied by the paraphernalia of high-tech medicine may cease to be what they once were in the minds of their occupants; familiar and comforting family rituals, such as holiday meals, may lose their charm when centered around a mammoth Flexicare bed; and much of the privacy and intimacy of ordinary family life may be sacrificed to the institutional culture that trails in the wake of high-tech medicine (1995:3).

Finally, caregiving brings with it numerous psychological costs. Caregivers can easily become depressed when their efforts cannot stop or even slow the disease process. This is especially true when caregivers must routinely inflict painful treatments on their charges or when the burdens of caregiving are unceasing, as when a parent must suction the lungs of a child with cystic fibrosis hour after hour, day after day, to keep the child from dying. Moreover, as this example suggests, caregivers also often bear the enormous psychological burden of being directly responsible for another person's life. In fact, family caregivers are now expected to manage in the home—often with little training or technical support—technology considered too complex for licensed practical nurses to manage in hospitals. Finally, caregivers of persons younger than themselves face anxieties about what will happen to their charges if the caregivers die first.

Easing the Burdens of Caregiving

The problems faced by family caregivers have led to the development of new organizations, new organizational structures, and a new occupation to ease the burdens of caregiving. Two major organizations, the National Alliance for the Mentally Ill (NAMI) and the National Alliance for Caregiving (NAC), are now devoted to family caregiving. Both organizations work to increase assistance to family caregivers and improve access to community-based care, and the NAMI additionally fights to decrease the stigma of severe mental illness.

Both **respite care** and **family leave programs** also were developed to ease the burdens of caregivers. Respite care refers to any system designed to give caregivers a break from their otherwise unrelenting responsibilities, including paid aides who provide care in the home for a few hours, day-care centers for elderly and disabled adults, and nursing homes that accept clients for brief stays. Unfortunately, only California and Pennsylvania fund respite care programs. In all other states, respite care is expensive and difficult to find; only 12% of those included

in the NAC and AARP (2009) survey had ever used respite care. Minimal data are available on the quality of these services (Kitchener and Harrington, 2004).

Similarly, although federal law gives employees the right to as many as 12 weeks of unpaid leave from work yearly to care for family members, few can afford to take unpaid leaves. In addition, the law does not apply to part-time workers, temporary workers, or employees of small firms. The law is also problematic because it reinforces the idea that caring for ill and disabled persons is the responsibility of the family—which, in practice, usually means women relatives—rather than the responsibility of society as a whole (Abel, 2000).

Finally, those who provide care to relatives or friends may turn for assistance to paid caregivers. Each day about 1.4 million Americans receive paid home care, most commonly in the form of help with bathing, dressing, and light housework (National Center for Health Statistics, 2010b). Most paid home care is provided by **home health aides**, who typically have no formal training, or **registered nurses**, who have received at least two years of nursing training and passed national licensure requirements. Aides are overwhelmingly minorities and women, and they are highly likely to be immigrants. Few receive any job benefits, and most receive only minimum wage. Because the growth in paid home health care is so new, little more is known regarding these workers or their work.

HEALTH CARE TECHNOLOGIES

Doctors and other healers have always used technologies in their work. Two hundred years ago, doctors used knives to cut veins and "bleed" patients of their illnesses and used strips of cloth to bandage the wounds afterward. One hundred years ago, doctors used mercury compounds and electricity in attempting to cure patients of masturbation or syphilis. In modern medicine, health care technology includes everything from Band-Aids to computerized patient record systems to heart–lung machines.

The Nature of Technology

Technology refers to any human-made object used to perform a task. In addition, the term is often used to describe processes that involve such objects. For example, the term *technology* can refer both to the overall process of kidney dialysis and to the equipment used in that process.

Although we often talk about technology as if it is inherently either good or bad—"technology has made our lives easier" or "technology has depersonalized medical care"—the reality is more complex (Heath, Luff, and Svensson, 2003; Timmermans and Berg, 2003b). The nature of a technology does determine the *range* of ways it might be used, but whether it is harmful, helpful, or both depend on who uses it in which ways. Electricity is helpful when used by doctors to stimulate muscle healing and harmful when used by doctors who are poorly educated or who work as torturers in dictatorships. Fetal monitors can depersonalize childbirth when nurses stare at the screens rather than pay attention to the pregnant

woman. But ultrasound imaging of fetuses can *personalize* pregnancy when fathers literally visualize their future children as real for the first time. In addition, such technologies can create a setting in which fathers, mothers, and health care workers can discuss the emotional aspects of pregnancy and child-rearing.

Similarly, we often talk about technology as if it is either a blank slate, lacking any inherent nature, or a force outside of human control. Again, the reality is more complex. For example, doctors and hospitals now face considerable pressure to collect data on patients using computerized medical databases in hopes that doing so will help identify and thus reduce medical errors (Timmermans and Berg, 2003a). Because these databases prompt doctors to ask patients a specific set of questions in a specific sequence, they implicitly encourage doctors to focus only on certain questions and to organize the answers they receive in certain ways. At the same time, doctors quickly learn to regain some control over the databases through how they ask their questions and record the answers. Similarly, although doctors who use these databases may press patients to answer specific questions, patients can assert control by instead addressing a different set of issues (Timmermans and Berg, 2003a).

For these reasons, we need to understand not only the nature of a given technology but also the cultural system that determines how a technology will be used, by whom, and for what purposes. In addition, we must study not only how society and social actors shape the use of technology but also how technology shapes society and social actors.

In this section, we look at how technologies develop and gain acceptance. We also consider how different groups within the health care world interact with technology—and with each other.

The Social Construction of Technology

In the same way that we talk about the social construction of illness, we can talk about the **social construction** of technology: the process through which groups decide which potential technologies should be pursued and which should be adopted. This concept in turn leads us to question who promotes and who benefits from the social construction of any given technology.

Like the social construction of illness, the social construction of technology is a political process, reflecting the needs, desires, and relative power of various social groups. These groups can include manufacturers, doctors, the government, and consumers. As a result, harmful technologies are sometimes developed and adopted, and needed technologies sometimes are not.

The history of cardiopulmonary resuscitation (CPR) offers a fascinating example of the social construction of technology. (*Contemporary Issues: Computed Tomography Scans* discusses another example, the rapid adoption of CT scans.) The purpose of CPR is to restore life to those whose hearts and lungs have stopped working. In earlier times, the very notion of such resuscitation would not have made any sense to doctors or the public. Death was considered to be in God's hands, and dead was dead. But since the rise of modern medicine, doctors have struggled to find ways to restore life to those who die suddenly.

CONTEMPORARY ISSUES

Computed Tomography Scans

The use of full-body computed tomography (CT) scans (typically referred to as "cat scans") has exploded since Oprah Winfrey was scanned on her show in 2001. Currently, about 62 million CT scans are conducted in the United States yearly. These scans are highly remunerative for doctors both because doctors who recommend CT scans often own the CT scan machines and because patients typically pay out of pocket.

The increase in screening has occurred primarily among healthy people who hope screening will uncover still-treatable health problems. Yet according to an article that made national headlines when it appeared in the prestigious *New England Journal of Medicine* (Brenner and Hall, 2007), a single series of CT scans delivers as much radiation—and as much danger—as the atomic bombs dropped on people living about 1.5 miles from "ground zero" in Hiroshima and Nagasaki. For years afterwards, survivors of those bombs suffered substantially increased rates of illness and death from cancer. The risks to CT users will be even greater because they will likely receive multiple scans over the years.

The widespread adoption of "full-body" CT scans reflects the belief—common among both doctors and the general public—that medical tests can do no harm. It also reflects the tendency for doctors to adopt procedures based on early information about their benefits and before sufficient information has accumulated about potential dangers. Without question, CT scans are tremendously useful for diagnosing certain illnesses in individuals with certain symptoms. But when used unnecessarily on people without any symptoms, scans expose people not only to dangerous radiation but also to great anxiety whenever they uncover tiny tumors or other tiny biological variations in the body that even doctors cannot interpret (Hillman and Goldsmith, 2010). For these reasons, the rapid rise in CT scans seems a case study in the social construction of technology.

At the same time, doctors have grown increasingly able to understand the slow trajectory of dying associated with cancer. And with the rise of the hospice movement (described earlier in this chapter), both doctors and the public have come to hold as an ideal the "good death" in which an individual comes to terms with his or her dying, makes peace with family and friends, and receives appropriate terminal care to minimize physical and emotional suffering.

None of this, however, applies to the sudden—and common—deaths caused by stroke or heart disease. In his award-winning book *Sudden Death and the Myth of CPR*, sociologist Stefan Timmermans (1999) argues that CPR and associated resuscitation techniques have become part of American medical culture because they appear to offer a "good death" in these circumstances. Innumerable television dramas portray heroic doctors who save apparently dead patients through CPR, and millions of dollars have been spent teaching the general public to perform CPR and outfitting community emergency response teams and hospital emergency rooms with resuscitation equipment. Yet CPR almost never succeeds except when healthy individuals drown or are struck by lightning. The typical person who receives CPR has *at best* a 1% to 3% chance—and probably much less—of surviving, at an estimated cost of $500,000 per survivor. Moreover,

"survival" may be brief and may be accompanied by severe neurological damage. As a result, according to Timmermans, emergency department doctors and emergency medical technicians overwhelmingly regard resuscitation as futile, so they joke, complain, or simply go through the motions whenever they have to use it.

Why, then, has CPR become so widely adopted? Timmermans argues that the widespread use of CPR reflects modern Americans' discomfort with death. The real benefit of CPR, according to Timmermans, is that it "takes some of the suddenness of sudden death away" (1999:110). CPR allows families and friends to believe they have done everything possible by getting their loved ones to treatment as fast as possible. It also gives families and friends time to gather and to recognize that death may be imminent, and it gives medical personnel a sense of technical accomplishment as they fight to keep their patients' bodily organs functioning as long as possible. The use of CPR, then, is part of the broader project of **death brokering**: the process through which medical authorities make deaths explainable, culturally acceptable, and individually meaningful, such as through pain management, "death counseling," or the gradual removal of life supports from dying patients (Timmermans and Berg, 2005). For these reasons and despite all its emotional and financial costs, CPR has become a valued and expected ritual in American culture.

At the same time, adoption of CPR illustrates the economics and politics, as well as the cultural forces, that underlie the social construction of technology. CPR would not have been so widely adopted if corporations had not had a vested economic interest in promoting it. Nor is it likely that CPR would have become the norm if corporations had been required to demonstrate its effectiveness before selling it. In fact, however, there are almost no legal requirements for manufacturers to demonstrate the safety or effectiveness of technical devices, so they rarely fund such research. As a result, doctors must depend on promotional materials from manufacturers and on their own clinical experiences in deciding whether to use a technology, and patients must rely on doctors' judgments.

The Technological Imperative

Once a technology enters the mainstream, the technological imperative can make it difficult to avoid. The **technological imperative** refers to the belief—held by both doctors and consumers—that technology is almost always good, so it is almost always appropriate to use all existing technological interventions, regardless of their cost. This belief is deeply embedded in American culture (and, to a lesser extent, in Western culture more generally). The belief in intervention (including technological intervention) is also highly stressed in medical culture and training, as Chapter 11 discusses. In addition, and as the history of CPR illustrates, the technological imperative is often reinforced by corporations that have a vested economic interest in selling a particular technology and doctors with a vested interest in offering a technology. Finally, the technological imperative is cemented whenever insurance companies, government regulatory agencies, or medical associations identify use of a particular technology as the "standard of care" for treating

or diagnosing a given illness. In these situations, doctors who don't use that technology may risk malpractice suits.

Prostate cancer testing offers an excellent example of the technological imperative. Among men, one almost inevitable consequence of aging is cancer of the prostate, a poorly understood bodily organ that produces chemicals believed necessary for reproduction. Most men develop prostate cancer by middle age, and virtually all do so if they live long enough (Kolata, 2005). Few, however, are killed by the disease because it typically grows so slowly that most who have prostate cancer instead die from heart disease, stroke, or some other condition before the cancer can become dangerous (Grob and Horwitz, 2009).

Currently, however, doctors have little ability to identify which men might *die* from prostate cancer. Instead, doctors can only hope to identify who *has* prostate cancer. To do so, most doctors routinely test middle-aged male patients at periodic intervals for prostate-specific antigen (PSA), a chemical produced by the prostate. If a patient's PSA level has increased significantly, doctors perform a biopsy—inserting a needle into the prostate to remove a few cells, which they then check for cancer. Unfortunately, PSA tests are highly inaccurate. About 30% of those who have cancer are *not* identified by the test and so derive no benefit from testing. In addition, about two-thirds of those who *are* told they have cancer based on test results in fact do *not* have it. These individuals too cannot benefit from this inaccurate diagnosis and likely will experience unnecessary emotional trauma, financial costs, and painful procedures because of it. Others are correctly identified as having some cancer cells in their body, but would likely have died from heart disease or something else long before the cancer would have caused any symptoms or health problems; sociologists use the term **pseudodisease** in cases such as these to refer to harmless conditions that are diagnosed as diseases based on medical tests (Mechanic, 2006).

If a biopsy suggests cancer, doctors usually perform a prostatectomy (that is, surgical removal of the prostate). The surgery succeeds in removing the cancer in about 80% of cases. Even in these cases, however, the risks of surgery can outweigh the benefits. Between 0.5% and 2% of patients die within a month of surgery, and another 5% experience serious and potentially deadly complications (Wilt et al., 2008). In addition, more than 30% experience serious difficulties in sustaining erections or controlling their urine. Perhaps most important, large studies using random samples and **controlling** for other variables have found no significant differences in survival rates between men who do and do not receive treatment (Wilt et al., 2008). In sum, as an editorial published by the *New England Journal of Medicine* declared, "PSA screening has at best a modest effect on prostate-cancer mortality … and comes at the cost of substantial overdiagnosis and overtreatment" (Barry, 2009). The widespread use of PSA screening thus offers a perfect example of the technological imperative.

Technology and the Changing Nature of Health Care

In addition to making certain tests and treatments almost unavoidable, new technologies have dramatically changed the very nature of health care for

both health care providers and consumers (Casper and Morrison, 2010; Clarke et al., 2010).

Just a few decades ago, health care was an intensely "hands-on" experience. The doctor would literally lay his (or, rarely, her) hands on the patient, feeling the belly to check for swelling or lumps, thumping the chest to listen for abnormal lung sounds, and so on. A thorough physical examination could take up to an hour of intense questioning and physical probing. As this suggests, medical care also relied heavily on listening to the patient's report of his or her symptoms and concerns. Surgery, too, was bloody, intimate, hands-on work.

These days, doctors give far less attention to patients' reports of their health and far more attention to results from medical tests. Those tests, meanwhile, are largely performed not by doctors but by technicians who collect and analyze blood samples, ultrasound readings, CT scans, and other tests. Meanwhile, an increasing proportion of doctors work primarily *within* the body as surgeons, spending little time interacting with patients. Moreover, surgeons now often use computers to manipulate microscopic surgical tools, further distancing their own bodies from their patients' bodies.

As this suggests, technology also has led to the rise of a wide range of new health care occupations, shifting many tasks from doctors to these new providers and threatening the balance of power within health care (a topic discussed more fully in the next chapter). At the same time, new technologies (coupled with changes in the structure of insurance and hospital care) increasingly have shifted care onto patients and their families and away from health care providers altogether. As the earlier discussion of family caregiving suggested, many families now have both the opportunity and, often, the financial need to provide high-technology care in the home, from injecting insulin in children with diabetes to operating ventilator machines for those who can't breathe on their own.

IMPLICATIONS

In this chapter, we examined three difficulties inherent in the ways we provide care to individuals who have illnesses or disabilities. First, we looked at some of the inherent contradictions of trying simultaneously to provide care and to make a profit. Health care workers—from medical students to home health aides—who labor long hours in difficult conditions to keep their employers' costs low cannot provide the quality of care they might like. Even institutions such as nonprofit hospices must contend with the demands of a wider system that emphasizes cutting costs and generating profits. Meanwhile, many other health care institutions have emerged specifically to make money, relegating caregiving to a secondary priority.

Second, we considered the difficulty of providing individualized care in institutional environments. To stay within their budgets large institutions must provide standardized care, ignoring individual preferences and desires. Patients must follow rules, schedules, and regimens established for efficiency and cost cutting, regardless of the impact on their quality of life.

Third, we explored some of the inherent difficulties of treating health care as an individual or family responsibility rather than a social responsibility. As we have seen, the burdens of caregiving can be enormous. Yet the United States offers little support to those who take on this responsibility. In contrast, other wealthy nations provide far more assistance; both Sweden and Finland, for example, provide long-term, paid leaves and free or inexpensive assistance with domestic chores to elderly persons who might otherwise need help from family members (Swedish Institute, 1997, 1999; Zimmerman, 1993).

In sum, the data presented in this chapter regarding the virtual social abandonment of ill and disabled individuals and of their caregivers suggest the low priority that American society places on caring for those who are weak or ill, especially if they also are poor. Technology will not cure these problems. Nor for that matter, is it inherently dehumanizing or otherwise problematic. Rather, technology is a tool, adopted for a combination of cultural, medical, emotional, and financial reasons, which can be used for good or ill. Only when our underlying social values and commitments change can we expect the lives of persons with illnesses and disabilities and their caregivers to improve significantly.

SUMMARY

1. Until about 1900, most Americans received all health care at home. Those who could not care for themselves or obtain care at home were relegated to almshouses—charity institutions with terrible conditions where orphans and criminals, as well as people with illnesses or disabilities, were "warehoused."
2. Voluntary (nonprofit private) hospitals first emerged in the late 1700s as a means of providing care to the "deserving sick." Early voluntary hospitals were run as total institutions. Hospital conditions improved dramatically during the Civil War and improved further as the new belief in germs made cleanliness desirable and technological changes made it economically feasible.
3. For-profit, private hospitals emerged as a way of offering better conditions to more affluent consumers. Public hospitals were developed to provide services to individuals with chronic mental or physical illnesses as well as to those considered the "undeserving poor." By the 1920s, hospital care had become a major part of American life and a center of medical education and research.
4. The initiation of Medicare and Medicaid dramatically increased the profits available to hospitals. Skyrocketing costs led the federal government to implement a system of *diagnostic-related groups*, under which hospitals receive a prepaid fee for each patient with a given diagnosis regardless of the actual cost of treatment. To maintain their profits, hospitals shifted toward remunerative outpatient services, technologies, and surgeries.
5. Hospitals now treat an older and more seriously ill mix of patients than in the past, primarily for the acute complications of chronic illnesses.

Hospitals—especially public hospitals—have become primary care providers for the poor, which has increased hospitals' financial problems.

6. Nursing homes offer care to those who need nursing or custodial care but not hospital care. Those who use nursing homes tend to be female and elderly, although young people increasingly live in nursing homes. Most residents are bankrupted quickly by the cost of care.
7. Nursing homes are primarily staffed by nursing assistants, who are overwhelmingly female, nonwhite, and low paid. Within nursing homes, both nursing assistants and residents are commodified: Nursing assistants become commodities to purchase as cheaply as possible, and residents become expenses to control.
8. Hospices are institutions designed to serve the needs of the dying. To gain social and financial support, hospices over time have become more routinized, medicalized, and profit oriented.
9. Hospice care saves insurers money, partly by shifting the cost of care to family members. Terminally ill patients who enter hospices typically live longer and experience a higher quality of life than do those who continue with medical care.
10. Most Americans still receive most of their health care at home, typically from female family members. The physical and emotional strains of caregiving have led to the development of respite care, paid home caregivers, and family leave programs.
11. *Technology* refers to any human-made object used to perform a task, from Band-Aids to kidney dialysis machines. Technology is never inherently good or bad. Its nature determines the *range* of ways it might be used, but whether it is harmful, helpful, or both depends on *who* uses it in *which* ways.
12. The *social construction of technology* refers to the *political* process through which groups decide which potential technologies should be pursued and which should be adopted. This process reflects the needs, desires, and relative power of various social groups, including manufacturers, doctors, and consumers.
13. Cardiopulmonary resuscitation (CPR) was designed to restore life to those whose hearts and lungs have stopped. It is almost never successful but has been widely adopted because it helps people come to terms with sudden death, because its manufacturers had a vested interest in promoting it, and because neither the government nor doctors required manufacturers to prove it was effective.
14. The technological imperative refers to the belief, among both doctors and consumers, that technology is almost always good and therefore it is almost always appropriate to use all existing technological interventions, regardless of their cost.
15. Because most men develop prostate cancer but few experience any related health problems, increased testing for this disease has led to skyrocketing rates of medical procedures and increased health problems but no increase in