

FRAMING

Health Issues in the Media

It's Right for You! The Framing of Drug Ads

I thought I could get myself through this on my own. . . . I started seeing signs developing within me I should have paid attention to. I pushed and pushed and pushed, until I pushed myself right into a corner. . . .

—“Mary” explaining how depression affected her life before her doctor prescribed Cymbalta, a drug for major depressive disorder and generalized anxiety disorder

You know when you feel the weight of sadness. You may feel exhausted, hopeless, anxious. Whatever you do you feel lonely and do not enjoy the things you once loved. Things just don't feel like they used to. These are some symptoms of depression, a serious medical condition affecting over 20 million Americans. . . . You just shouldn't have to feel this way anymore. . . . When you know more about what's wrong, you can help make it right.

—ad for Zoloft, an antidepressant drug

These television and Internet ads for prescription antidepressant drugs are only two of thousands of pharmaceutical advertisements that constantly bombard us. Drug advertising aimed at consumers have accounted for at least \$5 billion in annual advertising dollars for a number of years (Japsen, 2012). Most drug ads use *sympathetic and intuitive framing* to help television viewers, newspaper and magazine readers, and Internet users believe that they are not alone if they



J.B. REED/Landov

Increasingly, advertisements for prescription drugs are aimed at consumers, although they cannot purchase such products until a doctor prescribes them. Do you agree with this approach to informing patients? Why or why not?

Health in the United States

Even if we limit our discussion (for the moment) to people in the United States, why are some of us healthier than others? Is it biology—our genes—that accounts for this difference? Does the environment within which we live have an effect? How about our own individual lifestyle?

Social Epidemiology

The field of social epidemiology attempts to answer questions such as these. **Social epidemiology is the study of the causes and distribution of health, disease, and impairment throughout a population** (Weiss and Lonnquist, 2012). Typically, the target of the investigation is disease agents, the environment, and the human host. **Disease**

L02 *agents* include biological agents such as insects, bacteria, and viruses that carry or cause disease; nutrient agents such as fats and carbohydrates; chemical agents such as gases and pollutants in the

air; and physical agents such as temperature, humidity, and radiation. The *environment* includes the physical (geography and climate), biological (presence or absence of known disease agents), and social (socioeconomic status, occupation, and location of home) environments. The human *host* takes into account demographic factors (age, sex, and race/ethnicity), physical condition, habits and customs, and lifestyle (Weiss and Lonnquist, 2012). Let's look briefly at some of these factors.

Age Rates of illness and death are highest among the old and the young. Mortality rates drop shortly after birth and begin to rise significantly during middle age. After age 65, rates of chronic diseases and mortality increase more rapidly. **Chronic diseases are illnesses that are long term or lifelong and that develop gradually or are present from birth;** in contrast, **acute diseases are illnesses that strike suddenly and cause dramatic incapacitation and sometimes death** (Weitz, 2013). Two of the most

have high cholesterol, feelings of depression, patterns of sexual dysfunction, or whatever else may be bothering them. In many ads a “real person” gives his or her testimonial about how a particular drug has helped with his or her problem. The undertone of the person’s statement is to offer a *sympathetic* message to viewers (“I know what you’re going through because I’ve been there myself”). Then a narrator or voiceover (a person who is heard but not seen) makes several understanding (*intuitive*) statements that suggest to individuals in the media audience, “We know you don’t want to discuss this with anyone, but we can help.” Ads such as this offer a simple solution (in the form of a pill) to help people solve their problems if they will only follow the narrator’s advice: “Ask your doctor if [this product] is right for you.”

What are the strengths and limitations of framing prescription drug ads in this manner and addressing consumers directly rather than pitching the products only to the physicians who must prescribe the drugs? An obvious strength of direct advertising is that patients become aware of newer products and learn about certain illnesses or conditions of which they were unaware. However, major limitations exist when it comes to direct advertising of such products. Many drug ads do not tell the whole story: Some play down the fact that other drugs, or a nondrug option, may be more effective in treating the condition than the pill being marketed. Other ads encourage people who are not good candidates for a particular drug to insist that their physician prescribe it for them anyway.

Although more prescription drug ads today inform media audiences about possible side effects than those in the past, the narrators usually read the list of negative effects very quickly and then—in a highly reassuring voice—state that

most side effects are extremely rare. One example is an ad for Mirapex, the restless-leg-syndrome drug, which states, “Tell your doctor . . . if you experience increased gambling, sexual, or other intense urges.” Comments such as this may produce laughter from viewers rather than giving them a reason to seriously consider the possible negative consequences of certain prescription medications.

Today, the U.S. Congress and various governmental agencies continue to ponder the future of prescription drug ads that directly target consumers, but little is likely to come of these inquiries because spending on consumer drug advertising is so high and pressure from the pharmaceutical industry to continue these lucrative ads is so great. However, Mo Rocca (2007), of CBS News’ *Sunday Morning* show, offered the following humorous, short-term solution to dealing with the side effects of TV drug ads:

If there’s one side effect to all these ads, it’s heightened anxiety. . . . Maybe the best solution is to tune out the ads. Or at least ask your doctor if watching them is right for you. And in no instance should you watch them while you drink or operate heavy machinery. Otherwise, you’re likely to experience nausea, dizziness . . . and an uncontrollable urge to throw your TV out the window.

reflect & analyze

How might functionalist, conflict, and symbolic interactionist theorists differ in their explanation of these ads? As a sociology student, what effect (if any) do you think that prescription drug ads in the media have on people you know?

common sources of chronic disease and premature death are tobacco use, which increases mortality among both smokers and people who breathe the tobacco smoke of others, and alcohol abuse, both of which are discussed later in this chapter.

The fact that rates of chronic diseases increase rapidly after age 65 has obvious implications not only for people reaching that age (and their families) but also for society. Between 2010 and 2015, the percentage of the U.S. population ages 65 and over is expected to increase from 13 percent to 21 percent, and the percentage of those ages 80 and over is expected to double from 4 percent to 8 percent (United Nations, 2011). The cost of caring for the older population—especially those who must live in institutionalized settings—will increase in at least direct proportion to their numbers.

Sex Prior to the twentieth century, women had lower life expectancies than men because of high mortality rates during pregnancy and childbirth.

Preventive measures have greatly reduced this cause of female mortality, and women now live longer than men. For babies born in the United States in 2010, for example, life expectancy at birth is estimated to be 78.7 years, with 76.2 years for males and 81.1 years for females (Murphy, Xu, and Kochanek, 2012). Females have a slight biological advantage over males in this regard from the beginning of life, as can be seen in the fact that they have lower mortality rates both in the prenatal stage and in the first month of life (Weiss and Lonnquist, 2012).

social epidemiology the study of the causes and distribution of health, disease, and impairment throughout a population.

chronic diseases illnesses that are long term or life-long and that develop gradually or are present from birth.

acute diseases illnesses that strike suddenly and cause dramatic incapacitation and sometimes death.

However, gender roles and gender socialization also contribute to the difference in life expectancy: Men are more likely to work in dangerous occupations such as commercial fishing, mining, construction, and public safety/firefighting. As a result of gender roles, males may be more likely than females to engage in risky behavior such as drinking alcohol, smoking cigarettes (there is more social pressure on women not to smoke), using drugs, driving dangerously, and engaging in fights. Finally, women are more likely to use the health care system, with the result that health problems are identified and treated earlier (while there is a better chance of a successful outcome), whereas many men are more reluctant to consult doctors.

Because women on average live longer than men, it is easy to jump to the conclusion that they are healthier than men. However, although men at all ages have higher rates of fatal diseases, women have higher rates of chronic illness.

Race/Ethnicity and Social Class Racial-ethnic differences are also visible in statistics pertaining to life expectancy. Projections for infants born in 2010 reveal this sobering fact: Life expectancy for African American males is estimated at 71.8 years as compared to 76.5 for white males. For African American females, life expectancy is 78.0 compared to 81.3 for white females (Murphy, Xu, and Kochanek, 2012).



National Geographic/Getty Images

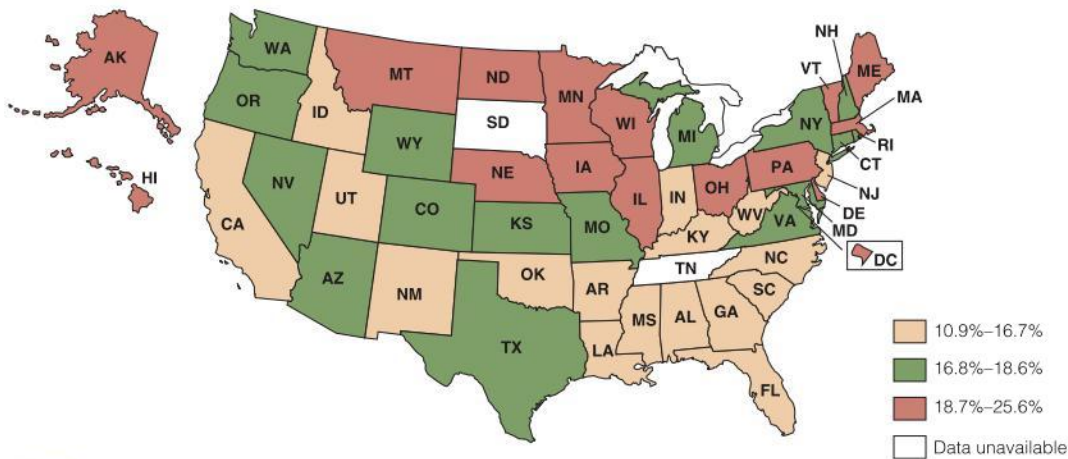
Occupation and life expectancy may be related. Men are overrepresented in high-risk jobs, such as construction, that may affect their life expectancies.

Although race/ethnicity and social class are related to issues of health and mortality, research continues to show that income and the neighborhood in which a person lives may be equally or more significant than race or ethnicity with respect to these issues. How is it possible that the neighborhood you live in may significantly affect your risk of dying during the next year? Numerous studies have found that people have a higher survival rate if they live in better-educated or wealthier neighborhoods than if the neighborhood is low income and has low levels of education. Among the reasons researchers believe that neighborhoods make a difference are the availability (or lack thereof) of safe areas to exercise, grocery stores with nutritious foods, and access to transportation, education, and good jobs. Many low-income neighborhoods are characterized by fast-food restaurants, liquor stores, and other facilities that do not afford residents healthy options.

As discussed in prior chapters, people of color are more likely to have incomes below the poverty line, and the poorest people typically receive less preventive care and less-optimal management of chronic diseases than do other people. People living in central cities, where there are high levels of poverty and crime, or in remote rural areas generally have greater difficulty in getting health care because most doctors prefer to locate their practice in a “safe” area, particularly one with a patient base that will produce a high income. Although rural Americans make up 20 percent of the U.S. population, only about 10 percent of the nation’s physicians practice in rural areas, and fewer specialists such as cardiologists are available in these areas.

Another factor is occupation. People with lower incomes are more likely to be employed in jobs that expose them to danger and illness—working in the construction industry or around heavy equipment in a factory, for example, or holding a job as a convenience store clerk or other position that exposes a person to the risk of armed robbery. Finally, people of color and poor people are more likely to live in areas that contain environmental hazards.

However, although Latinas/os are more likely than non-Latino/a whites to live below the poverty line, they have lower death rates from heart disease, cancer, accidents, and suicide, and they have a higher life expectancy (81.3 compared with 78.7 for non-Latino/a whites) (Murphy, Xu, and Kochanek, 2012). One explanation may be dietary factors and the strong family life and support networks found in many Latina/o families (Weiss and Lonnquist, 2012). Obviously, more research is needed on this point, for the answer might be beneficial to all people.



MAP 14.1 PERCENTAGE OF ADULTS WHO BINGE DRINK

Source: U.S. CDC, 2012a.

Lifestyle Factors

As noted previously, social epidemiologists also examine lifestyle choices as a factor in health, disease, and impairment. We will examine three lifestyle factors as they relate to health: drugs, sexually transmitted diseases, and diet and exercise.

Drug Use and Abuse What is a drug? There are many different definitions, but for our purposes, a **drug** is **any substance—other than food and water—that, when taken into the body, alters its functioning in some way**. Drugs are used for either therapeutic or recreational purposes. *Therapeutic* use occurs when a person takes a drug for a specific purpose such as reducing a fever or controlling a cough. In contrast, *recreational* drug use occurs when a person takes a drug for no purpose other than achieving a pleasurable feeling or psychological state. Alcohol and tobacco are examples of drugs that are primarily used for recreational purposes; their use by people over a fixed age (which

varies from time to time and place to place) is lawful. Other drugs—such as some antianxiety drugs or tranquilizers—may be used legally only if prescribed by a physician for therapeutic use but are frequently used illegally for recreational purposes.

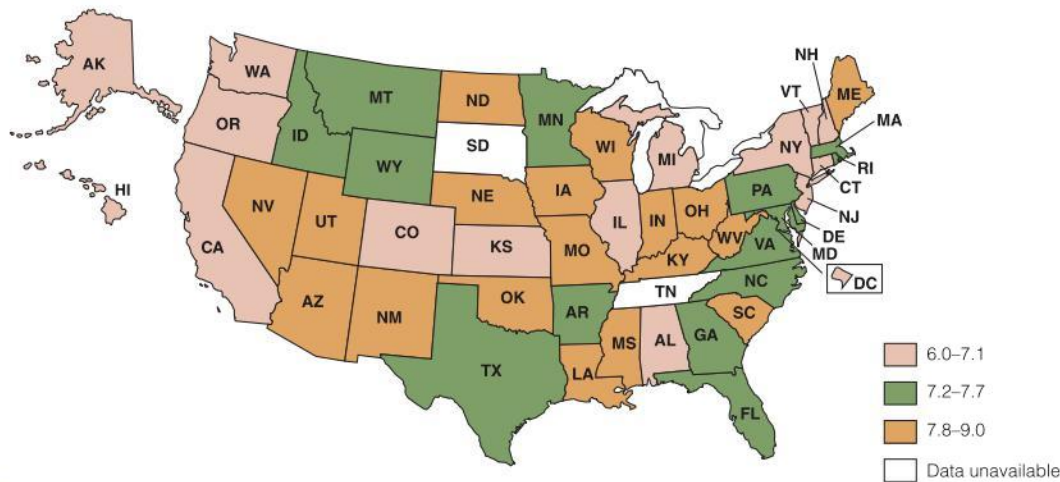
Alcohol The use of alcohol is considered an accepted part of the dominant culture in the United States. Adults in this country consume an average of 2.5 gallons of wine, 21.7 gallons of beer, and 1.4 gallons of liquor per year (U.S. Census Bureau, 2010). In fact, adults consume more beer on average than milk or coffee. However, these statistics overlook the fact that among people who drink, 10 percent account for roughly half the total alcohol consumption in this country (Levinthal, 2010).

Even short-term alcohol use has many negative effects, including motor vehicle crashes, violence against others, sexual aggression, spread of HIV and sexually transmitted diseases (STDs), unplanned pregnancy, and binge drinking and the risky behavior associated with such activity. *Binge drinking* is defined as men drinking five or more alcoholic drinks within a short period of time or women drinking four or more drinks within a short period of time (U.S. CDC, 2012a). More than 38 million U.S. adults engage in binge drinking, but the extent of binge drinking varies from state to state (see ● Map 14.1). The average largest number of drinks within a short period of time among binge drinkers ranges from six drinks in the District of Columbia to nine drinks in Wisconsin (see ● Map 14.2).



Can your neighborhood be bad for your health? According to recent research, it can indeed, especially if it predominantly contains fast-food restaurants, liquor stores, and similarly unhealthy lifestyle options.

drug any substance—other than food and water—that, when taken into the body, alters its functioning in some way.



MAP 14.2 THE AVERAGE LARGEST NUMBER OF DRINKS CONSUMED BY BINGE DRINKERS ON A SINGLE OCCASION

Source: U.S. CDC, 2012a.

Many long-term problems are associated with alcohol consumption as well. Chronic heavy drinking or alcoholism can cause permanent damage to the brain or other parts of the body. For alcoholics, the long-term negative health effects include *nutritional deficiencies* resulting from poor eating habits (chronic heavy drinking contributes to high caloric consumption but low nutritional intake); *cardiovascular problems* such as inflammation and enlargement of the heart muscle, high blood pressure, and stroke; and eventually to *alcoholic cirrhosis*—a progressive development of scar tissue that chokes off blood vessels in the liver and destroys liver cells by interfering with their use of oxygen (Levinthal, 2010). The social consequences of heavy drinking are not always limited to the person doing the drinking. For example, abuse of alcohol and other drugs by a pregnant woman can damage the unborn fetus.

Can alcoholism be overcome? Many people get and stay sober. Some rely on organizations such as Alcoholics Anonymous or church support groups to help them overcome their drinking problem. Others undergo medical treatment and therapy sessions to learn more about the root causes of their problem. Caroline Knapp (1996: 242–243), who started drinking at age fourteen and continued throughout college, describes how she felt after she regained sobriety and came to view herself as a recovering alcoholic:

I still think about drinking, and not drinking, many many times each day, and sometimes I think I always will. We live in an alcohol-saturated world; it's simply impossible to avoid the stuff. When I read the papers now, I find myself scanning the pages for items about drink-related disasters, things that will reinforce my sense that I've made the right choice: what celebrity got

pulled over for drunk driving; what college kid got drunk and plunged out of a five-story window; what alcohol-fueled argument between a couple fired up into a case of domestic violence. Evidence of the havoc liquor can wreak is there in black and white, almost every day, but it's not nearly as prevalent as the other messages: the liquor ads, the images of gaiety and romance, phrases like CHAMPAGNE BRUNCH: \$19.95. At times, I've grumbled to friends about longing to return to Prohibition, a gripe that stems from the feeling, familiar among many alcoholics, that if I can't drink, no one should. But alcohol occupies a large role in the social world and it's important for me to remember that I have to come to terms with it, that I still have a relationship with liquor, even if the relationship now has the quality of a divorce rather than an active involvement.

Nicotine (Tobacco) The nicotine in tobacco is a toxic, dependency-producing psychoactive drug that is more addictive than heroin. It is classified as a stimulant because it stimulates central nervous system receptors and activates them to release adrenaline, which raises blood pressure, speeds up the heartbeat, and gives the user a temporary sense of alertness. Although the overall proportion of smokers in the general population has declined somewhat since the 1964 Surgeon General warning that smoking is linked to cancer and other serious diseases, tobacco is still the single most preventable cause of disease, disability, and death in the United States (U.S. CDC, 2010b). Tobacco is responsible for about one in every five deaths in this country, and it is estimated that nearly 450,000 people die prematurely from smoking or exposure to secondhand smoke. Even people who never light up a cigarette

can be harmed by *environmental tobacco smoke*—the smoke in the air inhaled by nonsmokers as a result of other people's tobacco smoking and the residue of smoke on garments and furniture, for example (Levinthal, 2010). Researchers have found that environmental smoke is especially hazardous for nonsmokers who carpool or work with heavy smokers. Another 8.5 to 9 million people have a serious illness that is related to smoking (U.S. CDC, 2010b).

Illegal Drugs Marijuana is the most extensively used illegal drug in the United States. In 2011, 45.5 percent of twelfth graders had used marijuana in their lifetime; 22.6 percent had used it in the past thirty days. In the same year, daily or near daily marijuana use reached a thirty-year peak among high school seniors (Johnston et al., 2011). High doses of marijuana smoked during pregnancy can disrupt the development of a fetus and result in congenital abnormalities and neurological disturbances. Furthermore, some studies have found an increased risk of cancer and other lung problems associated with marijuana because its smokers are believed to inhale more deeply than tobacco users.



Since 2012, the U.S. Food and Drug Administration has required that all cigarette packages (such as the one shown here) carry a vivid color image about tobacco-related cancer disease and a warning about the negative consequences of smoking. Do you think that warnings such as these will help reduce the rate of smoking and tobacco-related deaths in the United States?

Another widely used illegal drug is cocaine. Cocaine may be either inhaled, injected intravenously, or smoked (“crack cocaine”). According to the National Institute on Drug Abuse, in 2009, 4.8 million Americans ages twelve and older had used cocaine, and one million had used crack at least once during the prior year. People who use cocaine over extended periods of time have higher rates of infection, heart problems, internal bleeding, hypertension, stroke, and other neurological and cardiovascular disorders than do nonusers. Intravenous cocaine users who share contaminated needles are also at risk for contracting HIV.

Each of the drugs discussed in these few paragraphs represents a lifestyle choice that affects health. Whereas age, race/ethnicity, sex, and—at least to some degree—social class are ascribed characteristics, taking drugs is a voluntary action on a person's part.

Sexually Transmitted Diseases The circumstances under which a person engages in sexual activity constitute another lifestyle choice with health implications. Although most people find consensual sexual activity enjoyable, it can result in transmission of certain *sexually transmitted diseases* (STDs), including HIV/AIDS, chlamydia, gonorrhea, and syphilis. Prior to 1960, the incidence of STDs in this country had been reduced sharply by barrier-type contraceptives (e.g., condoms) and the use of penicillin as a cure. However, in the 1960s and 1970s the number of cases of STDs increased rapidly with the introduction of the birth control pill, which led to women having more sexual partners and couples being less likely to use barrier contraceptives. Since that time, many people have become more aware of STDs, and organizations such as the U.S. Centers for Disease Control and Prevention have mounted aggressive public service campaigns to make individuals aware of choices that contribute to sexual health.

Chlamydia This infection is the most commonly reported STD in terms of number of annual cases (1.3 million) listed by the U.S. Centers for Disease Control and Prevention (2011c). Although this increase may partly be caused by an increase in screening and better reporting, it also is a issue for concern because chlamydial infections in women, which are usually asymptomatic, can result in pelvic inflammatory disease (PID)—a major cause of infertility, ectopic pregnancy, and chronic pelvic pain. Like other STDs, chlamydia can also help the transmission of HIV. Women are at higher risk of chlamydia, as shown in ● Figure 14.1. However, in recent years, more men also have been tested for

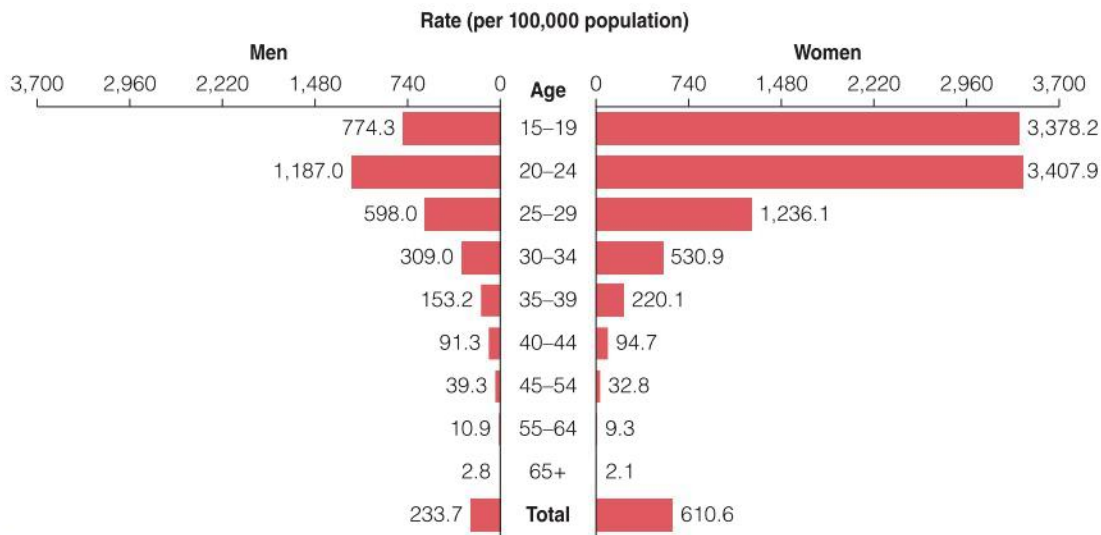


FIGURE 14.1 CHLAMYDIA—RATES BY AGE AND SEX, UNITED STATES: 2010

Source: U.S. CDC, 2011c.

chlamydial infection, resulting in a 36 percent increase in male cases reported during 2006–2010. Rates of this disease vary widely among racial and ethnic populations: The rate for African Americans in 2010 was eight times the rate for white Americans (U.S. CDC, 2011c).

Gonorrhea and Syphilis Gonorrhea, the second most commonly reported STD in the United States, is caused by a bacterium that can grow and multiply easily in the warm, moist areas of the reproductive tract. It can also grow in the mouth, throat, eyes, and anus. Untreated gonorrhea may lead to serious outcomes such as tubal infertility, ectopic pregnancy, and chronic pelvic pain. Gonorrhea can help the transmission of HIV infection, and in advanced cases, it can spread to the blood or joints and can be life threatening.

Specific populations are at higher risk for gonorrhea: Rates are highest among African Americans (18.7 times the rate of white Americans) and women (106.5 per 100,000 as compared to 94.1 per 100,000 for men), and the South had the highest gonorrhea rate among the four regions of the country (U.S. CDC, 2011c). Although antibiotics can cure gonorrhea, some strains of the infection have developed resistance to each of the antibiotics used for treatment.

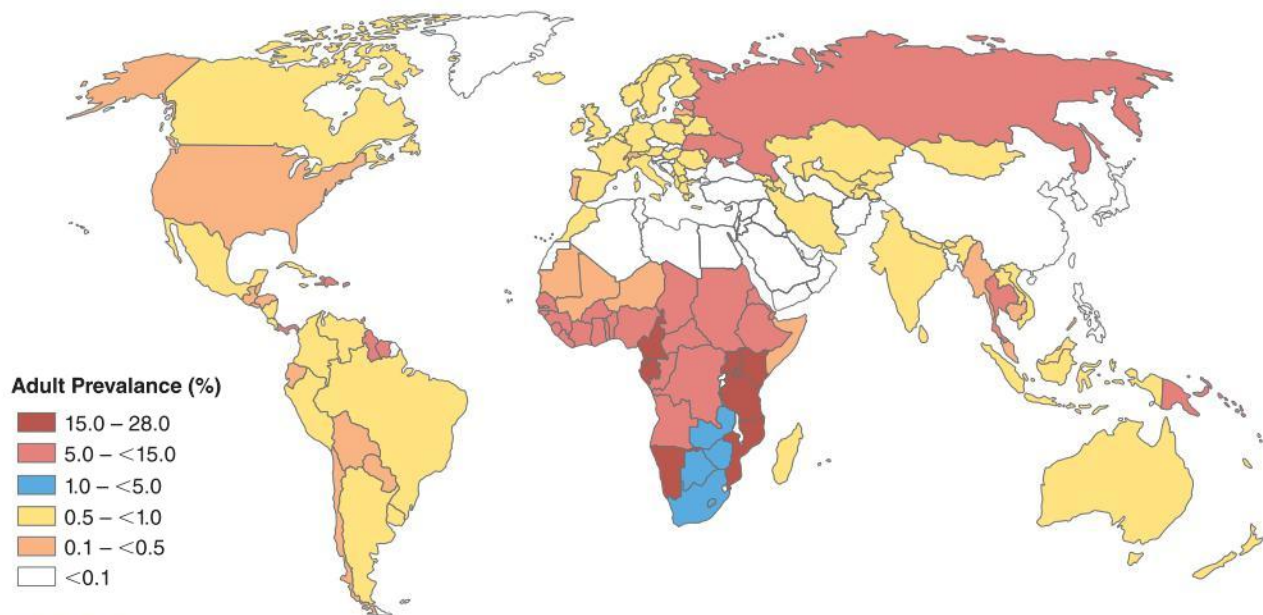
Syphilis is a genital ulcerative disease that can be acquired not only by sexual intercourse but also by kissing or coming into intimate bodily contact with an infected person. Untreated early syphilis in pregnant women results in perinatal death in up to 40 percent of cases and may lead to infection of the fetus in up to 80 percent of cases if syphilis was acquired during the four years prior to the pregnancy

(U.S. CDC, 2011c). Untreated syphilis can, over time, cause cardiovascular problems, brain damage, and even death. Penicillin can cure most cases of either gonorrhea or syphilis as long as the disease has not spread.

Like gonorrhea, syphilis is a major health problem in the South and in urban areas in other regions. High-risk populations include young African American men, all men who have sex with other men, and men who have sex with both men and women (U.S. CDC, 2011c).

AIDS AIDS (acquired immunodeficiency syndrome), which is caused by HIV (human immunodeficiency virus), is among the most significant health problems that this nation—and the world—faces today. Although AIDS almost inevitably ends in death, no one actually dies of AIDS. Rather, AIDS reduces the body's ability to fight diseases, making a person vulnerable to many diseases—such as pneumonia—that result in death.

AIDS was first identified in 1981, and the total number of AIDS-related deaths in the United States through 1985 was only 12,493; however, the numbers rose rapidly and precipitously after that. In recent years the U.S. Centers for Disease Control and Prevention has developed new estimates of HIV prevalence, or the total number of people living with HIV. Current estimates suggest that 1.2 million people are living with HIV/AIDS infection in the United States. One out of five persons living with HIV do not know they are infected. In the United States the majority (61 percent) of new HIV infections in 2009 was attributed to male-to-male sexual behavior, followed by heterosexual transmission (27 percent) and intravenous drug use (9 percent)



MAP 14.3 HIV INFECTIONS WORLDWIDE: 2009

Source: UNAIDS, 2010. © Cengage Learning.

(U.S. CDC, 2012c). Worldwide, the number of people with HIV or AIDS continues to increase, but progress has been made in some countries in addressing this epidemic. An estimated 34 million people worldwide are living with HIV/AIDS (Kaiser Family Foundation, 2011b). The annual number of new HIV infections worldwide declined by more than 20 percent since their peak in 1997. Nevertheless, there were about 2.7 million new infections in 2010. Almost all people with HIV (97 percent) live in low- and middle-income countries, particularly sub-Saharan Africa (see ● Map 14.3). In the United States, rates of HIV infection are highest among gay males. However, most cases of HIV infection worldwide are transmitted through heterosexual contact, and slightly more than half of all people with HIV/AIDS are women (Kaiser Family Foundation, 2011b).

HIV is transmitted through unprotected (or inadequately protected) sexual intercourse with an infected partner (either male or female), by sharing a contaminated hypodermic needle with someone who is infected, by exposure to blood or blood products (usually from a transfusion), and by an infected woman who passes the virus on to her child during pregnancy, childbirth, or breast feeding. It is not transmitted by casual contact such as shaking hands.

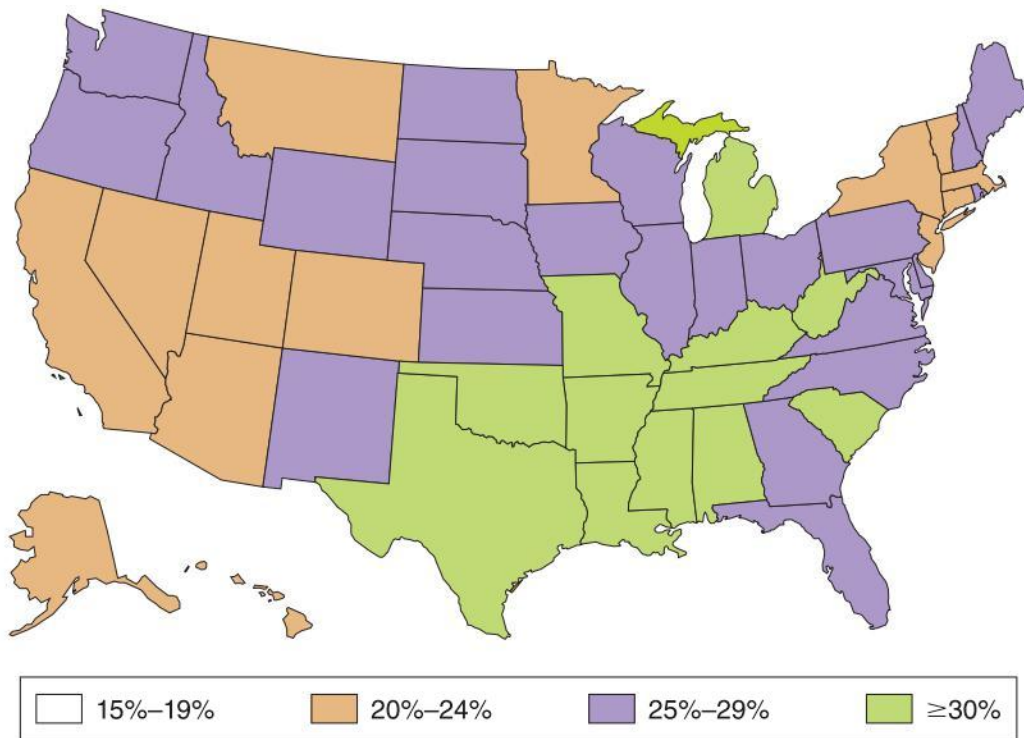
Staying Healthy: Diet and Exercise Lifestyle choices also include positive actions such as a healthy diet and good exercise. Over the past several decades, a dramatic improvement in our

understanding of food and diet has taken place, and many people in the United States have begun to improve their dietary habits. A significant portion of the population now eats larger amounts of vegetables, fruits, and cereals, substituting unsaturated fats and oils for saturated fats. However, according to the U.S. Department of Agriculture (2009: 2), “[A]verage U.S. diets are deficient in fruits and vegetables, and contain more fats and added sugars than recommended by dietary guidance.” Researchers predict that over the next few decades, obesity will shorten average U.S. life expectancy by 2 to 5 years, reversing the steady increase in life expectancy that has occurred over the past 200 years (Olshansky et al., 2005). ● Map 14.4 shows adult obesity rates across the United States.

Exercise is another factor. Regular exercise (at least three times a week) keeps the heart, lungs, muscles, and bones in good health and slows the aging process.

Health Care in the United States

Understanding health care as it exists in the United States today requires a brief examination of its history. During the nineteenth century, people became doctors in this country either through apprenticeships, purchasing a mail-order diploma, completing high school and attending a series of lectures, or obtaining bachelor’s and M.D. degrees and studying abroad for a number of years. At that time,



MAP 14.4 ADULT OBESITY IN THE UNITED STATES: 2010

Source: U.S. CDC, 2011e.

medical schools were largely proprietary institutions, and their officials were often more interested in acquiring students than in enforcing standards. The state licensing boards established to improve medical training and stop the proliferation of “irregular” practitioners failed to slow the growth of medical schools, and their number increased from 90 in 1880 to 160 in 1906. Medical school graduates were largely poor and frustrated because of the overabundance of doctors and quasi-medical practitioners, so doctors became highly competitive and anxious to limit the number of new practitioners. The obvious way to accomplish this was to reduce the number of medical schools and set up licensing laws to eliminate unqualified or irregular practitioners (Kendall, 1980).

The Rise of Scientific Medicine and Professionalism

Although medicine had been previously viewed more as an art than as a science, several significant discoveries during the nineteenth century in areas such as bacteriology and anesthesiology began to give medicine increasing credibility as a science (Nuland, 1997). At the same time that these discoveries were occurring, the ideology of science was being advocated in all areas of life, and people came

to believe that almost any task could be done better if the appropriate scientific methods were used. To make medicine in the United States more scientific (and more profitable), the Carnegie Foundation (at the request of the American Medical Association and the forerunner of the Association of American Medical Colleges) commissioned an official study of medical education. The “Flexner report” that resulted from this study has been described as the catalyst of modern medical education but has also been criticized for its lack of objectivity.

The Flexner Report To conduct his study, Abraham Flexner met with the leading faculty at the Johns Hopkins University School of Medicine to develop a model of how medical education should take place; he next visited each of the 155 medical schools then in existence, comparing them with the model. Included in the model was the belief that a medical school should be a full-time, research-oriented, laboratory facility that devoted all of its energies to teaching and research, not to the practice of medicine (Kendall, 1980). It should employ “laboratory men” to train students in the “science” of medicine, and the students should then apply the principles they had learned in the sciences to the illnesses of patients (Brown, 1979). Only a few

of the schools Flexner visited were deemed to be equipped to teach scientific medicine; nonetheless, his model became the standard for the profession (Duffy, 1976).

As a result of the Flexner report (1910), all but two of the African American medical schools then in existence were closed, and only one of the medical schools for women survived. As a result, white women and people of color were largely excluded from medical education for the first half of the twentieth century. Until the civil rights movement and the women's movement of the 1960s and 1970s, virtually all physicians were white, male, and upper or upper-middle class.

The Professionalization of Medicine

Despite its adverse effect on people of color and women who might desire a career in medicine, the Flexner report did help professionalize medicine. When we compare post-Flexner medicine with the characteristics of professions (see Chapter 13), we find that it meets those characteristics:

1. *Abstract, specialized knowledge.* Physicians undergo a rigorous education that results in a theoretical understanding of health, illness, and medicine. This education provides them with the credentials, skills, and training associated with being a professional.
2. *Autonomy.* Physicians are autonomous and (except as discussed subsequently in this chapter) rely on their own judgment in selecting the appropriate technique for dealing with a problem. They expect patients to respect that autonomy.
3. *Self-regulation.* Theoretically, physicians are self-regulating. They have licensing, accreditation, and regulatory boards and associations that set professional standards and require members to adhere to a code of ethics as a form of public accountability.
4. *Authority.* Because of their authority, physicians expect compliance with their directions and advice. They do not expect clients to argue about the advice rendered (or the price to be charged).
5. *Altruism.* Physicians perform a valuable service for society rather than acting solely in their own self-interest. Many physicians go beyond their self-interest or personal comfort so that they can help a patient.

However, with professionalization, licensed medical doctors gained control over the entire medical establishment, a situation that has continued until the present and—despite current efforts at cost control by insurance companies and others—may continue into the future.



Brigitte Sullivan/PhotoEdit

Crowded hospital emergency departments are a source of primary health care for many people. How do settings such as this compare with the luxury medical services of private wings of some hospitals described in this chapter?

Medicine Today

Throughout its history in the United States, medical care has been on a *fee-for-service* basis: Patients are billed individually for each service they receive, including treatment by doctors, laboratory work, hospital visits, prescriptions, and other health-related expenses. Fee for service is an expensive way to deliver health care because there are few restrictions on the fees charged by doctors, hospitals, and other medical providers.

There are both good and bad sides to the fee-for-service approach. The good side is that in the “true spirit” of capitalism, coupled with the hard work and scholarship of many people, this approach has resulted in remarkable advances in medicine. The bad side of fee-for-service medicine is its inequality of distribution. In effect, the United States has a two-tier system of medical care. Those who can afford it are able to get top-notch medical treatment. And where they receive it may not be much like the hospitals that most of us have visited:

Every afternoon, between three and five, high above New York's Fifth Avenue, the usual quiet of Eleven West is broken by the soft rustle of white linen cloths and the clink of silver and china as high tea is served room by room. . . . Down the hall, a concierge waits to take your dinner order, provide a video from a list of over 950 titles, arrange for a manicure or massage, or send up that magazine or best-seller that you wanted to read. No, this is not a hitherto unknown outpost of the Four Seasons or the Ritz, but a 19-room wing of the Mt. Sinai Medical Center, one of the nation's leading hospitals. . . .

Here at Mt. Sinai and a few other top hospitals . . . sheets are 250-count cotton, the bathrooms are marble and stocked with

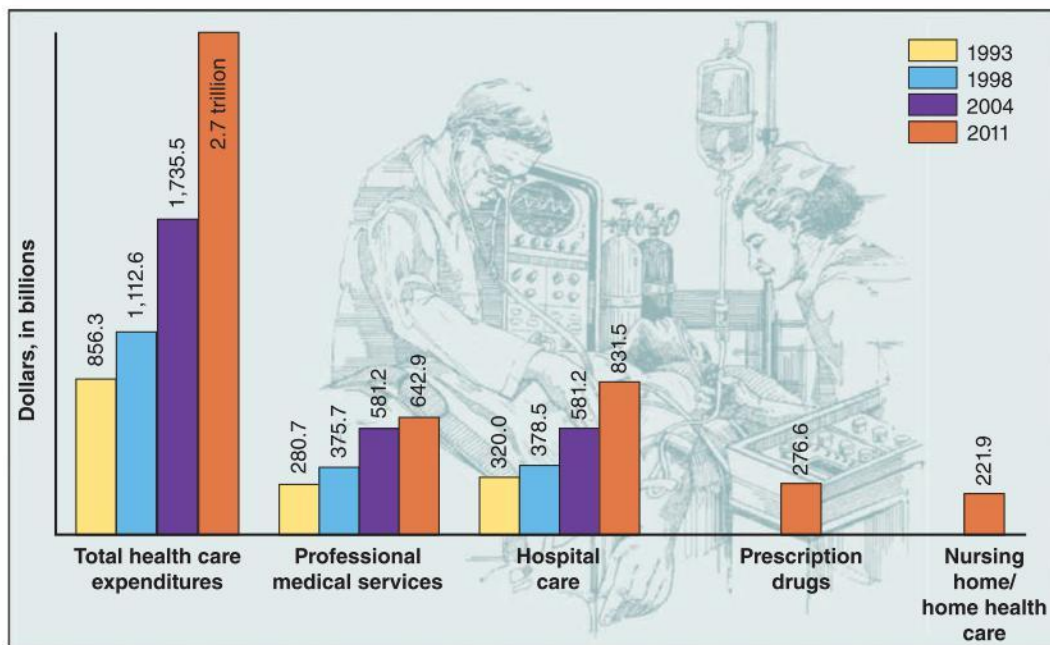


FIGURE 14.2 INCREASE IN COST OF HEALTH CARE, 1993–2011

Source: Plunkett Research, 2012. © Cengage Learning.

toiletries, and there is ample room to accommodate a nice seating group of leather wing chairs and a brocade sofa. And here no call button is pressed in vain. Hospital personnel not only come when summoned but are eagerly waiting to cater to your every need. . . .

On these select floors, multi-tiered food service carts and their clattering, plastic trays are gone. “Room service” is in full force. Meals are presented, often course by course, by bow-tied, black-jacketed waiters from rolling, linen-covered tables. (Winik, 1997)

This description was written in 1997, so you may ask, “Has this ended in the era of Occupy Wall Street and the more austere economic times of the 2010s?” Quite to the contrary. Recent articles in the *New York Times* and other media outlets describe stiff competition for affluent patients among hospitals nationwide that have resulted in the presence of concierges, butlers, and chefs for the wealthy and amenities such as waterfalls and grand pianos that cost patients as much as \$4,500 a day (Bernstein, 2012).

Obviously, this sort of medical care is not within the budget of most people. However, the cost of health care per person in the United States rose from \$141 in 1960 to more than \$8,000 in 2010 (Plunkett Research, 2012) and is still increasing. ● Figure 14.2 reflects how expenditures for health care have increased from 1993 to 2011. Keeping in mind the issues that have been raised throughout this text regarding income disparity

in the United States, the questions to be considered at this point are “Who pays for medical care, and how?” and “What about the people who simply cannot afford adequate medical care?”

Paying for Medical Care in the United States

Until recently, the United States was the only high-income nation without some form of universal health coverage for all citizens. In 2010 the U.S. Congress passed a sweeping health care reform bill that would gradually bring about some changes in how health care is funded. Let’s look first at the health reform legislation and then compare its provisions with previous and current methods of funding of health care in the United States.

The Patient Protection and Affordable Care Act of 2010

After a lengthy struggle in the U.S. Congress, a major health care reform bill was signed into law in 2010. One of the central tenets in the law was the creation of a new insurance marketplace that made it possible for individuals and families without coverage and small business owners to pool their resources to increase their buying power in order to make health insurance more affordable. Private insurance companies would compete for their business based on cost and quality. Advocates of the law believed that it might be a first step in curbing abuses in the insurance industry.

Health care reform was originally scheduled to occur in the following stages:

- **2010:** Adults who had been unable to get coverage because of a preexisting condition could join a high-risk insurance pool (as a stopgap measure until the competitive health insurance marketplace was scheduled to begin in 2014). Insurance companies must cover children with preexisting conditions. Policies could not be revoked when people get sick. Preventive services would be fully covered without co-pays or deductibles. Dependent children could remain on their parents' insurance plans until they reach the age of twenty-six.
- **2011:** Medicare recipients would have access to free annual wellness visits with no cost for preventive care, and those recipients who had to pay out of pocket for prescription drugs would receive substantial discounts.
- **2012:** The federal government would provide additional money for primary-care services, and new incentives would be offered to encourage doctors to join together in accountability-care organizations. Hospitals with high readmission rates would face stiff penalties.
- **2013:** Households with incomes above \$250,000 would be subject to higher taxes to help pay for health care reform. Medicare would launch "payment bundling" so that hospitals, doctors, and other health care providers could be paid on the basis of patient outcome, not services provided.
- **2014:** Most people would be required to buy health insurance or pay a penalty for not having it. Insurance companies could not deny a policy to anyone based on health status, nor could they refuse to pay for treatment on the basis of preexisting health conditions. Annual limits on health care coverage would be abolished. Each state must open a health insurance exchange, or marketplace, so that individuals and small businesses without coverage could comparatively shop for health packages. Tax credits would make insurance and health care more affordable for those who earn too much to qualify for Medicaid.
- **2018:** Insurance companies and plan administrators would pay a 40 percent excise tax on all family plans costing more than \$27,500 a year.
- **2019:** The health reform law should have reduced the number of uninsured people by 32 million, leaving about 23 million uninsured. About one-third of the uninsured would be immigrants residing in the country without legal documentation.

These are a few of the highlights of the plan, which is a document of more than 2,000 pages in length. However, in 2012, after a series of legal challenges

and an appeal from a decision of the U.S. Court of Appeals of the Eleventh Circuit, in Atlanta, the U.S. Supreme Court heard a challenge to the 2010 health care law on the issue of whether Congress overstepped its constitutional authority by requiring most people in the United States to purchase health insurance or be assessed a penalty. According to the Obama administration, Congress is justified in this action by the constitutional power granted to this legislative body "to regulate commerce" and "to lay and collect taxes." After extensive deliberations, the U.S. Supreme Court ruled that Congress did not exceed its constitutional authority, and the Patient Protection and Affordable Care Act was further implemented following the Court's decision. If this is the future of health care funding in the United States, how has it looked in the past and present? Let's look first at how private health insurance works.

Private Health Insurance Private health insurance is largely paid for by businesses and households. Beginning in the 1960s, medical insurance programs began to expand, and third-party providers (public and private insurers) began picking up large portions of doctor and hospital bills for insured patients. With third-party fee-for-service payment, patients pay premiums into a fund that in turn pays doctors and hospitals for each treatment the patient receives.

In the 2010s, private health insurance premiums have continued to increase for both individuals and families. The average annual premium for an individual in an employer-sponsored health insurance plan was \$5,429 in 2011. The average annual premium for family coverage was \$15,073, with workers contributing \$4,129 (on average) and employers paying \$10,944 (on average) of the cost. Between 2001 and 2010, the average premiums for family coverage increased 113 percent (Kaiser Family Foundation, 2011a).

Some believe that a third-party fee-for-service approach is the best and most cost-efficient method of delivering medical care. Others argue that fee for service is outrageously expensive and a very cost-ineffective way in which to provide for the medical needs of people in this country, particularly those who are without health insurance coverage. According to critics, third-party fee for service contributes greatly to medical inflation because it gives doctors and hospitals an incentive to increase medical services. In other words, the more services they provide, the more fees they charge, and the more money they make. Patients have no incentive to limit their visits to doctors or hospitals because they have already paid their premiums and feel entitled

to medical care, regardless of the cost. This is one of the spiraling costs that advocates of health care reform hope will be reduced.

Public Health Insurance Since the 1960s, the United States has had two nationwide public health insurance programs, Medicare and Medicaid. In 1965 Congress enacted Medicare, a federal program for people ages 65 and over (who are covered by Social Security or railroad retirement insurance or who have been permanently and totally disabled for two years or more). This program was primarily funded through Social Security taxes paid by current workers. Medicare has several components, referred to as Part A, Part B, Part C, and Part D. Medicare Part A (hospital insurance) helps cover inpatient care in hospitals, skilled nursing facilities, hospice, and home health care. Part B (medical insurance) helps cover doctors' services and outpatient care. It covers some of the services of physical and occupational therapists, and some home health care. Most people pay a monthly premium for Part B. Medicare Part C is an insurance plan run by private companies approved by Medicare. Medicare Part D provides prescription drug coverage.

Medicaid is the federal government's health care program for low-income and disabled persons and certain groups of seniors in nursing homes. Medicaid is jointly funded by federal–state–local monies, and various factors are taken into account when determining whether or not a person is eligible for Medicaid. Among these are age, disability, blindness, and pregnancy. Income and resources are also taken into consideration, as well as whether the person is a U.S. citizen or a lawfully admitted immigrant. Each state has its own rules regarding who may be covered under Medicaid, and some provide time-limited coverage for specific categories of individuals, such as uninsured women with breast or cervical cancer or those individuals diagnosed with TB (tuberculosis). As compared to Medicare, Medicaid has had a more tarnished image throughout its history. Unlike Medicare recipients, who are often seen as “worthy” of their health care benefits, Medicaid recipients have been stigmatized by politicians and media outlets for their participation in a “welfare program.” Today, many physicians refuse to take Medicaid patients because the administrative paperwork is burdensome and reimbursements are low—typically less than one-half of what private insurance companies pay for the same services.

When the health care reform law passed in 2010, both the Medicaid program and the Medicare program were in financial difficulty. In 2009 these two programs cost \$876.2 billion. Public health insurance accounted for 21 percent of the federal budget

in 2010 (CBPP, 2011). Under the 2010 Patient Protection and Affordable Care Act, eligibility for “free” Medicaid coverage would expand significantly, so cost containment might be difficult in this area. However, preventive health care services could improve the health of recipients while reducing costs.

Health Maintenance Organizations (HMOs) Created in an effort to provide workers with health coverage by keeping costs down, *health maintenance organizations* (HMOs) provide, for a set monthly fee, total care with an emphasis on prevention to avoid costly treatment later. The doctors do not work on a fee-for-service basis, and patients are encouraged to get regular checkups and to practice good health practices (e.g., exercise and eat right). However, research shows that preventive care is good for the individual's health but does not necessarily lower total costs. As long as patients use only the doctors and hospitals that are affiliated with their HMO, they pay no fees, or only small co-payments, beyond their insurance premiums.

Recent concerns about physicians being used as gatekeepers who might prevent some patients from obtaining referrals to specialists or from getting needed treatment have resulted in changes in the policies of some HMOs, which now allow patients to visit health care providers outside an HMO's network or to receive other previously unauthorized services by paying a higher co-payment. However, critics charge that those HMOs whose primary-care physicians are paid on a capitation basis—meaning that they receive only a fixed amount per patient whom they see, regardless of how long they spend with that patient—in effect encourage doctors to undertreat patients.

Managed Care Another approach to controlling health care costs in the United States is known as *managed care*—any system of cost containment that closely monitors and controls health care providers' decisions about medical procedures, diagnostic tests, and other services that should be provided to patients. One type of managed care in the United States is a *preferred provider organization* (PPO), which is an organization of medical doctors, hospitals, and other health care providers that enter into a contract with an insurer or a third-party administrator to provide health care at a reduced rate to patients who are covered under specific insurance plans. In most managed-care programs, patients choose a primary-care physician from a list of participating doctors. Unlike many of the HMOs, when a patient covered under a PPO plan needs medical services, he or she may contact any one of a number of primary-care physicians or specialists

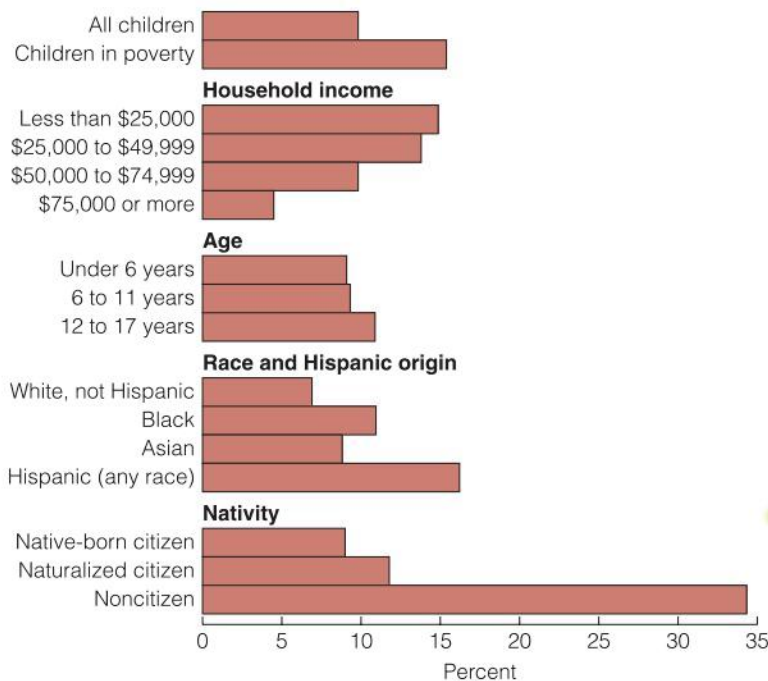


FIGURE 14.3 UNINSURED CHILDREN BY POVERTY STATUS, HOUSEHOLD INCOME, AGE, RACE, HISPANIC ORIGIN, AND NATIVITY: 2010

Source: U.S. Census Bureau, Current Population Survey, 2011 Annual Social and Economic Supplement.

who are “in-network” providers. Like HMOs, most PPO plans do contain a pre-certification requirement in which scheduled (nonemergency) hospital admissions and certain kinds of procedures must be approved in advance. Through measures such as this, these insurance plans have sought unsuccessfully to curb the rapidly increasing costs of medical care and to reduce the extensive paperwork and bureaucracy involved in the typical medical visit. For the foreseeable future, HMOs and PPOs are supposed to remain somewhat the same. After the passage of the health care reform measure, the Obama administration widely publicized a statement that people in plans such as these would not be affected by the new law. Rather, they would have assurance that they could get health care coverage even if they lost their job, changed jobs, moved out of state, got divorced, or were diagnosed with a serious illness.

The Uninsured Despite existing public and private insurance programs, about one-third of all U.S. citizens were without health insurance or had difficulty getting or paying for medical care at some time in the last year. Although full-time workers are more likely to have health insurance than those who work less than full time and persons who are unemployed, having a full-time job is still no guarantee of health insurance coverage: 15 percent of all full-time workers lacked health insurance in 2010 (DeNavas-Walt, Proctor, and Smith, 2011). In a worst-case scenario, some who are uninsured (despite being employed full time) make too little to afford health insurance but too much to qualify

for Medicaid. Even if their employers offer group health insurance, some employees cannot afford their share of the premiums.

Under the 2010 Patient Protection and Affordable Care Act, this situation would change in 2014, when each state would open a health insurance exchange, or marketplace, for individuals and small businesses without health insurance coverage. Prior to this, millions of people would remain uninsured. In 2010 an estimated 49.9 million people in the United States had no health insurance—more than 16 percent of the nation’s population.

Nearly one in ten U.S. children (7.3 million) were without health insurance in 2010 (DeNavas-Walt, Proctor, and Smith, 2011). ● Figure 14.3 shows that the uninsured rate for children in poverty (15.4 percent) was greater than the rate for all children (9.8 percent). Statistically speaking, as this figure shows, children who are more likely to be uninsured are ones who live in poverty, are Hispanic (any race), and are not citizens of the United States. The rate of uninsured children would be even higher if there were not state-sponsored programs such as CHIP, a

health maintenance organizations (HMOs) companies that provide, for a set monthly fee, total care with an emphasis on prevention to avoid costly treatment later.

managed care any system of cost containment that closely monitors and controls health care providers’ decisions about medical procedures, diagnostic tests, and other services that should be provided to patients.

health insurance plan for children that is offered on a sliding scale with premiums (down to zero) based on family income. Nearly 30 percent of all young adults between the ages of 19 to 25 were uninsured in 2010—the highest rate of uninsurance of all age groups.

Race and ethnicity are important factors in health insurance coverage. Although every racial and ethnic group is affected, Latinos/as and African Americans are more likely to be uninsured than are white (non-Hispanic) Americans. For Hispanic Americans the uninsured rate was 30.7 percent, as compared to African Americans at 20.8 percent, Asian Americans at 18.1 percent, and white (non-Hispanic) Americans at 11.7 percent. Across all racial-ethnic categories, 18.4 percent of people who are under the age of 65 were uninsured for some portion, or all, of 2010.

Paying for Medical Care in Other Nations

Other nations have various ways in which they provide health care for their citizens. **L05** Let's examine how other nations pay for health care.

Canada Health care in Canada is delivered through a publicly funded health care system. Services are provided by private entities and are mostly free to patients. Information remains private between physician and patient, and the government is not involved in patient care. Each citizen receives a health card, and all patients receive the same level of care. As long as a person's premiums are paid up, health coverage is not affected by losing or changing jobs.

How did the contemporary Canadian health care system get started? In 1962 the government of the province of Saskatchewan implemented a health insurance plan despite opposition from doctors, who went on strike to protest the program. The strike was not successful, as the vast majority of citizens supported the government, which maintained health services by importing doctors from Great Britain. The Saskatchewan program proved itself viable in the years following the strike, and by 1972 all Canadian provinces and territories had coverage for medical and hospital services (Murray, Linden, and Kendall, 2012). As a result, Canada has a **universal health care system—a health care system in which all citizens receive medical services paid for by tax revenues**. In Canada, these revenues are supplemented by insurance premiums paid by all taxpaying citizens.

One major benefit of the Canadian system is a significant reduction in administrative costs. Whereas

more than 20 percent of the U.S. health care dollar represents administrative costs, in Canada the corresponding figure is 10 percent (Weiss and Lonnquist, 2012). However, the system is not without its critics, who claim that it is costly and often wasteful.

The Canadian health care system does not constitute what is referred to as **socialized medicine—a health care system in which the government owns the medical care facilities and employs the physicians**. Rather, Canada has maintained the private nature of the medical profession. Although the government pays most health care costs, the physicians are not government employees and have much greater autonomy than do physicians in the health care system in Great Britain.

Great Britain Great Britain has a centralized, single-payer health care system that is funded by general revenues. The National Health Service Act of 1946 provides for all health care services to be available at no charge to the entire population. Although physicians work out of offices or clinics—as in the United States or Canada—the government sets health care policies, raises funds and controls the medical care budget, owns health care facilities, and directly employs physicians and other health care personnel (Weiss and Lonnquist, 2012).

Unlike the Canadian model, the health care system in Great Britain *does* constitute socialized medicine. Physicians receive capitation payments from the government: a fixed annual fee for each patient in their practice regardless of how many times they see the patient or how many procedures they perform. They also receive supplemental payments for each low-income or elderly patient in their practice, to compensate for the extra time such patients may require; bonus payments if they meet targets for providing preventive services, such as immunizations against disease; and financial incentives if they practice in medically underserved areas. Physicians may accept private patients, but such patients rarely constitute more than a small fraction of a physician's practice; hospitals reserve a small number of beds for private patients (Weiss and Lonnquist, 2012). Why would anyone want to be a private patient who pays for her or his own care or hospital bed? The answer is primarily found in the desire to avoid the long waits ("queues") that the general population encounters and the fact that private patients can enter the hospital for surgery at times convenient to the consumer rather than wait upon the convenience of the system.

People's Republic of China In recent years the People's Republic of China has seen many changes in the delivery and financing of medical

care. When most U.S. people speak of “Chinese medicine,” they are referring to treatments such as acupuncture, herbal remedies, or massage. However, health care in China is much more complex than the use of alternative remedies.

During the past two decades the health care system in China has become a complex mix of market-driven capitalism, communism, and massive government spending. The profit-driven system is based on fee-for-service practice by physicians and the sale of highly expensive pharmaceutical products that are marketed by doctors and hospitals. Much of the profit is through drug sales, particularly intravenous (IV) treatments, which are used much more widely than in the United States. Until reforms occurred in about 2008–2009, pharmaceutical products were very costly; however, they have become somewhat more affordable since that time.

Ironically, as the Chinese government stepped up funding for health care, social disease epidemics, such as obesity and/or illnesses related to excessive use of tobacco, alcohol, and salt, took their toll on many in the population: Diabetes, hypertension, and environmentally induced heart and lung diseases have remained on the upswing for a number of years (Mills, 2010).

What is the history of health care delivery and funding in China? After a lengthy civil war, in 1949 the Communist Party won control of mainland China but found itself in charge of a vast nation with a population of one billion people, most of whom lived in poverty and misery. Malnutrition was prevalent, life expectancies were short, and infant and maternal mortality rates were high. In the cities only the elite could afford medical care; in the rural areas, where most of the population resided, Western-style health care barely existed (Weitz, 2013). With a lack of financial resources and not enough trained health care personnel, China adopted a policy to create a large number of physician extenders who could educate the public about health and the treatment of illness and disease. Referred to as *street doctors* in urban areas and *village doctors* (formerly “barefoot doctors”) in the countryside, these individuals had little formal training and worked under the supervision of trained physicians (Weitz, 2013).

Over the past six decades, medical training has become more rigorous. All doctors receive training in both Western and traditional Chinese medicine. Most doctors who work in hospitals receive a salary; all other doctors now work on a fee-for-service basis. In urban areas about 94 percent of the working population has health insurance coverage paid for by employers, but individuals often pay large out-of-pocket fees because of gaps in health care coverage. Today, 60 percent of the population

of mainland China live in rural areas, where large numbers of migrant farm workers must provide for their own health care. New government initiatives established in the 2010s call for the establishment of a clinic in each rural community; however, many more physicians will be needed to provide adequate care for the millions of people living in these areas.

In urban areas the latest reports show that it is difficult to get into a hospital even with insurance. Increasing demands for services have placed the already overburdened system under greater stress, and many people line up outside the more prestigious hospitals early in the morning on the day before they want treatment to get their name on lengthy waiting lists. Although local doctors might be able to take care of their needs, many Chinese patients want to be treated in the more prestigious hospitals, where they believe they will receive higher-quality care. To help meet the growing demands on the health care delivery system, the Chinese government is attempting to improve thousands of medical centers and to focus on preventive care, especially for infants, children, pregnant women, and those in need of mental health care. Despite these efforts, both services and funding remain quite different when comparing urban and rural areas: The health care disparities remain great, and more money and medical personnel are needed throughout the system, but particularly in rural areas, to meet the needs of a rapidly growing population.

Regardless of which approach to health care delivery and financing that a nation uses, health care providers, hospitals, governmental agencies, political leaders, and the general public all face many difficult issues about the best way to meet patients’ needs and not bankrupt the medical system and the nation. One area that may increase costs and generate complex concerns is advanced medical technology.

Social Implications of Advanced Medical Technology

Advances in medical technology are occurring at a speed that is almost unbelievable; however, sociologists and other social scientists have identified

universal health care a health care system in which all citizens receive medical services paid for by tax revenues.

socialized medicine a health care system in which the government owns the medical care facilities and employs the physicians.

specific social implications of some of the new **LOG** technologies (see Weiss and Lonnquist, 2012):

1. *Advanced technologies create options for people and for society, but options that alter human relationships.* An example is the ability of medical personnel to sustain a life that in earlier times would have ended as the result of disease or an accident. Although this can be beneficial, technologically advanced equipment (that can sustain life after consciousness is lost and there is no likelihood that the person will recover) can create a difficult decision for the family of that person if he or she has not left a *living will*—a document stating the person's wishes regarding the medical circumstances under which his or her life should be terminated. Federal law requires all hospitals and other medical facilities to honor the terms of a living will.
2. *Advanced technologies increase the cost of medical care.* For example, the computerized axial tomography (CT or CAT) scanner—which combines a computer with X-rays that are passed through the body at different angles—produces clear images of the interior of the body that are invaluable in investigating disease. The cost of such a scanner is around \$1 million. Magnetic resonance imaging (MRI) equipment that allows pictures to be taken of internal organs ranges in cost from \$1 million to \$2.5 million. Can the United States afford such equipment in every hospital for every patient? The money available for health care is not unlimited, and when it is spent on high-tech equipment and treatment, it is being reallocated from other health care programs that might be of greater assistance to more people.
3. *Advanced technologies such as cloning and stem cell research raise provocative questions about the very nature of life.* In Chapter 11 we briefly discuss in vitro fertilization—a form of assisted reproductive technology. But during 1997, Dr. Ian Williams and his associates in Scotland took in vitro fertilization a step further: They cloned a lamb (that they named Dolly) from the DNA of an adult sheep. Subsequently, scientists have cloned other animals in the same manner, raising a number of profound questions: If scientists can duplicate mammals from adult DNA, is it possible to clone a perfect (whatever that may be) human being instead of taking a chance on a child that is born to a couple? If it is possible, would it be ethical? Like cloning, stem cell research has been an important and controversial issue in medicine. Stem cell research is important because these stem cells are building blocks that can be manipulated to perform the work of other



High-technology medical imaging devices such as the one shown here are very expensive. Some analysts question whether an expenditure of this size could be better used instead to help more people in different ways.

cell types. In other words, stem cells can be used to generate virtually any type of specialized cell in the human body. Stem cells are accessible in the skin and through extraction from umbilical cord blood and human embryos. These cells are important to medical science because they can be used to replace diseased or damaged human tissue. It remains to be seen how successful these procedures will be in treating patients and finding cures for Alzheimer's, Parkinson's, diabetes, cancer, and numerous other diseases. These technological advances also produce ethical dilemmas and intense political and religious debates. Specifically, opponents of embryonic stem cell research believe that a human life is taken when a human embryo is destroyed in this research. However, proponents of stem cell research respond that these studies do not always require the use of embryos.

At the same time that high-tech medicine is becoming a major part of overall health care, many people are turning to holistic medicine and alternative healing practices.

Holistic Medicine and Alternative Medicine

When examining the subject of medicine, it is easy to think only in terms of conventional (or mainstream) medical treatment. By contrast, *holistic medicine* is an approach to health care that focuses on prevention of illness and disease and is aimed at treating the whole person—body and mind—rather than just the part or parts in which symptoms occur. Under this approach, it is important that people not



image100/Corbis

The use of herbal therapies is a form of alternative medicine that is increasing in popularity in the United States. How does this approach to health care differ from a more traditional medical approach?

look solely to medicine and doctors for their health, but also that people engage in health-promoting behavior. Likewise, medical professionals must not only treat illness and disease but also work with the patient to promote a healthy lifestyle and self-image.

Many practitioners of *alternative medicine*—healing practices inconsistent with dominant medical practice—take a holistic approach, and today many people are turning to alternative medicine either in addition to or in lieu of traditional medicine. However, some medical doctors are opposed to alternative medicine. In understanding the medical establishment's reaction to alternative medicine, it is important to keep in mind the philosophy of scientific medicine—that medicine is a science, not an art. Thus, to the extent to which alternative medicine is “nonscientific,” it must be quackery and therefore something that is undoubtedly worthless and possibly harmful. Undoubtedly, self-interest is also involved in mainstream medicine's reaction to alternative medicine: If the public can be persuaded that scientific medicine is the only legitimate healing practice, fewer health care dollars will be spent on a form of medical treatment that is (at least to some extent) in competition with the medical establishment. But if all forms of alternative medicine (including chiropractic, massage, and spiritual) are taken into account, people spend more money on unconventional therapies than they do for all hospitalizations.

Sociological Perspectives on Health and Medicine

Functionalist, conflict, symbolic interactionist, and postmodernist perspectives focus on different aspects of health and medicine; each provides us with significant insights on the problems associated with these pressing social concerns.

A Functionalist Perspective: The Sick Role

According to the functionalist approach, if society is to function as a stable system, it is important for people to be healthy and to contribute to their society. Consequently, sickness is viewed as a form of deviant behavior that must be controlled by society.

LO7 This view was initially set forth by the sociologist Talcott Parsons (1951) in his concept of the *sick role*—the set of patterned expectations that defines the norms and values appropriate for individuals who are sick and for those who interact with them. According to Parsons, the sick role has four primary characteristics:

1. People who are sick are not responsible for their condition. It is assumed that being sick is not a deliberate and knowing choice of the sick person.
2. People who assume the sick role are temporarily exempt from their normal roles and obligations. For example, people with illnesses are typically not expected to go to school or work.
3. People who are sick must want to get well. The sick role is considered to be a temporary one that people must relinquish as soon as their condition improves sufficiently. Those who do not return to their regular activities in a timely fashion may be labeled as hypochondriacs or malingerers.
4. People who are sick must seek competent help from a medical professional to hasten their recovery.

As these characteristics show, Parsons believed that illness is dysfunctional for both individuals and the larger society. Those who assume the sick role are unable to fulfill their necessary social roles, such as being parents or employees. Similarly, people who are ill lose days from their productive roles in society, thus weakening the ability of groups and organizations to fulfill their functions.

According to Parsons, it is important for the society to maintain social control over people who enter the sick role. Physicians are empowered to determine who may enter this role and when patients are ready to exit it. Because physicians spend many years in training and have specialized knowledge about illness

holistic medicine an approach to health care that focuses on prevention of illness and disease and is aimed at treating the whole person—body and mind—rather than just the part or parts in which symptoms occur.

sick role the set of patterned expectations that defines the norms and values appropriate for individuals who are sick and for those who interact with them.

and its treatment, they are certified by the society to be “gatekeepers” of the sick role. When patients seek the advice of a physician, they enter into the doctor–patient relationship, which does not contain equal power for both parties. The patient is expected to follow the “doctor’s orders” by adhering to a treatment regime, recovering from the malady, and returning to a normal routine as soon as possible.

What are the major strengths and weaknesses of Parsons’s model and, more generally, of the functionalist view of health and illness? Parsons’s analysis of the sick role was pathbreaking when it was introduced. Some social analysts believe that Parsons made a major contribution to our knowledge of how society explains illness-related behavior and how physicians have attained their gatekeeper status. In contrast, other analysts believe that the sick-role model does not take into account racial–ethnic, class, and gender variations in the ways that people view illness and interpret this role. For example, this model does not take into account the fact that many individuals in the working class may choose not to accept the sick role unless they are seriously ill—because they cannot afford to miss time from work and lose a portion of their earnings. Moreover, people without health insurance may not have the option of assuming the sick role.

A Conflict Perspective: Inequalities in Health and Health Care

Unlike the functionalist approach, conflict theory emphasizes the political, economic, and social forces that affect health and the health care delivery system. Among the issues of concern to conflict theorists are the ability of all people to obtain health care; how race, class, and gender inequalities affect health and health care; power relationships between doctors and other health care workers; the dominance of the medical model of health care; and the role of profit in the health care system.

Who is responsible for problems in the U.S. health care system? According to many conflict theorists, problems in U.S. health care delivery are rooted in the capitalist economy, which views medicine as a commodity that is produced and sold by the medical–industrial complex. The **medical–industrial complex encompasses local physicians and hospitals as well as global health-related industries such as insurance companies and pharmaceutical and medical supply companies** (Relman, 1992).

The United States is one of the few industrialized nations that has relied almost exclusively on the medical–industrial complex for health care delivery and has not had any form of universal health coverage to provide some level of access to medical treatment for all people. Consequently, access to



Sean Justice/Photofest/Getty Images

According to the functionalist perspective, the sick role exempts the patient from routine activities for a period of time but assumes that the individual will seek appropriate medical attention and get well as soon as possible.

high-quality medical care has been linked to people’s ability to pay and to their position within the class structure. Those who are affluent or have good medical insurance may receive high-quality, state-of-the-art care in the medical–industrial complex because of its elaborate technologies and treatments. However, people below the poverty level and those just above it have greater difficulty gaining access to medical care. Referred to as the *medically indigent*, these individuals do not earn enough to afford private medical care but earn just enough money to keep them from qualifying for Medicaid. In the profit-oriented capitalist economy, these individuals are said to “fall between the cracks” in the health care system.

Who benefits from the existing structure of medicine? According to conflict theorists, physicians—who hold a legal monopoly over medicine—benefit from the existing structure because they can charge inflated fees. Similarly, clinics, pharmacies, laboratories, hospitals, supply manufacturers, insurance companies, and many other corporations derive excessive profits from the existing system of payment in medicine. In recent years, large drug companies and profit-making hospital corporations have come to occupy a larger and larger part of health care delivery. As a result, medical costs have risen rapidly, and the federal government and many insurance companies have placed pressure for cost containment on other players in the medical–industrial complex.

Conflict theorists increase our awareness of inequalities of race, class, and gender as these statuses influence people’s access to health care. They

also inform us about the problems associated with health care becoming “big business.” However, some analysts believe that the conflict approach is unduly pessimistic about the gains that have been made in health status and longevity—gains that are at least partially because of large investments in research and treatment by the medical–industrial complex.

A Symbolic Interactionist Perspective: The Social Construction of Illness

Symbolic interactionists attempt to understand the specific meanings and causes that we attribute to particular events. In studying health, symbolic interactionists focus on the meanings that social actors give their illness or disease and how these affect people’s self-concept and relationships with others. According to symbolic interactionists, we socially construct “health” and “illness” and how both should be treated. For example, some people explain disease by blaming it on those who are ill. If we attribute cancer to the acts of a person, we can assume that we will be immune to that disease if we do not engage in the same behavior. Nonsmokers who learn that a lung cancer victim had a two-pack-a-day habit feel comforted that they are unlikely to suffer the same fate. Similarly, victims of AIDS are often blamed for promiscuous sexual conduct or intravenous drug use, regardless of how they contracted HIV. In this case the social definition of the illness leads to the stigmatization of individuals who suffer from the disease.

Although biological characteristics provide objective criteria for determining medical conditions such as heart disease, tuberculosis, or cancer, there is also a subjective component to how illness is defined. This subjective component is very important when we look at conditions such as childhood hyperactivity, mental illness, alcoholism, drug abuse, cigarette smoking, and overeating, all of which have been medicalized. The term **medicalization** refers to the process whereby nonmedical problems become defined and treated as illnesses or disorders. Medicalization may occur on three levels: (1) the conceptual level (e.g., the use of medical terminology to define the problem), (2) the institutional level (e.g., physicians are supervisors of treatment and gatekeepers to applying for benefits), and (3) the interactional level (e.g., when physicians treat patients’ conditions as medical problems). For example, the sociologists Deborah Findlay and Leslie Miller (1994: 277) explain how gambling has been medicalized:

Habitual gambling . . . has been regarded by a minority as a sin, and by most as a leisure pursuit—perhaps wasteful but a pastime nevertheless. Lately, however, we have seen gambling



Comstock (RF)/Jupiter Images

Is gambling a moral issue or a medical one? According to sociologists, the recent trend toward viewing compulsive gambling as a health care issue is an example of the medicalization of deviance.

described as a psychological illness—“compulsive gambling.” It is in the process of being medicalized. The consequences of this shift in discourse (that is, in the way of thinking and talking) about gambling are considerable for doctors, who now have in gamblers a new market for their services or “treatment”; perhaps for gambling halls, which may find themselves subject to new regulations, insofar as they are deemed to contribute to the “disease”; and not least, for gamblers themselves, who are no longer treated as sinners or wastrels, but as patients, with claims on our sympathy, and to our medical insurance plans as well.

Sociologists often refer to this form of medicalization as the *medicalization of deviance* because it gives physicians and other medical professionals greater authority to determine what should be considered “normal” and “acceptable” behavior and to establish the appropriate mechanisms for controlling “deviant behaviors.”

According to symbolic interactionists, medicalization is a two-way process: Just as conditions can be medicalized, so can they be demedicalized. **Demedicalization** refers to the process whereby a problem ceases to be defined as an illness or a disorder. Examples include the removal of certain

medical–industrial complex local physicians, local hospitals, and global health-related industries such as insurance companies and pharmaceutical and medical supply companies.

medicalization the process whereby nonmedical problems become defined and treated as illnesses or disorders.

demedicalization the process whereby a problem ceases to be defined as an illness or a disorder.

Sociology WORKS!

Sociology Sheds Light on the Physician–Patient Relationship

DOCTOR: What's the problem?

(Chair noise).

PATIENT: . . . had since last Monday evening so it's a week of sore throat.

DOCTOR: . . . hm . . . hm . . .

PATIENT: . . . which turned into a cold . . . and then a cough.

DOCTOR: A cold you mean what? Stuffy nose?

PATIENT: uh stuffy nose yeah not a chest . . . cold . . .

DOCTOR: . . . hm . . . hm . . . And a cough.

PATIENT: And a cough . . . which is the most irritating aspect. . .

DOCTOR: Okay. Uh, any fever?

PATIENT: Not that I know of . . . I took it a couple of times in the beginning but haven't felt like—

DOCTOR: How bout your ears? . . . (Mishler, 2005: 322)

In this brief excerpt from the transcript of a discussion between a doctor and patient, the patient responds to the doctor's request for information by telling him what her symptoms are and how they began to change when her illness "turned into a cold . . . and then a cough." According to sociologists who study the social organization of health care, this transcript indicates that the physician wants the patient to continue speaking when he makes sounds such as "hm . . . hm," but he also wants to remain in control of the conversation. When the patient mentions that she has a "cold," for example, the doctor asks for further clarification of her specific symptoms so that he can determine, efficiently and in a short period of time, what kind of cold she has and what the treatment plan should be (Mishler, 2005). This is one brief passage from many pages of medical transcripts that researchers have used to study what they refer to as the struggle between the voice of medicine and the voice of the lifeworld (Mishler, 1984, 2005).

What are the voices of medicine and of the lifeworld? In this context, the voice of medicine refers to the technical, scientific attitude adopted by many doctors in their communication with patients. This type of discourse is generally abstract,

neutral, and somewhat distant. By contrast, the voice of the lifeworld refers to the natural, everyday attitudes that are expressed by patients when they talk to their physician in the hope of gaining additional insight on their medical condition. Some sociologists believe that a constant struggle exists between these two "voices" in the doctor–patient relationship and that this struggle affects the outcome of each medical encounter. The voice of medicine makes it difficult for patients to believe that their concerns are being heard when the physician is visibly in a hurry, does not listen, interrupts frequently, and/or talks down to the patient.

To minimize the voice of medicine, some sociologists advocate *therapeutic communication* between doctors and patients. In therapeutic communication (1) the physician engages in full and open communication with the patient and feels free to ask questions about psychosocial as well as physical conditions, (2) the patient provides full and open information to the physician and feels free to ask questions and seek clarifications, and (3) a genuine rapport develops between physician and patient (Weiss and Lonnquist, 2012). According to some social analysts, it takes a doctor no additional time to use a positive communication style that conveys friendliness, empathy, genuineness, candor, an openness to conversation, and a nonjudgmental attitude toward the patient. Such a communication style certainly helps physicians establish positive relationships with their patients. Of course, patients should also try to communicate in a positive manner with physicians, people whom the patients hope will be able to help them remain healthy or help them resolve an existing medical problem.

reflect & analyze

Sociologists who study the social organization of medicine will continue to look for new insights on the physician–patient relationship in the future. What other sociological perspectives do you believe might be useful in explaining the dynamics of doctor–patient communications or other social interactions (such as between physicians and other health professionals) that routinely take place within the health care system?

behaviors (such as homosexuality) from the list of mental disorders compiled by the American Psychiatric Association and the deinstitutionalization of mental health patients. The process of demedicalization also continues in women's health as advocates seek to redefine childbirth and menopause as natural processes rather than as illnesses (Conrad, 1996).

In addition to how health and illness are defined, symbolic interactionists examine how doctors and patients interact in health care settings (see "Sociology Works!"). Some physicians may hesitate to communicate certain kinds of medical information to patients, such as why they are prescribing certain medications or what side effects or drug interactions may occur.

[concept quick review]

Sociological Perspectives on Health and Medicine

A Functionalist Perspective: The Sick Role

People who are sick are temporarily exempt from normal obligations but must want to get well and seek competent help.

A Conflict Perspective: Inequalities in Health and Health Care

Problems in health care are rooted in the capitalist system, exemplified by the medical–industrial complex.

A Symbolic Interactionist Perspective: The Social Construction of Illness

People socially construct both “health” and “illness,” and how both should be treated.

A Postmodernist Perspective: The Clinical Gaze

Doctors gain power through observing patients to gather information, thus appearing to speak “wisely.”

Symbolic interactionist perspectives on health and health care provide us with new insights on the social construction of illness and how health and illness cannot be strictly determined by medical criteria. Symbolic interactionists also make us aware of the importance of communication between physicians and patients, including factors that may reduce effective medical treatment for some individuals. However, these approaches have been criticized for suggesting that few objective medical criteria exist for many illnesses and for overemphasizing micro-level issues without giving adequate recognition to macrolevel issues such as the effects on health care of managed care, health maintenance organizations, and for-profit hospital chains.

A Postmodernist Perspective: The Clinical Gaze

In *The Birth of the Clinic* (1994/1963), postmodern theorist Michel Foucault questioned existing assumptions about medical knowledge and the power that doctors have gained over other medical personnel and everyday people. Foucault asserted that truth in medicine—as in all other areas of life—is a social construction, in this instance one that doctors have created. Foucault believed that doctors gain power through the *clinical* (or “observing”) gaze, which they use to gather information. Doctors develop the clinical gaze through their observation of patients; as the doctors begin to diagnose and treat medical conditions, they also start to speak “wisely” about everything. As a result, other people start to believe that doctors can “penetrate illusion and see . . . the hidden truth” (Shawver, 1998).

According to Foucault, the prestige of the medical establishment was further enhanced when it became possible to categorize all illnesses within a definitive network of disease classification under which physicians can claim that they know why patients are sick. Moreover, the invention of new tests made it necessary for physicians to gaze upon the naked body, to

listen to the human heart with an instrument, and to run tests on the patient’s body fluids. Patients who objected were criticized by doctors for their “false modesty” and “excessive restraint” (Foucault, 1994/1963: 163). As the new rules allowed for the patient to be touched and prodded, the myth of the doctor’s diagnostic wisdom was further enhanced, and “medical gestures, words, gazes took on a philosophical density that had formerly belonged only to mathematical thought” (Foucault, 1994/1963: 199). For Foucault, the formation of clinical medicine was merely one of the more-visible ways in which the fundamental structures of human experience have changed throughout history.

Foucault’s work provides new insights on medical dominance, but it has been criticized for its lack of attention to alternative viewpoints. Among these is the possibility that medical breakthroughs and new technologies actually help physicians become wiser and more scientific in their endeavors. Another criticism is that Foucault’s approach is based upon the false assumption that people are passive individuals who simply comply with doctors’ orders—he does not take into account that people (either consciously or unconsciously) may resist the myth of the “wise doctor” and not follow “doctors’ orders” (Lupton, 1997).

Foucault’s analysis (1988/1961) was not limited to doctors who treat bodily illness; he also critiqued psychiatrists and the treatment of insanity.

The Concept Quick Review summarizes the major sociological perspectives on health and medicine.

Mental Illness

Mental illness affects many people; however, it is a difficult topic for sociological research. Social analysts such as Thomas Szasz (1984) have argued that mental illness is a myth. According to this approach, “mental illnesses” are actually individual traits or behaviors that society deems unacceptable, immoral, or deviant.