**5 HEALTH**

**5.1 DEFINING HEALTH, ILLNESS AND DISABILITY**

P.309 gETTING YOU THINKING

Answers are not provided for this activity as it is intended to encourage students to explore their own beliefs and understandings rather than be prescriptive.

P.316 Focus on skills: thousands of patients killed by drug and equipment errors

**1.** According to the article, annually 8,000 people are killed or seriously harmed by drug or equipment errors in
the NHS.

**2.** Emslie’s (2002) research claimed that there are 34,000 deaths annually in the NHS due to medical mistakes.

One possible reason for the disparity in the figures is that the category ‘medical mistakes’ is a far broader
one than ‘drug or equipment errors’. It is also possible that the report written for Jeremy Hunt refers just to the NHS in England, whilst the Emslie research covers the whole of the UK.

**3.** The aviation industry, like the NHS, is seen as carrying a heavy responsibility for passenger safety since errors can be fatal. The aviation industry has an impressive safety record, so Hunt suggests that the NHS needs to emulate that industry. However, it is questionable whether this is a fair comparator: airline passengers are unlike patients in many ways and the scale of the two industries is quite different.

**4.** **Arguments for**: the medical profession provides care, support and expertise to people who are ill, injured, dying or disabled, sometimes under the most onerous and challenging of circumstances. There is evidence too that the NHS has contributed to the rise in expectancy. People’s chances of surviving diseases such as cancer have significantly improved because of NHS care.

**Arguments against**: in carrying out their duties, the medical profession can cause unintended harm, known as clinical iatrogenesis as cited in the Smyth article. The medical profession, as in all professions, includes people who abuse their position of trust. Social historians such as Mckeown have questioned how much credit the medical profession should take for improvements in health. He argues that improvement in social conditions such as better diets and housing, the provision of clean water, sanitation and legislation to control pollution are just as important as medicine in improving the health of the British people. Health promotions too, particularly those encouraging people to give up smoking or reduce their alcohol intake have also proved relatively successful for the health of the nation.

P.321 Focus on skills: the village by Vic Finkelstein

**1.** The design of the buildings, shops, transport system and the environment.

**2.** Bruised foreheads, painful backs and lack of employment because of prejudice and discrimination.

**3.** The wheelchair-users ‘individualised’ the problems of the able-bodied, seeing them as a product of the ‘undesirable’ characteristics of able-bodied people. Finkelstein is, of course, using this parable to illuminate how the biomedical model of disability individualises the problems of disabled people in a world constructed by and for the able-bodied.

**4.** The view that disability is a social construction implies that it has more to do with society than it does with biology. It also implies that what counts as being disabled would vary from one society and one time to another.

It is generally accepted today that disability involves both biological and social elements. Physical and sensory impairments clearly entail biological factors, and the more severe these are, the greater the level of disability. However, it is also clearly true that society can either enable or disable people with impairments according to how it is organised and, in this sense, disability is socially constructed. For example, it can construct an environment that is disability-friendly in terms of access to buildings, entertainment, sport and transport systems. Both the state and the mass media could tackle prejudice and discrimination against disabled people and in so doing help to reduce differences in the way the disabled are seen and treated compared with the able-bodied.

In relation to mental illness, also recognised in legislation as a form of disability, however, there is still considerable debate about the exact nature of this phenomenon, with some arguing that ultimately all mental illnesses will be seen to have a biological basis and some others arguing that mental illness is entirely a social construct – as in Szasz’s contention that mental illness is a ‘myth’. This debate is far from settled.

p.322 Check your understanding

**1.** Morbidity is essentially any form of ill health.

**2.** Disablism refers to a set of beliefs and social practices that treat disabled people as inferior and which create barriers that prevent disabled people from being fully socially included.

**3.** ‘Reflexive mobilisation’ refers to attempts made by people to mobilise resources to change their bodies in response to what they perceive - through self-reflection - as deficiencies. This might involve, for example, working out at the gym, cosmetic surgery, tattooing, dieting and so on.

**4.** The biomedical model of health is a natural science based medical theory and practice which focuses on the internal workings of the body. In this model, ill health is a product of specific, usually objectively identifiable, causes such as bacteria, viruses or accidents. Ill health is a universal and absolute condition, not a social construct: either you are well or you are unwell and this would be true whatever the society or historical period. Medical professionals are the appropriate people to deal with serious ill health.

**5.** The ‘clinical iceberg’ is a product of a) the fact that some people who are sick don’t recognise that they are, b) that some people who recognise they are sick don’t seek help from medical professionals (e.g. they self-medicate), and c) they seek help from medical professionals, but the professionals fail to identify what’s wrong or think that they are hypochondriacs or malingerers. Consequently these groups are not included in official definitions and statistics of those experiencing illness.

**6.** Lay people’s understanding of health and ill health is shaped by a range of social influences including, family, education (including health education campaigns), peer groups, religion, the media and commercial interests. There can be few people today, for example, who are unaware that smoking has deleterious health consequences, but this was not the case until the early 1950s when Sir Richard Doll established a clear causal connection between smoking and lung cancer. Age is another social influence, for example, young people subscribe to very different ideas as to what is ‘fit’ or ‘healthy’ compared with the elderly. The latter group is also likely to put up with pain than visit their doctor compared with younger people. Class may also be a factor – the evidence suggests middle-class people feel comfortable in the presence of doctors and therefore confidently seek their help when ill. Working-class people may be reluctant to report illness because (a) they cannot afford to take time off work for fear of losing their jobs (b) they feel patronised by middle-class doctors and (c) and if they are men, they may see seeking the help of a doctor as a sign of weakness.

**7.** A ‘stigma’ is something which is seen as socially discrediting, that is, a negative label that highlights deficiency. Whenever people possess characteristics or behave in ways perceived to be ‘abnormal’ they carry the risk of being stigmatised, for example because they are abnormally fat or short. Hence, people with physical, sensory or intellectual impairments may experience stigmatisation because they are seen as ‘abnormal’.

**8.** Parsons suggested that one can usefully analyse the social situation of someone who is unwell using role theory. From this perspective, being sick involves occupying a particular social status and, like any social status, there is an associated set of rights and duties – the sick role. Thus, for example, someone who is sick has the right to be excused normal social obligations such as work, but also the duty to do what their doctor tells them to do to get better. Likewise, their doctor assumes certain obligations too such as the duty to keep the patient’s condition confidential and to refer them to specialists who can assist their recovery. Failure to conform to this sick role is a type of social deviance.

**9.** The biomedical and social constructionist perspectives on health and illness are essentially oppositional. From a biomedical perspective, health and ill health are incompatible categories or binary opposites: one cannot be both at the same time. Moreover, they are objectively verifiable categories that hold true universally (i.e. irrespective of time and place). From a social constructionist perspective, on the other hand, what counts as ‘healthy’ or ‘sick’ is a matter of social definition and can and does vary historically and cross-culturally.

Both positions are defensible. Homosexuality, for example, was seen as a mental illness for much of the 20th century, but neither the APA nor the WHO classify it in this way today. On the other hand, it is difficult to imagine any society at any period of history viewing, for example, gangrene as healthy.

(Note: it is important not to confuse social constructionist with social causation approaches. Not all sociologists embrace a social constructionist view of health and ill health. Some accept that many if not most medical conditions are objectively real, but are interested in examining how social factors influence the social distribution of these medical conditions.)

**10.** The view that no universal definition of the ‘normal’ human body can or does exist, raises similar issues to those explored in the answer to Q9 above.

Medical science, by necessity, has to operate with a notion of what constitutes normal (‘healthy’) bodily functioning since illness equates to abnormality of functioning. Medicine only has a view about bodily *appearance* in so far as the appearance may be symptomatic of some underlying pathology.

For social constructionists, just as what counts as health or ill health is socially and historically variable, so too is what counts as normal in terms of the body’s appearance – let alone what is seen as ideal! For example, what would have been normal in terms of height in the past wouldn’t be normal today: recent research suggests that the average British male is 4 inches taller today than 150 years ago.

Social constructionists have raised interesting questions about how certain physical conditions are evaluated and who is doing the judging. For example, short-sightedness is a condition that is experienced by a large section of the population. However, this disability is generally not stigmatised in the same way as other disabilities although if you wear glasses, especially when a child, you might have been subjected to some mild abuse or bullying. Sociologists working in the health field are interested in why some physical conditions are defined as unhealthy and problematic and others are not, for example, consider the social reaction to being hungover.

The word ‘normal’ also carries evaluative connotations: normal is seen as good, abnormal is seen as bad (or ‘deviant’). So ideas about ‘normal’ human bodies often get mixed up with what is good/bad, desirable/undesirable and so on. This can be illustrated by thinking about ‘fatness’. In statistical terms, it is now normal for people in the UK to be overweight. Currently, over 60 per cent of adults are overweight or obese. Yet, being fat is socially stigmatised.

In recent years a ‘fat acceptance’ movement has sought to tackle the prejudice experienced by fat people in society and related discriminatory behaviour (e.g. the recent – despicable, if one may be allowed to make a value-judgement - phenomenon of ‘fat shaming’ on the London underground). Yet, from a biomedical point of view, obesity is a real medical issue which carries increased risks of Type 2 diabetes, heart disease, various cancers, arthritis, sleep apnoea, etc.

It turns out, then, that this question raises some quite complex issues. But, to put it simply, whether there can be a universal definition of the normal human body depends crucially on what is meant by ‘normal’.

**5.2 HEALTH INEQUALITIES: CLASS, ETHNICITY AND REGION**

P.325 Focus on skills: babies born on right side of north-south divide live years longer

**1.** The article suggests that a north south life expectancy gap of as much as 8 years exists for baby boys and around 6 years for baby girls.

**2.** Among the reasons for the increased longevity of people aged 65 and over are: advances in medical science; better nutrition; improved public health (especially with regard to the decline in smoking and greater public knowledge about the dangers of alcohol abuse and obesity) and the decline in heavy industry (and therefore industrial accidents and health problems associated with heavy industry such as Asbestosis). All of these factors mean that a child born in 2016 is likely to live a great deal longer than a child born in 1956.

**3**. The view that regional health inequalities are directly related to economic status represents a structural-materialist explanation. Basically, this view suggests that health is directly linked to income and wealth differences and that there are regional differences in social class structures. There are certainly regional inequalities associated with e.g. differences in employment opportunities and the south is certainly more affluent than the north, in general. But, of course, each region contains rich and poor people and those in-between, so there are also intra-regional inequalities. There are also geographical differences in the distribution of health care resources. It is a fact that Scotland and the North of England have fewer doctors, nurses, specialist hospitals especially those focusing on cancer and paedriatrics, and consequently longer waiting lists for operations and cancer screening.

The main alternative explanation for regional inequalities in health is the cultural-behavioural explanation. This suggests that the main cause is differences in regional cultures and their associated life styles with some being more health-promoting and others more health-damaging. Edwina Currie, a Conservative Junior Health Minister in the 1980s famously (infamously?) suggested that northerners “die of ignorance and chips”. Certainly, there are regional differences in smoking, exercise, diet, etc., but how far these operate independently of material inequalities is an open question.

P.332 focus on skills: health – a matter of personal responsibility?

**1.** The Chief Inspector of General Practice argues that too many people neglect their health and that parents too often feed their children junk food. In this sense, they are poor role models for healthy eating. This view suggests that the Chief Inspector is sympathetic to the cultural or behavioural theory of health.

**2.** The King’s Fund’s research found that people with no educational qualifications were more than 5 times as likely to engage in four key health damaging behaviours: smoking, drinking, physical inactivity and poor diets, compared to people with degrees. The cultural behavioural theory argues that the main cause of health inequality is the differences in attitudes, values, beliefs and knowledge (i.e. in culture) of different groups and their associated behaviour. To the extent that the greater levels of health damaging behaviour of the less well qualified is a product of cultural differences, this research supports the culturalist theory.

**3.** Marmot and Stern make a powerful case for the extent to which people’s social circumstances and lived experience shape and constrain both their ideas and their behaviour. Marmot emphasises how these circumstances and experiences impact on people’s capacity for agency (action based on informed choice) by affecting their sense of how much power they have over their own lives. For example if you earn less money because you are unemployed and on benefits, you may be forced to buy cheap food for yourself and your children. You may not have the resources to make healthy choices. Stern emphasises the powerful influence of commercial interests in shaping people’s behaviour, for example, through advertising and how food manufacturers use high levels of fat, sugar and salt to make their products not only palatable but addictive.

**4.** (Note: The third line of the question should read: ‘…materialist explanations of class *inequalities* in…’, not ‘ …materialist explanations of class explanations in …’.)

The structural-materialist explanation of class inequalities in health focuses on the way in which the unequal distribution of income, wealth and power shapes and constrains people’s *life chances* including their chances of enjoying good health.

Cultural behavioural explanations, by contrast, focus on people’s *lifestyles* and the degree to which these are health damaging or health promoting. Lifestyles do clearly have a significant impact on health and, to some extent, people do have a choice over the lifestyles they pursue. But these choices are heavily constrained by a range of socio-economic factors:

* Early socialisation within the family (shaping values and attitudes and beliefs)
* Education (shaping levels of knowledge and understanding in relation to health)
* Income/wealth (shaping ability to e.g. afford a healthy diet)
* Sub-cultural values and norms (shaping ideas about ‘appropriate’ ways to behave)

 And, there are factors that impact on health over which people have little or no control:

* Prenatal exposure to health-damaging factors (e.g. smoking and alcohol consumption in pregnancy)
* Housing conditions (damp, overcrowded, cold, etc.)
* Occupation (e.g. risk of injuries, level of control over work life)
* Neighbourhood (e.g. level of social cohesion, levels of crime, levels of pollution)
* Position in the class structure (e.g. low status, low self-esteem = high levels of stress; high status, high self-esteem = lower levels of stress).
* Psycho-social illnesses caused by the stress and anxiety brought on by living in poverty and debt and in poor quality housing in areas with little sense of community or belonging, high crime rates and the constant threat of violence.

P.335 Check your understanding

**1.** Life expectancy, mortality rates and infant mortality.

**2.** Smoking, poor diets, lack of exercise, binge drinking and risk taking.

**3**. Epidemiology is the study of the distribution of ill health within a population.

**4.** A ‘dysfunctional society’ is one that fails to meet the needs of the members of the society, for example, people may feel little pride in their environment and/or lack a community spirit.

**5.** An artefact is something that is ‘man-made’ (sic). The artefact explanation of health inequality argues that health inequalities don’t really exist, but are purely a product of the way in which they are measured.

**6.** The social selection explanation of social class health inequalities argues that it is not class that determines health, but health that determines class, that is, the most fit and healthy members of society are able to compete more successfully for the top jobs than those who are frequently unwell. This also implies that the middle classes are somehow genetically healthier than the working classes. One of the problems with this explanation is that health status is not particularly strongly associated with social mobility. There are many other factors that play a bigger part such as an unmeritocratic education system, wealth and poverty, cultural capital and so on.

**7.** Poverty may have a number of negative effects on diet:

* It may be associated with under-nourishment (insufficient food) and mal-nourishment (the wrong kinds of food) e.g. foods high in fat that are filling, but not nutritious
* It may mean that more expensive but healthier foods, like fruit, are not purchased.
* It may mean that unhealthy foods that provide short-term pleasure (e.g. foods with high sugar content) are consumed more.

**8.** Marxists are drawing on structural-material theories to argue that the unequal distribution of wealth in society underlies the unequal distribution of health. In capitalist societies, wealth and income is concentrated in very few hands which means that those situated at the lower end of the socio-economic hierarchy do not have easy access to the material resources which would allow them to buy healthier housing and food, to invest in private medical insurance or to live in areas with high quality medical facilities. Moreover, they are likely to be working in jobs which are in the long-term detrimental to their health and life expectancy and/or unemployed and therefore subject to the psycho-social diseases associated with the stress of being constantly worried about paying bills and feeding children.

**9.** The structural-materialist explanation of class inequalities in health focuses on the way in which the unequal distribution of income, wealth and power shapes and constrains people’s *life chances* including their chances of enjoying good health. Cultural-behavioural explanations, by contrast, focus on people’s *lifestyles* and the degree to which these are health damaging or health promoting.

Another way of describing the contrast between these two views is to talk about ‘up-stream’ and ‘down-stream’ influences. Cultural-behavioural explanations focus on the proximate (immediate) causes of health inequalities (down-stream); structural-material explanations focus on the causes of the causes (up-stream).

**10.** The psycho-social view, associated particularly with Wilkinson and Pickett, argues that it is not so much poverty that causes ill health as the existence of wide disparities in the distribution of income and wealth in societies. More equal societies are healthier societies because people generally feel a strong sense of community and belonging, less stress and less resentment at others better-off than themselves. Moreover, there is some evidence that these societies experience less crime, and people express greater happiness.

In more unequal societies there are lower levels of trust and higher levels of stress, anxiety and frustration. These psychological states affect not only mental health, but – by weakening the immune system – physical health as well.

The evidence provided by Wilkinson and Pickett in *The Spirit Level* and associated publications provides strong empirical support for this thesis.

**5.3 GENDER AND HEALTH**

P.339 FOCUS ON SKILLS: UNDERSTANDING HOW MEN EXPERIENCE, EXPRESS AND COPE WITH SYMPTOMS OF ILLNESS

**1.** The evidence in the article is the fact that men need to be more distressed before they will seek medical help and are fearful of appearing emotionally vulnerable. This fits with the idea that they have been socialised into believing that ‘real’ men are emotionally tough and undemonstrative.

**2.** The research suggests that mental health issues connected with illness may not be picked up by health professionals because they fail to recognise the different ways in which such distress is manifested in men and women. For example, men may be angry, hostile and violent while women may be tearful and open about how upset they are.

**3.** The research quoted in the article supports the view that the links between gender and help seeking are more complex than once thought because the research suggests that “both genders were hesitant to tell their doctors that they were not coping”. Moreover, the article suggests that it is health professionals who largely create gender differences in help seeking because they subscribe to stereotypical notions about the way women express both physical and mental illness, for example, they expect women to be emotionally distressed, and consequently, expressions of such distress are interpreted by medical professionals as legitimate symptoms of illness. In contrast, men do not express their distress in conventional ways and consequently health professionals may fail to diagnose them as ill.

4. Whilst data on mortality is highly reliable, this is not the case for morbidity because there are a number of problems when it comes to measuring it. This is true for both male and female rates.

In relation to males, one way of measuring it is to ask men about their experience of ill health, but if men are reluctant to acknowledge they are unwell the resulting statistics will not be valid. Another way of measuring it is to examine GP visits, but again if men see reporting illness, pain and mental distress as unmanly, they will be reluctant to visit their GP. On the other hand, measuring female illness on the basis of visiting their GP is also unreliable because women visit GPs for reasons other than illness, for example, for pregnancy tests, for contraception or to obtain treatment for babies and toddlers.

Another reason why data on male illness may be unreliable, the article suggests, is because health professionals may fail to diagnose mental health problems in males.

Overall, therefore, the claim that data on male illness rates are unreliable is probably true.

P.340 Focus on skills: teenage boys strain to meet body ideals

**1.** The article suggests that boys increasingly suffer from a) pressure to ‘bulk-up’ by using unhealthy supplements (and, though not mentioned in the article, drugs such as steroids), b) body dysmorphia and c) eating disorders.

**2.** The lack of statistics is probably due to the fact that these problems are fairly recent in origin, or – at least – have only been recently recognised. Also, most of the medical and sociological focus with regard to these conditions has been on girls rather than boys.

**3.** The article suggests that today young men are being socialised to think about their body image in the same way as women have been in the past. It is not entirely clear why this should be the case, but it is likely that advertising associated with commercial interests has played a part as, for example, cosmetics manufacturers looking to extend their market by persuading young men about the ‘importance’ of looking good. Another trend is the increasing objectification of male bodies in TV, magazines, computer games, toys and films (such as the 2012 film *Magic Mike* about male strippers and those which focus on super heroes such as Batman).

**4.** The article provides data which suggests that at present it is still females who feel under more pressure to achieve an ‘ideal’ body, with 70 per cent of girls compared with 30 per cent of boys citing their relationship with their body as their ‘No. 1 worry’.

Traditionally, girls and women were socialised to see their chief goal in life as ‘making a good catch’ (i.e. attracting a husband), whilst boys were socialised to see their main goal in life as getting a good job. Looking sexually alluring was therefore important for girls and, even though the role of employment in women’s lives has changed significantly, media focus on women’s appearance is still intense, with e.g. popular downmarket magazines highlighting celebrities with ‘cellulite’ and upmarket magazines featuring unhealthily thin catwalk models. So there is no question that many girls feel pressure to achieve the ‘ideal body’. But it appears that this particular gender gap is narrowing as boys’ bodies are increasingly subjected to similar scrutiny.

P345. Check your understanding 5.3

**1.** Statistics on women’s GP visits may provide an unreliable indicator of women’s susceptibility to ill health because some at least of these visits may have to do with women’s reproductive role rather than ill health and, since women live longer than men on average, the average rate of visits for women will inevitably be higher than it would be if men and women shared the same age profile.

**2.** Marxists argue that capitalism impacts negatively on men’s health through: industrial accidents and diseases; working on long and unsociable shifts; through feelings of powerlessness, lack of control and alienation at work and through the effects of redundancy and unemployment.

**3.** The ‘feminisation of poverty’ refers to the fact that it is women rather than men who are now more likely to be in poverty and that women’s experience of poverty is likely to be more severe than men’s.

**4.** Embodiment refers to the fact that, as human beings, we have bodies and these are not only physical objects but they have meanings. These meanings are largely a product of the culture of the society we belong to. In recent years sociologists have become increasingly interested in the topic of identity and since our identities are inextricably bound up with our bodies, the topic of embodiment has received increasing attention.

**5.** One way in which working may improve women’s health is through breaking down feelings of isolation or being imprisoned in the home, particularly through caring responsibilities.

**6.** One way in which women’s health may be negatively affected is by embracing the traditional male culture of heavy drinking as a means of relaxation after the end of the working day. There is evidence from the USA that professional women in high stress jobs are now more likely to experience heart attacks compared with the past.

**7.** The traditional social expectations surrounding men (i.e. what counts as being masculine) can be seen as having negative consequences in terms of mortality rates in a number of ways. For example:

* If men are expected to be daring they are more likely to engage in risky behavior e.g. extreme sports, driving fast, being careless of their safety, etc.
* If men are expected to be strong, both physically and mentally, and not show emotion they may conceal feelings of sadness or inadequacy and delay seeking health care or even fail to access health care at all. This may be associated with higher rates of mortality including suicide.
* If men are expected to be stoical, they may use drink and drugs to self medicate which may also lead to higher mortality rates.

**8.** Bernard found that married women were less healthy than single women and that full time housewives were less healthy than women employed full time. She therefore argued that marriage makes women sick.

**9.** Materialist and Marxist theories of gender inequalities in health are similar in that both focus on economic influences on health. The key difference is that for Marxists it is a particular set of economic arrangements – those associated with capitalism – that is crucial.

**10.** The key issues are:

* Since women outlive men in virtually all societies it is likely that biological differences play a part. However, as the size of the gender life-expectancy gap varies cross-culturally and historically, biology can’t be the whole story.
* It is unclear whether men or women suffer from more ill health, statistics that suggest ‘women get sicker’ could be a consequence of the way the statistics are collected.
* There are various possible explanations for women’s greater longevity and for the distribution of ill health associated with gender. These are cultural-behavioural, structural-materialist (including Marxist), psycho-social and differential health care. Each has strengths and limitations.

**5.4 INEQUALITIES IN ACCESS TO HEALTH CARE IN CONTEMPORARY SOCIETY**

P.351 Focus on skills: chummy young doctors are bad for your health

**1.** The evidence that professional boundaries are becoming blurred for some doctors and patients comes from a survey of 338 oncologists (doctors who specialise in the treatment of tumours) under the age of forty which found that 50 per cent had given their patients their personal mobile phone numbers, 20 per cent had accepted social invitations and 14 per cent had accepted them as ‘friends’ on Facebook.

**2.** The researchers suggest that growing up in a ‘cyber-world’ was the cause of this blurring because communication on-line and via social media tends to be far less formal than traditional means of communication e.g. e-mails tend to start with ‘Hi’, letters with the more formal ‘Dear …’.

**3.** GPs, either by birth or occupational socialisation and status, are middle class. Consequently they are likely to find it easier to relate to middle class patients who are likely to share values, beliefs, attitudes, linguistic styles and interests in common. Moreover, research suggests that middle-class patients are more confident about conversing with their GPs, using medical terms and negotiating treatment plans with them. As a result they are more likely to ‘have a voice that will be heard’ than working class patients. In other words, they are more likely to have the cultural and social capital which makes the interaction with their doctor beneficial. Working class patients are less likely to have this cultural or social capital, and consequently interaction with their doctor may be less qualitative.

P.357 Check your understanding

**1.** a) failure to provide health information in minority languages, b) failure to provide culturally sensitive services (e.g. female doctors for Muslim women), c) differential treatment of White and African-Caribbean mental health patients.

**2.** Misallocated funding and the preferences of doctors (to work in more affluent areas).

**3.** ‘Pluralism’ is a social theory which argues that there are many – plural – centres of power in society and the job of the state is to mediate between these multiple interest groups, for example, managers, health professionals (further subdivided into surgeons/consultants, junior doctors, nurses and para-professionals) and patients and pursue policies that are in the interest of people as a whole.

**4.** ‘Marketisation’ refers to organising NHS services so that they resemble as closely as possible the way goods and services are provided through a market, where providers compete with each other to attract the custom of consumers. Markets in the NHS are more accurately referred to as quasi-markets because patients don’t ‘buy’ NHS services from providers, instead these services are commissioned from providers by local Clinical Commissioning Groups.

**5.** The ‘inverse prevention law’ is a term that appeared in the Acheson Report (1998) and refers to the situation where NHS preventative health services (such as screening facilities) are least available where they are most needed.

**6**. When the NHS was launched by the then minister of health, Aneurin Bevan, on July 5 1948, it was based on three core principles:

* that it meet the needs of everyone equally
* that it be free at the point of delivery
* that it be based on clinical need, not ability to pay

**7.** The NHS may discriminate against the elderly by treating them less favourably than other age groups e.g. by limiting screening or treatment to younger age groups, by patronising them or by treating them in undignified and disrespectful ways.

**8.** The middle class make more use of the NHS because they are more knowledgeable about the services available, more confident in dealing with medical professionals, are more likely to have a car making it easier to access services and are unlikely to lose pay if they visit NHS services during the working day.

**9.** There is a chicken and egg issue here: do gender differences in the *provision* of NHS services result from gender differences in the *demand* for services or does the demand for services depend on the provision? For example, according to the Mental Health Foundation, women are more likely to be **treated** for a mental health problem than men: 29 per cent compared to 17 per cent, but is this because more women actually suffer from mental health problems or more of the women who have mental health problems are diagnosed with these conditions? And, if the latter, is this because men are less likely to seek medical help when they have a mental health condition or because, if they do seek medical help, they are less likely to be given a mental health problem diagnosis?

There is also a lack of agreement amongst sociologists whether NHS provision for women is more generously funded or less generously funded than that for men.

 Consequently, one needs to be very cautious in generalising about this aspect of NHS provision.

**10.** The view that the organisation and funding of the NHS are just as important a cause of health inequalities as lifestyle or poverty is based on Tudor Hart’s ideas that there exists an inverse care law with regard to funding and provision of key health services. For example, it can be argued that the relatively poor health and life expectancy experienced by people in the North of the UK compared with those who live in the South is partly caused by the fact that the North receives less NHS investment than the South and that consequently there is a shortage of doctors, hospital beds and specialist services in the areas that need these the most.

However, Tudor Hart’s explanation only partly explains health inequalities in the UK. Other valid explanations can be found in the theories of material deprivation, Marxism, and Wilkinson and Pickett’s psycho-social theory. Funding inequality is a significant cause of health inequality, but so is the idea that poverty shapes lifestyle in very negative unhealthy ways.

**5.5 THE NATURE AND SOCIAL DISTRIBUTION OF MENTAL ILLNESS**

P362/3 Focus on skills: researching ADHD

**1**. Attention Deficit Hyperactivity Disorder (ADHD) is characterised by an inability to concentrate, impulsive behaviour and social awkwardness. In the UK, the NHS estimates that it affects between 2 and 5 per cent of school age children and three times as many boys as girls. It can continue into adulthood.

**2.** There are a number of possible reasons why parents and schools might be happy to accept that ADHD is a real condition:

* It relieves them from any blame for their children’s/pupils’ behaviour
* It provides a medical explanation for troubling and challenging behaviour, thereby helping to de stigmatise it
* It offers the prospect of treatment for this behaviour

**3**. The article focuses on the views of Dr Richard Saul who argues that the condition does not exist and that the symptoms associated with it are caused by more than 20 separate conditions. Saul is happy to accept that among the ‘real’ causes are disorders such as depression and bipolar disorder (what used to be known as manic depression). This is quite different from the view of Thomas Szasz for whom mental illness simply doesn’t exist. Szasz described the prescribing of Ritalin to children without their permission as a form of child abuse.

ADHD has been, and continues to be, a controversial medical condition, both in terms of whether it is a real syndrome and, if it is, what causes it. Controversy also surrounds the use of a drug, Ritalin, which is commonly used to treat it.

 Supporters argue that:

* ADHD is a real medical condition
* It is not a product of poor parenting – one child in a family can have ADHD when their siblings don’t
* Professor Hill – a child psychiatrist at Great Ormond St Hospital argues that: “...we are not medicating with mind-bending drugs, but treating with mind-*un*bending drugs.” (Guardian, 30/07/03)

 Critics argue that:

* At best, ADHD is being over-diagnosed
* At worst, normal variations in children’s behaviour and temperament are being regarded as evidence of mental disorder. These children are troubled, not sick.
* It is wrong to give children powerful psychoactive drugs with known possible negative side-effects

An early critic was the sociologist Steven Box (New Society, 01/12/77). He described the prescribing of Ritalin for ‘difficult’ children as nothing short of scandalous: “What they need is not drug therapy, but the opportunity to live their lives more fully.”

More recently the neurobiologist Steven Rose expressed similar views in 2003 (Red Pepper, Dec., 2003). Rose argued that an increasing number of social problems are being dealt with by medicine (i.e. they are being ‘medicalised’). Medication might alleviate the ‘symptoms’, but it leaves the underlying (social) causes unaddressed: “We are approaching a psycho-civilised society in which social tranquillity will be achieved not by changing the world, but by tailoring the mind.”

In conclusion, whilst ADHD is listed in both the WHO’s ICD10 and in the APA’s DSM IVR, it remains a contentious diagnostic label.

P.367 Check your understanding

**1.** Goffman found that some inmates accepted the ‘mentally ill’ label; some withdrew into themselves; some ‘played it cool’ by pretending to go along with the psychiatrists and nurses and some became institutionalised.

**2.** Busfield distinguishes between: disorders of thought (e.g. psychoses); disorders of emotion (e.g. neuroses) and disorders of behaviour (e.g. alcohol and drug dependence).

**3.** The ‘life-course model’ of mental illness argues that levels of mental illness are higher among the poor because the cumulative effect of the many stresses and setbacks they experience in their lives eventually overwhelms them and they become mentally ill.

**4.** ‘Social capital’ refers to the quality and quantity of connections people have with others. The greater the number and the deeper the connections, the greater someone’s social capital.

**5.** High social capital may prevent mental illness because it means that people have a wide support network and are unlikely to feel isolated and lonely.

**6.** Rosenhan’s experiments provide strong supporting evidence for labelling theory because they suggest that, once someone is labelled mentally ill, their behaviour – whatever form it takes – will be perceived as confirming the label.

**7.** Szasz concluded that mental illness doesn’t really exist – it is mythical – because when someone is diagnosed as ‘mentally ill’ there are no clear cut, objective biological or physical symptoms that can be pointed to. For Szasz, labelling bizarre or distressing states of mind as ‘illnesses’ represented what he called a ‘category-error’: they were not illnesses, but ‘problems of living’ as he put it.

**8.** The social realist perspective accepts that mental disorders are real even if their expression may vary between cultures and even if people who behave in deviant ways are sometimes wrongly diagnosed as mentally ill. Social realists therefore tend to support the view that the distribution of mental illness in a population is a product of social causes and to reject the view of social constructionists.

**9**. Labelling theory argues that (recorded) rates of mental illness are artefactual, that is they are a product of the application of medical labels to people who display troubling or bizarre behaviour or who are distressed in some way.

Critics argue that a major weakness of this perspective is that it cannot explain the origins of the behaviour or mental distress that is subsequently labelled, and that variations in rates of mental illness amongst groups are a product of the different social locations and lived experience of different groups in society.

**5.6 The role of medicine, the health professions and the globalised health industry**

P.372 Focus on skills: medics admit they don’t act in patients’ best interests

**1.** The evidence in the article which suggests that doctors do not always act in the best interests of their patients comes mainly from a survey of 550 doctors and medical students. Only 1 in 5 say that they can always act in their patients’ best interests and over 90 per cent say their job makes it hard to treat patients in a way they believe is right or involves tasks that conflict with their moral values. Additionally, it is alleged that doctors at Stafford Hospital failed to protest as patients were neglected to meet financial targets.

**2.** Members of the medical profession are widely believed to take a Hippocratic Oath (named after the Greek physician Hippocrates), but this is no longer the case.

In fact, they simply agree to abide by the principles of good medical practice, as defined by the General Medical Council. These state that: “Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and make sure your practice meets the standards expected of you in four domains: Knowledge, skills and performance; Safety and quality; Communication, partnership and teamwork and Maintaining trust” (GMC, 2015).

Doctors are then expected to ‘observe a strict code of ethics that work in favour of the patient’ and trust in doctors amongst the general public remains high. In the latest (2015) MORI poll on levels of public trust, doctors remain clearly the most trusted profession, with 90 per cent trusting them to tell the truth (compared to 16 per cent who trust politicians).

Illich (1976) certainly took a more jaundiced view of the medical profession. He believed that institutionalised medicine did more harm than good: “Doctor inflicted pain and infirmity have always been a part of medical practice. Professional callousness, negligence and sheer incompetence are age-old forms of malpractice.”

However, it needs to be noted firstly, that Illich’s main focus was the USA where medicine is much more closely intertwined with the world of commerce and, secondly, that his critique was aimed less at individual medical practitioners and more at medicine as a social institution. As such, he saw it as responsible for three kinds of *iatrogenesis* (doctor-caused harm): clinical, social and cultural.

Hence, the debate is not really about whether doctors *generally* behave ethically – which there is little reason to doubt, or, at least, there is little reason to doubt that they act any less ethically than any other profession – but about the effects of a health care system based essentially on biomedical assumptions. However, this is a complicated issue which there is not the space here to explore.

**3.** The BMA representsdoctors in the UK and, since the inception of the NHS, has been formally recognised for collective bargaining purposes within national negotiating machinery and by individual employers at local level. Moreover as the only formally recognised trade union for doctors, it certainly has some power. However, historically the evidence suggests that this power has been diminishing.

At the inception of the NHS, Aneurin Bevan, the Health Minister, complained following negotiations between the Ministry of Health and the BMA, that he had had to “stuff their (i.e. doctors’) mouths with gold” to persuade them to join the NHS. Currently (February, 2016), the BMA has had to resort to strike action in its negotiations with the DH over new contracts for junior hospital doctors (i.e. those below consultant level), the first strike in over 40 years. The fact that the BMA has had to strike is a sign of weakness, not strength, since if they were powerful their demands would have been met without recourse to industrial action.

Moreover, the various inquiries and reviews referred to in the question reveal that hospital doctors are under intense pressure as a result of funding cuts and that whistleblowers are routinely sanctioned for seeking to expose the situation in hospitals. Additionally, a survey of nearly 3000 GPs in England in February, 2016 (the *Guardian,* 03/02/2016*)* found that over two-thirds see their workload as ‘unmanageable’ some or all of the time.

It therefore appears that, far from being ‘too powerful’, the BMA today is struggling to defend its members’ interests against recent neoliberal government policies, which critics see as motivated by a desire to undermine the NHS. Elston argues that organisations such as the GMC and BMA are now subjected to pressures which mean that the ‘old professionalism’ which stressed the autonomy of doctors and the entitlement to self-regulation and internally moderated discipline is now giving way to a ‘new professionalism’ in which managers have more say in how doctors conduct themselves and doctors accept that they have to be more accountable to patients.

**4.** The view that ‘medical professionals are selfless individuals working for the good of the community’ is largely supported by functionalist perspectives on the role of the medical professions, which see them as performing a range of important social functions from caring for the sick to controlling official absences from work through the provision of ‘sick notes’.

Other sociological perspectives take less idealised views of medical professionals. For Weberians, professionalisation represents an occupational strategy designed to maximise occupational rewards. For Marxists, doctors carry out important functions in the interests of the bourgeoisie rather than the community as a whole.

Research suggests that the older generation of GPs do indeed embrace the view of medicine as a vocation and support a public service ethic. However, younger GPs are apparently motivated by obtaining ‘nice work’.

The idea that doctors are all selfless altruists is obviously naïve. They are normal people, not saints after all! For some – doctors in private practice and cosmetic surgeons, for example - financial motivations are clearly extremely important. Also, as in any profession, there are fraudsters, time-servers and, even, serial killers (Dr. Harold Shipman). Moreover, medicine is certainly a well paid profession relatively speaking, though this would be expected given that qualification as a doctor takes at least 6 years. In the end, however, the important issue sociologically is not whether doctors are ‘good’ or ‘bad’ people, any more than whether the rich are ‘good’ or ‘bad’. The crucial sociological issues are to do with groups, organisations, social institutions and power relationships in society.

P.380 check your understanding

**1.** Three ways in which professionalisation has been used as an occupational strategy by doctors: people can only practice as doctors if they are registered with the GMC; doctors do not have to follow NICE (the National Institute for Health and Care Excellence) guidance; full time consultants working in the NHS are permitted to engage in private practice (although the gross earnings from private practice for any financial year must not exceed 10 per cent of gross NHS salary).

**2.** One reason for increasing disillusionment with the medical profession is the publicity given in the media to medical errors and health scares such as those surrounding the MMR vaccine (which were later proven to be unfounded). Another, ironically, is related to the exaggerated expectations people have developed of medicine as a panacea (‘a pill for everything’) which are bound to be disappointed.

**3.** ‘Altruism’ refers to the principle and practice of working selflessly for the good of others.

**4**. ‘Discourse’ is an important concept in social constructionism. Burr (2003) suggests that it refers to a set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events.

**5.** ‘Proletarianisation’ is a Marxist concept which refers to an (alleged) process in which people in middle class jobs experience a decline in status and working conditions so that their jobs are more like those of the traditional working class or proletariat.

**6.** Friedson (1994) argues that doctors have greater discretion about how they carry out their jobs than other health workers due to the legal rights enshrined in their occupational contracts. However, the differences have been significantly eroded since the mid-nineties as a result of the introduction of medical audits, target setting and increased powers for some other health professions.

**7.** The NHS is dependent on overseas recruits because it cannot fill all the vacancies with native recruits, partly because enough haven’t been trained, partly because so many have left because of the stressful nature of the work and partly because of emigration by native qualified practitioners.

**8.** Barber believes doctors are ‘good for society’ because their practice is based on medical science, they are recruited meritocratically, their practice is legally regulated by the GMC and they are bound by strict ethical codes of conduct.

**9.** The global pharmaceutical industry seeks to influence doctors to prescribe their products by a range of methods that fall short in terms of ethical standards, such as: inadequate randomisation and lack of blinding of clinical trials, manipulation of trial results, failure to publish full results of clinical trials, marketing of drugs to doctors and the invention of new diseases (such as female sexual dysfunction).

**10.** Both Marxists and feminists emphasise the role of health professionals as agents of social control. Functionalists recognise this role, but do not see it as the main one.

For both functionalists and Marxists, health professionals help to police the boundary between the genuinely sick and malingerers/hypochondriacs, though the putative beneficiaries are different: ‘society’ for functionalists; ‘capitalists’ for Marxists. For Marxists, they also help to legitimate capitalism by mystifying the role of structural factors in shaping patterns of morbidity and mortality and emphasising immediate biomedical causes.

For feminists, health professionals allegedly help to reinforce patriarchal structures by the way they treat female patients and damage women through the ‘unnecessary’ medicalisation of female concerns such as pregnancy, childbirth and the menopause.

Critics of Marxist views argue that if doctors are agents of business interests, they aren’t very conscientious ones: the Coalition government’s Independent Review into Sickness Absence (2011) criticised GPs for being far too willing to sign workers off for extended periods, and many doctors are only too aware of the cultural and structural causes of ill health, but are not in a position to alter them.

Feminist views have been undermined by the significant change over the last 20 or 30 years in the gender composition of the health professions e.g. since the early nineties, more than half of all new medical students have been female. Moreover, the medical profession has itself raised questions about the growth of medicalisation. For example, in 2002, the BMJ devoted a whole edition to an examination of the question “Too much medicine?”

Hence, the view that the main function of the health profession is the social control of the population may be an exaggeration.