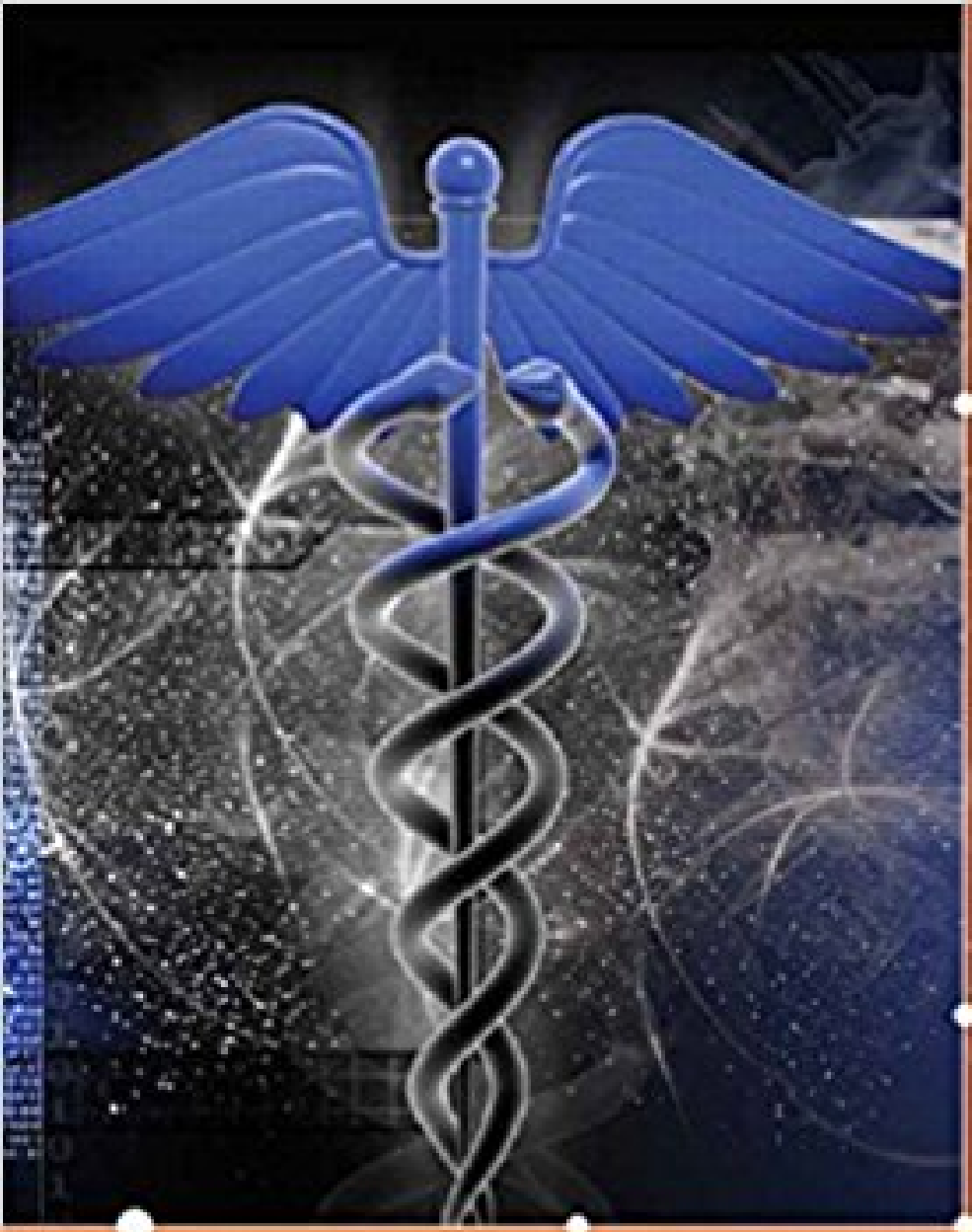

THIRTEENTH EDITION

Medical SOCIOLOGY

WILLIAM C. COCKERHAM

Thirteenth Edition

Medical Sociology

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DEDICATION

To Cynthia, and to Geoffrey, Sean, Scott, and Laura

CONTENTS

PREFACE

This is the thirteenth edition of a book that has been a standard text in medical sociology since it was first published in 1978—obviously a long time ago. The first edition was written on a typewriter (now permanently stored in the basement) in Champaign, Illinois, when I was a new faculty member in sociology and medicine at the University of Illinois. The work is now done on a computer and transmitted electronically to the publisher. The book has obviously stood the test of time as it has held its position for over 35 years in a competitive marketplace and changed significantly over the years as medical sociology itself has changed. This new edition is intended to address the current changes stemming from health care reform in the United States and other issues that constitute the focus of the field today, much as the previous editions discussed what was important at that time.

New to This Edition

- Coverage of Ebola, MERS, and updates on other pandemics (Chapter 1).
- Discussion of obesity as a disease (Chapter 2).
- New information on the decline of life expectancy among rural American white women (Chapter 4).
- New material on biomarkers, gene-environment interaction, and stress (Chapter 5).
- Analysis of the role of the hidden curriculum in medical schools (Chapter 10).
- Extensive review of the Affordable Care Act (Chapter 15).

Past Editions

As noted in other editions, it was an honor to have this book included on the International Sociological Association's list of "Books of the Century" in 2000. And it was 1 of only 10 Western sociology books (the others were all on theory or research methods) selected by Huaxia Publishing House in Beijing in 2000 to be translated into Chinese to meet the growing demand for sociology books in China. The translators were Yang Hui and Zhang Tuohong of Beijing Medical University. The book was also published in English in Beijing in 2005 by the Peking University Press, which further highlights the spread of medical sociology in China. Another Chinese-language version was published in Taiwan by the Wu-Nan Book Company. The book has also been translated into Spanish by Lourdes Lostao of the University of Navarra in Spain and published by Pearson in Madrid. Hojin Park, M.D., translated a Korean edition published in Seoul by ACANET. The growth in translations and readership signals the increasing interest in medical sociology on a global scale.

The Growth of Medical Sociology

The field of medical sociology has undergone considerable modification since the first edition. At that time, much of the research in medical sociology was dependent upon the sponsorship of physicians. A clear division of labor existed between sociologists working in academic departments in universities and those working in health institutions. Today, that situation has changed dramatically. Medical sociology is no longer dependent on the medical profession for funding or focus—although a strong alliance continues to exist in many cases. Having experienced sponsorships and partnerships with medicine in joint faculty positions at the University of Illinois at Urbana-Champaign, and later at the University of Alabama at Birmingham, I can personally attest to and appreciate medicine's significant role in the development of medical sociology. In many ways, this relationship has been more supportive than that of the general discipline of sociology, which did not fully embrace the field until it became too important to ignore.

Medical sociologists now exercise their craft in a variety of settings, as full-fledged professionals, often working as colleagues on research projects with professionals in medicine, public health, nursing, and other health-related fields. Furthermore, research and teaching in medical sociology, in both universities and health institutions, are increasingly similar in the application of sociological theory and usefulness in addressing problems relevant to clinical practice. In sum, medical sociology has evolved into a mature, objective, and independent field of study and work, supported by a vast literature. It constitutes one of the largest and most important subdisciplines in modern sociology.

Medical sociology has also experienced significant growth worldwide. In many countries, including the United States, Canada, Australia, Great Britain, Finland, Germany, and Singapore, medical sociologists are either the largest or one of the largest specialty groups in sociology. The European Society for Health and Medical Sociology is a large and active professional society, as are the medical sociology sections of the American, British, French, German, European, and International sociological associations. American and British medical sociologists have held joint meetings the past few years in London, Edinburgh, Boston, and Belfast, Northern Ireland.

Elsewhere, a growing and active group of medical sociologists from the French Sociological Association is gaining in strength, Canada formed a new Canadian Society for Sociology of Health (CSSH) in 2008, the Japanese Society of Health and Medical Sociology is working to further develop the field in that country and helped plan the 2014 ISA World Congress of Sociology held in Yokohama, while medical sociologists in Latin America hold regional conferences on a regular basis and have their own Spanish-language journals. The field is expanding in Russia, Eastern Europe, India, Africa, and, as noted, in China, as the importance of the subject matter for the people in those countries becomes increasingly apparent. In the meantime, the Research Committee on Health Sociology (RC 15) of the International Sociological Association, which I formerly served as president, met in Montreal in 2008; Jaipur, India in 2009; the ISA World Congress in Gothenburg, Sweden in 2010; the ISA Forum in Buenos Aires, Argentina in 2012; and the 2014 ISA World Congress in Yokohama, Japan to present research findings and network with others in the field. Numerous books, journals, college and university courses, and lecture series in medical sociology now exist in

different parts of the world; so it is obvious that medical sociology has a promising future. The publication of a new textbook, *Medical Sociology in Africa* (Amzat and Razum 2014) is evidence of medical sociology's expansion.

Since its inception, the principal goal of this book has been to introduce students to medical sociology and serve as a reference for faculty by presenting the *most* current ideas, issues, concepts, themes, theories, and research findings in the field. This edition—the thirteenth—continues this approach.

Acknowledgments

The material contained in the pages of this book is my own responsibility in terms of perspective, scope, topics, and style of presentation. Nevertheless, I am sincerely grateful to several people for their assistance in preparing the thirteen editions of this book. I would like to acknowledge the insightful comments of those colleagues who served as reviewers. For sharing their views and helping to improve the quality of this book, my appreciation goes to Lori Anderson, Tarleton State University; Melvin Barber, Florida A&M University; Paul Berzina, County College of Morris; Deirdre Bowen, University of Washington; Ann Butzin, Owens State Community College; Herbert Bynder, University of Colorado at Boulder; Christine Caffrey, Miami University (Ohio); Robert Clark, Midwestern State University; John Collette, University of Utah; Spencer Condie, Brigham Young University; Wendy Cook-Mucci, Tennessee Tech University; Morton Creditor, University of Kansas Medical Center; Norman Denzin, University of Illinois at Urbana-Champaign; Nancy DiMonte, Farmingdale State College; Karen A. Donahue, Hanover College; Barry Edmonston, Cornell University; Anne Eisenberg, SUNY-Geneseo; M. David Ermann, University of Delware; and Eliot Freidson, New York University.

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William C. Cockerham
Birmingham, Alabama

PART 1

Introduction

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CHAPTER 1

Medical Sociology

LEARNING OBJECTIVES

- Explain how social factors are important for health.
- Compare the dual nature (applied and theoretical) of medical sociology.
- Account for the emergence of new infectious diseases.

The purpose of this book is to introduce readers to the field of medical sociology. Recognition of the significance of the complex relationship between social factors and the level of health characteristic of various groups and societies has led to the development of medical sociology as a major substantive area within the general field of sociology. As an academic discipline, sociology is concerned with the social causes and consequences of human behavior. Thus, it follows that medical sociology focuses on the social causes and consequences of health and illness. Medical sociology brings sociological perspectives, theories, and methods to the study of health, illness, medical practice, and policy. Areas of investigation include the social causes of health and disease, health disparities, the social behavior of health care personnel and their patients, the social functions of health organizations and institutions, the social patterns of the utilization of health services, social policies toward health, and similar topics. What makes medical sociology important is the critical role social factors play in determining or influencing health outcomes.

The Social Determinants of Health

A major development in the study of health and disease is the growing recognition of the relevance of social determinants. The term *social determinants of health* refers to social practices and conditions (such as lifestyles, living and work situations), class position (income, education, and occupation), stressful circumstances, poverty, and economic (e.g., unemployment, business recessions), political (e.g., policies, government benefits), and religious factors that affect the health of individuals, groups, and communities, either positively or negatively. Social determinants not only foster illness and disability, they also enhance prospects for coping with or preventing disease and maintaining health. Once thought of as secondary or distant influences on health and disease, it now appears that social connections can be a fundamental cause of health problems (Link and Phelan 1995; Phelan and Link 2013). The social context of a person's life determines the risk of exposure, the susceptibility to a disease, and the course and outcome of the affliction—regardless of whether it is infectious, genetic, metabolic, malignant, or degenerative (Holtz et al. 2006). Thus, it can be claimed that "society may indeed make you sick or conversely promote your health" (Cockerham 2013a:1).

For example, in addressing the question of whether or not social factors matter to health, the National Research Council and the Institute of Medicine documented various links between social determinants and health (Woolf and Aron 2013). The most

important social factors determining health were found to be income, accumulated wealth, education, occupational characteristics, and social inequality based on race and ethnic group. These variables have direct effects on both unhealthy and healthy lifestyles, high or low risk health behavior, and on living conditions, food security, levels of stresses and strains, social disadvantages over the life course, environmental factors that influence biological outcomes through gene expression, and other connections (Cockerham 2005, 2013a, 2013b; Daw et al. 2013; Frohlich and Abel 2014; Goodman, Joyce, and Smith 2011; Phelan and Link 2013; Phelan, Link, and Tehranifar 2010; Miech et al. 2011; Montez and Zajacova 2013; Sandoval and Esteller 2012; Woolf and Aron 2013; Yang et al. 2013).

Social factors are also important in influencing the manner in which societies organize their resources to cope with health hazards and deliver health care to the population at large. Individuals, groups, and societies typically respond to health problems in a manner consistent with their culture, norms, and values. As Donald Light (Light and Schuller 1986:9) explains, "medical care and health services are acts of political philosophy." Thus, social and political values influence the choices made, institutions formed, and levels of funding provided for health. It is no accident that the United States has its particular form of health care delivery and other nations have their own approaches. Health is not simply a matter of biology but involves a number of factors that are cultural, political, economic, and—especially—social in nature. It is the social aspects of health that are examined in this book.

The Development of Medical Sociology

The earliest works in medical sociology were undertaken by physicians and not by sociologists who tended to ignore the field. John Shaw Billings, organizer of the National Library of Medicine and complier of the *Index Medicus*, had written about hygiene and sociology as early as 1879. The term *medical sociology* first appeared in 1894, in a medical article by Charles McIntire on the importance of social factors in health. Other early work by physicians included essays on the relationship between medicine and society in 1902 by Elizabeth Blackwell, the first woman to graduate from an American medical school (Geneva Medical College in New York), and James Warbasse who wrote a book in 1909 called *Medical Sociology* about physicians as a unique social class. Warbasse also organized a Section on Sociology for the American Public Health Association in 1909 that lacked sociologists and was comprised almost entirely of physicians and social workers (Bloom 2002).

It remained for Michael Davis and Bernard Stern to publish books on health with a sociological perspective. Davis published *Immigrant Health and the Community* in 1921 and Stern's book appeared in 1927, titled *Social Factors in Medical Progress.* A few publications followed in the 1930s, such as Lawrence Henderson's 1935 paper on the physician and patient as a social system that subsequently influenced Talcott Parsons's important conceptualization of the sick role years later. Henderson was a physician and biochemist at Harvard, who became interested in sociological theory and changed careers to teach in the new sociology department when it was formed in the early 1930s (Bloom 2002). Parsons was one of his students.

Medical sociology did not begin in earnest until after World War II, in the late 1940s, when significant amounts of federal funding for sociomedical research first became available. Under the auspices of the National Institute of Mental Health, medical sociology's initial alliance with medicine was in psychiatry. A basis for cooperation between sociologists and psychiatrists existed because of earlier research in Chicago in 1939 on urban mental health, conducted by Robert Faris and H. Warren Dunham. A particularly significant cooperative effort that followed was the publication in 1958 of *Social Class and Mental Illness: A Community Study* by August Hollingshead and Frederick Redlich. This landmark research, conducted in New Haven, Connecticut, produced important evidence that social factors could be correlated with different types of mental disorders and the manner in which people received psychiatric care. Persons in the most socially and economically disadvantaged segments of society were found to have the highest rates of mental disorder in general and excessively high rates of schizophrenia—the most disabling mental illness—in particular. This study attracted international attention and is considered one of the most important studies of the relationship between mental disorder and social class. The book played a key role in the debate during the 1960s, leading to the establishment of community mental health centers in the United States, as did other significant joint projects involving sociologists and psychiatrists, such as the Midtown Manhattan study of Leo Srole and his colleagues (1962).

Funding from federal and private organizations also helped stimulate cooperation between sociologists and physicians, with regard to sociomedical research on problems of physical health. In 1949, the Russell Sage Foundation funded a program to improve the utilization of social science research in medical practice. One result of this effort was the publication of *Social Science in Medicine* (Simmons and Wolff 1954). Other work sponsored by the Sage Foundation came later, including Edward Suchman's book *Sociology and the Field of Public Health* (1963). Thus, when large-scale funding first became available, the direction of work in medical sociology in the United States was toward applied or practical problem solving rather than the development of a theoretical basis for the sociological study of health.

This situation had important consequences for the development of medical sociology. Unlike law, religion, politics, economics, and other social institutions, medicine was ignored by sociology's founders in the late nineteenth century because it did not shape the structure and nature of society. Karl Marx's collaborator Friedrich Engels (1973) linked the poor health of the English working class to capitalism in a treatise published in 1845, and Emile Durkheim (1951) analyzed European suicide rates in 1897. However, Durkheim, Marx, Max Weber, and other major classical sociological theorists did not concern themselves with the role of medicine in society. Medical sociology did not emerge as an area of study in sociology until the late 1940s and did not reach a significant level of development until the 1960s. Therefore, the field developed relatively late in the evolution of sociology as a major academic subject and lacked statements on health and illness from the classical theorists. Consequently, medical sociology came of age in an intellectual climate far different from sociology's more traditional specialties, which had direct links to nineteenth- and early twentieth-century social thought. As a result, it faced a set of circumstances in its development different from that of most other major sociological subdisciplines.

A circumstance that particularly affected medical sociology in its early development was the pressure to produce work that can be applied to medical practice and the formulation of health policy. This pressure originated from government agencies and medical sources, both of which either influenced or controlled funding for sociomedical research but had little or no interest in purely theoretical sociological work. Yet the tremendous growth of medical sociology, in both the United States and Europe, would have been difficult without the substantial financial support for applied studies provided by the respective governments. For example, in the United States, where medical sociology has developed most extensively, the emergence of the field was greatly stimulated by the expansion of the National Institutes of Health in the late 1940s. Particularly significant, according to Hollingshead (1973), who participated in some of the early research programs, was the establishment of the National Institute of Mental Health, which was instrumental in encouraging and funding joint social and medical projects. "It was through the impetus provided by this injection of money," notes Malcolm Johnson (1975:229), "that sociologists and medical men changed their affiliations and embraced the field of medical sociology." When Alvin Gouldner (1970) described the social sciences as a well-financed government effort to help cope with the problems of industrial society and the welfare state in the West during the post–World War II era, medical sociology was a prime example.[1]

Parsons

However, a critical event occurred in 1951 that oriented American medical sociology toward theory. This was the appearance, in 1951, of Talcott Parsons's book *The Social System.* This book, written to explain a relatively complex structural-functionalist model of society, in which social systems are linked to corresponding systems of personality and culture, contained Parsons's concept of the sick role. Unlike other major social theorists preceding him, Parsons formulated an analysis of the function of medicine in society. Parsons presented an ideal representation of how people in Western society act when sick. The merit of the concept is that it describes a patterned set of expectations defining the norms and values appropriate to being sick, for both the sick person and others who interact with that person. Parsons also pointed out that physicians are invested by society with the function of social control, similar to the role provided by priests and the police, to serve as a means to control deviance. In the case of the sick role, illness is the deviance, and its undesirable nature reinforces the motivation to be healthy.

In developing his concept of the sick role, Parsons linked his ideas to those of the two most important classical theorists in sociology—Emile Durkheim (1858–1917) of France and Max Weber (1864–1920) of Germany. Parsons was the first to demonstrate the controlling function of medicine in a large social system, and he did so in the context of classical sociological theory. Having a theorist of Parsons's stature rendering the first major theory in medical sociology called attention to

[1]For historical discussions of the development of medical sociology, see Samuel Bloom (2002), William Cockerham (2001, 2013a, 2013b), and Fran Collyer (2012).

the young subdiscipline—especially among academic sociologists. Not only was Parsons's concept of the sick role "a penetrating and apt analysis of sickness from a distinctly sociological point of view" (Freidson 1970b:62), but also it was widely believed in the 1950s that Parsons and his students were charting a future course for all of sociology through the insight provided by his model of society.

However, this was not the case, as Parsons's model was severely criticized and his views are no longer widely accepted. Nevertheless, he provided a theoretical approach for medical sociology that brought the subdiscipline the intellectual recognition it needed in its early development in the United States. This is because the institutional support for sociology in America was in universities, where the discipline was established more firmly than elsewhere in the world. Without academic legitimacy and the subsequent participation of such well-known, mainstream academic sociologists in the 1960s, such as Robert Merton, Howard Becker, and Erving Goffman, all of whom published research in the field, medical sociology would lack the early professional credentials and stature it currently has in both academic and applied settings. Parsons's views on society may not be the optimal paradigm for explaining illness, but Parsons was important in the emergence of medical sociology as an academic field.

Practical Application versus Theory

The direction initially taken by medical sociology is summarized by Robert Straus (1957). Straus suggested that medical sociology was divided into two separate but closely interrelated areas—sociology *in* medicine and sociology *of* medicine.

The sociologist in medicine is one who collaborates directly with physicians and other health personnel in studying the social factors that are relevant to a particular health problem. The work of the sociologist in medicine is intended to be directly applicable to patient care or to the solving of a public health problem. Some of the tasks are to analyze the social etiology or causes of health disorders, the differences in social attitudes as they relate to health, and the way in which the incidence and prevalence of a specific health disorder is related to such social variables as age, sex, socioeconomic status, racial/ethnic group identity, education, and occupation. Such an analysis is then intended to be made available to health practitioners to assist them in treating health problems. Thus, sociology in medicine can be characterized as *applied research and analysis primarily motivated by a medical problem*, rather than a sociological problem. Sociologists in medicine usually work in medical schools, nursing schools, public health schools, teaching hospitals, public health agencies, and other health organizations. They may also work for a government agency, such as the U.S. Department of Health and Human Services or the Centers for Disease Control and Prevention, in the capacity of biostatisticians, researchers, health intervention planners, and administrators.

The sociology *of* medicine, however, has a different emphasis. It deals with such factors as the organization, role relationships, norms, values, and beliefs about health as a form of human behavior. The emphasis is on the social processes that occur in health-related situations and how these contribute to our fund of knowledge on medical sociology in particular and to our understanding of social life in general. The sociology of medicine shares the same goals as all other areas of sociology and

may consequently be characterized as *research and analysis of the medical or health environment from a sociological perspective.* Most sociologists of medicine are employed as professors in the sociology departments of universities and colleges.

However, problems were created by the division of work in medical sociology into a sociology of medicine and a sociology in medicine. Medical sociologists who were affiliated with departments of sociology in universities were in a stronger position to produce work that satisfied sociologists as good sociology. But sociologists in medical institutions had the advantage of participation in medicine, as well as research opportunities unavailable to those outside medical settings. Tension began to develop between the two groups over whose work was more important. This situation resolved itself as two major trends emerged to significantly reduce differences among medical sociologists. First, an evolution has taken place in medical sociological work generally toward research relevant to health practitioners and policymakers. This development is largely because of the willingness of government agencies and private foundations to fund only health-related research that can help solve problems or improve health conditions. Regardless of whether a medical sociologist works in a health care or academic setting, today much of the research in the field deals with topics that have practical utility. Moreover, many of the better studies, including those in medical settings with a practical focus, also use sociologically based theoretical models to illustrate the utility of their findings.

Second, a growing convergence among medical sociology and the general discipline of sociology took place. This situation is aided by the fact that all sociologists share the same training and methodological strategies in their approach to research. Theoretical foundations common throughout sociology are increasingly reflected in medical sociological work (Cockerham 2001, 2005, 2013a, 2013b, 2013c; Cockerham and Scambler 2010; Collyer 2012; De Maio 2010; Frohlich, Corin, and Potvin 2001; Karlsen and Nazroo 2002; Scambler 2002, 2012; Thoits 2011), while many health issues investigated by medical sociologists call for knowledge of social processes outside of the sociomedical realm. For example, studies of health reform may require consideration of the larger sociological literature on social change, political power, class, and the welfare state, while research on job-related stress requires familiarity with occupational structures. Therefore, as Bernice Pescosolido and Jennie Kronenfeld (1995:24) point out, medical sociologists "need to understand the general nature of social change and social institutions—to recognize, describe, and draw from these changes and institutions implications for health, illness, and healing." Thus, much of the future success of medical sociology is linked to its ability to utilize the findings and perspectives of the larger discipline in its work and to contribute, in turn, to general sociology.

While the division of medical sociology, as outlined by Straus (1957), has lost its distinctiveness in the United States, it never really developed elsewhere in the world. The difference was that in the United States, medical sociology was entrenched early in the universities and elsewhere it was much slower to be university-based, thereby avoiding the schism. By the 1940s and 1950s, several major American sociology departments, including Harvard, Yale, Columbia, and Chicago, offered courses in medical sociology, whereas in Britain, Germany, and other European countries, as well as in Australia, the field was largely centered in medical institutions at this time (Bloom 2002; Collyer 2012). Today, in comparison to the past, medical sociology has