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**MODULE PREPARED**

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# 1.Introduction and definitions

Health refers to the extent of a person’s physical, mental, and social well-being. This definition, taken from the World Health Organization’s treatment of health, emphasizes that health is a complex concept that involves not just the soundness of a person’s body but also the state of a person’s mind and the quality of the social environment in which she or he lives. The quality of the social environment in turn can affect a person’s physical and mental health, underscoring the importance of social factors for these twin aspects of our overall well-being.

Adults who are socially active live longer and are healthier than their more isolated peers.  
Social relationships are vital to maintaining good health. Conversely, social isolation creates health risks. Studies have shown that for patients with coronary artery disease, social isolation creates added risk of death. Recent evidence suggests a link between poor social ties and severe conditions such as cardiovascular disease, hypertension and cancer.

Many people (including students of sociology) often wonder about the relevance of social sciences (especially sociology) to health issues. In general, it is often a challenge to discuss the nexus between social science and health. Why medical sociology? What does sociology have to do with medicine or health? This module aims to answer these questions. It starts with the meaning of sociology and its links to health studies—a definition and brief history of medical sociology and topic description of the discipline. All health problems are conceived as social problems, which are the core focus of sociological studies. This module explains the characteristics of social problems with regard to health issues. Health problems are viewed as parts of social pathologies by advancing the sociological dimensions of health problems. The chapter then attempts to re-explain the topical description of medical sociology (first advanced by David Mechanic in 1968) and includes some current issues. The topical descriptions specifically include social aetiology of disease, cultural beliefs and social response to illness, sociology of medical care and hospitals, sociology of psychiatry, social transition and health care, traditional medicine (alternative medicine), sociology of bioethics, health policy and politics, social epidemiology, sociology of dying and death, and medical education.

Sociology has been variously defined since Auguste Comte coined the term in 1838. Simply, sociology is the study of human society and social problems. Sociology is the scientific study of social relations, institutions, and society (Smelser [1994](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR45)) . In addition, sociology can be defined as the scientific study of the dynamics of society and their intricate connection to patterns of behaviour. It focuses on social structure and how the structures interact to modify human behaviour, actions, opportunities, and how the patterns of social existence engender social problems. Social institutions include kinship, economic, political, education, and religious institutions. The institutions are like pillars that hold up society because they are the constituent parts of the social system (society). These parts are interdependent and interrelated with specialised functions towards the survival of the society. This is why the human society is often referred to as a social system. Every institution fulfils some functional imperatives. The family institution supports the procreation and socialisation of new members of society while the economic institution deals with the production and exchange of goods. The economic institution employs people from the family institutions, and the family in turn needs the goods and services produced by the economic institution. The health institutions are organised to cater to the well-being and survival of human beings.

Generally, sociology employs scientific approach to study and develops generalisations about human patterns, groupings, and behaviour. In a more concise definition, the American Sociological Association (ASA) defined sociology “as the study of social life, social change, and the social causes and consequences of human behaviour”. Social life is the most central part of the focus of sociology; it implies the connection which an individual holds with others in the society. To sociologists, social life or interaction is the essence of human existence. The process of social interaction itself may put individuals at risk of some communicable disease such as tuberculosis (TB) , severe acute respiratory syndrome (SARS) , and measles. In terms of communicable diseases, mere contact with an infected person (in the process of social interaction) can normally put others at risk. The investigation of social “causes” and consequences is basic in sociological research. There is often a problem of biomedical reductionism , assuming “only the germ causes the disease” without an interrogation of the social conditions enabling vulnerability to diseases. For instance, commercial sex work puts an individual more at risk of human immunodeficiency virus (HIV) than many other occupation groups: that is a kind of occupational condition, which is a risk factor for HIV.

Let discuss Mindful that unstable relationships can be harmful, the authors consider “The Dark Side of Social Relationships” and discuss the cumulative effect of social experience—citing health studies conducted at different stages of development (i.e., parents and children; adolescents and peers). Other topics include: social relationships and mental health, the costs and benefits of social relationships, public policy, and possibilities for future research.

World’s Health & Society program is an interdisciplinary program bridging critical heath studies, humanities (history, creative writing), and the social sciences (Indigenous studies, anthropology, sociology) to consider the social, cultural, political, historical and economic forces that shape health, well-being, and illness in both the Global North (Canada, US, EU, and the UK) and Global South (including nations like Peru, Kenya, Nepal, and many more).

This exciting and innovative program explores a wide range of influences including social media, art and aesthetics, cultural values, capitalist networks, and political ideologies as they shape everyday health and healing. In this program students will consider the scientific controversies surrounding mammograms, female circumcision, vaping, and supervised injection sites; the barriers in providing equitable health care delivery in resource poor and resource developed communities; and structural forces that contribute to poor health like environmental racism (Alberta’s oil sands, Dakota Access Pipeline), the contemporary effects of colonial legislation (like the Indian Act), and exclusionary practices and policies in health care development and delivery.

Sociology assumes that a functioning society depends upon healthy people and upon controlling illness. In examining social constructs of health and illness, sociologist Talcott Parsons identified what he called “ **the sick role**,” or the social definition of, the behavior of, and the behavior toward those whom society defines as ill. Parsons identified four components to the sick role.

The sick person is

* Not held responsible for being sick.
* Not responsible for normal duties.
* Not supposed to like the role.
* Supposed to seek help to get out of the role.

Society allows those who fulfill these criteria to assume the sick role, but society loses sympathy for and denies the role to those who appear to like it or those who do not seek treatment. In other cases, family and friends may show sympathy for a while, but lose patience with the victim and assume he or she is seeking attention or is a hypochondriac.

Although many believe that science alone determines illness, this sociological view points out that society determines sickness as well. For example, the culture defines diseases as legitimate if they have a clear “scientific” or laboratory diagnosis, such as cancer or heart disease. In the past, society considered conditions such as chemical dependency, whether drug‐ or alcohol‐based, as character weaknesses, and denied those who suffered from addiction the sick role. Today, drug rehabilitation programs and the broader culture generally recognize addictions as a disease, even though the term “disease” is medically contested. In today's culture, addicts may take on the sick role as long as they seek help and make progress toward getting out of the sick role.

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# 2.Objectives

* Study of the application of medicine within economic and social agendas.
* Examine various issues and dilemmas facing modern health policy creation, implementation and improvement, both in Africa and on the global scale.
* Understand the political, anthropological and economic aspects of the ideas of “illness” and “wellness” in contemporary societies.
* Understand the basic views of the sociological approach to health and medicine.
* List the assumptions of the functionalist, conflict, and symbolic interactionist perspectives on health and medicine.

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# 3.MODULE CONTENT

This module focuses on the behavioral, psychosocial and physiological aspects of health and their importance for social relationships; and explain how different types of social relationships (i.e., marriage, parenthood) encourage healthy behaviour.

Students will be encouraged to access current research and with the teaching components, will be able to apply the knowledge and skills gained to their own practice.

This module will be suitable for a range of health care and exercise professionals whose role involves improving and maintaining the health and well-being in our society.

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# 4.Health Problems as Social Problems

The historical focus of sociology is on social problems in human society. Social problems include health problems, crime , deviance, violence , poverty , inequality, population problems, delinquency, and institutional instability. Social forces such as modernisation and industrialisation marked the beginning of unprecedented social alteration, especially since the beginning of the eighteenth century. This social change led to a number of problems as a result of changes in the relations of production. The industrial revolution led to new forms of production systems, community relations, migration , urbanisation , and especially new forms of employer-employee relations. Industrialisation marked the overthrow of the family as an economic unit. This was a tremendous change in the social system with resultant consequences, hence emerging social problems such as unemployment, poverty, child labour , gender discrimination, crime, and health problems. This is not to argue that all these problems only emerged during the industrial revolution , but they rapidly multiplied during that period. Social problems are conceived as strains within the system, seen as the product of certain objective conditions within the society, which is inimical or detrimental to the realisation of some norms or values for members of the society (Lyman et al. [1973](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR38), . Any issue that threatens the well-being or survival of the society is regarded as a social problem. Weber ([1995](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR52),defined social problems “as a social phenomenon that is damaging to the society or its members, is perceived as such, and is socially remediable.”

It is important to note that just as crime is damaging to the society or individual, so is any health problem. Apart from this fact, a social problem can be identified through the following characteristics, which include:

1. It is an objective condition. This implies that it can be empirically defined. A social problem exists as a condition that can be verified. Even when subjective interpretation may be required, a social problem is an *evidence-based* problem, not just mere perception of an individual but a general knowledge that is usually definite. This represents a utilitarian view, which holds that social problems are objective things, or what Durkheim regarded as social facts (Smelser [1996](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR46)) . Smelser observed that the assertion is like the medical model which views social problems as a form of disease with an identifiable cause, definite symptoms, and calls for a cure.
2. It has social aetiology or could be linked to it**.** This implies that a social problem emanates from the pattern of social interaction, organisation, association, or simply is engendered by social conditions. This point should be noted as a relevant perspective in explanation of human health/diseases and not an absolute explanation. For instance, Wellcome ([2002](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR53), p. 30), summarising Day Karen’s research report, observed that “… Falciparum parasite [malaria] we see today arose about 3200–7000 years ago—an era that coincides with the dawn of agriculture in Africa . This was a time of massive ecological change, when humans began to live in large communities and the rainforest was being cut down for slash-and-burn agriculture… there was also a major change in the mosquito vector at that time, when it began biting humans instead of animals… ” It is further observed that P.*falciparum* migrated with Africans to other parts of the world. This means that the process of migration aids the spread of malaria . This is why Smelser ([1996](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR46)) also observed that the increasing world traffic of people would internationalise many health problems. It is for this reason that HIV, first diagnosed in the United States in the early 1980s (Jackson [2002](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR30)) , is now a global problem. Moreover, some diseases are rooted in genetics or heredity, thereby multiplying through marriage patterns or human relationships. Holtz et al. ([2006](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR26), p. 1665) observed that it is impossible to understand population health without considering the social origins of diseases—“the risk of exposure, host susceptibility, course of disease, and disease outcome; each is shaped by the social matrix… ” Social conditions are now invoked as fundamental causes of diseases in human society because such conditions affect exposure to diseases, as well as course and outcomes of diseases .
3. It poses social damage**.** A social problem often incapacitates the individuals in a society. As poverty prevents individuals from satisfying basic needs, so, too, health problems prevent individuals from functioning effectively as members of society. A health problem may reduce the functionality of an individual within the social system . Invariably, a social problem is inconsistent with the normative value of the society. Society wants its members to be healthy, and the unattainability of this desire shows a discrepancy between social value and reality. Such a discrepancy represents a social problem.
4. It affects the collectivity. A social problem is different from a personal problem in that the former affects a substantial number of people in the social system (see Harris [2013](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR27)) . Health problems are ubiquitous like other problems such as crime and poverty. There may be a geographical variation in the magnitude or frequency, but most social problems are a pandemic. It is thus a problem when a significant number of people believe that a certain condition is, in fact, a problem (Kerbo and Coleman [2007](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR34)) , and it constitute a problem to their social existence or wellbeing.
5. It requires social action. Social problems require collective action. The solution to any social problem does not reside in just any individual; it requires the majority to act in order to ameliorate the problem. It may necessitate institutional or community approaches. Health problems also require collective action. This is why there has been a lot of implementation of research and policy engagement to improve the health of the people. This is also why health issues often appear in development agendas.

The aforementioned attributes qualify health problems as social problems. This is separate from the social dimensions of health problems, which will be examined later in this book. Health problems can also come with other dimensions apart from the aforementioned attributes. It may not only be socially damaging but also biologically damaging. Often, a health problem may move from being biological pathology to social pathology or vice versa. Whichever form it takes, it constitutes a pathology that must be remedied by the society. Sociology has been relevant ever since Comte conceived it as a science that would provide *salvation* from all the social problems confronting the world. Improved relevance of sociology in human society will alleviate human suffering and provide equitable well-being. Therefore, the application of sociological methods and perspective and attention to the social dimensions of disease should provide a vital step forward in disease control.

Apart from the fact that health problems constitute a major social problem, it is important to further stress the relevance of sociology to health. First, in this case, it is human health. It is about the people, community, and society. The health of the society cannot be grasped without understanding the intricacies of the community or society itself. George Simmel conceived of human society as an intricate web of multiple relations—of people in constant interaction with one another (Coser [2004](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR10)) , of people who are bound with common fate, norms, values, socio-spatial conditions, exposures, and opportunities. It is about the health of people who build and share similar health institutions or who live, for instance, in an African rainforest where they are exposed to mosquito bites every day. It is also about the health of the community that has access or otherwise to simple preventive measures for malaria or diarrhoea. Health is about the society where there is self-accountability to take up smoking and bear the associated health risks. As mentioned earlier, any issue concerning the social collectivity is of enormous interest to sociology. Simply, health is one such issue of interest because it concerns the people and also affects the patterns of social interaction.

Apart from focusing on the people, health is intrinsic to human functioning or existence. It confers a form of capacity on the individual to perform social functions in human society. Human value or existence is enhanced by good health. Good health is instrumental to human survival and is required to strive for the basic necessities of life. As a contributing member of the social systems , one needs good health, and lack of this threatens the pattern of social interaction with other members in the social system. Health indicators have been used to assess the level of development in a society. It is also used as a measure of chance of survival in human societies. This is why health is a social value both at the individual and collective levels.

# 5.Medical Sociology Defined

Medical sociology is simply the application of sociological perspectives and methods in the study of health issues in human societies with a skewed focus on the sociocultural milieu that accounts for human health and illness. These perspectives include sociological theories and tools, which can be applied in the analysis of human health. In this case, the individual is examined as a member of the society, who partakes in the day-to-day functioning of the social system. The pre-comprehension is that humans exist within a socio-spatial milieu, which often affects their health. Such social conditions and the nature of human interaction are instrumental to the well-being of every individual in society. It is also assumed that the nature of social interaction and networking is a part of the determinants of human health. Sociologists are interested in issues regarding human health and employ systematic procedures to examine social phenomena. They have relied on quantitative and qualitative techniques to establish universal laws governing human societies. The essence of the methods is to look at the social links that can explain sociocultural linkages to health issues. In any case, medical sociology is the application of sociological theories, knowledge, and concepts to issues of health and illness (Hafferty and Castellani [2006](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR26)) .

Medical sociology can also be defined as the scientific study of the social patterning of health. In this case, it is a study of how social factors (e.g., class, race, gender, religion , ethnicity, kinship network, marriage, educational status, age, place , and cultural practices) influence human health. The idea of social patterning indicates that these social factors could be the determinants of human health status (see Chap. 10.1007/978-3-319-03986-2\_4). It is in this sense that some diseases may be referred to as diseases of poverty (e.g., malaria and TB) because they are much more prevalent in poor regions or among the poor. For example, a person residing in a slum is at a higher risk of being exposed to certain diseases which a person in affluent area may have lower risk of being exposed to. Medical sociology is distinct in its approach because it considers the “import that social and structural factors have on the disease and illness processes as well as on the organisation and delivery of health care” (Hafferty and Castellani [2006](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR26), p. 334) . Hafferty and Castellani further observed that these factors also include culture (e.g., values, beliefs, normative expectations), organisational processes (e.g., hospital setting), politics (e.g., health care policy, health budget, political ideology), economic system (e.g., capitalism , the costs of health care), and microlevel processes such as socialisation and identity formation.

Apart from pure research, medical sociologists are also interested in implementation or applied research. This involves the implementation of interventions to improve the health of the population through community engagement and participation in policy formulation and implementation. As Kaminskas and Darulis ([2007](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR33)) noted, medical sociologists utilise applied sociological methods—such as needs assessment, social impact assessment, and case management options—in health care settings using evaluation research methods. This area of applied research has attracted a lot of grants and promoted collaboration with others in the medical field through a multidisciplinary approach to health management .

Cockerham ([2001](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR9)) further observed that medical sociology has actually established itself as a strong subfield of sociology and removed itself from being a subordinate of medicine. He provided four major reasons for the strong academic locus of the subfield. First, the extension of focus from acute to chronic diseases strengthens the relevance of sociology to medicine because of the key roles of social condition and social behaviour in the prevention, onset, and management of chronic disorders. Medical sociologists are more relevant in the analysis of social conditions of health than physicians. Second, medical sociology has focused extensively on issues relating to clinical medicine and health policy . Third, success over the years in medical sociological research has promoted the professional status of medical sociologists in the analysis of the social patterning of health. Fourth, medical sociologists have studied medical practice and policies—at times with a critical stance to expose some blind spots.

**6**.A Brief History of Medical Sociology

Medical sociology has become a substantive subfield of sociology . It can be argued that medical sociology began with the conception of sociology by August Comte ([1896](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR7)) through his concept of organismic analogy . This can be a deductive argument since Comte did not intend to establish medical sociology as a subfield and did not attach the importance of sociocultural issues in health. Comte, and later Herbert Spencer ([1891](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR47), [1896](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR48)) , extensively compared human society to a biological being. Spencer observed that the universe consists of organic (living), inorganic (nonliving) and super-organic (society) entities. The idea of organismic analogy is that the human society has similar characteristics as that of the biological organism. The similarities include growth and development, differentiation of parts, specialisation of functions, interrelatedness, and interdependence of parts. The parts of the society include the social institutions, which work harmoniously for the survival of the society. The argument further relates that if one part is damaged, it will adversely affect other parts of the society. Health institution may be affected if the political institution is corrupt or not responsive to aspirations of the citizens. This is part of the reasons why strong political will is required in implementation of health programs.

The theory of Marx and Engels explains that economic infrastructure is the foundation on which other superstructures of the society rely. Inequalities in income translate to other forms of inequalities in human society, including health inequalities . This is why Marx’s proposition has been widely applied in all facets of life including health inequalities, accessibility to health care and allocation and distribution of health resources and infrastructures. Another major landmark is the work of Emile Durkheim ([1897/1951](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR12)) on suicide . This is directly related to medical sociology since it is about the issue of death. Durkheimian perspective on suicide will be explained in detail. The perspective examines the influence of social factors in self-termination of life. Durkheim identifies two major factors, which fluctuate to increase or decrease propensity to suicide. These factors are social regulation and integration. This has been a major sociological perspective in the analysis of suicide because it was a theory derived from empirical investigations. The works of Max Weber on bureaucratic rationality and social action have also been substantially applied in medical sociology to explain the organisation of health care institutions and why and how people care for others .At the time these classical sociological scholars (August Comte, Emile Durkheim, Max Weber, and Karl Marx) were writing, they did not have medical sociology in mind; however, their works provided the landmark for the development of a subfield of sociology called medical sociology. The works created the foundation for the emergence of sociological perspectives and methods that can be applied in the study of social patterning of health.

In 1848 Rudolf Virchow (a German physician) laid the foundation of social medicine (Holtz et al. [2006](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR28)) by advocating for the relevance and consideration of social factors in human health and disease. While this set a new agenda for medicine, it opened a wide passage for the social sciences involvement in the understanding of human health. The early 1900s marked the beginning in the study of sociological dimension of medicine, especially with the works of Charles McIntire (“The Importance of the Study of Medical Sociology,” published in 1894), along with other scholarly works of that period including the book by Elizabeth Blackwell ([1902](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR100)) and another by James P. Warbasse ([1909](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR101)), both on medical sociology (Bloom [2002](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR3); Hafferty and Castellani [2006](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR26), p. 332) .

In the 1950s, Talcott Parsons ([1951](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR42)) published a groundbreaking work with a section on the application of functionalism in medical sociology. He dedicated a substantial part of his work to the elaboration of the sick role , explaining the social trajectories of the sick within the social system and how the health institutions can support individuals to return to normal roles in the society. Parsons recognised the relevance of medicine for the society and drew attention to illness as a form of social deviance and the importance of sick role as a mechanism of social control (Freidson [1962](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR16); Stacey and Homans [1978](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR49)). This is the first conscious application of sociological theory in the understanding of human illness. The sick role concept facilitated the expansion of other areas of research including the patient-physician relationship, illness behaviour, medicalisation of deviance, and medical professionalism (Hafferty and Castellani [2006](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR26)) . The works of Freidson ([1961a/1962](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR16), [1961b](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR17)) and Mechanic ([1966](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR39), [1968](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR40)) also promoted the relevance and understanding of medical sociology.

Conrad ([2007](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR8)) described Eliot Freidson’s works as revolutionary in medical sociology. Freidson (1961, [1970a](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR18), [1975](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR20)) devoted his time to the study of professionalism and professionalisation in medicine which presents a comprehensive view of the social and professional dynamics of medicine with a particular reference to how disease and illness are constructed, power relations between the physician and patients, division of labour, ethical conducts, increasing commercialism, and bureaucratic control in medical practice. Freidson’s works were landmarks in the development of medical sociology. He practically demonstrated the relevance of sociology in medicine and health studies in general by situating his studies within applied domains .

During the same period, Glaser and Strauss ([1965](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR22), [1968](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR23)) also examined the social process of death and dying, and Erving Goffman ([1961](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR24), [1963](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR25)) released a masterpiece, *Asylums* , which introduced the concept of stigma and total institution. The *Asylums* focused mainly on the study of mental health patients and health care institutions. It was a remarkable breakthrough in the application of medical sociology to the study of health care institutions. The work of Goffman has been one of the most successful sociological pieces in the management of patients and health care institutions. The concern of this subsection is to trace the development of medical sociology: will expand some of the substantive theories of medical sociology.

The development of academic journals (e.g., *Journal of Health and Social Behaviour*; *Social Science and Medicine*; *Sociology of Health and Illness* in 1979) in the discipline, especially in the 1960s, also aided the development of the discipline (Hafferty and Castellani [2006](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR26)) ; and now there are many other dedicated and related journals including *Health and Place*,*Health Affairs*,*Women and Health*,*Reproductive Health Matters*,*Social Theory and Health*,*Medical Anthropology*,*The Lancet*,*Social History of Medicine*, and many others .

Furthermore, not only do medical sociologists proclaim self-relevance to medicine but medical scientists have increasingly come to the realisation that a number of significant health care issues are outside the walls of the hospitals, pharmaceutical and medical laboratories. Clausen ([1963](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR5), p. 1) observed that it has become apparent that “the understanding of health and disease requires a holistic approach in which the social and cultural aspects of human behaviour are appropriately related to the biological nature of every human being and the physical environment in which he[/she] lives.” Clausen further observed that the emphasis upon the holistic approach to medical science and comprehensive health care has moved medicine to seek the services of social scientists, notably in connection with public health , preventive medicine, and psychiatry. In short, there is an unprecedented *sociolisation* of medicine, a term used by Barbour ([2011](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR2)) to describe how sociology has come to shape the profession of medicine, and to add to it, how sociology shapes the understanding of health and illness in the society.

From the 1960s onwards, there has been increasing popularisation of medical sociology with many departments of sociology now having specialisation in medical sociology as an option, especially for graduate programs. Cockerham has observed that medical sociology comprises one of the largest and most active sociological specialties in the developed world and the subdiscipline is expanding in Asia, Africa , Latin America, and other regions. Specifically, Africa has not been left out in this development as medical sociology is now recognised as a subfield of sociology. Medical sociology is growing in strength and importance in South Africa (Gilbert [2012](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR21)) like in other African countries. There is a growing realisation that social issues are relevant and significant in explaining population health in Africa and elsewhere. The study of sexual behaviour and other social aspects of HIV/AIDS seemingly demonstrate the sociological milieu in the understanding of health. The first crops of medical sociologists in Africa were trained in western societies, specifically in the United Kingdom and United States . Now, the number of those trained in Africa is increasing, coupled with a demand for medical sociologists in health intervention in Africa.

Many medical sociologists from Africa now partner with their counterparts from other continents in addressing international health. Medical sociologists also collaborate with non-governmental organisations (NGOs) to address social determinants of health in communities. Likewise, there are many social science institutes in Africa (e.g., the Council for the Development of Social Science Research in Africa [CODESRIA]), which have incorporated health discourse as a priority. The introduction of the Health Institute by CODESRIA to train and offer small grants to young social scientists interested in health issues is part of this brilliant effort .

# 7.Topical Description of Medical Sociology

Many scholars have described medical sociology in various ways: sociology of health and illness or health sociology. “Medical sociology” is more encompassing to describe the broad aspect of sociology dealing with medicine and health in general. One particular description is that of Straus ([1957](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR50)) , who averred that medical sociology consists of sociology of medicine and sociology in medicine . Straus ([1957](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR50), p. 203) observed that “[s]tudies of the profession (of medicine) and those dealing with the organization of health resources are primarily in the sociology of medicine [while] teaching activities and research in which the sociologist is collaborating with the physician in studying a disease process or factors influencing the patient’s response to illness are primarily sociology in medicine.” Straus made the distinction as a result of activities and affiliations of 110 medical sociologists.

Straus ([1999](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR51), p. 109) further reiterated that sociology in medicine involves “activities that were associated with achieving the educational, research, or clinical goals of medicine. These were often collaborative with health professionals and occurred within health or medical institutions. They were carried out most frequently by sociologists who held appointments in health professional-schools, hospitals, or other health-care organisations.” On the other hand, sociology of medicine is close to what could be described as sociology of health and illness. It involves the study of social factors in disease aetiology, incidence, prevalence, distribution, social response to health and illness, therapeutic process, and community health needs .

Initially, Straus ([1957](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR50)) thought it was not feasible for a sociologist to engage in the sociology in and of medicine together; however, later he ([1999](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR51)) observed that because of crosscutting intellectual development, it is now feasible. Therefore, the distinction “of and in” is merely the distinction of activities, not that of persons involved. Medical sociology has now grown into a full subdiscipline of sociology with more diverged activities as a result of intellectual and research domains. It is now possible to present a topical description of medical sociology without a topical differentiation between that of sociology in or of medicine. Therefore, another major concern of students of sociology or professional is a clear topical description of medical sociology. It is imperative to explain the intellectual domain of medical sociology. The first major attempt at this was by David Mechanic ([1968](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR40)) , who highlighted a number of intellectual domains of medical sociology. Apart from the fact that there are still some new developments, a re-explanation of some of the domains in line with currents trends is necessary.

**8**.Social Aetiology of Disease

Medical sociology primarily focuses on the social causes of disease. Social causationism entails direct and indirect (social) exposure to diseases. While a medical doctor will simply note that a patient has HIV, a sociologist is more interested in the sexual network of the patient since HIV can be acquired through the process of sexual interaction with others in the society. This pattern of sexual relation is a social determinant. Another explanation is that the decision to engage in protective sex is entirely that of the parties involved. A medical sociologist is more interested in the “push” factors that expose individuals to any disease. Another example is the high prevalence of vesicovaginal fistula (VVF) in sub-Saharan Africa (SSA) . There are many social issues that expose women to the risk of VVF, which include age at marriage, access to maternal care, maternal education, and gender inequality , which prevent many women from obtaining permission for their partners to attend health facilities. Some of these issues are sociocultural issues, which need to be addressed in order to reduce the incidence of VVF in SSA.

The notion of social aetiology is embedded in risk factors, most of which occur at the individual or societal level ; however, some risks have to do with the norms and values of the societies. For instance, a culture which promotes gender inequality or male hegemony puts women at a risk of gender violence including sexual abuse and female infanticide . The assertion that lifestyle and living conditions could expose individuals to diseases is not new and has been a major focal point in preventive medicine. Particularly in the developing world, vulnerability to disease often has less to do with germs than with the so-called social causes—factors such as income, education, gender, occupation , housing , and access to health services. Social deprivation is a key predictor of distribution of diseases and life expectancy . The social causes also include poor sanitation, nutritional deficiencies, poor infrastructures (e.g., water supply), lack of safety at work, overcrowded or poorly maintained housing , environmental pollution, stress, and lack of exercise due to a sedentary lifestyle. The social causes can also be explained in terms of the lack of education on preventive measures or appropriate health behaviour.

These social causes often found in the social condition of the individuals or societies constitute the primary crux of medical sociology. The relevance of medical sociology can be assessed based on the efforts in addressing these social causes.

# 9.Cultural Beliefs and Social Response to Illness

Cultural beliefs and responses have direct consequences for both preventive measures and cure-seeking behaviour. Illness perception is usually conceived in terms of local definition of the illness—its perceived cause(s), vulnerability, severity, and perceived modes of transmission. This illness perception or local understanding and cultural beliefs also constitute a part of the core focus of medical sociology. There is a cultural repertoire for recognising, diagnosing, or defining the illness condition (Alubo [2008](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR1); Erinosho [2006](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR13)) . Illness is a deviation from societal norms and values, usually manifested through failure of an individual to perform his/her normal roles in the society. The course of illness is determined not merely by biomedical factors but also by the way the patients define and respond to the illness.

The response to illness often reflects a society’s medical beliefs about the causes of health problems, choices of treatment options, and other health-related concerns. Feyisetan et al. ([1997](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR14)) noted that certain disease-specific and non-disease-specific cultural beliefs may influence people’s health and health-seeking behaviour. This is why it is important to consider cultural beliefs and practices of the people when designing measures and programs aimed at improving their health (Comoro et al. [2003](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR6); Feyisetan and Adeokan [1992](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR15); Jegede [2002](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR31)). It is further noted that the adoption of both preventive and curative methods may also depend on people’s conception of the causes of illness and on their level of conviction about the efficacy of the preventive and curative methods (Feyisetan et al. [1997](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR14)) .

For instance, at the beginning of the HIV crisis in Africa , the problem was about people’s belief in the reality of the disease. For several years, the “HIV is real” campaign was widespread. The response then was very weak. In general, people who doubt the reality of a disease would not adopt any preventive measure. By the time the reality of AIDS (acquired immunodeficiency syndrome) was incontrovertible (at least to the general majority), the havoc had already been caused—HIV has eaten deep into all fabrics of the society and thousands of people are losing their lives daily. Additionally, there were a lot of causal misconceptions surrounding HIV/AIDS at the societal level, which also stymies adoption of both preventive and treatment options.

# 10.Sociology of Medical Care and Hospital

The concerns of this aspect are on the sociocultural aspects of medical care and hospital as a (social) institution. There are often options in medical care, especially traditional and modern approaches (Alubo [2008](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR1)) . This interaction of plural systems of health care may be complementary, competitive, or even conflicting. Choice is usually modified by the cultural belief system in the community. Another main issue is the cost of seeking medical care in relation to affordability and quality of services from medical institutions. These are interwoven issues that have constituted focal points in medical care. Another significant issue is the gender context of medical care and hospital. Analysis of gender issues in terms of care providers and receivers is vital in medical care. At times, experts analyse the importance of cultural competence in health care delivery and desirability of gender concordance (patient-practitioner) in health care .

There is also a significant focus on the hospital as a social or total institution , a small society or a home of the vulnerable population. This aspect also attempts to explain the competing interests for managing the patients in the hospital environment, and consider how these interests or influences manifest, and are resolved in the delivery of care. The experiences of patients and quality of service delivery (especially patients’ satisfaction with care) are also part of the focus. This aspect also attempts to examine perceptions of and social relations within health care institutions—the patient-practitioner, practitioner-practitioner relationships, work-related difficulties and adjustments, and the role of health professionals in society.

Sociologists also tend to unravel the bureaucratic structures in medical care or hospitals and how such structures influence health care delivery systems. What is the impact of *red tapism* on service delivery? How do standardisation or organisation hierarchies pattern the service delivery system? How are the health professionals responding to the changing bureaucracy in the medical setting? How are or can health workers be motivated to achieve the goals of health organisation or policies? All of these questions constitute parts of the research focus of medical sociologists.

In addition, power relations within the hospital management are also part of sociological research. There are resultant power scuffles that often affect health care delivery systems. The constituent units in the hospital (medical doctors [including various specialists], pharmacists, nurses, administrative staff [e.g., accountants and personnel officers], laboratory professionals, and other cadre employees [down to the lowest cadre such as cleaners]) have sometimes been in conflict as a result of power relations in work contacts. Conflict often arises as a result of interrelated and interdependent tasks and, in some cases, unclear definition and demarcation of tasks, especially among related professionals (e.g., physicians and physiotherapists in the management of a fracture). These power relations have been a core part of medical sociological research.

# 11.Sociology of Psychiatry or Social Psychiatry

Psychiatry is a medical subdiscipline that works most closely with the social sciences , especially sociology. The thrust of social psychiatry is on the social and cultural context of mental health and illness. Social psychiatry is concerned with the cultural and social factors that engender, precipitate, intensify, or prolong maladaptive behaviour and complicate the management of mental disorders. It is also defined as a field of psychiatry based on the study of sociocultural and ecologic influences on the development and course/trajectory of mental diseases . Because of evidence-based social aspects of mental health, social psychiatry is perhaps the most visible aspect of mental health management. It also leads to the emergence of subprofessionals in psychiatry, known as social psychiatrists. Mental health has much to do with lifestyles and social conditions. In fact, most manifestations of mental disorders depict the contravention of normal standards of behaviour in the society. This implies that in most cases, a mental disorder is recognised through excessive abnormal behaviour within the social system . Hence, there was a shift in psychiatric ideology to the patient’s behaviour and social relationships (Pilgrim and Rogers [1994](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR44)) .

Community psychiatry approach has been a major management approach in psychiatric treatment. This approach takes cognisant of the socio-spatial environment and the roles of significant others in the rehabilitation and re-integration of those with mental disorders. Positive support from such links will facilitate the rehabilitation and re-integration of the patients. Medical sociologists have been actively involved in the management of the patients and implementation of research necessary to improve patient management styles. There is also a growing body of research on the handling of patients in psychiatric hospitals, focusing on the use of physical and medical restraints and violence .

Social stigmatisation of the mentally ill is also part of the research focus in medical sociology. Stigmatisation prevents proper re-integration of the patients and may lead to relapse of the mental health condition following a worsening social condition of the patients. This is why medical sociologists often prioritise how to reduce social stigmatisation among all categories of patients. Most importantly, the works of Erving Goffman ([1961](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR24), [1963](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR25)) on total institution) and stigma have been the major guiding theoretical underpinnings in social psychiatry and social reaction to illness/diseases. More often, community psychiatry depicts the de-institutionisation approach advocated by the *Goffmanians* in order to minimise alienating experiences and estrangement of the patients. The aforementioned issues constitute some of the areas of involvement of medical sociology in psychiatry.

# 12.Social Transition and Heath Care

There are dual aspects of social transition as it relates to health care—a change in both the society and health care itself. Change in the society might inform change in health care and there could also be meaningful development in health care as a result of improved technology. Medical sociologists are interested in both. They are riveted in social dynamics and responses of various facets of social organisation. Social change is constant; hence, human society is constantly undergoing numerous forms of social transition. The health care institutions have continuously been responding to changes in all sectors of the society. As a result of changes in the economic systems, for instance, some societies practise a capitalist health system , while others adopt a socialised health care system with embedded variations in how the systems are implemented. Medical sociologists are interested in how social transitions, whether political or economic, affect health care systems. They are interested in the course, causes, and consequences of such social transitions in the health care sector.

Apart from the institutional focus regarding social change, medical sociologists also study how such changes affect health and illness behaviour of the individuals. Both the individual and the institution often respond to change. In this regard, it is important to document what social change means for the health of the community. Social change may also affect vulnerability to different forms of diseases. Modern inventions create possibilities in health care systems and also raise copious sociocultural apprehensions. The advancement in information and communication technology makes telemedicine possible and improves diagnosis and treatment of patients. The Human Genome Project (HGP) continues to create more possibilities in health care systems. We are now living in a world with assisted reproductive technology , stem cell research , and nanotechnology. Many individuals now desire to enhance their bodies instead of treating disabilities. The possibility of transplantation leads to a proliferation of organ markets. These are some typical examples of issues generating new research directions in the sociological study of health and change.

# 13.Traditional Medicine/Complementary and Alternative Medicine

Ethno-medicine , or traditional medicine (TM) , has been one of the major focal points of sociological research (see Sect. 10.1007/978-3-319-03986-2\_10#Sec2 for further elaboration) . The utilisation of TM in the prevention and treatment of diseases has been intensively researched by sociologists in an attempt to understand the sociocultural context associated with the continuous patronage of TM. What informs the choice of TM? How prevalent is the use of TM? Are patients getting results from TM? What is the cultural basis of the belief in TM? Are there diseases that are only amenable to TM? How does TM differ from the biomedical norm in the definition of disease, perception of symptoms, and treatment? How can TM be recognised and incorporated into the general health care system? How is TM itself organised as a health care alternative? What is the place of TM in health care policy? Is TM complementary or alternative to modern medicine? What are the limitations of TM in health care? These are some of the questions that sociologists want to answer.

In some countries, there is constant tension between traditional and modern medicine, especially as an alternative health care system. Unfortunately, most of the practices of TM are not amenable to science and are grossly less advanced than modern medicine. But the incessant reliance in some communities on TM informs its recognition as part of health care institutions. Such recognition is also necessary as most of such societies have limited access to modern health care . In addition, TM seems to be the closest health care system to underserved communities. More importantly, there is an argument that it conforms to the belief system of the community. It is because of these aforementioned reasons that sociologists are concerned about the developments in TM .

# 14.Sociology of Bioethics

There is now sociology’s engagement with bioethics, a field of growing interest that is defined by its concern with moral questions in biomedicine (De Vries [2003](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR11); Petersen [2011](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR43)) , whether it is called sociology in bioethics or sociology of bioethics . The field of medical ethics or bioethics in general is multidisciplinary because the ethical dilemma in health care requires the inputs and understanding of various professionals. Some of these moral perplexities are part of societal concerns for equity, equality, and justice in health care. A majority of these issues are sociocultural issues and general ethical or moral standards of behaviour in the society. This is why sociological insights are necessary if the ethical conundrums presented by medicine are to be successfully resolved in practice. The most vital tool in medicine is the “human body.” The body is a place where medical practices and interventions are exercised. The human and his/her body have a significant place in sociological impetus. Sociologists collaborate in resolving moral challenges in health care practice and research. Humphreys ([2008](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR29), p. 51) observed that the sociological approach has brought out some interesting perspectives, especially unintended consequences of behaviours that bioethics (and research ethics) may not have anticipated.

While the field of sociology of biomedical ethics is still emerging, especially in SSA, a number of medical sociologists hold interest in it. In developed countries, there is a growing relevance of bioethicists in health care regulations and practices. Sociologists generally want to understand how ethical challenges can be resolved within the limits of societal conscience and how moral values and ethical behaviours are embodied and lived by social agents. How do ethical resolutions conform to the cultural milieu of the society? How are resolutions in the best interest of the individual? What are the future implications of ethical resolutions? How do medical practices incline with the norms and values of the society? How can we structure the development of new technology and its application within the moral values of the society? Sociologists have often challenged bioethics to look beyond principlism (Petersen [2011](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR43)) . Humphreys ([2008](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR29)) noted that sociology of bioethics has concentrated on social processes within bioethical debate, on role relationships, and on the norms, values, and beliefs of those engaged in the bioethical endeavour. Invariably, sociology now has keen interest in the relevance of social processes in the understanding of moral uneasiness posed by some advancement in biomedical sciences such as biobanks, stem cell research , biotechnology, nanotechnologies, genetic testing , clinical trials , transplantation , and medical enhancement .

# 15.Heath Policy and Politics

One major factor that greatly influences the health of the society, beyond the handling of a stethoscope or syringe in the hospital, is *health policy and politics*. Health politics is about who gets what health resources, why and when. Such politics involves the creation of medical schools; construction of health facilities; recruitment and deployment of health personnel; determination of health workers’ benefits and their motivation, procurement, and provision of equipment; appointment of health care administrators; and initiation, formulation, and implementation of national, regional, or community health care policies. These issues are really crucial and are usually not under the control of the physicians, but rather the politicians or political leaders. This further signifies that a number of fundamental issues are beyond the confines of the hospital walls that must be properly considered in order to improve the health of the people.

Medical sociologists in particular are interested in the community or societal processes in the formulation of health policy . Most sociological questions include, among others: What are the social consequences of health care policy on the health of the community? Which policy is working, which is not, and why? How does health policy affect access to health care? What are the attitudes towards health policy? Who benefits from a particular policy and why? How can policies be modified to get better results? How are health facilities distributed and why? How adequate are health personnel and are they properly motivated to deliver national health policies? What is the influence of political will or political agenda on health care prioritisation? All of these questions are often treated using sociological perspectives and methods.

The intricacies involved in health care politics are often overwhelming and often require unparalleled attention if population health must be improved. In most SSA countries, there is paltry health political will, which accounts for poor health care facilities and, hence, high prevalence of health problems. There is often an insufficient budget and diminutive political will to implement the best practices, which explain the high rate of mortality from preventable diseases each year. The meagre foreign aid is mismanaged and good health policies often turn ineffective. There are critical issues for health policy and politics, which, if addressed, could improve population health in many countries. This is why medical sociologists consider health politics a part of the crux of the discipline .

# 16.Social Epidemiology

This is the study of the sociocultural factors in the distribution, incidence, and prevalence of health problems in human society. Jegede ([1996](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR32)) defined social epidemiology as the study of the disease process; its occurrence in population groups; those social and cultural factors that affect their incidence, prevalence, and distribution; and the host response in disease prevention and control in human population. Social epidemiology often focuses on what Krieger ([1994](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR35), 2001) described as the multifactorial aetiology or web of causation—an array of social determinants of health distribution, an interplay of host, agent, and environment. There are numerous interconnected risk factors in the social system , which exposes individuals to the agents of diseases. These multifactorial links constitute the focus of social epidemiologists. It is through the understanding of the multicausality of disease that the differential distribution of diseases can be explained. One fundamental principle in social epidemiology is that humans are embodied agents (both socially and biologically). The interplay of these embodiments plays significant roles in risk exposure and susceptibility. Social epidemiology is a marriage of sociological frameworks to epidemiological studies (Krieger [2001](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR36)) , which represent a holistic approach.

# 17.Sociology of Dying and Death

Medical sociologists are also interested in patterns of mortality in human society. The major focus is on the social factors responsible for differential mortality rates in different social groups and societies in general. Issues such as income, gender , race, education, marital status, and occupation are associated with death rates. Sociologists study the interplay of these factors with risk exposures. Life expectancy in various nations is also unconnected with social conditions. There is strong relevance of sociological frameworks in the analysis of death in human society.

Apart from this, death is also a biosocial issue. It is biological because of the failure of biological organ(s) in the body, which often signifies death. Certification of death is thus a biomedical necessity. Social death could, however, occur before (biological) death. The inability to be a functioning member of the society due to total social incapacitation, and signals the expectation of (biological) death. Apart from this, death itself is a form of social transition; a new form of being that creates a vacuum, which often signifies emptiness of social roles. This implies that death has significant social repercussions for the affected individuals and the society at large. Hence, society often prepares to cater for the social blankness created by death. Bryant ([2002](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR4)) observed that society shapes social structure to constrain and contain the disruptive effects of death.

Furthermore, one of the primary interests is on the causes of death in human society—especially those causes that have links with sociocultural issues. Such causes are usually studied sociologically and historically. This will expose the social patterns of death: which group dies more from what ailment and why. What are the sociological explanations of the exposure of the group to a particular ailment in the society? More so, sociologists are also interested in passage rite for the dead. Different societies respond and receive death in various ways. Other issues of interest include notions of good and bad death , death and social institution, social responses to death, political economy of death, death and religion , death after life, life after death, and increasing versus decreasing life expectancy across the globe.

# 18.Medical Education

The bedrock of sociology of medical education is the prioritisation of health and social origin of medical education, which has profound implications for knowledge orientation and dissemination, organisational arrangements, and access to such education . It focuses on current issues affecting medical students, the profession, faculty members, and the impact of medical education on the society at large. Light ([1988](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR37), p. 307) also observed that “the changing locus of medical education in the matrix of social, cultural, political, and organizational forces exhibited by the health care system calls for the attention of medical sociologists.” A number of research priorities in sociology of medical education include: how social changes affect delivery and content of medical education; access to medical education among various social groups; orientation of medical education; outcomes of medical education; and health policy and medical education. Mechanic ([1990](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121984/#CR41)) averred that focus of this area also includes how to improve medical curricula, cultural competence in medical education, and ethical behaviour of medical professionals as well as the study of the pattern and context of professional socialisation .

# 19.The Sociological Approach to Health and Medicine

We usually think of health, illness, and medicine in individual terms. When a person becomes ill, we view the illness as a medical problem with biological causes, and a physician treats the individual accordingly. A sociological approach takes a different view. Unlike physicians, sociologists and other public health scholars do not try to understand why any one person becomes ill. Instead, they typically examine rates of illness to explain why people from certain social backgrounds are more likely than those from others to become sick. Here, as we will see, our social location in society—our social class, race and ethnicity, and gender—makes a critical difference.

The fact that our social backgrounds affect our health may be difficult for many of us to accept. We all know someone, and often someone we love, who has died from a serious illness or currently suffers from one. There is always a “medical” cause of this person’s illness, and physicians do their best to try to cure it and prevent it from recurring. Sometimes they succeed; sometimes they fail. Whether someone suffers a serious illness is often simply a matter of bad luck or bad genes: we can do everything right and still become ill. In saying that our social backgrounds affect our health, sociologists do not deny any of these possibilities. They simply remind us that our social backgrounds also play an important role (Cockerham, 2009).

A sociological approach also emphasizes that a society’s culture shapes its understanding of health and illness and practice of medicine. In particular, culture shapes a society’s perceptions of what it means to be healthy or ill, the reasons to which it attributes illness, and the ways in which it tries to keep its members healthy and to cure those who are sick (Hahn & Inborn, 2009). Knowing about a society’s culture, then, helps us to understand how it perceives health and healing. By the same token, knowing about a society’s health and medicine helps us to understand important aspects of its culture.

An interesting example of culture in this regard is seen in Japan’s aversion to organ transplants, which are much less common in that nation than in other wealthy nations. Japanese families dislike disfiguring the bodies of the dead, even for autopsies, which are also much less common in Japan than other nations. This cultural view often prompts them to refuse permission for organ transplants when a family member dies, and it leads many Japanese to refuse to designate themselves as potential organ donors (Sehata & Kimura, 2009; Shinzo, 2004).

As culture changes over time, it is also true that perceptions of health and medicine may also change. Recall from  that physicians in top medical schools a century ago advised women not to go to college because the stress of higher education would disrupt their menstrual cycles (Ehrenreich & English, 2005). This nonsensical advice reflected the sexism of the times, and we no longer accept it now, but it also shows that what it means to be healthy or ill can change as a society’s culture changes.

A society’s culture matters in these various ways, but so does its social structure, in particular its level of economic development and extent of government involvement in health-care delivery. As we will see, poor societies have much worse health than richer societies. At the same time, richer societies have certain health risks and health problems, such as pollution and liver disease (brought on by high alcohol use), that poor societies avoid. The degree of government involvement in health-care delivery also matters: as we will also see, the United States lags behind many Western European nations in several health indicators, in part because the latter nations provide much more national health care than does the United States. Although illness is often a matter of bad luck or bad genes, the society we live in can nonetheless affect our chances of becoming and staying ill.

# 20.Sociological Perspectives on Health and Medicine

The major sociological perspectives on health and medicine all recognize these points but offer different ways of understanding health and medicine that fall into the functional, conflict, and symbolic interactionist approaches. Together they provide us with a more comprehensive understanding of health, medicine, and society than any one approach can do by itself (Cockerham, 2009). [Table “Theory Snapshot”](https://open.lib.umn.edu/sociology/chapter/18-1-understanding-health-medicine-and-society/#barkan-ch18_s01_s02_t01) summarizes what they say.

## 

## Table  Theory Snapshot

| **Theoretical perspective** | **Major assumptions** |
| --- | --- |
| Functionalism | Good health and effective medical care are essential for the smooth functioning of society. Patients must perform the “sick role” in order to be perceived as legitimately ill and to be exempt from their normal obligations. The physician-patient relationship is hierarchical: the physician provides instructions, and the patient needs to follow them. |
| Conflict theory | Social inequality characterizes the quality of health and the quality of health care. People from disadvantaged social backgrounds are more likely to become ill and to receive inadequate health care. Partly to increase their incomes, physicians have tried to control the practice of medicine and to define social problems as medical problems. |
| Symbolic interactionism | Health and illness are *social constructions*: Physical and mental conditions have little or no objective reality but instead are considered healthy or ill conditions only if they are defined as such by a society. Physicians “manage the situation” to display their authority and medical knowledge. |

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# 21.The Functionalist Approach

As conceived by Talcott Parsons (1951), the functionalist perspective on health and medicine emphasizes that good health and effective medical care are essential for a society’s ability to function. Ill health impairs our ability to perform our roles in society, and if too many people are unhealthy, society’s functioning and stability suffer. This was especially true for premature death, said Parsons, because it prevents individuals from fully carrying out all their social roles and thus represents a “poor return” to society for the various costs of pregnancy, birth, child care, and socialization of the individual who ends up dying early. Poor medical care is likewise dysfunctional for society, as people who are ill face greater difficulty in becoming healthy and people who are healthy are more likely to become ill.

For a person to be considered *legitimately* sick, said Parsons, several expectations must be met. He referred to these expectations as the sick role. First, sick people should not be perceived as having caused their own health problem. If we eat high-fat food, become obese, and have a heart attack, we evoke less sympathy than if we had practiced good nutrition and maintained a proper weight. If someone is driving drunk and smashes into a tree, there is much less sympathy than if the driver had been sober and skidded off the road in icy weather.

Second, sick people must want to get well. If they do not want to get well or, worse yet, are perceived as faking their illness or malingering after becoming healthier, they are no longer considered legitimately ill by the people who know them or, more generally, by society itself.

Third, sick people are expected to have their illness confirmed by a physician or other health-care professional and to follow the professional’s advice and instructions in order to become well. If a sick person fails to do so, she or he again loses the right to perform the sick role.

If all of these expectations are met, said Parsons, sick people are treated as sick by their family, their friends, and other people they know, and they become exempt from their normal obligations to all these people. Sometimes they are even told to stay in bed when they want to remain active.

Physicians also have a role to perform, said Parsons. First and foremost, they have to diagnose the person’s illness, decide how to treat it, and help the person become well. To do so, they need the cooperation of the patient, who must answer the physician’s questions accurately and follow the physician’s instructions. Parsons thus viewed the physician-patient relationship as hierarchical: the physician gives the orders (or, more accurately, provides advice and instructions), and the patient follows them.

Parsons was certainly right in emphasizing the importance of individuals’ good health for society’s health, but his perspective has been criticized for several reasons. First, his idea of the sick role applies more to acute (short-term) illness than to chronic (long-term) illness. Although much of his discussion implies a person temporarily enters a sick role and leaves it soon after following adequate medical care, people with chronic illnesses can be locked into a sick role for a very long time or even permanently. Second, Parsons’s discussion ignores the fact, mentioned earlier, that our social location in society in the form of social class, race and ethnicity, and gender affects both the likelihood of becoming ill and the quality of medical care we receive. Third, Parsons wrote approvingly of the hierarchy implicit in the physician-patient relationship. Many experts say today that patients need to reduce this hierarchy by asking more questions of their physicians and by taking a more active role in maintaining their health. To the extent that physicians do not always provide the best medical care, the hierarchy that Parsons favored is at least partly to blame.

# 22.The Conflict Approach

The conflict approach emphasizes inequality in the quality of health and of health-care delivery (Conrad, 2009). As noted earlier, the quality of health and health care differ greatly around the world and within the United States. Society’s inequities along social class, race and ethnicity, and gender lines are reproduced in our health and health care. People from disadvantaged social backgrounds are more likely to become ill, and once they do become ill, inadequate health care makes it more difficult for them to become well. As we will see, the evidence of inequities in health and health care is vast and dramatic.

The conflict approach also critiques the degree to which physicians over the decades have tried to control the practice of medicine and to define various social problems as medical ones. Their motivation for doing so has been both good and bad. On the good side, they have believed that they are the most qualified professionals to diagnose problems and treat people who have these problems. On the negative side, they have also recognized that their financial status will improve if they succeed in characterizing social problems as medical problems and in monopolizing the treatment of these problems. Once these problems become “medicalized,” their possible social roots and thus potential solutions are neglected.

Several examples illustrate conflict theory’s criticism. Alternative medicine is becoming increasingly popular , but so has criticism of it by the medical establishment. Physicians may honestly feel that medical alternatives are inadequate, ineffective, or even dangerous, but they also recognize that the use of these alternatives is financially harmful to their own practices. Eating disorders also illustrate conflict theory’s criticism. Many of the women and girls who have eating disorders receive help from a physician, a psychiatrist, a psychologist, or another health-care professional. Although this care is often very helpful, the definition of eating disorders as a medical problem nonetheless provides a good source of income for the professionals who treat it and obscures its cultural roots in society’s standard of beauty for women (Whitehead & Kurz, 2008).

Obstetrical care provides another example. In most of human history, midwives or their equivalent were the people who helped pregnant women deliver their babies. In the 19th century, physicians claimed they were better trained than midwives and won legislation giving them authority to deliver babies. They may have honestly felt that midwives were inadequately trained, but they also fully recognized that obstetrical care would be quite lucrative (Ehrenreich & English, 2005). In a final example, many hyperactive children are now diagnosed with ADHD, or attention deficit/hyperactivity disorder. A generation or more ago, they would have been considered merely as overly active. After Ritalin, a drug that reduces hyperactivity, was developed, their behavior came to be considered a medical problem and the ADHD diagnosis was increasingly applied, and tens of thousands of children went to physicians’ offices and were given Ritalin or similar drugs. The definition of their behavior as a medical problem was very lucrative for physicians and for the company that developed Ritalin, and it also obscured the possible roots of their behavior in inadequate parenting, stultifying schools, or even gender socialization, as most hyperactive kids are boys (Conrad, 2008; Rao & Seaton, 2010).

Critics of the conflict approach say that its assessment of health and medicine is overly harsh and its criticism of physicians’ motivation far too cynical. Scientific medicine has greatly improved the health of people in the industrial world; even in the poorer nations, moreover, health has improved from a century ago, however inadequate it remains today. Although physicians are certainly motivated, as many people are, by economic considerations, their efforts to extend their scope into previously nonmedical areas also stem from honest beliefs that people’s health and lives will improve if these efforts succeed. Certainly there is some truth in this criticism of the conflict approach, but the evidence of inequality in health and medicine and of the negative aspects of the medical establishment’s motivation for extending its reach remains compelling.

# 23.The Interactionist Approach

The interactionist approach emphasizes that health and illness are *social constructions*. This means that various physical and mental conditions have little or no objective reality but instead are considered healthy or ill conditions only if they are defined as such by a society and its members (Buckser, 2009; Lorber & Moore, 2002). The ADHD example just discussed also illustrates interactionist theory’s concerns, as a behavior that was not previously considered an illness came to be defined as one after the development of Ritalin. In another example, in the late 1800s opium use was quite common in the United States, as opium derivatives were included in all sorts of over-the-counter products. Opium use was considered neither a major health nor legal problem. That changed by the end of the century, as prejudice against Chinese Americans led to the banning of the opium dens (similar to today’s bars) they frequented, and calls for the banning of opium led to federal legislation early in the 20th century that banned most opium products except by prescription (Musto, 2002).

In a more current example, an attempt to redefine obesity is now under way in the United States. Obesity is a known health risk, but a “fat pride” movement composed mainly of heavy individuals is arguing that obesity’s health risks are exaggerated and calling attention to society’s discrimination against overweight people. Although such discrimination is certainly unfortunate, critics say the movement is going too far in trying to minimize obesity’s risks (Saulny, 2009).

The symbolic interactionist approach has also provided important studies of the interaction between patients and health-care professionals. Consciously or not, physicians “manage the situation” to display their authority and medical knowledge. Patients usually have to wait a long time for the physician to show up, and the physician is often in a white lab coat; the physician is also often addressed as “Doctor,” while patients are often called by their first name. Physicians typically use complex medical terms to describe a patient’s illness instead of the more simple terms used by laypeople and the patients themselves.

Management of the situation is perhaps especially important during a gynecological exam. When the physician is a man, this situation is fraught with potential embarrassment and uneasiness because a man is examining and touching a woman’s genital area. Under these circumstances, the physician must act in a purely professional manner. He must indicate no personal interest in the woman’s body and must instead treat the exam no differently from any other type of exam. To further “desex” the situation and reduce any potential uneasiness, a female nurse is often present during the exam (Cullum-Swan, 1992).

Critics fault the symbolic interactionist approach for implying that no illnesses have objective reality. Many serious health conditions do exist and put people at risk for their health regardless of what they or their society thinks. Critics also say the approach neglects the effects of social inequality for health and illness. Despite these possible faults, the symbolic interactionist approach reminds us that health and illness do have a subjective as well as an objective reality.

# 24.The Social Construction of Health

If sociology is the systematic study of human behaviour in society, **medical sociology** is the systematic study of how humans manage issues of health and illness, disease and disorders, and health care for both the sick and the healthy. Medical sociologists study the physical, mental, and social components of health and illness. Major topics for medical sociologists include the doctor-patient relationship, the structure and socioeconomics of health care, and how culture impacts attitudes toward disease and wellness.

The social construction of health is a major research topic within medical sociology. At first glance, the concept of a social construction of health does not seem to make sense. After all, if disease is a measurable, physiological problem, then there can be no question of socially constructing disease, right? Well, it’s not that simple. The idea of the social construction of health emphasizes the socio-cultural aspects of the discipline’s approach to physical, objectively definable phenomena. Sociologists Conrad and Barker (2010) offer a comprehensive framework for understanding the major findings of the last 50 years of development in this concept. Their summary categorizes the findings in the field under three subheadings: the cultural meaning of illness, the social construction of the illness experience, and the social construction of medical knowledge.

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# 25.The Cultural Meaning of Illness

Many medical sociologists contend that illnesses have both a biological and an experiential component, and that these components exist independently of each other. Our culture, not our biology, dictates which illnesses are stigmatized and which are not, which are considered disabilities and which are not, and which are deemed contestable (meaning some medical professionals may find the existence of this ailment questionable) as opposed to definitive (illnesses that are unquestionably recognized in the medical profession) (Conrad and Barker 2010).

For instance, sociologist Erving Goffman (1963) described how social stigmas hinder individuals from fully integrating into society. The **stigmatization of illness** often has the greatest effect on the patient and the kind of care he or she receives. Many contend that our society and even our health care institutions discriminate against certain diseases—like mental disorders, AIDS, venereal diseases, and skin disorders (Sartorius 2007). Facilities for these diseases may be sub-par; they may be segregated from other health care areas or relegated to a poorer environment. The stigma may keep people from seeking help for their illness, making it worse than it needs to be.

**Contested illnesses** are those that are questioned or questionable by some medical professionals. Disorders like fibromyalgia or chronic fatigue syndrome may be either true illnesses or only in the patients’ heads, depending on the opinion of the medical professional. This dynamic can affect how a patient seeks treatment and what kind of treatment he or she receives.

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# 26.The Social Construction of the Illness Experience

The idea of the social construction of the illness experience is based on the concept of reality as a social construction. In other words, there is no objective reality independent of our own perceptions of it. The social construction of the illness experience deals with such issues as the way some patients control the manner in which they reveal their disease and the lifestyle adaptations patients develop to cope with their illnesses.

In terms of constructing the illness experience, culture and individual personality both play a significant role. For some people, a long-term illness can have the effect of making their world smaller, more defined by the illness than anything else. For others, illness can be a chance for discovery, for re-imaging a new self (Conrad and Barker 2010). Culture plays a huge role in how an individual experiences illness. Widespread diseases like AIDS or breast cancer have specific cultural markers that have changed over the years and that govern how individuals—and society—view them.

Today, many institutions of wellness acknowledge the degree to which individual perceptions shape the nature of health and illness. Regarding physical activity, for instance, the Public Health Agency of Canada recommends that individuals use a standard level of exertion to assess their physical activity. This rating of perceived exertion (RPE) gives a more complete view of an individual’s actual exertion level, since heart rate or pulse measurements may be affected by medication or other issues (CSEP N.d.). Similarly, many medical professionals use a comparable scale for perceived pain to help determine pain management strategies.

# 27.The Social Construction of Medical Knowledge

Conrad and Barker show how medical knowledge is socially constructed; that is, it can both reflect and reproduce inequalities in gender, class, race, and ethnicity. Conrad and Barker (2010) use the example of the social construction of women’s health and how medical knowledge has changed significantly in the course of a few generations. For instance, in the early 20th century, pregnant women were discouraged from driving or dancing for fear of harming the unborn child, much as they are discouraged from smoking or drinking alcohol today.

Pink has been associated with breast cancer since 1991, when the Susan G. Komen Foundation handed out pink ribbons at its 1991 Race for the Cure event. Since then, the pink ribbon has appeared on countless products, and then by extension, the colour pink has come to represent support for a cure of the disease. No one can argue about the Susan G. Komen Foundation’s mission—find a cure for breast cancer—or the fact that the group has raised millions of dollars for research and care. However, some people question if, or how much, all these products really help in the fight against breast cancer (Begos 2011).

The advocacy group Breast Cancer Action (BCA) position themselves as watchdogs of other agencies fighting breast cancer. They accept no funding from entities, like those in the pharmaceutical industry, with potential profit connections to this health industry. They have developed a trademarked “Think Before You Pink” campaign to provoke consumer questioning of the end contributions made to breast cancer by companies hawking pink wares. They do not advise against “pink” purchases; they just want consumers to be informed about how much money is involved, where it comes from, and where it will go. For instance, what percentage of each purchase goes to breast cancer causes? BCA does not judge how much is enough, but it informs customers and then encourages them to consider whether they feel the amount is enough (Think Before You Pink 2012).

BCA also suggests that consumers make sure that the product they are buying does not actually *contribute* to breast cancer, a phenomenon they call “pinkwashing.” This issue made national headlines in 2010, when the Susan G. Komen Foundation partnered with Kentucky Fried Chicken (KFC) on a promotion called “Buckets for the Cure.” For every bucket of grilled or regular fried chicken, KFC would donate 50 cents to the Komen Foundation, with the goal of reaching $8 million: the largest single donation received by the foundation. However, some critics saw the partnership as an unholy alliance. Higher body fat and eating fatty foods has been linked to increased cancer risks, and detractors, including BCA, called the Komen Foundation out on this apparent contradiction of goals. Komen’s response was that the program did a great deal to raise awareness in low-income communities, where Komen previously had little outreach (Hutchison 2010).

What do you think? Are fundraising and awareness important enough to trump issues of health? What other examples of “pinkwashing” can you think of?

# 28.Global Health

**Social epidemiology** is the study of the causes and distribution of diseases. Social epidemiology can reveal how social problems are connected to the health of different populations. These epidemiological studies show that the health problems of high-income nations differ greatly from those of low-income nations. Some diseases, like cancer, are universal. But others, like obesity, heart disease, respiratory disease, and diabetes are much more common in high-income countries, and are a direct result of a sedentary lifestyle combined with poor diet. High-income nations also have a higher incidence of depression (Bromet et al. 2011). In contrast, low-income nations suffer significantly from malaria and tuberculosis.

How does health differ around the world? Some theorists differentiate among three types of countries: core nations, semi-peripheral nations, and peripheral nations. Core nations are those that we think of as highly developed or industrialized, semi-peripheral nations are those that are often called developing or newly industrialized, and peripheral nations are those that are relatively undeveloped. While the most pervasive issue in the Canadian care system is timely access to health care, other core countries have different issues, and semi-peripheral and peripheral nations are faced with a host of additional concerns. Reviewing the status of global health offers insight into the various ways that politics and wealth shape access to health care, and it shows which populations are most affected by health disparities.

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# 29.Health in High-Income Nations

Obesity, which is on the rise in high-income nations, has been linked to many diseases, including cardiovascular problems, musculoskeletal problems, diabetes, and respiratory issues. According to the Organisation for Economic Co-operation and Development (2013), obesity rates are rising in all countries, with the greatest gains being made in the highest-income countries. The United States has the highest obesity rate for adults, while Canada rated fifth. Wallace Huffman and his fellow researchers (2006) contend that several factors are contributing to the rise in obesity in developed countries:

1. Improvements in technology and reduced family size have led to a reduction of work to be done in household production.
2. Unhealthy market goods, including processed foods, sweetened drinks, and sweet and salty snacks are replacing home-produced goods.
3. Leisure activities are growing more sedentary; for example, computer games, web surfing, and television viewing.
4. More workers are shifting from active work (agriculture and manufacturing) to service industries.
5. Increased access to passive transportation has led to more driving and less walking.

Obesity and weight issues have significant societal costs, including lower life expectancies and higher shared health care costs. High-income countries also have higher rates of depression than less affluent nations. A recent study (Bromet et al. 2011) shows that the average lifetime prevalence of major depressive episodes in the 10 highest-income countries in the study was 14.6 percent; this compared to 11.1 percent in the eight low- and middle-income countries. The researchers speculate that the higher rate of depression may be linked to the greater income inequality that exists in the highest-income nations.

# 30.Health in Low-Income Nations

countries, malnutrition and lack of access to clean water contribute to a high child mortality rate. (Photo courtesy of Steve Evans/flickr)

In peripheral nations with low per capita income, it is not the cost of health care that is the most pressing concern. Rather, low-income countries must manage such problems as infectious disease, high infant mortality rates, scarce medical personnel, and inadequate water and sewer systems. Such issues, which high-income countries rarely even think about, are central to the lives of most people in low-income nations. Due to such health concerns, low-income nations have higher rates of infant mortality and lower average life spans.

One of the biggest contributors to medical issues in low-income countries is the lack of access to clean water and basic sanitation resources. According to a 2011 UNICEF report, almost half of the developing world’s population lacks improved sanitation facilities. The World Health Organization (WHO) tracks health-related data for 193 countries. In their 2011 World Health Statistics report, they document the following statistics:

1. Globally, the rate of mortality for children under five was 60 per 1,000 live births. In low-income countries, however, that rate is almost double at 117 per 1,000 live births. In high-income countries, that rate is significantly lower than 7 per 1,000 live births.
2. The most frequent causes of death for children under five were pneumonia and diarrheal diseases, accounting for 18 percent and 15 percent, respectively. These deaths could easily be avoidable with cleaner water and more coverage of available medical care.
3. The availability of doctors and nurses in low-income countries is one-tenth that of nations with a high income. Challenges in access to medical education and access to patients exacerbate this issue for would-be medical professionals in low-income countries (World Health Organization 2011).

# 31.Conclusion

A sociological understanding emphasizes the influence of people’s social backgrounds on the quality of their health and health care. A society’s culture and social structure also affect health and health care.

The functionalist approach emphasizes that good health and effective health care are essential for a society’s ability to function. The conflict approach emphasizes inequality in the quality of health and in the quality of health care.

The interactionist approach emphasizes that health and illness are social constructions; physical and mental conditions have little or no objective reality but instead are considered healthy or ill conditions only if they are defined as such by a society and its members.

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