DICTIONARY OF MEDICAL SOCIOLOGY

William C. Cockerham, Ferris J. Ritchey

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Dictionary of
Medical Sociology

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and
Ferris J. Ritchey

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William C. Cockerham dedicates this work to Carl and Jewel Cockerham.

Ferris J. Ritchey dedicates this work to Wanda, Daniel, Sarah, Kitty, Lynn, and Neal Ritchey. It is done in fond memory of Irving L. Webber and Phillip Ritchey.

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Preface

As a scientific discipline or specialty develops an identity, consensus typically emerges as to which concepts are central to the field, as well as precise definitions of those concepts. In the discipline of medical sociology, and the broader area of the sociology of health and illness, a dictionary of terminology is long overdue. As a sociological specialty, medical sociology has a distinct history and literature spanning over four decades. This literature is a synthesis of medical and sociological knowledge reflecting analysis of the relationship between medicine, health, and society. Besides medical sociologists, physicians, nurses, psychologists, social workers, therapists, hospital administrators, health insurance companies, health economists, and others rely on the basic insights of sociology in research, patient care, and job performance.

This dictionary should help not only scholars and students of medical sociology but also practitioners and researchers in related fields who encounter sociological terminology and require definitions. Where terms are used in more than one way, we provide multiple definitions or seek a consensus definition for the field. For all but the most standard entries, we supply a brief discussion of the theoretical and practical contributions of the term and describe the contexts to which it applies. For appropriate entries, we provide cross-references to related terms to assist the reader in placing a concept in its conventional research context. Cross-references are those terms in **bold**. We hope, then, that a brief study of the dictionary will function to orient readers to the scope of medical sociology.

Entries were selected by a systematic review of the indices of over a dozen medical sociology texts and scholarly works. In addition, we scanned volumes of the past five years of several major sociological journals. We also searched lists of keywords from reference works and software, such as *Index Medicus*, *Sociological Abstracts*, and *Medline*. Sociology is a research discipline for many applied fields; furthermore, sociology borrows terminology from related fields. Thus, we found it necessary to establish a set of criteria for inclusion in this dictionary. These criteria were: (1) any generic terms created by medical sociologists, and subsequently employed frequently in sociological research; (2) descriptive terms created by medical sociologists for which a thorough definition is warranted; (3) terms from related disciplines which are regularly used by medical sociologists because of practical utility (e.g., *prevalence*); and (4) the exclusion of terms from related disciplines for which a reader would expect to find a definition elsewhere (e.g., *bipolar disorder*, a psychiatric term). In general, terms shared by both sociology and related disciplines were included if they were often used by medical sociologists because their applications suited typical sociological levels of analysis (community, group, organization, structure, relationship, etc.) and theoretical scope. We also included definitions of selected sociological theoretical orientations, such as functionalism and symbolic interaction.

On the practical side, the accompanying bibliography contains many references useful for a literature search related to a particular concept. The style of citation is that of the *American Sociological Review*. The bibliography entries are in alphabetical order by last name of first author.

Entries in this dictionary, of course, are alphabetized, but without definite articles such as *an* and *the*. Where multiple forms of a concept are commonly used, cross-references are made to what we think is the most widely used and recognized form.

The authors would like to acknowledge the assistance of Jeffrey M. Clair and Michael Wrigley, who provided ideas on the inclusion of certain terms. They would like also to thank Takayo Ashford and Christine Lindquist for assisting with library searches and Kelli Lawhon, Sheila Widener, and Jackie Skeen for assembling the manuscript.

Introduction: An Overview of Medical Sociology

Although a relatively new subdiscipline of the general field of sociology, medical sociology has developed to the point that a dictionary helping to define its terms and areas of study has become necessary. Today medical sociologists comprise one of the largest groups of sociologists in the world. For example, the Medical Sociology Section is the largest speciality represented in both the British and German Sociological associations and the second largest among American sociologists. There are also European and Japanese Societies of Health and Medical Sociology. Since its inception in the years following World War II, medical sociology has not only acquired a large number of practitioners, but it has attracted significant funding for research, provided employment opportunities within and outside academia, and produced numerous books and a high volume of publications in specialized and general journals.

Medical sociology began with a different orientation when compared to sociology's ''core'' fields (Ruderman 1981). Unlike religion, law, politics, modes of economic production, and basic social processes, medicine was ignored by sociology's early theorists because it was not an institution shaping society. Medical sociology did not come of age until the late 1940s and early 1950s in an intellectual climate far different from sociology's traditional specialties with direct roots in nineteenth-century social thought. Consequently, medical sociology evolved in circumstances dissimilar to those of most other sociological subdisciplines. The principal difference is that medical sociology was expected by funding agencies and policymakers to be an applied field producing social knowledge that could be used in medical practice, public health campaigns, and health policy formulation. In contrast, other sociological specialties concerned with social stratification, groups, organizations, work, politics, and the like were grounded in theory and featured classical studies by major figures in the field.

Yet, the tremendous growth of medical sociology in both the United States and Europe in recent years most likely would not have been possible without the substantial financial support for applied studies provided by the respective governments. For example, in the United States, where medical sociology has reached its most extensive development, the emergence of the field was greatly stimulated by the expansion of the National Institutes of Health (NIH) in the late 1940s. Particularly significant, according to August Hollingshead (1973), who participated in some of the early research programs, was the establishment of the National Institute of Mental Health (NIMH) that was instrumental in encouraging and funding joint social and medical projects. ''It was through the impetus provided by this injection of money,'' noted Malcolm Johnson (1975:229), ''that sociologists and medical men changed their affiliations and embraced the field of medical sociology.'' When Alvin Gouldner (1970) discussed the social sciences as a well-financed government effort to help cope with the problems of industrial society and the welfare state in the West during the post–World War II era, the prototypical social science in this effort was medical sociology.

The same situation prevailed in Europe. A study conducted in the early 1980s concluded that government funding of research was *the* initial attraction to the field by the majority of respondents (Claus 1982). Few were primarily affiliated with a university sociology department, and ties to the general discipline of sociology were depicted as weak. Work affiliation rather than professional prerequisites tended to determine identification as a medical sociologist, and the dominant employment pattern was to work in an applied role, typically research, in a medical institution. Furthermore, only about one-fourth of the respondents held a doctoral degree in sociology, and approximately one-third of those identifying themselves as medical sociologists had not received any formal training in medical sociology (defined as at least one course/seminar/workshop in medical sociology during their education).

In the beginning of medical sociology's expansion, it is clear that many people in the field had tenuous roots in mainstream sociology and a work perspective oriented toward applied rather than theoretical interests (Cockerham 1983). This condition was reinforced by the tendency of increased levels of funding to correspond with increased demands for applied sociology that can be articulated into public policy by the sponsoring agency. The base for medical sociology in its formative years was in medical institutions, and many medical sociologists had little or no connection to the parent discipline.

This situation led Robert Straus (1957) to suggest that medical sociology had become divided into two areas: sociology *in* medicine and sociology *of* medicine. The sociologist *in* medicine is a sociologist who collaborates directly with physicians and other health personnel in studying the social factors that are relevant to a particular health problem. The work of the sociologist in medicine is intended to be directly applicable to patient care, and other practical uses in the area of health. Thus, sociology in medicine can be characterized as *applied research and analysis primarily motivated by a medical problem* rather than a sociological problem. Sociologists in medicine usually work in medical schools, nursing schools, public health schools, teaching hospitals, public health agencies, and other health organizations.

The sociology *of* medicine, on the other hand, has a different emphasis. It deals with such factors as the organization, role relationships, norms, values, and beliefs of medical practice as a form of human behavior. The emphasis is on the social processes that occur in the medical setting and how these contribute to our understanding of medical sociology in particular and to our understanding of social life in general. The sociology of medicine shares the same goals as all other areas of sociology and may consequently be characterized as *research and analysis of the medical environment from a sociological perspective.* Although some sociologists of medicine are employed in health institutions, the majority work as professors in the sociology departments of universities and colleges.

However, the division of work in medical sociology into a sociology of medicine and sociology in medicine eventually created problems. Medical sociologists affiliated with departments of sociology in universities were in a stronger position to produce work that satisfied sociologists as good sociology. But sociologists in medical institutions had the advantage of participation in medicine as well as research opportunities unavailable to those outside medical practice. A certain amount of tension began to develop between the two groups over whose work was the most important. What happened to change this situation was a general evolution in medical sociology toward work that combined both applied and theoretical perspectives by medical sociologists in all settings. The division of the field as outlined by Straus lost its distinctiveness in the United States and never really developed in Western Europe. Most research in medical sociology today, regardless of whether it is in a sociology department in a university or in a medical institution, deals with practical problems.

Although the potential for dependence on medicine was a real possibility in the first years of medical sociology's development, the situation became less of a reality over time. Medical sociology did not evolve as a field providing research services in support of medicine. Rather, medical sociologists followed their own path and, in fact, became critics of medicine when the situation was warranted, as seen in some well-known studies dealing with the lack of access to health care by the poor (Kosa, Antonovsky, and Zola 1969), as well as medical mistakes (Millman 1977), failures (Bosk 1979), and opposition to health reform (Starr 1982). By the late 1990s, medical sociology had not only established an independent position relative to medicine, but it had also turned to mainstream sociology for its basic orientation. As Bernice Pescosolido and Jennie Kronenfeld (1995) point out, current thinking in medical sociology is often guided by concepts and theories associated with the parent discipline. And as the parent discipline adjusts its perspectives to the social changes accompanying the transition from the industrial age into postindustrial or late modern/postmodern society, further reconnections with medical sociology are predicted.

MEDICAL SOCIOLOGY: THE BEGINNING

Elizabeth Blackwell, the first woman to graduate from an American medical school, named a collection of essays on health topics *Medical Sociology* in 1902 and James Warbasse published a book of essays on medicine and society entitled *Medical Sociology* in 1909. In 1935, biologist and physician Lawrence Henderson, whose work strongly influenced Talcott Parsons, published a paper on "The Physician and Patient as a Social System" in the *New England Journal of Medicine* (Gerhardt 1989). Interest in the field, largely on the part of physicians, was slowly growing but, as noted, medical sociology did not begin in earnest until after World War II. It was at this time that significant amounts of government funding for sociomedical research became available in the United States and Western Europe. Under the auspices of the National Institute of Mental Health, medical sociology's initial alliance in medicine was with psychiatry, a medical specialty that was undergoing a struggle of its own for professional status within its wider discipline. Prior to this time, sociologists had conducted important epidemiological research on mental disorders, creating a basis for cooperation between sociologists and psychiatrists. A particularly significant result of such cooperation was the publication in 1958 of *Social Class and Mental Illness: A Community Study* by Hollingshead (a sociologist) and Frederick Redlich (a psychiatrist). This landmark research produced important evidence that social factors were correlated with different types of mental disorders and the manner in which people received psychiatric care. This study attracted international attention and remains the best-known study in the world of the relationship between mental disorder and social class. The book played a key role in the debate during the 1960s leading to the establishment of community mental health centers in the United States.

Monies from federal and private organizations also helped stimulate cooperation between sociologists and physicians in regard to sociomedical research on problems of physical health. In 1949 the Russell Sage Foundation funded a program to improve the utilization of social science research in medical practice. One result of this program was the publication in 1954 of *Social Science in Medicine*, co-authored by Leo Simmons (a sociologist) and Harold Wolff (a physician), intended to provide a framework for collaboration between social scientists and medical doctors. Other work sponsored by the Russell Sage Foundation and appearing a few years later, included Edward Suchman's *Sociology and the Field of Public Health* (1963). This book described how sociology could be applied to public health practice. When large-scale funding initially became available in the late 1940s, medical sociology was primarily oriented toward an applied approach.

THE CONTRIBUTIONS OF TALCOTT PARSONS

A critical event took place in medical sociology in 1951 that reoriented the field in a theoretical direction. This was the appearance of Talcott Parsons's *The Social System*. This book, written to explain a complex functionalist model of society in which social systems are linked to corresponding systems of personality and culture, contained Parsons's concept of the sick role. Unlike other major social theorists preceding him, Parsons included an analysis of the function of medicine in his view of society. In the mid-1930s, Parsons (1951) had made the decision to examine professional occupations and practice, a neglected area at that time in comparisons of capitalism and socialism. The relationship of the professional to his or her client seemed to fit neither the popular notion of a self-interested, profit-maximizing, capitalistic model, nor a socialistic equalitarian model. Among the professions, Parsons (1951:428–429) chose to study medical practice because it was an area of long-standing interest and one in which he felt he had a relatively good command of empirical material.

In his investigation of the social significance of medical practice, Parsons was led to consider the nature of "psychic disease"; this in turn caused him to be introduced to the work of the Austrian psychoanalyst Sigmund Freud. Freud, along with sociologists Emile Durkheim of France and Max Weber of Germany, became a central influence upon Parsons's perspective. Freud's ideas of transference and countertransference helped Parsons draw analogies between the roles of parent-child and physician-patient, while Freud's structure of the personality and theory of the unconscious assisted Parsons in developing his perspective on the role of individual motivation in social systems. Although Parsons's dependence upon psychoanalytic theory in his concept of the sick role is sometimes forgotten, Freud's views on motivation are integral features of Parsons's approach (Gerhardt 1989). The sick person is presumably motivated to recover (as a result of socialization and the formation of the superego) and yet may perhaps also be motivated, either consciously or unconsciously, to desire the "secondary gain" of privileges and exemptions from normal social roles that accompany sick role legitimation.

Parsons, however, not only turns to Freud to explain how the normative culture is internalized in the personality through socialization but also uses the work of Durkheim (on moral authority) and Weber (on religious values) to set the background for his approach to socialization. Aspects of this perspective are not entirely incompatible with symbolic interaction theory as expressed through George Herbert Mead's (1934) concept of the role of the "generalized other" in the socialization process. As Richard Münch, (1993) points out, Parsons constructed a particularly fruitful synthesis of the classics that unites the contributions of Freud, Durkheim, and Weber into a general theory of action. By bringing a concept of health and illness into his general scheme, Parsons was the first to demonstrate the role of medicine in macro-level social systems and did so within the parameters of classical theory.

It has been claimed that Parsons's concept of the sick role represents the most important single theoretical contribution to medical sociology to date (Fox 1979). The usual justification for this claim is that his sick role provides the most consistent and systematic approach to analyzing the behavior of sick people in Western society. Another reason, however, can be offered to support the significance of the concept. That is, it should be recognized that having a theorist of Parsons's stature render the first major theory in medical sociology called needed attention to the young subdiscipline—particularly among academic sociologists. Not only was the Parsons concept of the sick role "a penetrating and apt analysis of sickness from a distinctly sociological point of view" (Freidson 1970a:228), but it was widely believed at the time that he and his students were charting a future course for all of sociology through the insight to be provided by Parsonian theory generally. Consequently, whatever area of sociology that came under Parsons's scrutiny was likely to attract attention. Without a doubt, his sick role concept stimulated a considerable body of research in medical sociology. Although extensive criticism was to subsequently lessen the acceptance of his ideas, this outcome does not negate the significant influence that Parsons initially had on promoting debate and research within medical sociology.

In fact, it has been argued that in no other area of sociology has Parsons's approach achieved a more influential position than in medical sociology. This argument, presented by Ruderman (1981), however, takes Parsons to task for removing medical sociology from the substance of medicine. In being a distinctly sociological concept, the sick role had directed the perspective of medical sociologists outside medicine exclusively toward theoretical sociology. It is Ruderman's perspective that medical sociology was harmed by the hold of Parsonian theory because it oriented sociological interest in medicine toward the purely social aspects of health situations, thereby leading sociologists to fail to consider the entire experience of being ill and to neglect the actual content of medical knowledge.

Yet, in rebuttal, it should be noted that Parsons's approach established a theoretical basis for medical sociology that brought the subdiscipline the intellectual recognition that it needed in its early development in the United States. The institutional base for sociology in the United States was in the universities, where the departments at Harvard, Chicago, and

Berkeley established the discipline more firmly than anywhere else in the world. Without academic legitimacy and the subsequent participation of such well-known mainstream academic sociologists as Robert Merton, Everett Hughes, Howard Becker, and Erving Goffman, all of whom published research in the field, medical sociology would lack the theoretical basis and professional position that it currently has in both academic and applied settings. Structural-functionalist theory may not be the optimal paradigm for explaining illness, but Parsons formulated a concept of the illness experience in relation to society that had a profound effect on the subsequent development of medical sociology: Parsons made medical sociology academically respectable.

THE POST–PARSONS ERA

The next major area of research after Parsons developed his concept of the sick role was medical education. Merton and his colleagues in *The Student Physician* (1957) extended the functionalist mode of analysis to the socialization of medical students, with Renée Fox's paper on training for uncertainty ranking as a major contribution. Shortly thereafter, Howard Becker and his associates published *Boys in White* (1961), a study of medical school socialization conducted from a symbolic interactionist perspective. This study, which was to become a sociological classic, proved important for both its theoretical and methodological content. The techniques in participant observation employed in *Boys in White* proved to be the basis for the subsequent innovations in both theory and method developed by Barney Glaser and Anselm Strauss in *The Discovery of Grounded Theory* (1967) and *Status Passage* (1971). Other research in medical education focused on the training of nurses and much of it, especially the work of Fred Davis (1972), reflected a symbolic interactionist framework of analysis.

With the introduction of symbolic interactionist research into an area previously dominated by functionalism, medical sociology became an arena of debate between two of sociology's major theoretical schools. This debate stimulated more interest in the field by academic sociologists, and beginning in the 1960s there was a virtual flood of publications dealing with medical sociology. Furthermore, the Medical Sociology Section of the American Sociological Association became one of the largest and most active groups in the ASA. In 1966 the *Journal of Health and Social Behavior*, founded in 1960, became an official ASA publication, making medical sociology one of the few sociological subdisciplines publishing its own journal under ASA auspices.

During the mid-1960s, the symbolic interactionist perspective came to dominate a significant portion of the literature. One feature of this domination was the numerous studies conducted with reference to labeling theory and the subsequent controversy it provoked. Although labeling theory pertained to deviant behavior generally, the primary center of argument was focused on the mental patient experience. In this area, Thomas Scheff (1966) became the principal proponent of the labeling approach and Walter Gove (1970) his principal critic. Labeling theory was also used to express findings resulting from studies of physical health. For example, Eliot Freidson (1970b) used a labeling orientation to propose an alternative concept of the sick role.

Sociologists expanded their work in mental health during the late 1950s and 1960s to include not only studies of mental patients but also studies of stigma, stress, families coping with mental disorder, and other areas of practical and theoretical importance. Erving Goffman's *Asylums* (1961), a study of life in a mental hospital, set forth his concept of "total institutions" that has emerged as a significant theoretical statement in the general discipline of sociology. An abundant literature subsequently evolved, making the sociology of mental disorder a major subfield within medical sociology (Cockerham 1996).

Two other categories of research were particularly prominent in the 1960s. These other categories were help-seeking behavior and death and dying. Help-seeking behavior, or reasons that certain people do or do not seek out professional services when they think they are ill, is and remains an important research problem. The seminal study in this regard was Earl Koos's *The Health of Regionville* (1954), which had demonstrated an important link between social class and perceived symptoms of illness or disability. As for the relevance of ethnicity in health services utilization, it remained for Suchman (1965a) to study beliefs in and degree of acceptance of modern medicine among several ethnic groups in New York City. Building upon Freidson's (1960) concept of the lay-referral system, Suchman found that the greatest resistance to using physician services was in lower class neighborhoods characterized by strong ethnic identification and extended family relationships. In another paper, Suchman (1965b) made a second major contribution by formulating a model of the illness experience. Related research by Mark Zborowski (1952), David Mechanic and Edmund Volkart (1961) and Irving Zola

(1966) produced important information on social variations in the perception of illness.

Public and professional interest in death and dying during the late 1960s practically became a fad, and research in medical sociology was instrumental in promoting this development. The work of Glaser and Strauss (1965, 1968) and David Sudnow (1967) called attention to the social facets of the dying experience—especially the problem of death as a solitary experience in the modern hospital where the dying patient was often found to be both socially and psychologically isolated. Sudnow depicted the difference between "social" as opposed to "clinical" death, while Glaser and Strauss (1965) developed a theory of awareness contexts derived from a lack of openness among hospital staff who worked with terminally ill patients.

The accumulation of a vast literature resulted in efforts to summarize the field through textbooks written for the many courses in medical sociology appearing in colleges and universities across the country. The first medical sociology textbook was Norman Hawkins's *Medical Sociology* (1958). Next came Samuel Bloom's *The Doctor and His Patient* (1963), intended largely for use by medical students, while two collections of edited readings, E. Gartly Jaco's *Patients, Physicians, and Illness* (1979) and Howard Freeman et al.'s *Handbook of Medical Sociology* (1989), reached three and four editions, respectively. As for textbooks, the first edition of Mechanic's *Medical Sociology* appeared in 1968, followed two years later by Rodney Coe's *Sociology of Medicine* (1st ed., 1970) and Robert Wilson's *The Sociology of Health* (1st ed., 1970). Also forthcoming in 1970 were Freidson's *Profession of Medicine* (1970a) and *Professional Dominance* (1970b). Freidson's latter book became a major statement on the social aspects of medical professionalization.

THE RECENT PAST: 1970–1990

At the beginning of the 1970s, there were a number of books and articles on medical sociology. But except for Leon Robertson and Margaret Heagerty's *Medical Sociology: A General Systems Approach* (1975), no American textbooks were published between 1970 and 1977. In 1977, however, there began a wave of new books as several medical sociologists took the opportunity to provide fresh material. First came Daryl Enos and Paul Sultan's *The Sociology of Health Care* (1977) and Andrew Twaddle and Richard Hessler's *A Sociology of Health* (1977), followed by a second edition in 1987. Next came the first edition of

William Cockerham's *Medical Sociology* (1978), followed by John Denton's *Medical Sociology* (1978), and second editions of the Coe (1978) and Mechanic (1978) books. Subsequent textbooks were Minako Maykovich's *Medical Sociology* (1980), William Rosengren's *Sociology of Medicine* (1980), Frederic Wolinsky's *The Sociology of Health*, which appeared in two editions (1980 and 1988), Emily Mumford's *Medical Sociology* (1983), and Richard Kurtz and H. Paul Chalfant's *The Sociology of Medicine and Illness* (1984). Another book, *The Sociology of Medicine* (1989), consisted of a collection of essays by Rene Fox on a variety of topics. Three editions of the Cockerham text appeared in the 1980s (1982, 1986, 1989).

Besides textbooks, several readers were published—including readings assembled by Howard Schwartz and Cary Kart (1986), which appeared in two editions; Gary Albrecht and Paul Higgins (1979), Mechanic (1980), Peter Conrad and Rochelle Kern (1990), with three editions; Linda Aiken and David Mechanic (1986), and Phil Brown (1989).

The research conducted in medical sociology from the early 1970s until 1989 reflected change both in the interests of medical sociologists and in the delivery of health services in the United States. Some of this research centered on measuring the organizational characteristics and effectiveness of hospitals and other health care agencies. Studies dealing with stress and the impact of life events on physical and mental health also attracted numerous researchers, and publications in this area are now common in medical sociology (Mirowsky and Ross 1989). Other work focused on the construction of quantitative models, such as the model developed by Ronald Andersen and his colleagues (1975) for the measurement of variables significant in the utilization of physician services. As noted, medical perspectives did not consistently shape sociological research, as several objective studies critical of medical practice were published in the 1970s.

Interest in the use of health services remained a major focus because patterns of utilization in the United States changed. Medicare and Medicaid public health insurance programs reduced financial barriers to health care by the poor, and several studies showed that physician utilization by the lower classes became greater than that of higher social strata (Andersen and Anderson 1979; Cockerham 1995). Furthermore, the culture of poverty barrier—which consists of lower-class and ethnic beliefs, attitudes, and norms operating to restrain interaction with physicians—became less important than the studies in medical sociology found in the 1950s and 1960s. Systems barriers inherent in the organization and psychological environment of welfare medicine now appear to be a significant factor reducing use of physician services by the poor, who might otherwise possibly utilize such services to an even greater extent because of greater need. Rounding out the literature on health care delivery were several critiques from a Marxist perspective provided by Vicente Navarro (1976, 1986) and Howard Waitzkin (1983).

In the meantime, in Western Europe, especially in Great Britain, Germany, and the Netherlands, medical sociology was evolving into a full-fledged subdiscipline. Medical sociology began developing in Britain in the mid-1960s and has become a major area of sociological work. The first textbook in medical sociology in Britain, *Sociology in Medicine*, was published by Mervyn Susser and William Watson in 1962; two other editions followed with American materials, the most recent published in 1985 with Kim Hopper. Other books that contained views of the literature in British medical sociology included David Robinson's *Patients, Practitioners and Medical Care* (1973) and Anne Cartwright and Robert Anderson's *General Practice Revisited: A Second Study of Patients and Their Doctors* (1981), a follow-up to an earlier survey in 1964. David Tuckett published a reader, *An Introduction to Medical Sociology* (1976), while Bryan Turner's *Medical Power and Social Knowledge* (1987) provided a selective view of medical sociology that utilized sociological theory in a critique of medicine. Moreover, the British instituted two journals for medical sociology, *Social Science & Medicine*, which serves an international readership and *Sociology of Health and Illness*.

Two areas in which British medical sociologists excelled were applied medical sociology, written largely for students in health fields and emphasizing the analysis of medical practice. The applied medical sociology books included R. Kenneth Jones and Patricia Jones's *Sociology in Medicine* (1975) and David Armstrong's *An Outline of Sociology as Applied to Medicine* (1989), which had three editions, the last appearing in 1989. Also there were edited books such as Caroline Cox and Adrian Mead's *A Sociology of Medical Practice* (1975) and Donald Patrick and Graham Scambler's *Sociology as Applied to Medicine*, which included a third edition in 1991.

The second area is in micro-level studies of interaction in medical settings, especially analysis of everyday work in professional practice. From this growing tradition in British medical sociology has emerged a series of studies analyzing clinical work from the viewpoints of the participants within a relatively broad symbolic interactionist and ethnomethodological framework. These ethnographies provide accounts of day-to-day relationships between patients, practitioners, and others in medical organizations in a richness of detail not typically available in American work. Some of the studies in this mode are G. Stimson and A. Webb's *Going to See the Doctor* (1975), W. Wadsworth and D. Robinson's *Studies in Everyday Medical Life* (1976), Alan Davis and Gordon Horobin's *Medical Encounters* (1977), Robert Dingwall's *The Social Organization of Health Visitor Training* (1977), Paul Atkinson and Christian Heath's *Medical Work* (1981), and Atkinson's *The Clinical Experience: An Ethnography of Medical Education* (1981). Another book produced in this tradition was Ray Fitzpatrick et al.'s *The Experience of Illness* (1984).

The first German textbook on medical sociology, *Lehrbuch der Medizinischen Soziologie* was authored by Johannes Siegrist in 1974 and is in its fifth edition (1995). Among the other German-language texts dealing specifically with medical sociology and not a combination of medical psychology and sociology (that tend to be weighted more heavily in favor of psychology) are two books that appeared in 1975. These are Christian von Ferber's *Soziologie für Mediziner* and an edited book, *Medizinsoziologie*, by Brigitte Geissler and Peter Thoma, a second edition of which appeared in 1979. Two other books published in 1978 were *Medizinische Soziologie*, by Hans-Ulrich Deppe, western Germany's leading Marxist medical sociologist, and *Medizinische Soziologie*, by Wilhelm Roessler and Herbert Viefhues. More recent texts are those by Paul Lüth, *Medizin in unserer Gesellschaft* (1986), and an edited book by Alexander Schuller and his colleagues, *Medizin-Soziologie* (1992).

Schuller and American medical sociologist Donald Light co-edited an important work on Germany's health care delivery system, *Political Values and Health Care: The German Experience* (1986). Other major German studies in medical sociology include those of Günther Lüschen et al., *Health and Illness in America and Germany* (1989) and *Health Systems in the European Union* (1995).

As elsewhere, medical sociology remains relatively new in Germany. Only since 1958 have German scholars shown an interest in the field, and medical sociology had no foothold in German medical education until 1970 (Cockerham 1983). A traditional relationship between sociology and medicine grounded in social medicine dates from the efforts of certain German historical figures in 19th-century medicine, primarily Rudolf Virchow, Salomon Neuman, and Alfred Grotjahn, to emphasize the link between illness and social conditions. Virchow, whose work in cellular pathology is a major contribution to the development of Western medicine, once declared that medicine is a social science. His insight in this regard is often cited as historical justification for cooperation between medicine and sociology in Germany. But what might have been a promising intellectual climate for medical sociology in West Germany was, until the 1970s, compromised by the rivalry with social medicine and the neglect of medical sociology by academic sociologists.

According to Elizabeth Claus (1982), medical sociology gained control of medical sociological knowledge in West Germany because of the increasing number of sociologists conducting medical sociological research. Medical sociology has now become the largest sociological subfield in sociology in terms of participants. With the collapse of communism in 1989 and 1990 and the subsequent reunification of Germany, the expansion of medical sociology into eastern German universities is likely to occur. The East German State had a Marxist-based medical sociology, so some tradition exists for the field's growth in the region (Hüttner 1987).

One of the most significant publications in medical sociology in the 1980s was Paul Starr's *The Social Transformation of American Medicine* (1982), which won the Pulitzer prize. Starr's book examined the decline in status and professional power of the medical profession and the rise of large corporate health care delivery systems oriented toward profit. Major areas of research in medical sociology in the late 1980s included studies of health differences between men and women (Verbrugge 1985, 1989), social stratification and health (Kaplan 1989), health lifestyles (Cockerham, Kunz, Lueschen, and Spaeth 1986; Cockerham, Kunz, and Lueschen 1988), and AIDS (Weitz 1989), as well as further investigation of the changing professional status of physicians (Ritzer and Walczak 1988).

Efforts were also underway to demonstrate the utility of theory in medical sociological work. In the United States, Waitzkin's (1989) use of Marxist theory to analyze physician-patient interaction represents a major contribution, while Barry Glassner (1988, 1989) applied postmodern theory to an analysis of the body and the self. Research on the body received major attention during this period, especially in Europe where Bryan Turner's book, *The Body and Society* (1984), initiated the sociological debate on this topic. Turner based much of his insight on the earlier work of the French theorist Michel Foucault (1973), who examined the ways in which medical knowledge was used to socially control the human body through institutions like the clinic. Also in Europe, medical sociologists like Britain's Graham Scambler edited a groundbreaking book entitled *Sociological Theory and Medical Sociology* (1987) that brought together a variety of theoretical perspectives on health and medicine, and Germany's Uta Gerhardt produced an extensive theoretical discussion—spanning a decade of work—in her book *Ideas about Illness: An Intellectual and Political History of Medical Sociology* (1989).

THE 1990s

Important work in medical sociology continues in the 1990s. Current research topics include stress (Thoits 1995), women's health (Ross and Bird 1994), AIDS (Rushing 1995), health lifestyles (Cockerham, Abel, and Lüschen 1993), homelessness (Ritchey, La Gory, and Mullis 1991), patient-physician encounters (Atkinson 1995; Waitzkin 1991), and health care reform (Navarro 1995; Starr 1994). There is also growing interest in cross-national comparisons of health care delivery (Gallagher and Subedi 1995; Lüschen et al. 1995; Subedi and Gallagher 1996). Reconnections with the parent discipline of sociology are continuing, as seen in a variety of areas, including the integration of the work of classical theorists like Max Weber into medical sociological research (Cockerham, Abel, and Lüschen 1993).

Textbooks on medical sociology continue to enter the marketplace as well. Richard Kurtz and H. Paul Chalfant produced a second edition in 1991 and issued a set of audiocassettes based on their book in 1994. New texts that entered the field included Peter Freund and Meredith McGuire's *Health, Illness, and the Social Body* (1991), the second edition in 1995. This book focuses on power relations in medicine and uses Marxist and conflict theory as its orientation. Gregory Weiss and Lynne Lonnquist published *The Sociology of Health, Healing, and Illness* in 1994, and another new textbook is that of Rose Weitz entitled *The Sociology of Health, Illness, and Health Care* (1996). In Britain Graham Scambler et al. came out with a new edition in 1991, and Sarah Nettleton published a text, *The Sociology of Health and Illness* (1995), using a social constructionist perspective. However, the books that have stood the test of time better than any other intended for classroom use in medical sociology are the Peter Conrad and Rochelle Kern reader now in its fourth edition (1994) and Cockerham's *Medical Sociology*, originally published in 1978 and issued in a sixth edition in 1995.

The works cited in this overview of medical sociology are not an exhaustive list, but the literature reviewed clearly demonstrates a solid foundation for the field. Medical sociology is one of the most important and fastest-growing areas of sociology, with the potential of producing ever more significant contributions to sociological knowledge. This discussion has focused primarily on the United States and Western Europe, but medical sociology is becoming increasingly important in Russia, Eastern Europe, and Japan. Publications from Japanese medical sociologists, for example, include English-language books by Masahira Anesaki (Powell and Anesaki 1990) and Kyoichi Sonoda (1988). Medical sociology has become a global discipline and popularity and usefulness is high as the twenty-first century approaches.

A

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)
The end stage of human immunodeficiency virus (HIV) disease known as AIDS. AIDS is a particularly deadly disease that destroys a person's immunity against infection, thus leaving the individual defenseless against a variety of other viruses, cancer, and pneumonia. The AIDS virus is primarily transmitted through vaginal or anal intercourse, intravenous (IV) drug use, blood transfusions or is passed to newborn infants while they are in the womb by infected mothers. Oral sex has low but potential risk (Rushing 1995). The World Health Organization (WHO) estimates that about one million people in the United States have the AIDS virus. On a global scale, WHO estimates that 10 million people are infected, with about 6.5 million of them in Africa. By the year 2000 WHO estimates that up to 40 million people may be infected. Africa is noteworthy because AIDS is believed to have originated there and the principal means of transmission—in contrast to the rest of the world—is through heterosexual relations. Centers for Disease Control and Prevention data show that about 55 percent of all reported cases of AIDS in the United States are homosexual or bisexual men, 24 percent are IV drug users, 7 percent result from heterosexual contacts, 5 percent are homosexuals and IV drug users, 2 percent are blood transfusion recipi-

ents, 1 percent are hemophilia patients, and the remaining 5 percent are from other or undetermined sources (Cockerham 1995).

AIDS is a disease of particular interest to medical sociologists because it has been characterized as a disease of society in the most profound sense (Nelkin, Willis, and Parris 1990). This is because the transmission of AIDS is grounded in the conduct of social life, primarily sexual behavior, and has the potential for changing sex habits and lifestyles worldwide. As William Rushing (1995) explains, the prevalence of AIDS depends on the behavior of populations and the social and cultural factors that underline such behavior. The sociological implications of AIDS involve not only the widespread modification of sexual behavior, but the deeply discrediting stigma attached to AIDS victims, the subjective distress associated with contracting AIDS, and the moral and religious debate centering on certain cases of AIDS as punishment for what is perceived by some as a deviant lifestyle. AIDS can take on the attributes of a master status in that it can become the single most important social characteristic of an infected person. Having AIDS often negatively influences the attitudes and behavior of others (Weitz 1989). For a discussion of the social dimensions of the AIDS epidemic, see Rushing (1995).

ACUTE ILLNESS (DISEASE)

Unhealthy conditions of short-term duration characterized by the sudden onset of symptoms (such as pain, discomfort, or inflammation), requiring urgent attention, and responsive to self-treatment or medical intervention (DeFriese and Earp 1989). Many acute illnesses have self-limiting natural histories, that is, that they will have no lasting health impact, and affected persons may expect to recover without extensive medical attention. The common cold is an example of a self-limited acute illness. Non–self-limiting acute conditions are those which require medical intervention to prevent further complications or death.

Sociological interest in acute illness focuses on its demographic and ecological correlates. In addition to identifying risk factors associated with various acute conditions, this focus contributes to an understanding of disease causation. Sociologists also study the organization of acute care services and its relationship to health care receipt. Finally, studies of acute illness, by revealing variations in the perception of symptoms, contribute to an understanding of the illness process (DeFriese and Earp 1989). Contrast with **Chronic disease (illness)**.

ADHERENCE (TO MEDICAL REGIMEN)

The degree to which a medical patient follows the treatment instructions of a physician. Adherence rates are typically measured as percentages of patients who purchase and use prescribed medicines and who return for scheduled physician visits.

Adherence is usually conceived as a medical encounter outcome variable, with distinctions made between two types of predictor variables: (1) systemic factors (i.e., health practitioner and organizational setting variables) and (2) personal factors (i.e., disease severity, patient health risk behavior, health attitudes, demographic characteristics, and financial enabling variables). Research findings suggest that personal factors are more important in predicting adherence to medical regimen than systemic factors (Roter 1989).

AGENT

An infectious organism (virus, bacteria, fungus, etc.), toxic substance (carcinogens, pollutants, etc.), or injurious object (vehicles, machinery, weapons, even dangerous toys) that is capable of producing disease, injury, or death. This term was originally used with reference only to infectious agents but, as chronic degenerative diseases and injuries have replaced communicable diseases as the major causes of mortality and morbidity, the term has been expanded to include noninfectious substances. *See also* **Infectious agent**.

AIDS

See **Acquired immunodeficiency syndrome**.

ALLIED HEALTH ENTERPRISES

''Manufacturers of pharmaceuticals and medical supplies and equipment which play a major role in research, development, and distribution of medical goods'' (Cockerham 1995:272). The allied health service industry thrived after World War II, spurred on by government subsidization of hospital construction, medical research and health care services. These enterprises, located outside hospitals and clinics, used animals and artificial simulations in the early stages of research and signified a separation of technological development from the clinical setting. This shift of locus resulted in medical role differentiation that threatened the professional status of those practitioners working in clinical settings. For example, pharmacological research moved from the hospital to the pharmacological labs of large drug companies. Ultimately, hospital pharmacists were left with nothing to do, because drug manufacturers supplied their products in "unit doses," ready for nurses to administer to the patient (Birenbaum 1982; Penna 1987). Eventually, pharmacists based in hospitals altered their roles to include more direct patient care. (*See* **Professional boundary maintenance.**) Other issues related to allied health enterprises are their contributions to health care quality and cost inflation, competition among hospitals for the status that accompanies the acquisition of state-of-the-art technologies, and ethical issues related to the processes by which technology is developed and marketed (Bell 1989).

ALLIED HEALTH PERSONNEL

Nonphysician health practitioners with doctor-assistant status who, together with physicians, comprise a health team capable of providing all levels of care to patients. Allied health practitioners include nurses, nurse's aides, nurse anesthetists, nurse-practitioners, nurse-midwives, physician assistants, physical therapists, laboratory technicians, clinical pharmacists, pharmacy technicians, medical records librarians, community health workers, anesthesiologist's assistant, blood bank technologists, cytotechnologists, electroneurodiagnosticians, emergency medical technicians, occupational therapists, perfusionists, radiologic assistants, respiratory therapists, and sonographists. Some allied health practitioners, such as nurse-practitioners, nurse-midwives, clinical pharmacists, and physical therapists, are attaining doctor-alternative status with the legal right to provide patient services independent of physician directives (Coe 1978:251–256; Ritchey and Raney 1981; Ritchey et al. 1989; Weiss and Lonnquist 1994:208–212).

ALLOPATHIC PHYSICIANS

The largest group of medical practitioners in the United States in the mid-nineteenth century, who called themselves "regular" physicians and whose legitimacy rested on claims of following traditional medical procedures developed in Europe. Allopathic physicians founded the American Medical Association in 1848 (Coulter 1980:395–396). The term "allopathic" was coined by Samuel Hahnemann (1755–1843), the German physician who founded homeopathy, to distinguish his holistic approach from what he considered the narrow, biocentric methods of allopathy. However, allopathic doctors were the ones who embraced scientific medicine and evolved to become the present-day physician (Jones 1978:5–6). *See also* **Homeopathic medicine**.

ALTERNATIVE HEALTH CARE PRACTITIONERS

Medical practitioners who provide direct health services, but do not hold the Doctor of Medicine (M.D.) degree, and may be sought out by patients for financial, cultural, or religious reasons. Sociology texts once referred to these practitioners as marginal or unorthodox, because there are questions as to the extent to which these practitioners adhere to scientific principles (Wardwell 1979). Among alternative practices and practitioners are: **Chiropractic medicine; Curandera/os; Faith healers; Folk healers; Homeopathic medicine**.

ALTRUISTIC SUICIDE

As described by Emile Durkheim (1951), altruistic suicide refers to a situation in which a person takes his or her life because of a strong sense of obligation to society. This person has placed the welfare of the group above welfare of self. A spy who takes a poison capsule to avoid disclosing state secrets is an example of altruistic suicide (Schaefer and Lamm 1995:11), as is the ancient practice of hara-kiri in Japan. The emphasis in Durkheim's analysis of suicide is on social rather than individual causes and illustrates how a society might induce enough stress among people to cause them to take their own lives. *See also* **Anomic suicide; Egoistic suicide; Fatalistic suicide**.

AMBULATORY CARE

Walk-in care provided to patients who do not require an overnight stay in a hospital or other medical care facility.

AMBULATORY CARE CENTER

Health care organization affiliated with and usually located at a hospital, but for which services are provided to patients who do not require an overnight stay.

ANCILLARY HEALTH CARE ORGANIZATION

Health care organization that provides support services for health care providers. Such support organizations include medical equipment and pharmaceutical supply companies, financial institutions, health insurance companies, government and professional regulatory agencies, professional associations, and research and consulting firms (Andersen and Mullner 1989:145–163). *See also* **Direct-service health care organization**.

ANOMIC SUICIDE

As described by Durkheim (1951), anomic suicide is the taking of one's own life because the person's norms have failed. This does not mean the person was without norms; rather, the individual perceives his or her society's norms as no longer relevant to personal welfare. Usually this condition is caused by a sudden change that generates the breakdown of norms and values important in one's life. In this case, norms would no longer bind the person to society or restrain an individual from taking his or her life. Anomic suicide is therefore due to ''society's insufficient presence in individuals'' (Durkheim 1951:256). *See also* **Altruistic suicide; Egoistic suicide; Fatalistic suicide**.

APPLIED MEDICAL SOCIOLOGY RESEARCH

Sociological research designed specifically to aid health practitioners in delivering services and health policymakers in organizing services. Applied research usually answers medical rather than sociological questions and is intended to provide a practical solution to a problem. The need for sociological input in the solution of medical problems was a major stimulant for the development of medical sociology. (See ''Introduction: An Overview of Medical Sociology'' in this dictionary.)

AVERAGE LENGTH OF STAY, HOSPITAL

A measure of how long patients stay in a hospital, computed by dividing the number of inpatient days by the number of admissions during a specified reporting period (American Hospital Association 1992:xxiv). A ''risk-adjusted'' hospital stay may be computed for a particular disease, to assess its personal and financial impact, or for a particular demographic group. In the United States, the average length of hospital stays has declined in the past two decades because of cost-containment strategies and a shift to outpatient hospital services made feasible by new and less invasive technologies.

AVOIDANCE

Deliberately trying to remain ignorant of one's physical or mental condition in order to avoid knowing about an unwanted affliction. Avoidance is a form of denial.

Avoidance was initially recognized as a typical response to terminal illnesses when cancer rates increased in the 1960s and 1970s. More recently, the phenomenon is studied as an obstacle to effective preventive health behavior, such as performing self-examinations or seeking mammograms for early detection of breast cancer. The onset of the acquired immunodeficiency syndrome (AIDS) epidemic has brought new attention to this concept. Persons unknowingly infected with the human immunodeficiency virus (HIV), by avoiding tests to detect it, put their sex partners at risk of infection and slow public health efforts to arrest the epidemic.

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B

BAREFOOT DOCTOR

Local residents in rural areas of the People's Republic of China who receive three to eighteen months of basic medical training in disease prevention, maintenance of inoculation records, community sanitation techniques, emergency first aid, and diagnosis and treatment of their home community's common ailments. The descriptive term *barefoot,* arose in eastern China, where most people spend considerable time in rice paddies without shoes. The institution of the barefoot doctor in the 1960s provided the majority of the rural population with at least some routine access to health care, but few exist today as large collective farms were replaced by household farming on state-owned land in the 1980s (Liu et al. 1995).

BED OCCUPANCY

The percent of a hospital's (or other health facility's) available beds to which patients are assigned on a given day. A hospital's *bed occupancy rate* is the average bed occupancy for a particular time period, computed as the average bed occupancy divided by the number of available hospital beds during that period (Pol and Thomas 1992:81).

The size of a hospital's bed occupancy is a barometer of its economic viability, and a precipitous drop in bed occupancy often signals financial problems. Bed occupancy influences the size of the workforce, especially in nursing, and low occupancy results in layoffs. Recent cost containment efforts of government, and of health insurance companies and the large corporate employers who fund them, have caused a reduction in long-term treatments and shortened hospital stays. The resulting drop in bed occupancy has forced some hospitals to reduce the number of usable beds or to rededicate beds to the treatment of mental illnesses, substance abuse, or new specialty areas, such as women's health.

BEHAVIOR MODIFICATION

A form of therapy based on theories of learning and techniques of behavioral conditioning derived from the classical conditioning experiments in psychology of Ivan Pavlov (1849–1936) and Edward Thorndike (1874–1949). Behavior modification is based on the premise that behavior is learned but can also be unlearned and replaced with socially appropriate behavior. The focus is on behavior that is externally observable and measurable. Therapeutic techniques include symptom desensitization (learning to approach feared situations or objects without anxiety), positive reinforcement (reward), aversive conditioning (punishment), extinction (eliminating a stimulus), conditioned avoidance (electric shocks or drugs paired with situational stimuli), and contingency contracting (agreeing with others to engage in certain behavior in return for a similar response).

Behavior modification is subject to four limitations: (1) there are serious questions as to whether people can actually be "conditioned" to the extent that they respond more or less automatically to stimuli that cause them to act a certain way; (2) even if such conditioning is possible, there are questions concerning the duration of the effects and their strength in real-world, nonclinical settings; (3) behavior modification may not be a totally sufficient form of a theory in which the complexity of the disorder may require more than just learning new behaviors; and (4) the technique requires that patients be willing and able to learn and have a certain amount of will power, but some mental patients may not be able to do so (Cockerham 1996).

However, behavior modification also has some strengths. It is based on extensive research in experimental psychology and can obtain satisfactory short-term results for simple problems like bed-wetting (Bellack, Hersen, and Kazdin 1990).

BEHAVIORAL RISK FACTORS (BRF) ANALYSIS

A research model based on identifying behavioral predictors (such as substance use—alcohol and tobacco consumption—and poor dietary, exercise, and driving behaviors) of the relative risk of mortality and morbidity. In the United States, the **Centers for Disease Control and Prevention** (CDC) sponsors an annual nationwide Behavioral Risk Factor Surveillance Survey (BRFSS) to assist state health departments with health promotion and injury/disease prevention. Presently, BRFSS analysis is applicable primarily to developed, industrialized First World countries, where high rates of morbidity and mortality are related to behavioral, as opposed to biological, causes.

BIOMEDICAL ETHICS

Moral reasoning on issues related to the development of biomedical technologies and the distribution of health services. Biomedical issues include decisions on terminating life-support machinery; use of reproductive technology and genetic counseling and screening; behavioral control modification; controversial clinical research projects, animal rights, and the balance of therapeutic (i.e., curative) and preventive research funds; the distribution of scarce medical resources and services such as in organ transplants and kidney dialysis; the consequences of cost-containment strategies for quality of and access to health care; and the development of for-profit hospitals. Whereas philosophers may view ethics as inherent in human nature, sociologists tend to emphasize that ethics are culturally bound; that is, ethics vary among world cultures. Since 1980, the field of biomedical ethics has become institutionalized, as reflected in the development of government protocols for research and its application, increasing litigation and the judicial precedents established therefrom, and increasing attention given to ethics in medical education (Sorenson and Swazey 1989:492–497).

BIRTH RATE

See **Crude birth rate; General fertility rate.**

BRITISH NATIONAL HEALTH SERVICE

See **National Health Service.**

BUREAUCRACY, HOSPITAL

See **Hospital organizational structure.**

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C

CAREGIVER BURDEN
See **Caregiver/caregiving**.

CAREGIVER/CAREGIVING
A role requiring the provision of assistance to someone lacking physical or psychological functional independence. Caregiving is a role performed by those taking care of frail elderly and by parents of small children. The key feature of assuming this role is the dependency of the care recipient. The literature on caregiving focuses on informal care, that provided by family members and friends, although the actions of formal caregivers (i.e., trained professions) is receiving some attention.

A primary caregiver is a family member with the major responsibility for providing basic instrumental care, such as feeding and transporting, and making decisions that the care recipient is incapable of making. Primary caregivers are typically female (i.e., wives or daughters). Secondary caregivers are family members who provide indirect or intermittent assistance, either to the care recipient or to the primary caregiver. Men are more likely to provide secondary care, especially financial support.

Gerontological caregiving literature has established the potential for distress to arise for informal, family caregivers, especially with highly dependent care recipients, such as victims of late-stage Alzheimer's disease. Caregiving is a captive role (Aneshensel, Pearlin, and Schuler 1993). Moreover, depending on the functional capacity of the patient and the competing roles of the caregiver, caregiving engenders some degree of role strain (i.e., an overload of demands and obligations), role ambiguity (i.e., unclear role demands), and interpersonal role conflicts with family members. In a word, caregiving can be burdensome. Among social scientists the problem of caregiver burden has become so apparent that some now refer to the caregiver as the "hidden patient" (Haug 1996).

Distress is an outcome of informal caregiving, largely because of the lack of structure in the caregiving role. In terms of role dimensions, caregiving to the frail elderly is a potentially stressful dual role, with both patient *and* provider obligations, but lacking both patient and provider privileges (Clair, Ritchey, and Allman 1994). Physicians, for instance, are likely to interact with caregivers as though they are simply extensions of the patient and, thus, bestow sick role obligations on them, such as acceptance of professional competence (Parsons 1951; *see* **Sick role**). The caregiver may be held to these obligations to a greater extent than the patient, who may reject or fail to comprehend sick role obligations. At the same time, the caregiver role is essentially an extension of the physician's role yet must be performed with limited medical knowledge and without the comprehensive auxiliary health support system that accompanies physicians working in medical settings. The marginal status of caregivers is revealed further by the absence of sick-role privileges, such as exemption from normal roles. In fact, an inverse relationship often holds between patient privilege and caregiver privilege; that is, as the patient becomes sicker and gains the privilege of normal role exemption, the demands of caregiving increase (Clair, Ritchey, and Allman 1994). Caregiver burden is likely to continue as a major area of sociological research as the population ages.

CATASTROPHIC ILLNESS

An insurance industry term that refers to an illness or injury whose treatment may require medical cost reimbursements that go beyond conventional limits of medical insurance coverage. Coverage for such illnesses is typically provided in supplemental insurance policies. Such catastrophic illnesses include severe head and spinal cord injuries, **acquired immunodeficiency syndrome (AIDS)**, and highly disabling episodes of cancer, liver, and heart disease.

CAUSE OF DEATH

A mortality measure derived from official death certificates. Standard death certificates require a physician to stipulate (1) the disease or condition directly leading to death, (2) antecedent causes (i.e., any morbid conditions giving rise to the above cause), (3) any underlying condition that initiated events leading to death or, in the case of accident or violence, the circumstance producing death, and (4) any other significant conditions contributing to death but not related to the disease or condition causing it. The third stipulation, the underlying condition, is used in public documents for computing cause-specific mortality (Last 1983: 26–27).

Mortality measures have marginal reliability, because of the complexities surrounding deaths, and variability in the way physicians assign causes. For example, a terminally ill cancer patient may die of cardiac failure unrelated to the cancer. One physician may stipulate cancer as the underlying cause, while another may choose not to make that stipulation.

CAUSE-SPECIFIC MORTALITY

See **Cause of death.**

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

Federal agency located in Atlanta, Georgia, that is responsible for investigating and controlling health problems that can affect the general public in the United States and elsewhere.

CERTIFICATION

See **Medical speciality certification.**

CHIROPRACTIC MEDICINE

An approach to healing based on spinal manipulation and the principle that most human illness results from misalignments of the spinal vertebrae (called subluxations). Chiropractory was founded by Daniel David

Palmer in 1895. The discipline has survived attacks by the medical profession and, currently, over 20,000 licensed chiropractors deliver services in all fifty states. *Chiropractic* is Greek for ''done by hand'' and present-day chiropractors are restricted to noninvasive and nondrug treatments and procedures (Wardwell 1979; Weiss and Lonnquist 1994:224–230).

CHIROPRACTOR

A person licensed to practice chiropractic medicine. There are about 25,000 chiropractors in the United States. *See also* **Chiropractic medicine**.

CHRISTIAN SCIENCE MEDICINE

A type of faith healing based on the beliefs and practices of members of the Christian Science Church founded in 1866 by Mary Baker Eddy. A basic tenet of Christian Science is that disease and pain are illusions that emanate from an individual's distorted view of his or her spiritual nature and, thus, physical as well as mental and spiritual health are attained through prayer and spiritual renewal. Christian Scientists believe they possess the capacity to heal themselves through intensive prayer and Bible study, although Christian Science practitioners licensed by the church are available to assist them. While many Christian Scientists seek conventional medical care for some health problems, especially functional conditions such as broken bones, many others may put themselves or their children at risk of death rather than seek conventional care. Recent court cases have ruled that, while parents may put themselves at risk of serious medical complications or death because of their religious beliefs, they are not free to put their children at risk (Cockerham 1995: 139).

CHRONIC DISEASE (ILLNESS)

The long-term irreversible presence of a disease state or impairment that requires supportive care, self-care, maintenance of function, and prevention of further disability (Lubkin 1986:6). Heart disease, cancer, and diabetes are examples of chronic diseases. *Contrast with* **Acute illness (disease)**.

COGNITIVE FUNCTIONING

The ability of a person to perform mental tasks, such as reasoning, memory, and communication, to a sufficient degree that personal independence in living is maintained. Cognitive functioning may be impaired by illness (such as Alzheimer's disease), medications, or injury.

COMMODIFICATION OF HEALTH CARE

Refers to the use of health care and health products to be bought and sold in the marketplace. This process takes two forms. First is product marketing, the creation by the medical industry of new health needs, such as the marketing of mouthwash to cure ''halitosis'' (Conrad and Kern 1994:234). Second is the general transition of the medical sector from the goal of serving patients to the goal of creating profitable diagnostic and treatment procedures and protocols (Waitzkin 1991:218). Commodification encourages both sick and healthy people to become consumers of health services and products (Freund and McGuire 1995). Commodification is characteristic of capitalist societies, especially the United States, where government-sponsored universal national health insurance is lacking, and most health services are delivered in the private sector. Marxist theorists, in particular, identify commodification as a process in which the affluent buy the best health care, and the poor, with the worst overall level of health, lack the financial resources to purchase quality care (Waitzkin 1995).

COMMUNICABLE DISEASE

''An illness due to a specific infectious agent or its toxic products which arises through transmission of that agent or its products from an infected person, animal, or inanimate reservoir to a susceptible host, either directly or indirectly through an intermediate plant or animal host, vector, or inanimate environment'' (Benenson 1985:447).

COMMUNITY HEALTH CENTER (CHC)

Federally funded primary health care facilities in low-income areas where health services are either nonexistent or inadequate. The CHC program succeeded the Neighborhood Health Centers Program of the Office of Economic Opportunity of the 1960s (Andersen and Mullner 1989:149). The CHCs are intended to fill the gaps in health care accessibility left by other federally sponsored programs such as Medicaid, but relatively few are in existence because of funding and staffing difficulties.

COMMUNITY HOSPITALS

A nonfederal, publicly accessible, short-term acute care, general, or special service hospital. For its annual census of hospital types and services, the American Hospital Association uses the following operational definition: ''All nonfederal short-term general and other special hospitals, whose facilities and services are available to the public. (Other special hospitals include obstetrics and gynecology; eye, ear, nose, and throat; rehabilitation; orthopedic; and other individually described specialty services. . . .[and] may include a nursing-home-type unit and still be classified as short-term, provided that the majority of its patients are admitted to units where the average length of stay is less than 30 days'' (American Hospital Association 1992:xxiii). *See* **Noncommunity hospital** for other types of hospitals.

COMMUNITY MENTAL HEALTH

See **Community psychiatry**.

COMMUNITY MENTAL HEALTH CENTER (CMHC)

Community mental health centers are facilities funded primarily by the federal government that provide mental health services on an outpatient basis in local communities. Congress enacted the Mental Retardation Facilities and Community Mental Health Centers Construction Act in 1963 to provide easily accessible and locally controlled mental health centers to help people with psychiatric problems in their own communities. At the time, this was considered a bold, new approach for providing more effective and humane care for the mentally ill than that available in mental hospitals. This approach was sponsored by the community mental health movement in the 1960s, which was both a political and social movement whose goal was to offer an alternative to mental hospitalization. Efforts at reform were stimulated by the reports of sociologists like Erving Goffman, whose book *Asylums* (1961) detailed the dehumanizing aspects of life in mental hospitals.

The most significant roles of community mental health center programs are (1) deinstitutionalization—assisting the chronically mentally ill to live outside mental hospitals; (2) providing mental health services, including emergency care, in local areas; and (3) working with schools, the police, youth and community organizations, and church groups to help prevent psychological problems. In the early 1990s, there were 691 community mental health centers nationwide. However, levels of federal funding diminished significantly during the 1980s, and financial support for this program remains a serious problem. Most people who use the services are poor, benefits from both public and private health insurance tend to be low, and state funds have not offset declines in federal support. Moreover, some people object to having mental patients in their midst and many patients live in low-quality housing where crime, drug and alcohol abuse, and poverty are common. Others have joined the homeless population. Although successful programs exist, the community mental health programs overall have not met with great success (Cockerham 1996; Issac and Armat 1990). *See also* **Deinstitutionalization**.

COMMUNITY PSYCHIATRY

A subspecialty of psychiatry that focuses on population, community, and environment, as opposed to viewing mental illness as strictly a personal, pathological health condition. Community psychiatry is concerned with helping mentally disturbed people adapt to their living environments and develop psychosocial coping skills through the coordination of community-based prevention, educational, treatment and rehabilitation programs.

Community psychiatrists are clinical practitioners in the broader field of community mental health, whose other professionals include community psychologists; crisis, family, and substance abuse counselors; evaluation researchers with sociological and public health training; and community health administrators who coordinate regional services. The development of community psychiatry began in the 1950s with the movement away from treating mentally ill persons in isolated institutional settings. *See also* **Deinstitutionalization.**

COMPLIANCE

See **Adherence (to medical regimen)**.

CONFLICT THEORY

A theoretical perspective in sociology that maintains that all social systems contain inequality, which causes conflict and in turn generates social change. Conflict theory claims that a true consensus about social norms and values does not exist; rather, a society's norms and values are those of the dominant group and are imposed by them on the less privileged in order to maintain their advantage. Social processes are therefore essentially struggles over resources. People want or need certain things and maneuver to acquire them and advance their interests in relation to others.

The foundation for conflict theory is derived from the work of Karl Marx (1818–1893) and Max Weber (1864–1920). Marx sought to explain the social changes in Western society brought on by the political revolutions of the eighteenth century and the rise of industrial capitalism. He argued that human history is a story of conflict between two major social classes—those who own the economic means of production and those who do not. The more the unequal distribution of goods and services between these two groups, the greater the conflict and potential for revolutionary change.

Weber suggests that social divisions are based not only on money and property, as a Marxian analysis would indicate, but also on prestige or status and political influence. These are the factors that separate different groups in society from one another. The conflicts these factors generate, according to Weber, are permanent features of social life.

Contemporary approaches to conflict theory in capitalist nations like the United States have moved away from emphasizing class struggle and instead concentrate on analyzing the competition that takes place among interest groups such as labor, management, geographical regions, political parties, business corporations, professional groups like the American Medical Association, and agencies within governments. British sociologist Ralf Dahrendorf, for instance, is an especially well-known representative of modern conflict theory. Dahrendorf (1988) focuses on explaining the relationship between conflict and inequality, but he rejects Marx's claim that economic factors are the major source of inequality. He argues that inequality in modern societies stems also from the unequal distribution of political power. Power and authority, states Dahrendorf, are scarce resources as well, and those who have them are interested in maintaining the status quo, while those who lack them are interested in acquiring them and changing the status quo.

Another view of conflict comes from British sociologist Bryan Turner (1988), who argues that modern societies are best understood as having a conflict between the principles of democratic politics (emphasizing equality and universal rights) and the organization of their economic systems (involving the production, exchange, and consumption of goods and services, about which there is considerable inequality). Therefore, on the one hand, people have political equality; on the other hand, they lack social equality.

This unresolved contradiction, in Turner's view, is a more or less permanent feature of all modern societies and a major source of conflict. Ideologies of fairness are constantly challenged by the realities of inequalities, and they influence governments to try to resolve the situation through politics and welfare benefits. In the meantime, various groups maneuver to protect their interests. One example was the flurry of responses by doctors, insurance companies, the small-business lobby, and other interest groups to the William J. Clinton administration's proposals for health care reform in 1993, which contributed significantly to its defeat.

Conflict theory has not produced a large body of literature in medical sociology, despite its popularity in the general discipline of sociology. The reasons for this are not clear, since areas like national health reform, access to quality care, and the rising costs of care would appear to be topics awaiting analysis from a conflict perspective. Among the scholars contributing to medical sociology from a conflict perspective, Vicente Navarro (1986, 1995), on capitalist medicine and health reform, and Howard Waitzkin (1991), on the patient-physician relationship, stand out.

CONSUMERISM, HEALTH

The exploration and selection of health goods and services by individuals seeking the types of health care available in the market that they believe is best for them. Health consumerists suggest a less dependent position on the part of laypersons in relation to acquiring health care. According to Leo Reeder (1972), the concept of the person as a consumer rather than a patient became established in the 1960s; doctors were regarded as health providers, so a new relationship of provider-consumer emerged in direct opposition to the old relationship of physician-patient with its emphasis upon patient dependency. This role relationship places the consumer on a more equal footing with physicians. It also provides the philosophy behind increased involvement by laypersons as consumer groups in health legislation and regulation.

CONTROL, SENSE OF

Feelings of being able to think about problems and do something about them (Mirowsky and Ross 1989). Upper- and middle-class persons are more likely to have experienced greater opportunities in life and acquired a stronger sense of control over the situations they face than lower-class persons. A major outcome of these cumulative experiences and the perception derived from them is a greater expectation that planning and effort will be successful. Lower-class persons may be less likely to expect that their efforts to avoid negative outcomes, including poor health, will succeed and, therefore, are more likely to be passive in coping with problems. Upper- and middle-class persons appear significantly more likely to actively assume responsibility for their health because of their stronger sense of control.

COPING BEHAVIOR AND PROCESSES

The process by which an individual appraises and responds to environmental and social stressors in an effort to reduce the demands imposed by stressors and to prevent or minimize stress-related illness.

The study of stress-related illnesses and experiences that lead to illness is often framed with a life-stress model (Lin, Dean, and Ensel 1986; Pearlin 1989; Pearlin et al. 1990). Such illnesses and stressful life situations include coronary heart disease, psychological depression, post-traumatic stress syndrome, and burdensome caregiving to frail elderly with Alzheimer's disease or other conditions causing dependency. The life-stress model has three sets of variables that provide a causal framework. First are **stressors**, features of a social and physical environment that make individuals vulnerable to psychological or physiological strain. Psychological and social stressors include stressful life events, such as divorce, loss of job, death of spouse or child; role strains and conflicts, such as family and employer-employee conflicts and cultural and social mobility; psychological trauma, such as unexpected loss or injury of a loved one, criminal victimization, and natural disasters; and environmental conditions, such as crowding, poverty, or residing in high-crime areas. Second are stress-induced physical and psychological *outcomes*, such as anxiety, depression, peptic ulcers, heart disease and other stress-related conditions. Coping behaviors are the third category of variables, and they account for the fact that individuals respond to stressors in different ways. Coping is a process which, to the degree that it is successful, intervenes to moderate the effects of stressors.

A number of strategies have been found to result in good adjustment to stressors, and the success of coping hinges on an individual's psychological and social resources. The former, which are given concentrated attention by psychologists, include the individual's past experience with similar stressors, general personality traits, attitudes, constitutional makeup, sense of mastery and control over external events, self-esteem, and self-efficacy. In contrast, sociologists view the coping process in terms of social resources, the intervention of other individuals, and the availability of structural and community resources that may potentially moderate or buffer the effects of stressors (Lin, Dean, and Ensel 1986; Pearlin 1989; Pearlin et al. 1990). Informal social resources include the quantity and quality of social contacts and networks (family support, friendships, and confidants). Formal social resources include knowledge of, and physical and financial access to, treatment, preventive and assistance services, such as professional counselors (including legal and financial counselors). From the sociological view, a reduction in stress-related illness comes about by eliminating stressors, and providing social support for those who are under stress. The community mental health perspective in psychology takes a similar approach (Kessler and Wortman 1989:69–81).

CORPORATE MEDICINE

The term *corporate medicine* refers to the ownership and operation of medical facilities for profit by business corporations. These facilities include hospitals, emergency care centers, and nursing homes. Some 13.3 percent of all U.S. hospitals in 1992 were owned by profit-making corporations. These hospitals, many organized into multihospital chains, typically provide services to people with private health insurance. Compared to not-for-profit hospitals, the cost of care in corporate-owned facilities is usually more expensive, but they provide more attractively furnished rooms, good food, friendly staff, and efficient services. In the context of corporate care, the physician is an employee in a setting managed by people trained in business, not medicine. In corporations, doctors are not as likely to play the decisive role in decision making about policy, budgets, capital investments, salaries, and promotions. Consequently, there is less professional autonomy for physicians who practice medicine in a corporate facility (Cockerham 1995; Starr 1982).

CORPORATISM

A form of health care delivery common to Germany, consisting of (1) compulsory membership by the population in a national health insurance program and (2) a set of institutions situated between the government and its citizens with the authority to manage health care under government auspices (Light 1986). These intermediate organizations receive deductions from workers' pay and employer contributions and use these monies to pay for health services according to a schedule of fees. Fee amounts are negotiated annually between various physician, hospital, and patient organizations under the general supervision of Germany's Ministry of Labor and Social Security. In a corporatist system, the government does not play a major role in financing health services; instead, the government's primary function is one of overall administration.

COST-BENEFIT ANALYSIS

An assessment of the net benefits (''benefits minus costs, appropriately discounted over time'') of medical technologies and services, in relationship to all social groups for which costs and benefits accrue (Eastaugh 1992b:292).

Cost-benefit analysis typically follows cost-effectiveness analysis, which focuses on the narrow objective of rank ordering alternative treatments for a single ailment, primarily in terms of monetary expenditures of providers. The broader cost benefit analysis additionally assesses intangible benefits, including ethical considerations, and weighs the monetary costs and benefits of not only providers, but also of patients (Eastaugh 1992b:292–293). *See also* **Cost-effectiveness analysis**.

COST CONTAINMENT

(1) The efforts of medical care providers ''to find rationally effective and socially acceptable ways of reducing medical care costs without diminishing the quality of patient care'' (Fox 1989:147). Such efforts include managed care health insurance programs, hospital quality assurance, and utilization review committees. (2) Governmental strategies aimed at reducing cost inflation in the provision of medical services. Such strategies include Diagnostic-related groups (DRGs) reimbursement procedures for the federal government's Medicare program. (*See also* **Diagnostic-related groups**.) (3) In the United States, a social movement of the 1970s, 1980s, and 1990s aimed at reducing cost inflation in the provision of medical services. This movement stresses that cost inflation is due to structural features of the health care system, including the medical profession's control of health institutions; inaccessibility of the uninsured to even minimal medical services, while the insured have access to costly, purportedly unneeded services such as cosmetic surgery and

heart transplants; and the privatization and corporatization of health services with their profit taking and segmented, market-directed delivery systems. The existence of this movement reflects the political and ideological underpinnings of health care delivery and is part of the development of biomedical ethics (Fox 1989:230).

COST-EFFECTIVENESS ANALYSIS

In terms of effectiveness relative to cost, the rank ordering of ''preferred alternatives for achieving a single goal or specified basket of benefits'' from a medical technology or innovative service system (Eastaugh 1992b:292–293).

Whereas cost-effectiveness analysis answers the question of what treatment alternative gains the most benefit relative to cost—for a provider organization—cost-benefit analysis takes into consideration broader ethical questions of what other interests lose or gain from such treatments (Eastaugh 1992b:292). *See also* **Cost-benefit analysis**.

COST SHIFTING

The practice of medical care providers, especially hospitals, of charging excessive fees for insured patients to offset the cost of providing care to uninsured patients.

CRUDE BIRTH RATE

For a specified area, the number of births in proportion to the midyear total population, expressed as the number of births per 1,000 population (Pol and Thomas 1992:159). *See also* **General fertility rate**.

CRUDE MORTALITY RATE

See **Mortality rate**.

CULTURAL CONTEXT OF ILLNESS

Cultural norms, beliefs, social structures, and material conditions that are conducive to illness and which influence how disease symptoms are perceived and acted upon. Such cultural variables may be distinguished as personal (demographic and socioeconomic indicators, social identities, social networks and relationships, and social and psychological resources) or societal (quality and accessibility of medical services). (See Catalano 1989; Kaplan 1989; Kessler and Wortman 1989).

CULTURAL LAG

The delay in time between changes in one realm of culture, such as mental culture, and inevitable changes in related realms, such as material and normative culture (Ogburn 1922).

Cultural lag is a useful concept for examining how social disorder and ethical dilemmas result from variable rates of social and cultural change within the larger social milieu. For example, the accumulation of medical knowledge (e.g., curative theories) proceeds at a faster pace than the invention of spinoff material technologies and treatment regimens. Changing knowledge and technology make old forms of organization obsolete and call for innovation; yet social resistance to such changes causes lags in the adoption of new technologies and organizational structures. For instance, a less invasive surgical technique eliminates the need for long hospital stays, but because of delays in acceptance by physicians and delays before insurance companies agree to pay for the innovation, many years may pass before the technique is provided on an outpatient basis. Cultural lag is especially apparent in the ethical controversies created by changing medical technology, such as the moral and legal confusion surrounding the termination of life supports for moribund patients. And cultural lag theory is a meaningful approach to understanding how interests within medicine (such as professionalism and the service ethic) retard change induced by external forces (such as increasing malpractice litigation, government regulation, and consumerism) (Ritchey 1981).

CURANDERISMO

Folk healing among some Mexican, Latin-American, and Mexican-American communities based on religious ideas together with the ancient humoral theory of Hippocrates that disease results from an imbalance of hot and cold forces within the body. Its practitioners, **Curanderas** and **Curanderos**, treat not only biological but also psychological and spiritual disorders. Furthermore, they resolve interpersonal conflicts among individuals in the community. The techniques of *curanderismo* include herbal, folk, drug and food treatments, and prayer offerings before religious objects such as statues of Jesus Christ or the Virgin Mary, candles, and crucifixes. The practices and beliefs of *curanderismo* reflect among Mexican and Latin societies the cultural influences of Mayans and Aztecs as well as that of the conquering Spanish and their Catholic religion (Cockerham 1995:144–146; Weiss and Lonnquist 1994:238–240).

CURANDERA (FEMALE), CURANDERO (MALE)

A practitioner of curanderismo. *See also* **Curanderismo**.

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D

DEATH RATE
See **Mortality rate**.

DEATH ROLE
The pattern of role obligations, responsibilities, and privileges perceived as appropriate for someone who is identified as terminally ill.

When performing the sick role, a patient is expected to desire to get well and is afforded the privilege of commanding dependence on physicians (Parsons 1951). In contrast, a terminally ill patient is expected to restrict demands on physicians, keep complaints to a minimum, accept palliative treatments in place of curative ones, and rely more heavily on personal and family resources to deal with the emotional issues surrounding an oftentimes protracted dying process. With terminally ill patients, the physician's role changes also, as he or she tends to follow a pattern of regressive intervention (Clair 1990). *See also* **Regressive intervention; Sick role**.

DEATH TELLING
Strategies used by health and service professionals to deliver news of

impeding death (Clark and LaBeff 1982:366). Death telling is often problematic because normative guidelines are not well defined. Scholars of death telling emphasize its processual aspects, particularly its implications for status passage by dying patients and their families. At least five typical death-telling strategies have been identified in terms of directness, exhaustiveness of detail, and mode of delivery (verbal versus nonverbal). The particular strategy used is determined by situational and conditional factors, and various occupations are prone to use different strategies; for example, law enforcement professionals are most likely to use direct methods (Clark and LaBeff 1982).

DEFENSIVE MEDICINE

The performance of diagnostic tests and treatment procedures by a medical practitioner which, but for the threat of malpractice action, would not have been performed (Brenno 1987). Defensive medicine is an instance of medical diagnostics and treatment being performed for sociolegal rather than medical reasons. *See also* **Malpractice, medical**.

DEINSTITUTIONALIZATION

A shift in locus of mental illness treatment from large state hospitals to federally supported community mental health centers and community hospitals. This movement to outpatient services for the mentally ill began in the 1950s as new medications allowed many mentally ill individuals to function normally for extended periods of time. The failure of both local and federal governments to adequately fund mental treatment for the un- and underinsured, as well as the legal movement toward securing the rights of mentally ill persons, has resulted in many chronically mentally ill persons becoming homeless (Cockerham 1996). As a consequence, in public parlance the term *desinstitutionalization* has become synonymous with "dumping people on the streets."

DEMEDICALIZATION

(1) The political and ideological process by which the medical profession *loses* influence over various aspects of society (c.f., Ivan Illich's [1976] concept of medicalization). (2) Of deviance: The political and ideological process by which the medical profession, as an agent of social control, *loses* influence over which social problems and behaviors are defined as **sickness** (unintentional deviance) as opposed to badness

(volitional deviance). For example, heroin addiction, once viewed strictly as a medical condition, is now seen as criminal behavior (Conrad and Schneider 1992:29). *See also* **Medicalization**.

DEPRESSION

Depression refers to feelings of depressed mood and loss of interest. According to the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (1994), typical symptoms of depression include decreased energy; feelings of worthlessness or guilt; difficulty in thinking, concentrating, and making decisions; changes in appetite, weight, sleep, and psychomotor activity; or recurrent thoughts of death or suicide. Depression is categorized in psychiatry as a form of mood disorder. The two major types of mood disorders are (1) depressive disorder, which is characterized by at least two weeks during which a person experiences either a depressed mood or loss of interest or pleasure in nearly all activities, and (2) bipolar, which involves extreme mood swings between depression and mania. Mood disorders are the most common form of mental disorder and are more prevalent among women than men. Many people, about one of five adults, become significantly depressed at some point(s) in their lives, although the majority (over 90 percent) are not treated by professionals (Cockerham 1996).

Depression is a key variable of interest to sociologists in models of coping behavior (Lin and Ensel 1986; Pearlin 1989; *see also* **Coping behavior and processes**). These models show depression to result from stressors, many of which are social in origin and outside the control of the individual. For sociologists, high rates of depression and other indicators of personal distress signal unhealthy living environments and exposure to daily stressors. For example, high rates of depression are found among recipients of government aid (e.g., welfare mothers) and especially among the homeless (Ritchey et al. 1990). Great distress among these categories of people clearly reveals depression, for many affected individuals, to originate in social structure and conditions of living, as opposed to biological dysfunction.

DEPROFESSIONALIZATION

A decline in professional status and power resulting from a deterioration in those characteristics which distinguish professions from other occupations, especially the loss of autonomy over work and control over clients (Cockerham 1995:259–260; Ritzer and Walczak 1988:6). Professional characteristics include occupational control over a body of specialized, abstract knowledge; a service ethic geared toward enhancing public trust; licensing and admission boards with control over who enters the field; control over educational and practice standards and legislation that concerns the profession; freedom from lay evaluation and control; and in general, great autonomy over day-to-day tasks (Goode 1960:903).

The deprofessionalization of physicians became a topic of interest in the 1980s; for example, *Milbank Quarterly* devoted an entire issue to "the changing character of medical practice" (vol. 66, suppl. 2, 1988). It suggests that physicians have clearly lost degrees of autonomy and control over the past two decades. But, as Eliot Freidson (1985) argues, in the face of tremendous technological and social change, physicians still dominate in two important ways: control over fellow workers and control of entry into the field (Freidson 1985).

DEVIANCE

Any act or behavior that violates social norms. Most norms allow for some variations within a permissible range, but truly deviant behavior, such as that caused by mental disorder, typically exceeds the range of permissible behavior. Deviant behavior can therefore, be regarded as behavior which (1) differs, (2) breaks rules or violates norms, and (3) is exceedingly offensive (Cockerham 1996:93). *See also* **Norms**.

DIAGNOSTIC-RELATED GROUPS (DRGS)

The Social Security Administration's prospective payment system for reimbursement of Medicare services, wherein hospitals are reimbursed "for costs of care provided to Medicare patients at a flat illness-specific rate that is established in advance" (Smith and Fottler 1985:1).

On the basis of previous cost data, categories were established with a case mix adjustment method that weighted assorted variables, including severity, acuity (urgency), complexity (complications and interaction with other conditions), intensity of care, typical length of stay, whether surgery is involved, treatment difficulty (patient's response to therapy), patient age, bed size, and geographic and urban-rural location of the hospital (Eastaugh 1992b:204–219; Smith and Fottler 1985:1–30; Worthman and Cretin 1986).

Prompted by experimentation in New Jersey, the DRG system was mandated in the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97–248) and the Social Security Amendments of 1983 (P.L. 98–21) and instituted in October of 1983 (Smith and Fottler 1985:1). Replacing the retrospective fee-for-service reimbursement system, which encouraged hospitals and physicians to liberally order diagnostic tests and extend hospital stays, the aim of DRGs was to foster cost-consciousness and efficiency. Evaluation research reveals DRGs to have clearly reduced length-of-stay for hospital visits, with concomitant cost reduction and without loss of quality (Broyles 1990; Finkler, Brooten, and Brown 1988).

DIPLOMA NURSES

Nurses who hold diplomas from hospital-based schools, once the major source of nurses. Most nurses today however, hold either associate degrees from two-year colleges or bachelor's degrees from four-year colleges and universities. In 1961, some 83.6 percent of all graduates from nursing schools were diploma nurses, but only 7.9 percent were in this category by 1992–1993 (Nursing Data Review 1996).

DIRECT-SERVICE HEALTH CARE ORGANIZATION

Health care organizations that, through individual-based or community-based frameworks, provide direct treatment to populations. Such community-based organizations include health departments, which focus on sanitation, food, air and water quality, and mass immunization programs. Individual-based direct services include primary care, acute care, and long-term care medical facilities (Andersen and Mullner 1989:146).

DISABILITY

A physical or mental inability or limitation in performing activities or roles expected of individuals within their usual environment. Disabilities result from *impairments*, the "loss and/or abnormality of mental, emotional, or physiological structure or function" (Nagi 1991). A person's ability to function is often the basis upon which an individual is determined to be sick, either by the dysfunctional person or other people having knowledge of his or her condition (Cockerham 1995). Physical disabilities often carry social stigmas, such as altered mobility and negative body image (Bury 1991; Charmaz 1991; Zola 1982). Consequently, people with a physical impairment not only require medical treatment, but may have to make social, attitudinal, and economic adjustments. As a result of their disabilities, physically handicapped persons often lead restricted lives, are socially isolated, discredited as less than normal, and feel they are a burden to others. All of these factors can combine to reduce the disabled person's sense of self-worth, unless alternative means of satisfaction can be found.

In the past, the term *handicap* was used instead of *disability*, but the former lost favor as society began to recognize that handicaps were a characteristic of environments, such as restricted access to buildings, lack of "handicap" parking spaces, and so on. The term *handicap* was then seen as a symbol that reinforced personal stigma by blaming the disabled person for failure of function, rather than blaming the restrictive environment (Greer and Greer 1983).

DISEASE

In medical sociology, a disease is considered an adverse physical state consisting of a physiological dysfunction within an individual, as compared to an illness (psychological awareness of a disease) or a sickness (a social state).

DISEASE AGENT

See **Agent**.

DISEASE ETIOLOGY

The cause of disease. In epidemiology, disease etiology refers to the entire process of causation, not simply the causative agent, such as a bacterium. The etiology (cause) of a disease, its agent (means of transmission), the environment within which the disease is transmitted, and host risk factors all must be identified and interrelated before the disease can be considered understood. The epidemiological approach provides multiple points of intervention for treatment, and especially for preventing the spread of disease (Graham and Reeder 1979:72–74). *Contrast to* **Doctrine of specific etiology**.

DISEASE-SPECIFIC MORTALITY RATE

See **Mortality rate**.

DISENGAGEMENT THEORY

Disengagement theory is a sociological theory of aging that contains three basic propositions: (1) a process of a mutual withdrawal of aging individuals and society from each other is natural; (2) this process of withdrawal is inevitable; and (3) it is also necessary for ''successful'' aging on the part of both the old person and society (Cockerham 1997; Cumming and Henry 1961). Disengagement theory, based on structural-functionalist theory, maintains that although all people eventually die, society's institutions need to survive if social stability is to be continued. An orderly means of transferring power from older members of society to younger ones is therefore necessary. Disengagement theory supports the notion that it is to society's benefit to phase out those individuals whose deaths would disorder the smooth functioning of the social order. Accordingly, societies develop norms requiring that an individual retire from work around a certain age; a rite of status passage—usually a retirement ceremony—often marks the occasion. Disengagement, however, is typically not a single event, but a gradual process as the older person withdraws from his or her work activities over time. This process allows for an orderly transition of younger persons into the positions of older persons.

The disengagement of society from individuals is only part of disengagement theory. The other part is that individuals themselves select to withdraw from particular social roles when they become old. By becoming disengaged, they can focus on personal interests rather than be preoccupied with work, career, raising a family, and the like. Hence, withdrawal is a natural and preferred process for the individual. Disengagement theory is able to describe the social processes that occur when older people withdraw from their usual roles as a result of age, especially situations that require them to retire from their job at a certain age.

With recent increases in life expectancy and quality of life among the elderly, disengagement theory has been challenged. Increasingly, the theory fails to account for people who do not want to disengage and refuse to do so.

DOCTOR–PATIENT RELATIONSHIP

See **Patient–physician relationship**.

DOCTRINE OF SPECIFIC ETIOLOGY

In the search for the causes of disease, the assumption that every disease has a single specific cause, such as a bacterium. This doctrine held sway among scientifically trained physicians and researchers in the late 1800s following the widespread development of bacteriology, when ''germ theory'' was the dominant paradigm of medical research (Denton 1978:17–18). Adherence to such a doctrine today would evoke criticism, given the predominance of chronic diseases with complex etiologies. *See also* **Disease etiology**; **Germ theory of disease**.

DURKHEIM, EMILE (1858–1917)

Ranked with Karl Marx and Max Weber as one of the most important social theorists of all time. Durkheim played a major role in the establishment of sociology as a scientific discipline in general and functionalist theory in particular. Although Durkheim is not a central figure in medical sociology, his study of suicide in 1897 is a sociological classic and his perspective influenced other scholars who worked in the field, such as Talcott Parsons, who formulated the concept of sick role (1951). *See also* **Altruistic suicide; Anomic suicide; Egoistic suicide; Fatalistic suicide; Functionalist theory; Parsons, Talcott.**

E

EGOISTIC SUICIDE

As described by Emile Durkheim (1951), the taking of one's own life as a result of lack of integration of an individual into society. High rates of egoistic suicide occur in societies that leave individuals to their own resources, causing them to lose any sense of affiliation with the larger society and any sense of constraint on their own behavior. Egoistic suicide occurs when people become detached from society and, finding themselves suddenly on their own (e.g., unemployed or widowed), they are overwhelmed by the resulting stress to the point that they take their own lives. Suicide by a lonely, homeless person would be an example of egoistic suicide. The emphasis in Durkheim's analysis of suicide is on social rather than individual causes. *See also* **Altruistic suicide; Anomic suicide; Fatalistic suicide**.

EMERGENCY MEDICAL TECHNICIAN (EMT)

Licensed health care practitioners who staff emergency ambulance and rescue vehicles and are specially trained in stabilizing the life functions of acutely ill or injured individuals.

Until the 1970s, ambulances were often staffed by untrained drivers who were frequently employed by hospitals or funeral homes that operated the service as a form of outreach for living and dead customers, respectively. Their modus operandi was to transport victims to hospitals as rapidly as possible. In contrast, EMT care is based on stabilizing the life functions of trauma victims at the site of injury or illness before initiating transport (e.g., retrieving a pulse and respiration, controlling blood pressure, stopping bleeding, restricting the mobility of broken limbs). The EMTs are a form of physician extender in that they maintain communication with physicians in the emergency or trauma units of hospitals. Research on emergency care revealed the use of professionally trained EMTs to greatly reduce the mortality rate of trauma victims. The influx of combat-experienced medical technicians from the Vietnam War provided impetus for emergency medical technician licensing.

EPIDEMIOLOGICAL CATCHMENT AREA

The specification of a geographic area targeted for epidemiological study or public health intervention.

EPIDEMIOLOGY

The science of epidemics. However, modern-day epidemiologists investigate not only infectious diseases, but all sources of illness and bodily injury—including heart disease, cancer, alcoholism, drug addiction, suicide, automobile accidents, and falls. Epidemiology draws upon the knowledge and research techniques of several scientific fields. Physicians, public health personnel, sociologists, biologists, biostatisticians, biochemists, psychologists, entomologists, ornithologists, veterinarians, demographers, anthropologists, and others conduct epidemiological work.

The focus of the epidemiologist is on the health problems of large groups or entire populations of people. Their role is much like that of a detective investigating the scene of the crime for clues; in this case the criminal being sought is what or who is causing a large number of people to be ill or injured. The goal is to find the source of the health problem and then control or eliminate it. This is accomplished by identifying the (1) agent (cause), (2) host (biological and behavioral characteristics of the people or animals most susceptible to the effects of the agent), and (3) environment (environmental conditions which allow the health problem to flourish).

Epidemiology originated as a method of scientific inquiry in 1854 with

John Snow's investigation of a water-borne cholera epidemic in London. Since that time, epidemiology has focused on sanitary conditions (mid-nineteenth century), infectious diseases (late nineteenth to mid-twentieth centuries), and chronic diseases (late twentieth century). It is moving toward the next era of eco-epidemiology in which investigations extend from the molecular level to connections between societies at the global level (Susser and Susser 1996).

ETIOLOGY

See **Disease etiology**.

EUTHANASIA

From the Greek, "good death"; a terminally ill person's decision to intentionally allow the dying process to take its natural course.

Passive euthanasia involves withholding extraordinary life-preserving measures from a moribund patient—one who is dying and perceived beyond reasonable doubt to have no chance of recovering normal mental and/or physical functions. In legal debates over when to forgo life support for dying patients or when to "pull the plug" on those already on support, passive euthanasia is often referred to as the "right to die." **Living wills** afford healthy individuals the right to legally stipulate their wishes to forgo artificial life support in the event of brain death or to forgo extraordinary measures, such as resuscitation, when moribund (Humphry 1994:113).

Active euthanasia involves proactive procedures that lead to death as a secondary effect. Such is the case with terminal cancer patients when a physician prescribes enough pain medication to relieve pain, knowing that the dosage level may compromise respiration. Physician-assisted suicide is an extreme form of active euthanasia, wherein a physician assists conscious patients in terminating life. Euthanasia is done only with the consent of a patient or his/her guardian (in the case of brain-dead patients). Physician-assisted suicide is currently illegal in the United States but is allowed in certain cases in the Netherlands. *See also* **Physician-assisted suicide**.

F

FAITH HEALERS

Practitioners or religious figures who proclaim to heal physical and mental illnesses through religious or supernatural means such as prayer, affirmation of faith, and the laying on of hands. Some faith healers assert that spiritual guidance is a form of psychological therapy effective only for psychophysiological ailments. Others assert that faith healing has unlimited applications because it constitutes divine intervention with God directly imparting miracles (Denton 1978:119). **Christian Science medicine** is an example of faith healing.

FATALISTIC SUICIDE

As described by Emile Durkheim (1951), the taking of one's own life out of a sense of powerlessness in the face of intolerable suppression or regulation. A prisoner might seek fatalistic suicide as a form of escape (Schaefer and Lamm 1995:11). However, Durkheim did little to develop the concept of fatalistic suicide, and it is not considered to be a major form of suicide. The emphasis in Durkheim's analysis of suicide is on social rather than individual causes. *See also* **Altruistic suicide; Anomic suicide; Egoistic suicide**.

FECUNDITY

The ability of a woman to conceive and produce live offspring. Measures of fecundity of a population are estimates of the potential of the population to reproduce; they center on the number and proportion of women in a population who are of child-bearing age and not restricted by custom from reproducing.

FEE-FOR-SERVICE SYSTEM

The fee-for-service system of health care delivery is one in which the patient or the patient's health insurance company (sometimes both) pays a fee directly to a health care provider for his or her services. Fee-for-service is the dominant form of health care delivery in the United States. All other developed countries, including Canada, Japan, and the nations of the European Union, have some type of national health insurance in which the government or approved organizations, not patients, pay the direct costs of health care and guarantee access to that care for all or most to its citizens. Fee-for-service systems, in contrast, are held to discriminate against people who are unable to pay the fees and lack the insurance to do so.

FERTILITY

(1) The reproductive experience of a population (Pol and Thomas 1992:153). (2) A measure of the production of live offspring in a population, discounting stillbirths, fetal deaths, and abortions (Last 1983: 37).

Fertility measures include a simple count of annual births, crude birth rates adjusting for population size, and general fertility rates adjusting for the population-at-risk (i.e., females of child-bearing age). Fertility rates may also be specified by age group of fecund women (i.e., age-specific fertility rate; Pol and Thomas 1992:159–165). *See also* **Crude birth rate; General fertility rate**.

FLEXNER REPORT

A landmark study conducted in the 1910s by the American Medical Association and the Carnegie Foundation for the Advancement of Teaching at the behest of and under the direction of Abraham Flexner. Based on site visits and other information, the report distinguished scientific from nonscientific medical schools, set basic standards for medical education, and resulted in the closing of medical schools that failed to meet these standards. This report marked the beginning of a seventy-year period of ''medical dominance'' wherein M.D.s (physicians holding doctor of medicine degrees), through their national and local medical associations, gained control over virtually all proprietary aspects of delivering medical services (Freidson 1970a; Rosen 1979; Starr 1982:118–123).

FOLK HEALERS

Health practitioners whose diagnostic and treatment theories and techniques reflect common cultural beliefs about the causes and cures of illness. Folk healers are often identified with reference to an ethnic group. For instance, **curanderas** and **curanderos** are Mexican-American folk healers.

FOLK MEDICINE

Home remedies, rituals, procedures, ideas and forms of treatment used by laypersons to care for their own illnesses (Denton 1978:112). Folk medicine is a diverse set of ideas and treatments including home remedies passed down through generations, over-the-counter drugs, and nutritional supplements, whose uses are influenced by marketing practices.

FOR-PROFIT HOSPITAL

Profit-seeking hospitals that pay income and property taxes (Eastaugh 1992a:416). These may be **proprietary hospitals** (single hospitals with a small number of shareholders, such as the traditional doctors' hospitals), or investor-owned (companies with a large number of stockholders, such as hospital chains).

FOUCAULT, MICHEL (1926–1984)

A French poststructuralist philosopher concerned with the use of knowledge as a form of social control. Foucault's work is of interest to medical sociologists because of his focus on the way knowledge, especially medical knowledge, has been used to control human bodies and sexuality in the interest of society. Foucault describes how power is reproduced and evolves to a higher level of rationality through discourse and the production of knowledge. He argues that discourse (dialogue) is not necessarily liberating; rather, it can be constraining when it leads to the control over an individual's body or mind by knowledge experts (physicians) and systems of surveillance (the state, church, and medical profession). Foucault's publications of relevance to medical sociologists include *Madness and Civilization: A History of Insanity in the Age of Reason* (1965), *The Birth of the Clinic: An Archaeology of Medical Perception* (1973), *Mental Illness and Psychology* (1976), and *The History of Sexuality* (1978–1988).

FREIDSON, ELIOT (1923–)
A medical sociologist noted primarily for his landmark studies of the medical profession in the 1960s and 1970s (Freidson 1970a; 1970b; 1975). Freidson challenged Talcott Parsons's (1951) functionalist description of the physician–patient relationship by asserting that the physician's status constituted a form of "medical dominance" that may be detrimental to good patient care and relationships with other health care workers. Freidson's work was also distinct in its detailed focus on the work environment of medical care provision, the division of labor among health providers, and especially the relationship between types of tasks (e.g., routine therapeutic versus cognitive decision-making tasks) and their implications for professional status, control, and autonomy. He asserted that medical dominance hinges on the medical profession's control of decision-making tasks. His work is relevant to both medical sociology and the sociology of professions.

FUNCTIONALIST THEORY
Functionalist theory is derived from the initial work of the French sociologist Emile Durkheim (1858–1917). Durkheim was concerned with those social processes and constraints that integrate individuals into the larger social community. He believed that when a society was strongly integrated, it held individuals firmly under its control (Durkheim 1950, 1951). Individuals were integrated into a society as a result of their acceptance of community values reinforced through social interaction with others believing in the same value system. Especially important were participation in events celebrating a society's traditions and also involvement in work activities.

As members of society, individuals are constrained in their behavior by laws and customs. These constraints are "social facts," which Durkheim (1950:13) defined as "every way of acting, fixed or not, capable of exercising on the individual an external constraint." What Durkheim suggests is that society has an existence outside and above the individual.

Values, norms, and other social influences descend on the individual to shape his or her behavior. Social control is, therefore, real and external to the individual.

This approach is based on the view that society is held together in a state of equilibrium by harmonious patterns of shared norms and values. What makes social life possible is the expectation that people will behave in accordance with the norms and values common to their particular social system. This process is functional because it results in social harmony and counterbalances dysfunctional processes, like crime and illness, that disrupt the social order. The tendency of a society toward self-maintenance through equilibrium is very similar to the biological concept of homeostasis, in which the human body attempts to regulate physiological (internal) conditions within a relatively constant range in order to maintain bodily functioning. A person may suffer from warts, indigestion, a broken leg, or perhaps even from a nonmalignant cancer and still be generally healthy. Likewise, a social system is viewed in the functionalist perspective as maintaining social functioning by regulating its various parts within a relatively constant range. A social system may have problems with crime and delinquency, but still maintain an overall capacity to function efficiently.

According to functionalist theory, sickness is dysfunctional because it also threatens to interfere with the stability of the social system. The medical profession functions to offset the dysfunctional aspect of sickness by both curing and preventing disease and by establishing technology by which handicapped persons can assist in self-maintenance and in maintenance of the social system. This analytical approach is the basis for Parsons's (1951) theory of the sick role, a central concept in medical sociology today. *See also* **Parsons, Talcott; Sick role**.

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G

GENERAL ADAPTATION SYNDROME

A theory proposed by Hans Selye (1956) that human physiologic stress reactions involve several protracted and deleterious stages culminating in premature aging due to wear and tear on the body. Previous conceptions of stress response focused on initial alarm reactions manifested in immediate physiologic changes in the autonomic and neuroendocrine systems (Cockerham 1995:70).

GENERAL FERTILITY RATE

For a specified area, the number of births at the midpoint of a year in proportion to the population at the midpoint of a year at risk of giving birth, typically expressed as the number of births per 1,000 females aged 15 to 44 years (Pol and Thomas 1992:159).

GENERAL HOSPITAL

Multipurpose hospital providing a broad range of short-term and acute-care medical and surgical services. General hospitals may also provide a variety of other health-related functions, including training of health practitioners, research laboratories, and health education and prevention programs (Cockerham 1995).

GERM THEORY OF DISEASE

The premise that every disease has ''a specific pathogenic cause whose treatment could best be accomplished by removing or controlling that cause within a biomedical framework'' (Cockerham 1995:6). This premise developed with advances in bacteriology made in the late 1800s and has greatly influenced medical practice since. It has lead to the search for single causes for diseases and for drugs as ''magic bullets'' to be shot into the body to kill or control disease (DuBos 1959). Germ theory legitimates physicians' tendencies to focus exclusively on a clinical medicine grounded in precise scientific laboratory procedures, while ignoring the social causes of disease. Germ theory has declined in influence as acute communicable diseases have waned in comparison to chronic degenerative diseases, which have complex social causes and thus are susceptible to preventive health behavior.

GERONTOLOGY

The scientific study of aging and includes its social, psychological, and biological processes.

GOFFMAN, ERVING (1922–1982)

A leading American sociologist who made several important contributions to the study of face-to-face interaction. Although Goffman did not specialize in medical sociology, many of his early ideas and concepts evolved out of his research on mental patients. His work remains particularly important to medical sociologists in the areas of mental health and stress. One of his best-known works is *Asylums* (1961), which depicts patterns of social interaction on a mental hospital ward and life in a total institution.

Although working within a symbolic interactionist tradition, Goffman developed his own approach to studying human behavior. In his book *The Presentation of Self in Everyday Life* (1959), Goffman utilized a dramaturgical, or ''life as theater'' perspective that focused on the manner in which people manage the impressions of themselves they project to others. Goffman had two distinct views of the roles of ''the self'' in social interaction: first, the self as an image of a person formed from the flow of events in encounters with others and, second, the self as a kind of player in a ritual game who copes judgmentally with a situation. This aspect of Goffman's work identifies the calculative element in dealings between people and presents them as information managers and strategists maneuvering for gain in social situations (Manning 1992).

Goffman's principal contribution to the understanding of stress arises from his claim that the self is a sacred object. The self is more important than anyone in challenging the integrity of that self as a social object in an embarrassing situation. Each self is special, and in social relationships that very special self each person has nourished and protected for a lifetime is put on display. Goffman has said that role-specific behavior is based not upon the functional requirements of a particular role, but upon the appearance of having discharged a role's requirements. Thus, stress may be induced when people fail in their performance. Otherwise, people might not be so willing to take such great care that they act out lines of behavior considered appropriate to their situation.

Goffman also studied stigma (1963) and suggested frame analysis (1974) as a method of analyzing how people define the reality of social situations. Goffman has been criticized for portraying social interaction as a game or mere role-playing, in which people are superficial and opportunistic entities, lacking a stable sense of themselves. Nonetheless, he emerges as a major twentieth-century sociologist whose work is important in a number of areas. *See also* **Stigma; Total institution, mental hospital as a**.

GROUP PRACTICE (ORGANIZATION OR SETTING)

A medical practice setting with three or more physicians who are formally organized (Havlicek 1984:1). This term points to the physical setting of services as opposed to a system of insuring patients and financing services, such as is the case for the term **health maintenance organization**. In contrast to a solo-practice physician's office, a group practice allows several physicians to share capital expenditures, overhead costs, auxiliary and clerical staff, and night and weekend on-call hours. Where such arrangements are for physicians of a single specialty, each physician will have his or her own patients. Multispecialty group practices provide a formal referral network among the specialists within the group.

H

HEALTH

(1) As defined by the **World Health Organization,** a state of complete physical, mental, and social well-being, and not merely the absence of disease or injury. This definition emphasizes the fact that health is not merely the absence of negative traits such as illness or injury, but requires the presence of positive traits such as feelings of well-being, traits which are social and psychological as well as physical (Cockerham 1995:2). (2) The ability to function adequately in normal everyday activities (DuBos 1981). This definition emphasizes the consequential aspects of disease and illness, particularly their social consequences.

HEALTH BEHAVIOR

The behavior undertaken by a person who believes himself or herself to be healthy for the purpose of preventing health problems (Kasl and Cobb 1966). Health behavior involves the kinds of activities, habits, and lifestyles that healthy people pursue to stay well.

HEALTH BELIEF MODEL

A social psychological model of health behavior designed to explain the motivation and activity of healthy people to avoid the threat of illness. The Health Belief Model is based on the work of Irwin Rosenstock (1966) and his colleague Marshall Becker (1974). The model is derived to a great extent from the theories of psychologist Kurt Lewin, who suggested that people exist in a life space consisting of regions with both positive and negative valences (values) (Becker 1974). An illness would be a negative valence and have the effect of pushing a person away from its region, unless it would cause the person to enter a region of even greater negative valence. For example, a person might risk becoming ill in order to complete an important task. While people are pushed away from regions with negative valences, they are attracted toward regions of positive valences. A person's behavior is therefore oriented toward finding regions with the positive values.

Within this framework, human behavior is seen as being dependent upon two primary variables: (1) the value placed by a person upon a particular outcome and (2) the person's belief that a given action will result in that outcome. Accordingly, the Health Belief Model suggests that preventive action taken by an individual to avoid a disease is due to that particular individual's perception that he or she is personally susceptible and that the occurrence of the disease would have at least some severe personal implications.

The assumption is that taking a particular action reduces susceptibility or, if the disease occurred, reduces severity. The perception of the threat posed by the disease, however, is affected by modifying factors. These factors are demographic, sociopsychological, and structural variables that can influence both perception and the corresponding cues necessary to instigate action. Action cues are required because while an individual may perceive that a given action will be effective in reducing the threat of disease, that action may not be taken if it is further defined as too expensive, too unpleasant or painful, too inconvenient, or perhaps too traumatic.

So despite recognition that action is necessary and the presence of energy to take it, a person may still not be sufficiently motivated to do something. The likelihood of action also involves a weighing of the perceived benefits to action contrasted to the perceived barriers. Therefore, a stimulus in the form of an action cue is required to trigger the appropriate behavior. Such a stimulus could be either internal (perception of bodily states) or external (interpersonal interaction, mass media communication, or personal knowledge of someone affected by the health problem).

The Health Belief Model has been employed successfully in several studies of (preventive) health behavior (see Cockerham 1995:105). The merit of the model is that even when an individual recognizes personal susceptibility, he or she may not take action *unless* the individual also perceives that being ill will result in serious difficulty. Thus, the individual's subjective assessment of the health situation becomes the critical variable in the utilization of health services. In fact, a person's subjective assessment may be more important than an objective medical diagnosis.

Unfortunately, the usefulness of the Health Belief Model is limited in that it has been applied mostly to preventive situations in which behavior is voluntary. Obviously, however, many people who seek health services are motivated to take action only by the appearance of clear and definite symptoms, and the Health Belief Model does not apply to this circumstance.

HEALTH CARE

(1) Behavioral definition: Medicinal and preventive measures taken by the self or others to maintain functional health status. (2) Institutional definition: A society's cultural and organizational arrangements directed at maintenance of the health status of its population.

Health care is distinguished from *medical care*, which is a more narrowly defined concept. Health care refers to any behaviors or institutional functions aimed at maintaining or enhancing health status, including preventive measures such as brushing teeth, exercising, dietary practices, and injury prevention. The term *medical care* refers to only those practices and institutional functions controlled by medical practitioners.

HEALTH CARE ACCESSIBILITY

Sufficient availability of personal and health system resources such that individuals are able to obtain health care in accordance with their needs (Aday and Andersen 1975:13–14; Donabedian 1972:111). Accessibility is analyzed with distinctions among the need, demand, and utilization of services, between process and outcome indicators, between characteristics of the health system and those of the population at risk, and between behavioral (utilization) and subjective (satisfaction) outcomes of care-seeking (Aday and Andersen 1975:13–14). Thus, as an ideal type, a truly accessible health care system is one in which appropriate services are available and easily obtainable in an area and in which individuals in the area have the knowledge and financial resources to utilize services in accordance with their true needs.

HEALTH CARE DELIVERY SYSTEM

A society's institutional and organizational arrangements directed at the provision of health care services. The system includes health and medical facilities, health professional schools, allied health enterprises, voluntary agencies, health insurance companies, and private and governmental research facilities.

Health care delivery systems tend to be culturally bound; that is, the system will fit neatly with the cultural and economic values of a society. For instance, in the United States, the system reflects values of free enterprise and individualism, with less governmental control relative to other industrial countries.

HEALTH CARE ORGANIZATION

As a sociological construct, the organizational and structural aspects of the health care system, addressing the issues of who provides services and with what organizational and financial arrangements.

HEALTH CARE PROVIDER

Professionally trained health practitioners who make their living providing care directly to patients. Physicians qualify as the best-trained and most expert of all providers. In many cases, they control both the patient's access to care and the work of other providers. Health care providers include nurses, physician assistants, emergency medical technicians, physical therapists, and other caregivers who follow doctors' orders in treating patients, but also dentists, optometrists, clinical psychologists, and chiropractors who generally work independently of physicians. The key characteristic of the health care provider is that the person has formal training, certification, and a work identity as a health caregiver. Although in special circumstances lay persons, folk healers, and faith healers can lay claim to being health care providers, they lack claims to technical expertise that belong to formally trained and certified practitioners.

HEALTH CARE RATIONING

Limiting expenditures on medical care, especially by restricting access to costly but perhaps beneficial technologies that some segments of the population can afford (Conrad and Kern 1994:408; Weiss and Lonnquist 1994:305). Rationing of health care services may be implicit or explicit. Conrad and Brown (1993) and other sociologists have long argued that health care is already rationed implicitly in the United States on the basis of ability to pay (*see also* Mechanic 1979). Those with financial resources, especially private health insurance, gain access to state-of-the-art medicine; those lacking resources go without or receive intermittent and limited care through underfunded public medical care systems.

Explicit rationing is the use of cost-benefit analysis in making decisions about health expenditures (Eastaugh 1992b:300–302). For example, the Medicare program's cost-reimbursement method, called **diagnostic-related groups (DRG)**, limits expenditures based on measures of severity of a condition. Local communities often limit funding for public community hospitals or restrict private investment in new hospitals or technologies.

Explicit governmental rationing of health services is common in both industrialized and developing countries. But in the United States, with the exception of DRGs, there has been great political opposition to the concept of rationing care. Callahan (1994) notes that explicit rationing is contradictory to basic American values, which themselves fuel cost inflation in health care. In the name of freedom and the pursuit of happiness, as Americans ''we indulge our hostility to governmental control and planning . . . cherish the idea of limitless medical progress . . . [and] long for quality in medicine and health care, which in practice we define as the presence of high-class amenities (no gross queuing or open wards for us) and a level of technology that is constantly improving'' (Callahan 1994:411–412). In fact, ''rationing'' as a policy position has been demonized by political rhetoric to the point that politicians refuse to discuss it.

HEALTH CARE UTILIZATION

The use of the services of physicians and other health care providers. The decision to utilize health care is typically based on predisposing, enabling, and need components (Aday and Andersen 1975). The predisposing component consists of sociodemographic variables like education and gender and attitudes and beliefs about health care. The enabling component refers to factors like family income, health insurance coverage, availability of services, and access to a regular source of care. The predisposing and enabling components establish the conditions within which a person is or is not likely to seek health services when stimulated by the need. The need component consists of health status (self-rating of health), disability, or diagnosis. The best predictor of health care utilization is the need variable, especially the perceived seriousness of one's symptoms (Cockerham 1995:127). Health care utilization, however, varies by gender, race, social class level, employment status, and insurance coverage. In the study of health care accessibility, utilization measures are associated with rates of service need and demand. Such research reveals underutilization among those with no regular source of care, the uninsured working poor, the severely mentally ill, and the homeless (Aday and Andersen 1975; Mechanic and Aiken 1989). *See also* **Health care accessibility**.

HEALTH DEMOGRAPHY

A field applying the knowledge and methods of demography to the study of the health of large populations. Health demography concerns itself with the manner in which such variables as age, marital status, education, and income influence both the health status and health behavior of populations and, in turn, how health-related phenomena affect demographic characteristics (Pol and Thomas 1992:1).

HEALTH EDUCATION

(1) Educational programs, distributed through schools, physician offices, and public outreach programs, geared toward increasing preventive health behaviors and early detection of disease. (2) A social movement begun in the 1960s to integrate health curriculum into elementary and secondary schools. As is the case with any social movement, the health education movement provokes political debates over, for example, whether sex education should be part of the curriculum. (3) A college degree major oftentimes titled "health and physical education." Such programs were previously called "physical education" and focused almost exclusively on training coaches for organized sports activities (a curriculum now sometimes called "sports management"). The field of health and physical education focuses on exercise, nutrition, prevention of injury, and preventive health behavior, with students and the general public as its audience. For advanced college degrees, the curriculum typically includes courses in public health and sociology as well as education.

HEALTH HAZARDS

See **Behavioral risk factors (BRF) analysis.**

HEALTH IDEOLOGY

Within a society or social group, the ideas, values, and doctrines about health care that legitimate or justify health norms and behaviors. Ideologies are often shaped by the particular group interests of those in power yet must appeal to the basic values of a society (Braybrooke 1967:127; Edelman 1988).

A more specific term, **medical ideology**, refers to the value system that justifies physician control over medical care delivery. Health ideology, however, is a broader term referring to how a society comes to socially construct its widely held beliefs about health and sickness behavior. The term *ideology* links social structure to societal values. For example, the American values of material comfort, individual freedom, and achievement lead to norms that define beauty as a competitive endeavor. Such norms, for instance, include the acceptance of cosmetic surgery as a valid health endeavor. Ideology may have unintended consequences, such as the increase in eating disorders related to the norm that equates thinness with beauty. *See also* **Medical ideology**.

HEALTH LIFESTYLES

Collective patterns of health-related behavior based on choices from options available to people according to their life chances (Cockerham, Rütten, and Abel 1995). These life chances include age, gender, race, ethnicity, and other relevant variables that impact on lifestyle choices. The behavior generated from these choices can have either positive or negative consequences on body and mind but nonetheless form an overall pattern of health practices that constitute a lifestyle.

Health lifestyles include forms of interaction with the medical profession for physical checkups and preventive care, but the majority of activities take place outside the health care delivery system. These activities typically consist of choices and practices, influenced by the individual's life chances or probabilities for realizing them, that range from brushing one's teeth and eating properly to relaxing at health spas. For most people, health lifestyles involve decisions about food, exercise, coping with stress, smoking, alcohol and drug use, risk of accidents (i.e., seatbelt use), and physical appearance. Consequently, health lifestyles can be conceptualized as ways of living pursued by generally healthy people who wish to maintain or enhance their health and avoid sickness and injury.

Health lifestyles have become especially important determinants of health in advanced societies. According to Robert Crawford (1984), there have been three major reasons for this development: (1) There has been a growing recognition among the general public that the major disease patterns have changed from acute or infectious illnesses to chronic diseases—like heart disease, cancer, and diabetes—that medicine cannot yet cure and which are not self-limiting; (2) Numerous health disasters, such as AIDS and cigarette-induced lung cancer, are caused by particular styles of living; (3) There has been a virtual campaign by the mass media and health care providers emphasizing lifestyle change and individual responsibility for health. The result has been a growing awareness that medicine is no longer the automatic answer to dealing with all threats to one's health. Therefore, strategies on the part of individuals to adopt a healthier lifestyle have gained in popularity. As Crawford explains, when threats to health persist in the environment and medicine cannot provide a cure, self-control over the range of personal behaviors that affect health is the only remaining option. This means the person will be confronted with the decision to acquire and maintain or to disregard a healthy lifestyle. This situation assumes that people have choices in health-related behavior, but some people may have little or no choice in relation to living in an unhealthy environment, such as neighborhoods with high levels of poverty and violence or exposure to pollutants.

The theorist in sociology whose work provides much of the general foundation for current concepts of health lifestyles is Max Weber (1864–1920). Although Weber was concerned with lifestyles in general and did not directly address health lifestyles, his work suggests that, when lifestyles are oriented toward producing health, the aim of the activity is ultimately to enhance consumption as people maintain health to live longer, enjoy life, be sexually attractive, enjoy physical activity, continue working, and so forth. Furthermore, while health lifestyles seem to be most characteristic of the upper and middle classes, the potential exists for them to spread across social boundaries. The quality of participation may differ significantly, but the level of participation in advanced societies may be spreading nonetheless. Regardless of one's particular socioeconomic position, an important feature of modern society appears to be the tendency for many people to adopt a healthy lifestyle within the limits of their circumstances and opportunities (Cockerham, Abel, and Lüschen 1993).

Taking issue with Karl Marx's contention that class (wealth) is the predominant factor in determining someone's social rank, Max Weber asserts that status (prestige) and power (political influence) are also important. Weber focused on the difference between class and status, pointing out that, while class is an objective dimension of social life signified by how much money and property a person has, status is subjective, consisting of the amount of esteem a person is accorded by others. Typically, a person's occupation and level of education are the basis of such esteem.

The linkage between individual self-esteem and patterned lifestyles is found in Weber's concept of status group, a category of people who share similar material circumstances, prestige, education, political influence, *and* a similar lifestyle. In fact, a particular lifestyle is the manifest feature distinguishing one status group from another. Weber made the pertinent observation that lifestyles are not based upon what one produces, but on what goods and services one consumes. Thus, for Weber, the difference between status groups does not lie in their relationships to the means of production as suggested by Marx, but in their relationships to the means of consumption. This view applies to health lifestyles because when someone pursues a healthy style of life, that person is attempting to produce good health according to his or her degree of motivation, effort, and capabilities. Yet the aim of this activity, as Weber's insight suggests, is ultimately one of consumption.

Weber did not ignore the socioeconomic conditions necessary for a specific lifestyle. Weber deliberately used three distinct terms to express his view of lifestyles: *Stilisierung des Lebens* (stylization of life), *Lebensführung* (life conduct), and *Lebenschancen* (life chances). *Lebensführung* and *Lebenschancen* are two components of *Stilisierung des Lebens* (Abel 1991; Abel and Cockerham 1993; Cockerham, Abel, and Lüschen 1993). *Lebensführung* (life conduct) refers to the choices that people have in the lifestyles they wish to adopt, but the potential for realizing these choices is influenced by their *Lebenschancen* (life chances). Ralf Dahrendorf (1979:73) notes that Weber is ambiguous about what he really means by life chances, but the best interpretation is the ''probability of finding satisfaction for interests, wants, and needs.'' For Weber, the notion of life chances therefore refers to the probability of acquiring a particular lifestyle, which means the person must have the financial resources, status, rights, and social relationships that support the chosen lifestyle. One's life chances, then, are shaped by one's social circumstances. Similarly, attaining a healthy lifestyle is constrained to some degree by life chances.

HEALTH LOCUS OF CONTROL

See **Locus of control, health**.

HEALTH MAINTENANCE ORGANIZATION (HMO)

A health service cooperative delivery organization with a defined patient membership, with financing through prepaid insurance premiums on a capitation basis, and a treatment philosophy geared toward health maintenance and disease prevention.

A form of managed care, HMOs developed in response to perceived inefficiencies of traditional therapeutic-oriented, fee-for-service payment systems. They have several structural restraints designed to reduce costs, provide care continuity, and achieve better patient health status: patients must specify a primary care physician whose permission is required for specialty care; physicians receive set fees or salaries removing monetary incentives to provide excessive services; there is a preventive service philosophy with patients being allowed a set number of preventive services. The original HMO concept, developed in the late 1960s, envisioned geographically centralized services ranging from primary care through hospitalization.

Currently several health service models are considered HMOs because they involve prepayment and restrictions on system access. An HMO staff model is a self-contained, -owned and -operated HMO that serves only its enrollees. An HMO group model is the only source of care for its enrollees, but the health service providers serve other patients, including fee-for-service patients. An HMO network model is one in which a management team supplies patient enrollees with assorted groups of service providers. An HMO gatekeeper Independent Practice Association (IPA) model is one whose practice organization receives a management fee from the HMO for each patient enrollee who chooses an HMO physician from its primary physician staff. Finally, there is the HMO traditional IPA model. This is the most predominant form because it allows freedom of choice. The practice organization receives a fee from the HMO for each service it provides to HMO patient enrollees, but enrollees are not required to choose a physician in the organization as their regular physician (DeFriese and Earp 1989:209).

The majority of HMOs switched to for-profit status in the 1980s and targeted employed, middle-class enrollees at the expense of government-plan (i.e., Medicaid and Medicare) enrollees. Thus, the growth of HMOs has failed to significantly solve the fee-for-service systems' tendencies toward cost inflation and restricted care accessibility (Buchanan et al. 1992:1–6). *See also* **Managed care.**

HEALTH OCCUPATIONS

A broad term referring to all health care service providers, including "orthodox" professional workers (such as physicians, nurses, pharmacists, dentists, optometrists, etc.), allied health workers (such as medical laboratory technicians, occupational therapists and anesthesiologist's assistants), and "marginal," or alternative healers (such as chiropractors and acupuncturists) (Wardwell 1979; Weiss and Lonnquist 1994:197–245). Thus, health occupations may be categorized in terms of level of expertise, with *profession* reserved for those who control cognitive tasks, or in terms of legal control, with M.D.s (doctor of medicine physicians) defining what constitutes "orthodox" medicine (Freidson 1970b). *See also* **Health professions.**

HEALTH OUTCOMES

Measures of the "end result of the operation of the health care delivery system" (Pol and Thomas 1992:291). Such measures typically include incidences and rates of mortality and morbidity and global measures of the overall health status of individuals.

Health outcomes often are viewed as one quantitative and "objective" measure of the effectiveness and quality of health care services. When reported as free-standing descriptive statistics, however, without controls for confounding variables such as direct measures of service quality and the makeup of the patient population, health outcome data can be misleading. For example, the Social Security Administration (U.S. Department of Health and Human Services), which oversees the Medicare program, now requires hospitals to report mortality rates of patients with specified diagnoses, such as myocardial infarction. A hospital with a high mortality rate may be presumed by many to provide low quality or defective services. In fact, such hospitals often serve poverty neighborhoods where patients arrive sicker, older, and in the advanced stages of disease. From a scientific point of view, health outcome data are useful only as a dependent variable in a theoretically sound causal model with necessary statistical controls.

HEALTH PROFESSIONS

Those health occupations with the professional attributes of control over esoteric knowledge and cognitive tasks, high occupational prestige centering on a service ethic, autonomy over work, and control of licensing and entry into the field (Larson 1977:xvii).

It is widely accepted that physicians have the essential attributes of a profession, although even this has recently been called into question (Haug 1988; Ritzer and Walczak 1988). Nursing and other health occupations have only degrees of professional status, because their control over cognitive tasks and autonomy over work are restricted by physicians.

Professionalization of an occupation may be viewed as a historical process, with a work group's collective status and authority varying over time (Freidson 1970a, 1970b; Larson 1977; Starr 1982). For example, modern scientific medicine gained stature and legitimacy late in the 1800s, as those medical practitioners advocating **germ theory of disease**, together with advocates of scientifically based public health reform, began to exhibit success in the eradication and prevention of communicable diseases. By the second decade of the 1900s, these "orthodox" practitioners attained sufficient public and political power to reform medical education and licensing. With justification from data acquired for the Flexner Report, the American Medical Association closed over thirty medical schools deemed unscientific. This began a seventy-year period of medical dominance by M.D.s (health professionals with doctor of medicine degrees). During this era, local medical societies, the medical staffs of hospitals, state medical associations, the American Medical Association, and the American Hospital Association maintained a monopoly over every aspect of health service delivery.

This tremendous professional control began to diminish in the 1960s as the U. S. government played an increasing role in health care finance through the Medicare and Medicaid programs. The rapid increase in health expenditures caused the government to demand cost accountability, resulting in the institution of professional review. Professional control and autonomy diminished further in the 1970s and 1980s, as both governments and private corporations instituted cost control measures (such as DRGs) that ultimately reduced practitioner decision-making autonomy. By the 1990s, corporate management of medical facilities and health insurance programs posed severe threats to professional control, even to the extent of greatly affecting treatment decisions (Light and Levine 1988; Wolinsky 1988).

Underlying these manifest changes in the status of the medical profession were organizational changes in practitioner-patient relationships that evolved as a result of technological change. For example, increasing medical knowledge and technology necessitated increasing medical specialization, resulting in spatially and temporally fragmented delivery of care. From the standpoint of physicians, this required intraprofessional cooperation among physicians of assorted specialties that in turn reduced individual autonomy (Freidson 1975). From the standpoint of patients, seeing a variety of specialists in various locations on different days lessened the opportunity for them to develop deep, trustful relationships with a *personal* physician, a trend that undermines the service ethic dimension of professionalism. Increasing knowledge and technology also stimulated the development of allied health professions, each pressing for greater status, income, and autonomy. By the 1970s, the medical profession encountered an assortment of role boundary challenges, or ''turf battles'' from long-term health professions, such as nursing, physical therapy, and pharmacy, as well as newly developed health roles, such as medical technicians, physician assistants, nurse practitioners, and nurse midwives.

These internal changes within medicine were accompanied by broad societal changes, such as the depersonalization of relationships in society evident in increasing litigation (Ritchey 1981). Moreover, in the current postmodern era, science is challenged by alternative belief systems, many of which are creations of mass marketing and media advertising. Thus, physicians and other regulated professionals must compete for health dollars with companies promoting such health behavior options as dietary and vitamin supplements, health devices, and spiritual healing systems. Ultimately, having jurisdiction over a body of knowledge and the professional stature that accompanies it hinges on economic market forces, political processes, and public persuasion, as well as work organization processes. *See also* **Allied health personnel; Alternative health care practitioners; Deprofessionalization; Flexner Report; Health occupations; Limited practitioners; Physician extender; Profession; Professional autonomy; Professional boundary maintenance; Professional dominance; Quasi practitioners.**

HEALTH PROMOTION

(1) Through public awareness education and community-based risk screening and diagnosis programs, organized interventions geared at disease prevention and early detection of disease. (2) A social movement begun in the 1960s aimed at focusing public attention on preventive health behavior. Such movements foster competition for research and program implementation funding, for example, between the medical and public health establishments, which concentrate on therapeutic and preventive approaches to disease, respectively. Most public funding is still awarded toward efforts to cure chronic diseases, such as cancer and heart disease. Health promotion, however, is now an integral part of health education and product advertising, although there is much potential for consumer fraud with the latter.

HEALTH SERVICES DISTRIBUTION (MALDISTRIBUTION)

The geographic distribution of health services relative to the kinds and quantities of services needed by populations. Maldistribution is a poor match between an area's health service needs and its accessible service providers.

The United States and many other countries have a typical pattern of physician service maldistribution: an oversupply of specialists and an undersupply of primary care physicians in urban areas and a shortage of all kinds of services in rural areas where there are high patient-to-physician ratios. An especially troublesome shortage in rural areas is that of obstetrics-gynecology services (Fondren and Ricketts 1993; Pastor, Huset, and Lee 1989).

HEALTH SERVICES MALDISTRIBUTION

See **Health services distribution (maldistribution).**

HEALTH STATUS

In health surveys, an individual's self-report of the quality of the state of his/her health, typically assessed with the following questionnaire item: ''How would you rate your health? Would you say you are in excellent health, good health, fair health, or poor health?'' Studies of the validity of self-reported health status typically find it to be an accurate assessment of an individual's state of health (Cockerham 1997).

HELP-SEEKING BEHAVIOR

That part of the illness process that involves efforts to access formal medical service providers, especially physicians, when one is ill or otherwise has been defined as sick (Suchman 1966). From a behavioral perspective, help seeking concerns the issue of which circumstances (biological as well as psychosocial) lead an individual to seek out a physician or alternative practitioner. From a structural perspective, help seeking is an issue of medical care access; that is, what behavioral, organizational, and financial circumstances facilitate or inhibit the receipt of health care services. For a discussion of help seeking for health, see Pescosolido 1992. *See also* **Illness process.**

HIV

See **Acquired immunodeficiency syndrome.**

HOLISTIC MEDICINE

A medical paradigm that views patients in the totality of their environments and as mental, emotional, social, and spiritual, as well as physical, beings (Gordon 1980:3). In addition to its emphasis on psychosocial context, this paradigm is characterized by an emphasis on individualized treatment; a deemphasis on statistical deductions; a view of health as a positive state rather than the absence of disease; the importance of health promotion and prevention; individual responsibility for health, self-help and self-care; the mobilization of innate healing capacity; physical contact (the laying on of hands) between practitioner and patient; good nutrition and exercise; a view of illness not merely as misfortune, but as a potential opportunity for discovery; an appreciation of sensuousness and sexuality; and an appreciation of the relationship of the life course to health (Gordon 1980:3–27).

From a social movements perspective, holistic medicine is a professional movement of the mid- to late twentieth century. This movement is said to respond to the "excesses of biomedicine" (Gordon 1980:15). It is critical of orthodox medicine which, advocates of holistic medicine contend, views patients as diseased organisms.

HOMEOPATHIC MEDICINE

An approach to healing based on the *law of similars* (i.e., like cures like), the notion that the way to treat illness is to prescribe drugs that stimulate similar symptomatology if given to a healthy person. The rationale is that the drug will produce a similar but weaker disease that the body can easily overcome and, in the process, also overcome the natural disease (Coulter 1980:395–400; Weiss and Lonnquist 1994:34).

Homeopathy was founded by the German physician Samuel Hahnemann (1755–1843) in the early 1800s as a response to the dominance of regular, or what Hahnemann called ''allopathic,'' physicians. He saw the latter as biocentric, too focused on single causes, and too focused on the standard notion that medicine should be of a contrary quality to the disease (Coulter 1980:396).

HOSPICE; HOSPICE CARE

Nonmedical services provided to patients who are terminally ill, with an emphasis on palliative care and family involvement. Hospice, as a concept of serving the ill, focuses not on curing, but on relieving symptoms and dealing with the psychosocial aspects of the dying process (Rakich, Longest, and Darr 1992:277–280). The patient's close friends and relatives, who are provided support and bereavement care, are considered part of the unit of care.

Hospice services may be provided in an independent community-based facility or by a unit of a hospital, although many of the services may be provided off site. Hospices may also be organized as service programs operated by hospitals, health care organizations, home health agencies, or voluntary organizations, such as religious groups (Rakich, Longest, and Darr 1992:277–280).

The origin of hospice care can be traced back over 2,000 years to India. The concept was popularized in modern times by Cicely Saunders, who established St. Christopher's Hospice near London in 1967, and Elisabeth Kübler-Ross (1969), whose book *On Death and Dying* stimulated open discussion of death and the need to serve terminally ill patients outside a medical model (Davidson 1985:2). As a developing institution, hospice care is a cultural response to increasing longevity of the population and subsequent increases in chronic, terminal illnesses, especially cancer.

HOSPITAL

A facility with at least six beds that is licensed by the state as a hospital or which is operated as a hospital by a federal or state agency. The first hospitals were established by the Romans and spread throughout

Western Europe with the rise of Christianity. Medieval hospitals were primarily centers for the practice of religion among the lower-class sick and injured but changed in character to poorhouses and later to death houses for the poor when hospitals were increasingly secularized in the wake of the Renaissance and the Reformation (Cockerham 1995:226–290). It was not until the late nineteenth century that the hospital as we know it emerged as a center of medical technology.

The first hospital in the United States was established by William Penn in Philadelphia in 1713. By 1992, there were 5,619 short-stay and 447 long-term hospitals in the United States. The ownership of hospitals in the United States may be classified as: (1) nonprofit, (2) proprietary (profit-making), and (3) government. Short-stay hospitals, the most common type, are those in which patients are expected to stay only a few days or weeks. About 5 percent of all short-stay hospitals are owned by the federal government. Among the remaining short-stay hospitals, 57 percent are nonprofit, 13 percent are profitmaking, and 25 percent are owned by the state and local governments. Long-term hospitals include a few general service facilities, but the majority are specialty hospitals providing psychiatric, tubercular, and other types of care.

HOSPITAL BEDS; STATISTICAL BEDS; HOSPITAL BED SIZE

As a measure of size or capacity of hospitals, the daily average of the "number of beds, cribs, and pediatric bassinets regularly maintained (set up and staffed for use) for inpatients" (American Hospital Association 1992:xxiv). For reporting purposes, the American Hospital Association uses eight bed-size categories: 6 to 24 beds, 25 to 49, 50 to 99, 100 to 199, 200 to 299, 300 to 399, 400 to 499, and 500 or more (1992:xxiii).

In the United States, 1983 was a peak year in which just over one million staffed beds were available in all community hospitals. By 1991 the number had declined to 924,049, with the greatest reduction in rural hospitals (American Hospital Association 1992:xi). The decline was a response to reduced hospital admissions and length of stays following the institution of cost-containment strategies, such as prospective-payment Diagnostic-related groups (DRGs) health care reimbursement methods. *See also* **Diagnostics-related groups (DRGs)**.

HOSPITAL ORGANIZATIONAL STRUCTURE

Formal, highly stratified, quasi-bureaucratic, and quasi-authoritarian, consisting of a centralized administrative bureaucracy and an informal, decentralized, professional medical staff. Hospitals consequently, have a dual authority system, one administrative and the other medical. The classic, ideal bureaucracy, a highly formal, rational organizational structure aimed at maximizing efficiency, was described by Max Weber (1978) as having the following features: (1) specialization (division of labor) based on rational organizational function; (2) centralization of authority, a strict, hierarchy of authority (organizational chart) with important decisions made by occupants of the top positions; (3) formalization, formal systems of rules that guide virtually every action of the workers; (4) impersonality, the separation of the individual from the role, such that personality has minimal effects on job performance; and (5) individual job security and organizational stability, effects of political power derived from the organization being large in membership. In contrast to the rigidity of bureaucracy, professions are distinguished by (1) a body of esoteric knowledge requiring extensive training and the development of personal competence and expertise; (2) a service ethic that places the welfare of the client above the requisites of organizational efficiency; and (3) worker autonomy, so that the professional is entrusted and allowed to work without supervision (Goode 1960).

The hospital is an excellent example of a professional bureaucracy, a large organization with the main organizational tasks being carried out by professionals. Compared to the ideal bureaucracy, a professional bureaucracy is organized around the delivery of services to client subjects, rather than the production of goods. It has (1) a division of labor based on expertise, which makes task assignments less susceptible to an a priori rational design; (2) decentralized authority, because important decisions are made not by remote authorities but by those delivery services; (3) less formalization of rules, because professional work is highly complex and varied and thus not amenable to rational design and definite specifications; (4) less impersonality, because professional esteem affords some individuals an inordinate amount of power allowing them to negotiate their roles; and (5) less stability, because professionals seek career enhancement outside the organization. The organizational structure of the hospital becomes ever more complex as hospital finance is corporatized.

HOSPITAL SICK ROLE

Consists of five basic components, including the four of Parsons' (1951) sick role in which the sick person (1) is exempt from normal social roles, (2) is not responsible for his or her condition, (3) should try to get well, and (4) should seek technically competent help, with the addition of (5) an obligation to accept hospital routine (Lorber 1975). The hospital role differs from a general sick role in that hospital patients have the additional requirement of cooperating with hospital authority.

HOSPITAL STAY

See **Average length of stay, hospital.**

HOST

In epidemiology, a person or animal wherein an infectious agent or toxic substance subsides, causing disease or injury (Benenson 1985:450). This term was originally used with reference only to infectious disease, but as chronic degenerative diseases and injuries have replaced communicable diseases as the major causes of morbidity and mortality, the term has broadened to include persons or animals with these conditions.

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I

IATROGENIC DISEASE

Physician-caused illness and disease, such as the adverse side effects of medications and surgery. The term is typically used pejoratively, as a criticism of the assumption that modern medicine necessarily represents progress (see, e.g., Illich 1976). Iatrogenic injury resulting from physician negligence may constitute medical malpractice. *See also* **Malpractice, medical.**

ILLNESS

A state or condition of suffering as a result of a disease or sickness (Cockerham 1995:149). In sociology, an illness is a subjective state, pertaining to an individual's psychological awareness of having a disease, symptoms, or pain and typically modifying his or her social behavior as a result. This definition contrasts with that of a disease, which is a physiological dysfunction within an individual.

ILLNESS BEHAVIOR

The activity undertaken by a person who feels ill for the purpose of defining that illness and seeking relief from it (Kasl and Cobb 1966).

Illness behavior is an important variable in medical sociology because not everyone responds the same way when sick. Some people go to physicians for treatment when they experience symptoms of illness, while others with the same symptoms may attempt self-care or dismiss the symptoms as not needing attention. Some people may even deny the experience of symptoms out of anxiety for what the symptoms may mean (e.g., AIDS, cancer). Subjective interpretations of feeling states when ill are the basis of illness behavior. Models of illness behavior have been developed by Parsons (1951) in his well-known concept of the sick role, Suchman (1965a and b, 1966) on stages of the illness experience, and Freidson (1970a) with a labeling theory perspective on acting sick. See also Haug et al. (1991) for a discussion of self-care and Pescosolido (1992) for an analysis of help-seeking behavior. *See also* **Help-seeking behavior; Self-care; Sick role**.

ILLNESS EXPERIENCE

The decisions, behaviors, and outcomes associated with stages of illness. Edward Suchman (1965, 1966) specified the following stages of the illness experience: (1) symptom experience, (2) assumption of sick role, (3) medical care contact, (4) dependent patient role, and (5) recovery and rehabilitation.

The illness experience perspective focuses on the juncture between personal and structural variables, with an emphasis on social and cultural restraints on behavior. The illness experience is not simply a response to biological conditions but requires decision making at all stages and is dependent on the resources available. For example, medical care contact may be inaccessible to some individuals (e.g., the poor, medically indigent, or homeless), even though they might have willingly accepted the sick role (Weiss and Lonnquist 1994:130–151).

ILLNESS PROCESS

See **Illness experience**.

IMPAIRED COGNITIVE FUNCTIONING

See **Cognitive functioning**.

INCIDENCE

"[T]he number of *new* cases of a specific health disorder occurring within a given population during a stated period of time'' (Cockerham 1995:14).

INFANT MORTALITY RATE (IMR)

The death rate for infants in their first year of life. The IMR is expressed as deaths per 1,000 live births and computed as the number of deaths to infants under one year of age for a given year, divided by the number of live births for that year, times 1,000 (Pol and Thomas 1992: 198).

INFECTIOUS AGENT

''An organism (virus, rickettsia, bacteria, fungus, protozoa and helminth) that is capable of producing infection or infectious disease'' (Benenson 1985:451).

INFORMED CONSENT

The understanding arrived at when physicians inform patients about the risk involved in medical care. The law in the United States since the 1960s has been to require informed consent from patients whose treatment involves surgery or other forms of risk, except in narrowly defined emergencies. The law requires that physicians inform patients about their medical condition and the available courses of treatment and obtain consent to proceed. In an emergency, treatment without informed consent may be justified if three conditions are present: (1) the patient must be incapable of giving consent and no lawful surrogate is available; (2) there is a danger to life or serious impairment; and (3) immediate treatment is necessary to avert those dangers (Rosoff 1981). Otherwise, informed consent is required for all treatment involving risk to the patient.

Informed consent protects patients from a doctor's arbitrary decisions by making the patient aware of all possible consequences of treatment. Informed consent also increases the patient's participation in decision making and extends patient rights and authority by allowing the patient the opportunity to refuse treatment. Traditionally, physicians have argued that their training, integrity, and professional ethics are sufficient protections of the well-being of patients. Doctors are sworn to do no harm to patients. Because of the complexities of medical decision making, physicians may argue that most patients are incapable of understanding those complexities and should therefore trust a doctor's decisions. However, when risk is involved, the direction of the law in the United States is to require the patient's informed consent to medical procedures. The guiding legal principle behind informed consent is one of respect for the patient and the preservation of individual freedom in the context of health care (Garrett, Baillie, and Garrett 1989). The principle is connected to both the right of privacy (right to noninterference) and law of assault and battery (unwanted touch).

The patient or lawful surrogate must be capable of understanding the consequences of the consent, and the physician must provide the necessary information in a way that can be understood. Physicians are therefore *required* to communicate effectively with their patients. Four approaches to the disclosure of information have evolved: (1) patient preference, (2) professional custom, (3) prudent person rule, and (4) subjective substantial disclosure (Garrett, Baille, and Garrett 1989). *Patient preference* involves telling the patient only what he or she wants to know, which can be time-consuming (requiring unnecessary information) and inefficient and which may fail to meet the standards of informed consent. *Professional custom* involves telling the patient what is normally or customarily told patients in similar situations, which leaves the doctor free not to disclose relevant information. In this case, patients may lack information that would cause them to reject treatment. Furthermore, what is standard care for one doctor may not be the same for another; thus, standards may vary and patients may not be informed about the range of options available. The *prudent person rule* is based on the assumption that the doctor should provide the information a prudent person would want to know in making a decision about his or her treatment. Such information would likely include the diagnosis, recommended treatment, risks and consequences, benefits, alternatives, and prognosis if no treatment is given. Finally, the *subjective substantial disclosure rule* involves telling the patient everything that is relevant—not just what a prudent person would want to know. This includes disclosure of both subjective and objective factors important to the patient. The prudent person and subjective disclosure rules most fully meet the requirements of informed consent.

INPATIENT CARE

Hospital care requiring overnight lodging. *See also* **Outpatient care.**

L

LABELING THEORY

A perspective maintaining that once a person is defined, or labeled, by other people in a certain way, others will respond to him or her in accordance with the label. Labeling theory, a variant of symbolic interaction, emerged as a major theory of deviant behavior and provided the theoretical background for numerous studies of mental health in the 1960s and 1970s. The sociologists most influential in the development of labeling theory included Edwin Lemert, Howard Becker, and Thomas Scheff.

Lemert (1951) focused on the manner in which deviant acts become symbolically attached to persons who commit them. He came up with the concepts of *primary deviance* and *secondary deviance*. Primary deviance denotes a situation in which a so-called normal person acts differently or strangely, but the behavior is rationalized as atypical by others because it is perceived as uncharacteristic of the person's own true self. Secondary deviance, on the other hand, is more serious, referring to a situation in which a person is relegated to the deviant role; that is, being deviant is thought to be a typical characteristic of that individual.

Becker made further contributions to labeling theory through the insight in his book *Outsiders* (1973). In it he argues that social groups create deviance by making rules whose infraction constitutes deviance. Deviance is therefore not a quality of the act a person commits but, rather, a consequence of the definition applied to the act by others. Whether or not an act is deviant thus depends on how other people react to it. However, the responses of other people are problematic because their interpretation of the situation is the deciding factor, and not all people see things the same way. The focus of *Outsiders* is upon marijuana smokers, who view marijuana use as normative behavior in their own subculture, but who are criminals in the eyes of the wider society.

Thus, the labeling approach stresses that judgments of what is deviance are relative, depending upon the perceptions of others. Therefore, the critical variable in understanding deviant behavior is the social audience that has knowledge of the act in question because the audience determines what is and what is not deviant.

The sociologist who is best known for linking labeling theory and mental disorder is Thomas Scheff. In reviewing the labeling approach to deviance, Scheff (1966/1984) observes that mere rule breaking is not enough in itself to cause others to respond to the rule breaker as mentally ill. Scheff has, therefore, added the concept of *residual rule breaking* to the labeling view of mental illness. Residual rule breaking is based upon the idea that most social conventions or norms are fairly clear and understood; yet there is a residual area of social convention that is assumed to be so natural that it is part of human nature. These residual conventions include such behaviors as looking at the person one is talking to or responding to someone who calls a person by name. To violate these residual conventions goes beyond just violating norms; it involves acting contrary to human nature. Such so-called unnatural behavior may come to be regarded by others as mental illness.

The residual rule breaker may be publicly labeled mentally ill depending upon certain contingencies, such as the identity of the rule breaker, the particular rule broken, the amount of tolerance available, any alternative explanation that might clarify or rationalize the rule-breaking behavior, and the social context in which the behavior takes place. Scheff contends that when a person has been labeled mentally ill and people respond to that person in accordance with that label, a deviant has been created by society. Scheff points out that at some time virtually everyone acts crazy. But if a person is labeled mentally ill and attracts the attention of a community's formal system of social control for mental illness, then that individual will be processed and sent to a mental hospital largely as a matter of routine. When this occurs, that person will be ''launched on a career of 'chronic' mental illness'' and is thus irreparably stigmatized as a mental patient (Scheff 1975:10).

Despite its merits in providing a framework to analyze the variety of perceptions people may hold about deviant acts and deviant persons, labeling theory contains some serious weaknesses. Lemert's concentration upon the transition from primary deviance to secondary deviance has been criticized on the grounds that it neglects the issue of what caused the deviance in the first place (Taylor, Walton, and Young 1973). This criticism can be applied to labeling theory as a whole because societal reaction alone does not explain why certain people commit deviant acts and why others in virtually the same circumstances do not. A label in itself does not cause deviance. Some situations (e.g., crime, alcoholism, drug addiction, suicide, neurologically based aberrant behavior) are generally defined by most people as being deviant—yet people do these things regardless of how they are labeled, and their reasons for doing so may have nothing to do with the label attached. Another deficiency of labeling theory rests in its attempts to explain the characteristics of deviants and deviant acts. Jack Gibbs (1971) notes that if deviant acts and actors do share characteristics other than societal reaction, such characteristics are not defined or explained.

Walter Gove (1970a, 1970b, 1975a, 1975b) has been the leading critic of Scheff and the labeling approach to mental illness. Gove's argument has three central themes. First, he rejects the notion that lower-class persons are more readily labeled as mentally ill than the affluent, because he feels there is quicker recognition of mental illness and less tolerance for it among members of the upper social strata. Second, being labeled mentally ill does not, in his view, result in lasting stigma for former mental patients. And third, he believes that those persons who are mentally ill have an inherent mental condition quite apart from how they are labeled.

This latter criticism is especially important because it recognizes that mentally ill people have something wrong with them, regardless of how they are labeled. This situation represents the single most important weakness in the application of labeling theory to mental disorder, other than societal reaction to residual rule breaking. Further, it does not explain why certain people become mentally ill and why others in the same social circumstances do not. The merit of Scheff's work and of labeling theory in general is that it (1) recognizes the problematic aspects of reaction to mental disorder and (2) explains how people labeled as mentally ill may be forced into a deviant role because of how other people respond to them. *See also* **Symbolic interaction**.

LAY-REFERRAL SYSTEM

Laypersons—family members, friends, and neighbors—who assist individuals in interpreting their symptoms and recommending a course of action. The concept of the lay-referral system originated with Eliot Freidson (1960), who described the process of seeking medical help. This process involves securing advice about seeking professional care or otherwise dealing with the symptoms from a group of potential consultants, beginning in the family and extending outward to more select, authoritative lay persons. Lay-referral systems are most common in working-class and lower-class neighborhoods.

LIFE EXPECTANCY

The amount of time, usually expressed in years, that a person is expected to live. In the United States, for example, the average life expectancy at birth in 1993 was 78.8 years for females and 72.2 years for males.

Care must be taken in interpreting life expectancy figures. Life expectancy is computed by factoring death rates for various age groups. Therefore, if any age group has a high death rate, this brings down the computed figure of *life expectancy from birth.* For example, a nation with a high infant mortality rate (say, 40 infant deaths per 1,000 births) will have a relatively low overall life expectancy figure (say, 54 years). In fact, people in that nation who survive childhood diseases may live into their seventies. Thus, it is worthwhile to examine life expectancy for specific age groups. This age-adjusted computation reveals, for instance, that in the United States people over sixty-five can expect to live to an average of eighty-five years. That is, the life expectancy from sixty-five years of age is about twenty years (Maddox and Glass 1989:250). *See also* **Infant mortality rate (IMR); Longevity**.

LIMITED PRACTITIONERS

A category of orthodox medical practitioners who are confined to diagnosing illness and providing treatment for particular parts of the body. Among limited practitioners are dentists, podiatrists, optometrists, and psychologists (Wardwell 1979:235; Weiss and Lonnquist 1994:224). *See also* **Orthodox medicine**.

LIVING WILL

A legal document through which a competent person provides an explicit "advance directive" in the event that if he or she is in a persistent vegetative state, is irretrievably comatose, is being sustained only by artificial means, and is unable to consent to treatment, then it is the patient's wish that medical personnel forgo extraordinary means to sustain life.

Living wills are used to withhold or withdraw life-sustaining technology (such as artificial respirators) and provide legal immunity from charges of negligence and/or manslaughter to medical personnel. Living wills are legal in about forty states, and about one-fifth of the adult population of the United States has signed them (Weiss and Lonnquist 1994:343–344).

LOCUS OF CONTROL, HEALTH

Sense of control a person has over his or her health. Typically, locus of control measures distinguish *internal* from *external* social control. People with an internal locus of control believe that they can master, control, or effectively alter the environment. In contrast, those with an external locus of control believe that they are more or less at the mercy of the environment, fate, chance, luck, or the powerful. Generally persons in the lowest socioeconomic groups express the greatest external locus of control (Cockerham 1995:124).

The Health Locus of Control Scale measures whether people have an internal or external sense of control over their health (Wallston, Maides, and Wallston 1976). People who have a strong internal locus of control tend to actively promote their health through a healthy lifestyle, while those with an external locus tend to be passive and rely on fate, luck, or physicians to keep themselves healthy.

LOCUS OF HEALTH INTERVENTION

The place in the epidemic process at which resources are concentrated in an effort to reduce its impact. The epidemic process is comprised of four critical sets of variables: agent, vector (transmission agent), host, and environment. Depending on the nature of a particular disease, focusing on one or more of these loci may be the most efficient and effective way of reducing incidence rates. For example, cholera and malaria epidemics may best be attacked at the locus of the environment, by cleaning up water distribution systems and eliminating mosquito breeding grounds, respectively. In contrast, until effective vaccines and drug therapies are found, the best approach to fighting the acquired immunodeficiency syndrome (AIDS) may be to educate individuals (the hosts) on safe sex practices. Political dimensions of the AIDS epidemic illustrate how the choice of locus of intervention is not merely a practical scientific matter. Resistance to safe-sex public health policies and public displeasure with homosexuality and drug abuse reveal that political, moral, ethical, and economic factors enter decisions on locus of intervention. *See also* **Agent; Host; Transmission agent**.

LONGEVITY

An increase in life expectancy of members of a population. Longevity is a recent, late-twentieth century phenomenon that creates new challenges for the health care system (Moody 1994:2–10). People in their later years are at greater risk of developing chronic diseases. Thus longevity increases the demand for specialized, nursing home, and home health care; generates cost inflation; and creates ethical dilemmas concerning self-determination of death and quality of life versus quantity.

LONG-TERM HEALTH CARE ORGANIZATION

Medical facilities and cooperatives providing rehabilitative, palliative, nurturing, and custodial support services to individual patients. Specific types of long-term care organizations include nursing homes, hospices, adult day care centers, rehabilitation centers, continuing care retirement communities, and companies providing home health care services (Andersen and Mullner 1989:146; Evashwick 1993:184). *See also* **Community hospitals; Primary health care organization; Rehabilitation**.

M

MALPRACTICE, MEDICAL

An instance in which a physician or other medical practitioner causes injury or death to a patient through negligent behavior. Because of **medical uncertainty**, arriving at an accurate estimate of whether negligence has occurred for an untoward medical outcome is usually very difficult, except for *res ipsa loquitur* cases—those cases that ''speak for themselves,'' such as the amputation of a healthy limb. Malpractice claims against physicians and hospitals have increased dramatically in the past two decades (Ritchey 1993:114) with periods characterized as the ''malpractice crisis.'' It is unclear whether rising litigation is due primarily to an increase in iatrogenic (i.e., physician-caused) injury and illness or to changes in personal injury or tort law, although the rapid increase of all types of litigation since 1970 suggests the latter.

Increasing malpractice litigation has consequences beyond the obvious financial and personal costs of injury claims. Increasing malpractice liability insurance premiums for health practitioners and hospitals contribute significantly to cost inflation. Fear of litigation leads to costly defensive medicine and has changed the physician-patient relationship, making it more impersonal, formally rational, and sometimes adversarial (Ritchey 1981; 1993). The malpractice crisis is a good illustration of how institutions outside medicine have pervasive effects on health care delivery. *See also* **Defensive medicine.**

MANAGED CARE

A system for operating medical care delivery organizations that involves minimizing health care costs by monitoring how doctors treat specific illnesses, limiting referrals made to specialists, and requiring authorization prior to hospitalization, among other cost-control measures (see Rakich, Longest, and Darr 1992:281). Under the directives of a contract, primary care physicians operate as gatekeepers who restrict the amount of expensive testing and must sign off on any patient referral to specialists. **Health maintenance organizations (HMOs)** and **Preferred provider organizations (PPOs)** typically follow the philosophies of managed care.

In the 1990s, managed care has gained wide acceptance as medical care costs continue to increase. States are considering reorganizing Medicaid-reimbursed care on managed care principles, and the Social Security Administration's Medicare program is considering the same. In the private sector, the economies realized through managed care organizations make them highly competitive in bidding for corporate health insurance contracts.

The movement toward the managed care model represents a paradigm change in the organization of medical services. It involves the rationalization of health care delivery, with the application of calculations and quantitative analysis, albeit to an activity with great uncertainty (see Ritchey and Sommers 1993; Ritzer and Walczak 1988). In the traditional fee-for-service reimbursement methods of insurance companies, physicians could order diagnostic tests, referrals, and treatments without regard to cost or quantity. With managed care, nonphysician professionals trained in business management and health administration programs (those with master's of business administration [MBA] degrees or doctorates in health services administration) now conduct continual quality and cost management appraisals of physician activities. Many procedures are disallowed outright, such as cosmetic surgeries or certain brands of prescription medications. In addition, so-called normal rates for all diagnostic and treatment procedures are established. If a physician orders a procedure significantly more often than his or her colleagues, then this behavior, considered deviant, is brought to that physician's attention with the implicit sanction that the behavior be reduced. Therefore, physicians must reorient their behaviors to meet the dictates of the organization's business officers. Physician autonomy is greatly reduced, thus supporting theories of deprofessionalization. Managed care organizations are criticized, especially by competing organizations, for potentially reducing patient access to services. While the potential exists for some patients to receive insufficient treatment, managed care surely reduces much unnecessary treatment. *See also* **Deprofessionalization; Health maintenance organization.**

MARGINAL PRACTITIONERS

A category of medical practitioners ''whose services cover the entire range of bodily functions and disorders but who employ techniques unacceptable to orthodox medicine'' (Weiss and Lonnquist 1994:224; Wardwell 1979:239). From the standpoint of orthodox medical practitioners (i.e., physicians with doctor of medicine [M.D.] degrees), professional marginality hinges on the extent to which these alternative practitioners are viewed as adhering to scientific theory, principles, and techniques. Among marginal practitioners are chiropractors, acupuncturists, and ethnic faith healers such as **curandera/os.**

MASTER STATUS

A person's overall position in society, stemming from a major social characteristic such as age, race, or gender. A disease like AIDS can take on the attributes of a master status, since it can be the single most important social characteristic of an individual who has the disease. Regardless of a person's other characteristics, people with AIDS may find that it confers a master status that negatively influences the attitudes of other people toward them, thereby causing them to be devalued socially.

MATERNAL MORTALITY; MATERNAL MORTALITY RATE

Deaths related to childbearing and birth delivery. The rate for a given year is computed as the number of female deaths due to childbearing-related causes divided by the number of births (Pol and Thomas 1992: 199).

MEDICAID

A federal–state health insurance program for the poor established in 1965 by amendments to the Social Security Act. The federal government provides matching funds to the states, ranging from 50 to 78 percent depending on the per capita income of the states involved. Each state is required to cover all needy persons receiving cash assistance. Eligible health care services include inpatient and outpatient hospital services, laboratory and Xray services, skilled nursing home services, and physicians' services, plus other forms of health care covered at the option of the individual states. For instance, it permits states to include not only the financially needy but also the medically needy, the aged, the blind, and the disabled poor as well as their dependent children and families. In 1986, Congress passed legislation extending Medicaid coverage to children under five years of age and pregnant women with incomes below the poverty level, which in 1996 was $15,600 annually for a family of four or $7,740 for a single person.

In the United States, 35.1 million citizens utilized Medicaid in 1994. Of total Medicaid expenditures, 57 percent derive from the federal government, while 43 percent comes from state budgets. The cost to federal and state governments in 1994 was $107.9 billion. Medicaid was originally intended to cover people on welfare, but the extension of benefits to children and pregnant women from low-income families, who may or may not be on welfare, indicates that the insurance is also being used to cover people with medical expenses who have no other source of health insurance. However, since Medicaid is administered by the states, it is subject to variation in levels of benefits.

MEDICAL DEMOGRAPHY

See **Health demography**.

MEDICAL DISCOURSE

A method of studying doctor–patient interaction that focuses on the transfer of information in medical encounters and how it is structured by professional control and differing patient and physician ideologies, expectations, and social contexts. This approach is one associated with the critical sociology of Howard Waitzkin (1991). It proposes that the medical encounter, in addition to its focus on a therapeutic agenda, serves to reinforce capitalist ideologies of control of the population by elites such as physicians. It points to the unintended consequences of miscommunication in health encounters that arise from unstated ideological assumptions. *See also* **Therapeutic agenda**.

MEDICAL ETHICS

See **Biomedical ethics**.

MEDICAL IDEOLOGY

Within a society or social group, the ideas and doctrines about health care delivery that legitimate action or justify maintenance of extant social structures and conditions (Edelman 1988). Ideologies are often shaped by the particular group interests of those in power yet must appeal to the basic values of a society (Braybrooke 1967:27).

From a critical sociology perspective, medical ideology is reflected in propaganda put forth by the medical profession to justify its economically favorable position (Waitzkin 1983). Widespread acceptance of medical ideas and authority is said to result also in the medicalization of deviance (Conrad and Schneider 1992). *See also* **Health ideology; Medicalization**.

MEDICAL INDIGENCY

(1) For an individual, the situation of being without the financial capability to purchase medical care. (2) For a society, the social problem of a significant segment of the population lacking accessibility to medical care. Medical indigence and general impoverishment are separate phenomena, because some poor people have access to medical services (through, for example, Medicaid), while many otherwise self-sufficient individuals and families lack access to medical care for lack of health insurance.

MEDICAL-INDUSTRIAL COMPLEX

A pejorative term highlighting the movement of health care delivery to the corporate sector of the economy, where new and traditional service providers seek investment dollars and generate high profits at the cost of professional autonomy and patient care quality and accessibility (Wohl 1984).

The concept, derived from the term *military-industrial complex*, implies that corporate control of medical services evokes ethical dilemmas, because the pursuit of profit is bound to take precedence over the service ethic; other ethical considerations, such as the maldistribution of services also are involved.

MEDICALIZATION

(1) The political and ideological process by which the medical profession increases its practical and ideological influence over various aspects of society (Illich 1976). As scientific medicine gained acceptance in the early to mid-twentieth century, the authority and competence of physicians as rational judges of health issues went unchallenged. In the late twentieth century, that authority has been challenged, especially on morally complex issues such as terminating treatment for moribund patients, using fetal tissue in research, performing abortions, and so on. The waning of medicalization has been called demedicalization, and the medical profession is said to be threatened with deprofessionalization as other institutions challenge its authority on controversial issues. (2) Of deviance: The political and ideological process by which the medical profession, as an agent of social control, gains control over which social problems and behaviors are defined as **sickness** (unintentional deviance) as opposed to badness (volitional deviance). For example, heroin addiction, once viewed strictly as a medical condition, is now seen as criminal behavior. As regards society's attempts to control behaviors, medicalization is the increasing influence of medical institutions and the medical profession on aspects of life that previously had not been perceived as medical entities. Another recent example of the medicalization of deviance is the influence of physicians in directing norms of child development; disruptive behavior is now much more likely to be defined as attention deficit disorder, with drugs (such as Ritalin) being prescribed to treat it (Conrad and Schneider 1992:29). *See also* **Demedicalization; Deprofessionalization.**

MEDICAL LIABILITY

See **Malpractice, medical.**

MEDICAL MODEL OF HEALTH

The basic premise of therapeutic medicine and its practitioners, particularly physicians, that health, disease, and illness are essentially an issue of organic pathology in individual patients (Conrad and Kern 1994: 7).

The medical model is criticized for its exclusion of social factors in the etiology and treatment of illness. The model is curative rather than preventive, and many public policy makers assert that society's health care resources may best be spent on health prevention. Others argue that the medical model has too greatly influenced the structure of medical education, producing health practitioners who are ill prepared to deal with the psychosocial aspects of illness and treatment.

MEDICAL REFERRAL

The actions and processes by which a patient is directed to a particular medical practitioner. The study of patient referrals reveals patterns of patient transfers within the medical system. The most common type of medical referral is from one physician to another, typically from a primary care physician to a specialist, but sometimes from a specialist to another specialist. Among the more than seventy medical specialties, at least four are widely recognized as primary care physicians—general/family practice, internal medicine, pediatrics, and obstetrics/gynecology. The process of referral from such primary physicians to other specialists is increasingly structured, as **managed care** organizations (such as health maintenance organizations) gain greater influence in the financing of health services. In such arrangements, primary care physicians serve as gatekeepers to the more expensive specialists, thereby controlling the number of referrals.

Research on referrals has also included lay-referral systems, the processes by which persons solicit information from friends and relatives when searching for, or choosing, a new physician or a course of action when health care needs arise. *See* **Lay-referral system**.

MEDICAL SECT

A dissident group of medical practitioners and their followers who set themselves apart from the established institutions of medicine, likely follow a charismatic leader, promote alternative medical practices and theories, and perceive of themselves as ''neglected and scorned apostles of truth'' (Starr 1982:95). Medical sectarianism was common in the United States in the nineteenth century. *See also* **Thomsonian medicine**.

MEDICAL SOCIOLOGY

The study of the social causes and consequences of health and illness (Cockerham 1995:2). Medical sociologists study the social aspects of health and disease, the social functions of health organizations and institutions, the relationship of health care delivery systems to other social systems, the social behavior of health care workers and those people who are consumers of health care, and patterns of health services.

MEDICAL SPECIALTY CERTIFICATION

"Formal recognition of a skill in a specialty" by a medical specialty board or a professional association (Rakich, Longest, and Darr 1992:65). For physicians, the American Board of Medical Specialties, with representatives from professional associations for various medical specialties, monitored twenty-three specialty boards in 1996. Specialty boards certify training programs and provide hospitals and managed care networks with the means to evaluate the competence of physicians. Specialty certification is different from medical licensing, which is formal approval by government for the general right to practice medicine for profit (Rakich, Longest, and Darr 1992:65).

Other health care professionals, allied health workers, and health facility management fields also have certification agencies, such as the National League of Nursing and the Accrediting Commission on Education for Health Services Administration (Rakich, Longest, and Darr 1992:64–65). *Certification* is the term used to signify the competence of individual practitioners, while *accreditation* signifies the competence of an organization or training program such as a hospital or medical school.

MEDICAL UNCERTAINTY

An inherent characteristic of the practice of medicine pertaining to the fact that much of what a practitioner encounters falls outside "habitual patterns of observation, thought, and expectation" (Fox 1989:183).

Medical uncertainty hinges on the complexity of human biology, the limits of knowledge, and the enormous variation among individuals in the ways they respond to disease and treatment. The extensive literature on medical uncertainty carries the theme that "Scientific medicine is itself a symbolic system for coping with the fears and uncertainties of medicine" (Gerrity et al. 1992:1024–1025). Learning to deal with medical uncertainty is a key part of the socialization process in medical training (Fox 1957).

Medical uncertainty has both positive and negative outcomes. On the one hand, it provides rewarding challenges and serendipity to medical researchers (Fox 1989:183–184). On the other hand, it complicates everyday practice situations, and when patient injuries can result from inaccurate decisions, it enhances practitioner fears of malpractice litigation (Ritchey 1993:117–118).

MEDICARE

Passed by Congress in 1965 as an amendment to the Social Security Act, Medicare is a federally administered program providing hospital insurance (Part A) and supplemental medical insurance (Part B) for people sixty-five years or older, regardless of financial resources; disabled people under the age of sixty-five who receive cash benefits from Social Security or railroad retirement programs; and certain victims of chronic kidney disease. Hospital insurance benefits include (1) inpatient hospital services for up to 90 days a year for an episode of illnesses, plus a lifetime reserve of 60 additional days after the initial 90 days have been used; (2) care in a nursing home for up to 100 days after hospitalization; and (3) up to 100 home health visits after hospitalization.

Supplementary Medicare insurance benefits include (1) physicians' and surgeons' services, certain nonroutine services of podiatrists, limited services of chiropractors, and the services of independently practicing physical therapists; (2) certain medical and health services, such as diagnostic services, diagnostic X-ray tests, laboratory tests, ambulance services, some medical supplies, appliances, and equipment; (3) outpatient hospital services; (4) home health services (with no requirement of prior hospitalization) for up to 100 visits in one calendar year; and (5) outpatient physical and speech therapy services provided by approved therapists.

There are specified deductible and coinsurance amounts for which the beneficiary is responsible. The deductible in 1995 for the hospital insurance (Part A) was $716; for the medical insurance (Part B) it was $100, with a 20 percent coinsurance amount also required for most Part B services. After a beneficiary pays the first $100 for Part B services, Medicare pays 80 percent of the charges it approves. The hospital insurance is financed primarily through Social Security payroll deductions, while the medical insurance plan, whose participation is voluntary, is financed by premiums paid by the enrollees and from federal funds. The medical insurance premium in 1996 was $42.50 a month. Congressional reforms in welfare are expected to raise the premiums paid by enrollees.

The Medicare program is under the overall direction of the Secretary of Health and Human Services and is supervised by the Bureau of Health Insurance of the Social Security Administration. Most of the day-to-day operations of Medicare are performed by commercial insurance companies and Blue Cross/Blue Shield plans that review claims and make payments. Requests for payment are submitted by the provider of services and signed by the beneficiary; reimbursement is made on the basis of reasonable charges as determined by the private insurance companies who issue the payments. In 1992, a total of $129 billion in Medicare benefits was paid under coverage extended to 36 million people.

MENTAL DISORDER

According to the American Psychiatric Association (DSM-IV 1994), (1) it is a condition that is primarily psychological and that alters behavior, including changes in physiological functioning if such changes can be explained by psychological concepts, such as personality, motivation, or conflict. (2) It is a condition that in its ''full-blown'' state is regularly and intrinsically associated with subjective stress, generalized impairment in social functioning, or behavior that one would like to stop voluntarily because it is associated with threats to physical health. (3) It is a condition that is distinct from other conditions and that responds to treatment.

Of the three criteria described above, the first separates psychiatric from nonpsychiatric conditions. The second specifies that the disorder may be recognizable only in a later stage of its development (''full-blown'') and that its identification depends upon consistent symptomatology (''regularly associated with''). The disorder must arise from an inherent condition, and the impairment in functioning must not be limited to a single situation but should include an inability to function in several social contexts (''generalized impairment in social functioning''). The second criterion also includes ''behavior that one would like to stop voluntarily,'' for instance, compulsive eating or smoking. The third criterion places the definition within a medical perspective by limiting it to distinct treatable conditions.

This definition was first presented in the American Psychiatric Association's Diagnostic (DSM-III) published in 1985 and continued in DSM-III-R (1987) and DSM-IV (1994). However, as DSM-IV (1994:xxi) observes, no definition of mental disorder adequately specifies its precise boundaries; therefore no operational definition exists that covers all situations. Such vagaries in diagnosis are emphasized by proponents of labeling theory. *See also* **Labeling theory**.

MORBIDITY

(1) "Any departure, subjective or objective, from a state of physiological or psychological well-being" (Last 1983:64). (2) The level of disease within a population. (3) The study of disease within a population.

MORBIDITY RATE

The amount of sickness in a population.

MORTALITY

(1) The study of death within a population. (2) The rate of occurrence of death in a population. *See also* **Mortality rate**.

MORTALITY RATE

An incidence of death rate, "using as a numerator the number of deaths occurring in the population during the stated period of time, usually a year. A total or crude mortality rate utilizes deaths from all causes, usually expressed as deaths per 1,000, while a disease-specific mortality rate includes only deaths due to one disease and is usually reported on the basis of 100,000 persons" (Benenson 1985:454).

MULTIHOSPITAL SYSTEM

Two or more acute care hospitals owned, leased, or managed by a corporation (Haglund and Dowling 1993). In the United States, there are over 300 multihospital systems, which encompass about half of all community hospital beds. More hospitals are being absorbed into these large systems, with for-profit, investor-owned hospital chains having the most rapid growth in both hospitals and available beds in the early 1990s. For a hospital, the advantages of participation in a larger organizational structure are better chances of economic survival in a highly competitive environment and opportunity for growth (Haglund and Dowling 1993: 150).

N

NATIONAL HEALTH INSURANCE

Government-sponsored health insurance providing comprehensive health care coverage for the general population. Most major nations of the world, excluding the United States, have some form of national health insurance covering all or most expenses for health care. National health insurance removes financial barriers to medical treatment and guarantees access to care for all or most citizens and other qualified residents of a country. Some national health insurance programs are administered directly by the central governments (Great Britain), county or municipal governments (Sweden), or indirectly through other agencies and institutions (Germany). Different nations have different levels of insurance coverage. Great Britain's national health insurance, for example, covers all residents, while Germany excludes the most affluent, who have the option to purchase public or private insurance. Japan covers 70 percent of costs until age 70, when all expenses are covered (Cockerham 1995).

The enactment of a national health insurance program for the United States was the goal of the Clinton Administration's effort at health reform in 1994. The Clinton proposals were directed toward meeting the medical needs of the approximately 15 percent of the population without health insurance. Persons without coverage were typically those under the age of 65 who did not qualify for Medicare or whose income was not low enough (the near-poor) to qualify for Medicaid. The failure of health reform leaves the problem of the uninsured unresolved in the United States. *See also* **Medicaid; Medicare**.

NATIONAL HEALTH SERVICE

A national health service (NHS) is a health care delivery system in which the central government takes direct responsibility for delivering patient care. In NHS, the government employs physicians, nurses, and other health care workers, owns the hospitals and clinics, and funds health services through payroll deductions and general tax revenues. Patients have little or no out-of-pocket costs for their care.

The most widely known model of an NHS is the British National Health Service. Established in 1948, the British system is intended to provide equal access to health care across social classes and regions. Patients choose a general practitioner who is paid an annual capitation (per capita) fee for each patient registered with them, up to a maximum of 3,500 patients for a solo practitioner or 4,500 for a partnership. General practitioners are paid a fee for each patient, regardless of whether the patient receives any care from them over the course of the year. The general practitioner is required to provide medical services free of charge. Patients cannot go directly to specialists, known as consultants in Britain, without being referred by their general practitioner. Generally, specialists are the only physicians who treat patients in hospitals. Physicians have the right to treat private patients, who are responsible for paying their own bills. The NHS also provides maternity benefits and death benefits to survivors and manages sickness benefit funds, which supplement incomes when wages are lost because of illness or injury (Cockerham 1995:293–297).

From its inception, the British NHS has been controversial—although a majority of the population appears to support the system (Graig 1993). However, lack of financial resources, aging facilities, long waiting periods for appointments and elective surgery, and worker discontent over levels of pay have been serious problems. Nevertheless, the NHS has accomplished its goal of free health care to all citizens, and Britain's overall health profile is among the best in the world, despite the persistently poor health of the lower class (Cockerham 1995:297). Poor health among the lower class in Britain is primarily due to the unhealthy lifestyles and living environments associated with poverty, rather than a lack of access to quality health care in the NHS (Hart 1991).

NATUROPATHIC MEDICINE

With an emphasis on preventive health, an approach to health and healing based on the premise that the body has natural healing powers that may be enhanced primarily by nutritional changes and secondarily by botanical medications and meditation.

Naturopathic medicine originated in Germany in the late nineteenth century and was brought to the United States in 1892 by Benedict Lust, who by 1896 was instrumental in founding the first naturopathic college and procuring licensing in the District of Columbia. Presently, there are five colleges of naturopathic medicine located in the United States and Canada (Mills 1966; Twaddle and Hessler 1987:190).

NEIGHBORHOOD HEALTH CENTER

See **Community health center**.

NONCOMMUNITY HOSPITAL

''[F]ederal hospitals, long-term hospitals, hospital units of institutions [such as prisons], psychiatric hospitals, hospitals for tuberculosis and other respiratory diseases, chronic disease hospitals, institutions for the mentally retarded, and alcoholism and chemical-dependency hospitals'' (American Hospital Association 1992:xxiii). *See also* **Community hospitals**.

NORMS

Expectations of behavior shared by people in social situations. A norm has the effect of acting as an ideal standard intended to guide or control behavior in a manner acceptable to the people concerned. Most norms are expressed not as firm rules and regulations, but as abstract concepts held by a group, community, or society about what constitutes appropriate behavior in specific situations. *See also* **Deviance**.

NURSE-MIDWIFE

Registered nurses who attain additional education (usually a master's degree) in obstetrics and gynecology and are certified by the American College of Nurse-Midwives. With an emphasis on women's and family health, ''nurse-midwives provide prenatal, intranatal, and postpartal care to expectant families,'' including prenatal health examinations, management of normal labor and delivery, infant care counseling, and nutritional and family planning. Nurse-midwives have prearrangments for physician intervention when complications arise in a delivery. Some states do not have licensure of nurse-midwives (Doheny, Cook, and Stopper 1987: 178).

In addition to the place of nurse-midwives in the division of labor within medical care delivery, the development of nurse-midwifery is of interest to sociologists as an instance of historical conflict over professional roles and boundaries. In the United States, until allopathic physicians (M.D.s) gained control over medical licensing in the late 1800s and early 1900s, women's health care, and especially the well-care requirements of natality, were carried out by midwives. The ideological and legal battles that occurred between physicians and midwives over jurisdiction of prenatal and birthing care led to the virtual elimination of midwifery by 1950—except in remote areas. Yet midwifery has slowly made a comeback in American society because of the availability of practitioners and the desire of some women to have a natural childbirth. Some 24 states now allow nurse-midwives to deliver babies under a doctor's supervision and some 4,000 nurse-midwives are certified to provide services. *See also* **Professional boundary maintenance**.

NURSE-PRACTITIONER

Registered nurses with up to two years of additional training in health assessment in one or more of the specialized areas of family medicine; pediatrics; emergency medicine; or adult, ambulatory, critical, or geriatric care. Such assessments may include medical histories, physical examinations, and evaluation of findings to determine physical and psychosocial health status. Many nurse-practitioners work on site with medical teams under the direct supervision of physicians. Others work alone in remote rural areas or underserved inner-city neighborhoods but practice under legal restrictions requiring physician referral for complicated medical cases (Doheny, Cook, and Stopper 1987:179).

The development of a relatively autonomous nurse-practitioner role occurred in response to technological, organizational, and sociocultural changes in medical care delivery such as: (1) increasing specialization and the development of the team care concept in hospital practice, (2) professional movements aimed at enhancing the status of allied health professions, (3) the maldistribution of physician services, and (4) patients' desires for more personal and psychosocially oriented interaction in medical encounters.

O

ORTHODOX MEDICINE

Medical practitioners having official government approval whose therapeutic philosophies conform to the dominant medical ideologies of the society and are thus endowed with cultural authority. Since the mid-1800s, medical orthodoxy has hinged on claiming a scientific basis for knowledge. Physicians acquiring doctor of medicine (M.D.) degrees are the orthodox practitioners of modern Western society, as well as other scientifically trained practitioners such as nurses, pharmacists, dentists, and physical therapists. The allopathic physicians of the early to mid-ninteenth century were the first regular or orthodox physicians in the United States. Orthodox practitioners are to be contrasted with alternative practitioners. *See also* **Allopathic physicians; Alternative health care practitioners**.

OSTEOPATHIC MEDICINE

A mechanistic approach to healing based on spinal manipulation (Bourdillon, Day, and Bookhout 1992:5–9). Training focuses on anatomy and biomechanics (i.e., motion of the joints), supplemented by a full medical curriculum, resulting in a doctor of osteopathy (D.O.) degree.

The first school of osteopathy was founded by Andrew Taylor Still in 1892. In contrast to chiropractors, who are not always accepted as legitimate scientific practitioners by M.D. physicians, osteopaths gained such acceptance in the 1970s by modifying their educational curricula. Today, osteopaths frequently practice alongside M.D.s., although most D.O.s are in solo, private practice settings. There are about 28,000 osteopaths in the United States.

OSTEOPATHY

See **Osteopathic medicine**.

OUTPATIENT CARE

Medical care provided at a hospital, but without an overnight stay. The ratio of outpatient-to-inpatient hospital care has increased in the past two decades as a reaction to cost-containment strategies. Furthermore, less invasive and less injurious diagnostic and treatment technologies have made outpatient care more feasible. *See also* **Inpatient care**.

P

PARSONS, TALCOTT (1902–1979)

A leading American sociologist who played a major role in the development of medical sociology. Parsons's importance for medical sociology stems from the publication of his book *The Social System* in 1951. Written to explain a functionalist model of society in which social systems are linked to corresponding systems of personality and culture, this book contained Parsons's concept of the sick role. Unlike other major social theorists preceding him, Parsons formulated an analysis of the function of medicine in his view of society. Parsons presented an ideal representation of how people in Western society should act when sick. The merit of the concept is that it describes a patterned set of behavioral expectations for sick persons and the people interacting with them. Parsons also pointed out that physicians are invested by society with the function of social control over deviant behavior, giving them a role similar to that of priests. In the case of the sick role, illness is the deviance, and its undesirable nature reinforces the motivation to be healthy.

Parsons developed his concept of the sick role in the context of classical sociological theory. He linked his ideas to those of Emile Durkheim and demonstrated the controlling function of medicine in a large social system. Some have argued that Parsons's concept of the sick role represents the most important single theoretical contribution to medical sociology to date (Fox 1989; Wolinsky 1988). Moreover, having a theorist of Parsons's stature rendering the first major theory in medical sociology called attention to the young subdiscipline, especially among academic sociologists. Not only was Parsons's concept of the sick role ''a penetrating and apt analysis of sickness from a distinctly sociological point of view'' (Freidson 1970b:62), but it was widely believed in the 1950s that Parsons and his students were charting a future course for all of sociology through the insight provided by his model of society.

This, of course, was not the case, as Parsons's ideas—including his concept of the sick role—were strongly criticized. Parsons nevertheless provided a theoretical approach for medical sociology that brought the subdiscipline the intellectual recognition it needed in its early development in the United States. Parsons's views on society may not be the optimal paradigm for explaining illness, but Parsons helped make medical sociology academically respectable. For a review of Parsons's theoretical orientation in relation to medical sociology, see Uta Gerhardt (1989).

PATIENT-PHYSICIAN RELATIONSHIP

The relationship between a doctor and a patient which is oriented toward the doctor helping the patient deal effectively with a health problem (Parsons 1951). The physician has the dominant role since he or she is invested with the medical knowledge and expertise that is needed, while the patient has the subordinate position oriented toward accepting, rejecting, or negotiating the recommendation for treatment being offered (Cockerham 1995). The patient–physician relationship continues to be a central theme in medical sociology theory and research.

PHYSICIAN-ASSISTED SUICIDE

With the consent of a terminally ill patient, physician action to bring about a patient's death with a minimum of physical and psychological pain. According to its proponents, physician-assisted suicide is a form of ''mercy killing,'' or euthanasia, and has been illegal in all fifty states until only recently. ''Death with dignity'' has been advocated by the Hemlock Society and others for decades, but only recently have physicians openly participated in purposive euthanasia. The contemporary movement to legalize physician-assisted suicide is championed by Dr. Jack Kevorkian, who has assisted in numerous suicides and been charged several times with murder by the state of Michigan. Kevorkian uses a confrontational approach to promote legalization and public acceptance of physician-assisted suicide. His criminal charges and trials provided a forum for challenging legal basis and the constitutionality of state laws pertaining to physician-assisted suicide. Kevorkian has been found not guilty in many cases, and his guilty verdicts have not withstood appeal. In Michigan, the state legislature passed a law specifically designed to stop Kevorkian's activities. The Michigan Court of Appeals overturned the law in May of 1994, but it was later reinstated by the Michigan Supreme Court. In 1994, Washington state's law banning physician-assisted suicide was struck down by a Seattle judge. However, in 1996, federal appeals courts in the states of Washington and New York held physician-assisted suicides to be legal and laws against it to be a violation of a patient's constitutional right to personal liberty. The issue will be decided by the U.S. Supreme Court in 1997.

PHYSICIAN'S ASSISTANT

A health care occupation whose role is to provide a broad range of medical treatment to patients under the direction and supervision of a physician. The function of a physician's assistant (PA) is often similar to that of a physician, in that the PA provides primary care, some surgical and trauma procedures, and works in other medical specialties such as ophthalmology, obstetrics-gynecology, cardiology, and rheumatology. The physician's assistant is an extension of the physician and performs only those procedures which the physician authorizes. The physician, not the PA, remains ultimately responsible for the patient. Physician's assistants and nurse-practitioners are comparable in many ways, but the nurse-practitioner focuses on nursing care and can work independently of doctors.

PHYSICIAN COMMUNICATION STYLE

In the presence of a patient, the way a physician "verbally or paraverbally interacts to signal how literal meaning should be taken, interpreted, filtered, or understood" (Norton 1978:99). Many communication styles have been identified, such as dominant, affiliative, dramatic, contentious, relaxed, open, and friendly. Two styles have been found to be strongly correlated with patients' satisfaction with medical care—affiliative styles, positively, and dominant/active styles, negatively. These relationships suggest that competence in communication is a facet of medical competence (Buller and Buller 1987).

PHYSICIAN EXTENDER

Health practitioners, such as nurse-practitioners, physician's assistants, and emergency medical technicians, who maintain direct communication with, and work under the authority of, physicians but extend the physician's reach into underserved geographic locations.

Physician extenders work primarily in remote rural communities and urban slums. They have the autonomy to treat routine ailments, which are the vast majority of primary care visits, but have a physician on call for emergency situations and for referral for additional care. *See also* **Nurse-practitioner; Physician's assistant**.

PHYSICIAN INCENTIVE PLAN

Income bonuses awarded by hospitals to their physicians to encourage them to reduce costs by ordering fewer and less expensive diagnostic procedures and treatments (Smith and Fottler 1985:112–113). Incentive plans, spurred by cost-containment strategies such as prospective payment systems, have been criticized for their potential for reducing the quality of care.

PHYSICIAN–PATIENT RELATIONSHIP

See **Patient–physician relationship**.

PREFERRED PROVIDER ORGANIZATION (PPO)

A form of health organization in which employers purchase group health insurance that allows them to send their employees to particular hospitals and doctors for discounts. The doctors and hospitals associated with a PPO are expected to provide their usual services to PPO members, but lower charges are assessed against the members' group health insurance plans. *See also* **Managed care**.

PREPAID GROUP PRACTICE

Group practice providing health care services to patients who pay a specified amount in advance, usually monthly, in return for health care. The focus is on preventive care, that is, keeping patients healthy so that they will not need expensive services. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) are forms of prepaid group practices. *See also* **Health maintenance organization; Preferred provider organization.**

PREVALENCE

The *total* number of cases of a health disorder that exists at any given time. Point prevalence is the total number of cases at a certain point in time, usually a particular day or week. Period prevalence is the total number of cases to exist and occur during an extended period of time, usually a month or year. Lifetime prevalence is the number of individuals in a targeted population at risk who have had a health disorder at least once in their lifetime. Prevalence includes the accumulation of new cases with previously existing ones, in contrast to **incidence** which tabulates only new cases over time.

PREVENTIVE CARE

Care provided by health practitioners intended to prevent disease or illness. Physical examinations and immunizations are typical forms of preventive care. Preventive care is more common among higher socioeconomic groups than lower ones and is a major factor is the higher level of health among affluent social classes.

PRIMARY CAREGIVER

See **Caregiver/caregiving.**

PRIMARY HEALTH CARE ORGANIZATION

Medical practice arrangements among primary care physicians who provide basic preventive, health maintenance, and disease detection services to individual ambulatory patients. Specific types of primary care organizations include solo practice, partnerships, and group practice physician offices; hospital outpatient departments; health maintenance organizations; community health centers; clinic/hospital emergency rooms; and walk-in urgent care facilities. *See also* **Community hospitals; Long-term care organizations.**

PRIVATE NOT-FOR-PROFIT (NONPROFIT) HOSPITAL

A hospital that operates with no surplus of revenues over expenses. This term is considered an anachronism, because the revenues of many such classified hospitals do exceed expenses. Nonprofit, moreover, cannot be equated with tax-exempt, which is a status many for-profit hospitals have acquired (Eastaugh 1992a:416).

PROFESSION

An occupational category distinguished by (1) a body of esoteric knowledge requiring extensive training and the development of personal competence and expertise; (2) a service ethic that places the welfare of the client (e.g., a patient) above the requisites of organizational efficiency and enhances occupational status through the development of public trust; and (3) worker autonomy, wherein the individual professional is viewed as an expert who may work without supervision and, collectively, the occupation controls entry into the field (Goode 1960).

The medical profession once fit the ideal profession. Medical knowledge is highly complex, and individual patient cases vary in response to treatment, making task routinization impossible; subsequently, the practice of medicine is part art as well as science. The claim to a service ethic is anchored in the facts that the market is virtually inexhaustible, and nearly all people are required at some point to entrust their lives to physicians. Professional autonomy is enhanced by the high status afforded a profession.

PROFESSIONAL AUTONOMY

Freedom to work without supervision by higher authorities. At the individual level, professional autonomy is reflected, for example, in a physician's decisions going unquestioned by nurses, organizational officers, or even professional colleagues. At a collective level, professional autonomy is reflected, for example, in medicine's direct control of who enters the field (i.e., medical school admissions and licensing).

A contemporary issue of medical sociology is the question of whether the medical profession has lost autonomy (Light and Levine 1988). Medicine is now practiced by health teams composed of assorted physician specialists as well as assisting personnel such as nurses and allied health professionals (diagnostic and treatment technicians and therapists). Governments and corporations play an increasingly influential role in resource allocation, which directly and indirectly influences treatment decisions. Patient consumers are now quick to question the physician's decisions, and severe untoward outcomes promptly evoke malpractice litigation (Ritchey 1993). Managed care organizations indirectly pressure physicians to alter their medical decisions for cost containment. These changes suggest that physicians are undergoing deprofessionalization (Haug 1988; Ritzer and Walczak 1988). *See also* **Deprofessionalization**.

PROFESSIONAL BOUNDARY MAINTENANCE

A profession's ''attempt to negotiate the boundaries of an area in the social division of labor and establish control over it'' (Larson 1977:xvii; Freidson 1970b; Ritchey and Sommers 1993:120).

Boundary maintenance and adjustment among health professions is a continual process wherein professions compete for the right to perform medical procedures, maintain cultural and workplace authority, and control access to patients. Since the early twentieth century, physicians (M.D.s) have controlled most cognitive, decision-making medical tasks that bestow high prestige upon a profession. Physicians have delegated simpler, routine tasks to other health professions. When boundary disputes reach the public eye, they are oftentimes referred to as turf battles.

Currently, most auxiliary health professions are attempting to expand their boundaries, and physicians are restricting these efforts to some degree. The relatively new role of clinical pharmacy (doctors of pharmacy), characterized by hospital pharmacists delivering direct patient counseling and participating in drug treatment decisions, is one case in point. Research suggests that this new role will gain acceptance, at least among certain medical specialties, because it fills a functional niche in patient care; however, physicians tolerate pharmacy role expansion as long as physician authority and autonomy are not strained (Ritchey and Sommers 1993). Similarly, the role of physical therapist is gaining in scope and autonomy. In several states, physical therapists now are a point of entry into the medical care system, having the right to provide services without a physician's referral (Ritchey et al. 1989).

The fluidity of role boundaries among health professions is evident in historical trends. Prior to the twentieth century, physicians and pharmacists had similar roles, with both professions diagnosing and prescribing treatment (Kronus 1976). Similarly, prior to World War I, physical therapists worked with a great degree of autonomy (Ritchey et al. 1989: 71). Assorted theories on the topic of professional boundary maintenance include power theory and conflict theory, which focus on direct political actions of the medical profession and its ability to co-opt change advocated by auxiliary health professions (Kronus 1976; Adamcik et al. 1986); interactive process theory, which focuses on negotiated order and the workplace interactions that support or undermine physician authority (Mesler 1991); and medical rationalization theory, which focuses on how general cultural change, especially technological and political, creates the need for innovative organization and thereby opens opportunities for role expansion (Ritchey and Sommers 1993).

PROFESSIONAL BUREAUCRACY

See **Hospital organizational structure**.

PROFESSIONAL DOMINANCE

A term used to highlight the physician monopoly in the twentieth century over virtually all profitable aspects of medical care.

The evidence for professional dominance includes physician control over the legal right to classify what constitutes illness, control over licensing of all health professions, great work autonomy and insulation from outside regulation, direct and indirect authority over all diagnostic and therapeutic prescriptions in patient care, and ability to withstand the role boundary expansion of other health professions (Freidson 1970b).

Since the late 1960s, physician dominance has been increasingly challenged (Wolinsky 1988). Other health professions such as nursing, pharmacy, and physical therapy are expanding their roles to include autonomous decision-making tasks. Health care finance and organization are being corporatized. Patients are seeking alternative forms of care, are quick to criticize care provision, and are increasingly suing physicians for malpractice. Some have raised the question of whether physicians are undergoing deprofessionalization (Haug 1988). *See also* **Deprofessionalization**.

PROFESSIONAL ETHICS

See **Biomedical ethics; Profession**.

PROFESSIONAL SOCIALIZATION

The process by which laypersons are transformed into professionals through ‘‘the acquisition of a large body of knowledge, skills, and distinctive modes of reasoning, and the internalization of shared attitudes, values, and patterns of behavior relevant to the work'' of the profession (Fox 1989:46).

The peculiar characteristics of professional work require an extensive process of education wherein two difficult sets of knowledge and skills are learned: the highly complex esoterica of the field and the professional ethics required to deal with clients. Medical education is in many ways a prototype of professional education in general. Medical students must learn to absorb large amounts of information in a judicious way, so as not to waste time. They must learn to deal with dead bodies and dying patients. They must acquire clinical skills to know how to deal with living patients. And finally they must learn to deal with the uncertainty of medicine (Fox 1989:72–107).

Medical socialization is not a process that ends with formal training. Physicians and other health professionals must learn not only the norms of providing care in everyday settings, such as private offices and hospitals but also the norms regulating the business, legal, and interprofessional relationships and in general the professional subculture that shapes the larger structural context of medical work.

Research on the socialization of health professions is scarce. Fox (1989:75–76) notes that all research on physician socialization focuses exclusively on medical education (i.e., students and resident physicians); none follows what socialization processes occur thereafter. Furthermore, because thorough studies of medical education are lacking since the 1960s, the findings are dated and subject to the biases of the period, such as the predominance of white males. Finally, there is little on the socialization of other health professionals such as nurses, pharmacists, and alternative practitioners.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION (PSRO)

Hospital and community committees established by federal legislation in 1970 to review and evaluate the medical care given to Medicaid and Medicare patients. The PSROs are composed of licensed physicians who determine whether the services rendered are medically necessary, meet professional standards of quality, and are provided as efficiently and effectively as possible (Williams and Torrens 1993:170–171).

PROLETARIANIZATION (OF MEDICAL PRACTICE)

``The process by which [physicians have been] divested of control over certain prerogatives relating to the location, content and essentiality of [their] task activities and [are] thereby subordinated to the broader requirements of production under advanced capitalism'' (McKinlay and Arches 1985:161).

The notion that medicine is undergoing proletarianization challenges the medical dominance argument that physician work is especially esoteric and prestigious, that physicians control health care organizations and that they retain autonomy over their work. (*See* **Professional dominance**.) Using a Marxian theoretical framework, proponents of the proletarianization position question the very assumption that physicians do or have ever maintained dominance (Navarro 1988). They point to the corporatization of medicine, the loss of autonomy, and increasing bureaucratization as signs that physicians are becoming manual wage laborers. Vicente Navarro (1988) takes issue with both the professional dominance and proletarianization positions in an effort to bring balance to this theoretical debate.

PROPRIETARY HOSPITAL

Profit-making hospital typically owned by a business corporation; may be part of a multihospital chain.

PROSPECTIVE PAYMENT SYSTEM

A system of health insurance reimbursement where, based on a patient's diagnosis, ''hospitals are paid an amount fixed *in advance*, [in] an effort to encourage efficiency and contain hospital costs'' (Smith and Fottler 1985:1). *See also* **Diagnostic-related groups**.

Q

QUACKERY

The proprietary medical practices and products of people posing as physicians or of physicians who have lost their licenses to practice medicine. Quackery involves fraudulent claims to expertise or bogus medical techniques. Quackery has a long tradition that extends back to the snake-oil sales of charlatans who roamed the American frontier. The key feature that distinguishes quackery from other widely accepted, but unscientific medical practices is a false claim that the practice or product is scientifically valid.

QUALITY ASSURANCE (QA) PROGRAMS

Based on statistical analysis of adverse medical events in hospital care, programs designed to alter provider and management practices to prevent treatment errors or minimize their impacts on patients (Eastaugh 1992b: 236).

QUASI PRACTITIONERS

A category of health practitioners "whose services to the sick are incidental to another function, usually religious'' (Weiss and Lonnquist 1994:224), and whose methods have not been or cannot be empirically validated (Wardwell 1979:243). *See also* **Christian Science medicine; Faith healers**.

R

REFERRAL
See **Medical referral.**

REGRESSIVE INTERVENTION
A physician's purposeful withdrawal, gradual or abrupt, from the curative health care process once a patient is classified as terminally ill (Clair 1990). A central ethic of physician training is to save the life of patients by arresting the disease process through progressive and aggressive action. For terminally ill patients, this objective becomes unattainable, causing physicians to perceive their skills as irrelevant to those patient cases. Feelings of failure lead some physicians to become emotionally detached, and physician interventions shift toward simplified palliative strategies involving minimal interactions with patients and their families (Clair 1990). This disengagement and regression from the care process is usually incremental because, over the last two decades, most physicians have become aware of the need not to regress too quickly. Criticism of physicians' dealings with dying patients and their families enticed the hospice movement, creating formal organizations and procedures for easing the dying process. *See also* **Death role; Hospice; Hospice care.**

REHABILITATION

Post-acute care, long-term treatment to aid persons in regaining mental and/or physical functional abilities lost to injury or illness.

In 1990, the United States had 128 rehabilitation hospitals and 781 rehabilitation units in other hospitals, with nearly 29,000 total beds (Evashwick 1993:189). Rehabilitation is ideally part of a continuum of care where acute services are provided prior to rehabilitation, and needed long-term care is continued after rehabilitation.

RESPITE CARE

Temporary in-home health care designed to give family members temporary relief from the burdens of continual caregiving to dependent relatives (Klein 1986). Respite care often allows families to delay nursing home placement of their loved ones.

RESTRICTED ACTIVITY DAYS

The number of days, in a specified period of time (usually the previous two weeks), a person was not able to do the things he/she usually does because of not feeling well.

This measure of health is typically assessed through an interview, such as the Health Interview Survey conducted annually by the U.S. Public Health Service. As a research variable, restricted activity days is viewed as one health outcome and may be specified with respect to particular diseases. Respiratory diseases and back problems are two sets of medical ailments that account for much restricted activity. For economists, restricted activity days may be used to estimate loss of productivity due to illness.

RISK MANAGEMENT FUNCTIONS (IN HEALTH SERVICE ORGANIZATIONS)

''[A]ctivities in health organizations that are intended to conserve financial resources from loss. Those functions include a broad range of administrative activities intended to reduce losses associated with patient, employee, or visitor injuries; property loss or damages; and other sources of potential organizational liability'' (Harpster and Veach 1990:378). The rise in liability claims in the health care arena since the 1960s led to the development of risk management activities. Many health care organizations, especially hospitals, employ risk managers who have degrees in health services management, and/or backgrounds in loss prevention (Rakich, Longest, and Darr 1992:453).

S

SALUTOGENESIS

An approach to the study of morbidity that focuses on the causes of health rather than the causes of disease (pathogenesis). This approach targets the healthy as well as the ill and raises the question of why, under similar circumstances of risk and vulnerability, healthy individuals remain healthy.

Aaron Antonovsky's (1979) salutogenic model looks for resistance factors and coping strategies that ward off disease. The model encompasses macro-level variables that place the individual's experiences and socialization in a broader sociocultural and historical context. He distinguishes generalized resistance resources—physical, biochemical, material, cognitive, emotional, attitudinal, interpersonal, and sociocultural—that provide individuals and groups with meaningful life experiences that prepare them to successfully avoid and combat physical and mental stressors. A key health-producing personality trait in this model is a sense of coherence, a ''global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that one's internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected'' (Antonovsky 1979; Twaddle and Hessler 1987:372). The model supports preventive health initiatives by directing attention to sociocultural predispositions and life experiences that produce health, rather than those that produce illness.

SELF-CARE

A layperson's preventing, detecting, and treating his or her own health problems. Self-care is self-initiated and self-managed and is the most common response to symptoms of illness by people throughout the world (Haug et al. 1991). According to Alexander Segall and Jay Goldstein (1989:154), a number of factors have promoted renewed interest in self-care on the part of laypersons. These factors include (1) the shift in disease patterns from acute to chronic illnesses and the accompanying need to displace medical intervention from an emphasis on cure to care; (2) growing public dissatisfaction with medical depersonalized care; (3) recognition of the limits of modern medicine; (4) the increasing visibility of alternative healing practices; (5) heightened consciousness of the effects of lifestyles on health; and (6) a desire to exercise greater personal responsibility in health-related matters.

SELF-HELP GROUPS

Voluntary support groups composed of people with a common disease, ailment, or social circumstance who come together to share their knowledge, experiences, and burdens.

There are an estimated half million self-help, or support, groups in the United States, among them Alcoholics Anonymous, Al-Anon, and Alateen; Grief Support Group; Alliance for the Mentally Ill; and support groups for people with Alzheimer's disease, acquired immunodeficiency syndrome (AIDS), anorexia, bulimia, cancer, colitis, diabetes, impotence, infertility, menopause, multiple sclerosis, and Parkinson's disease, their families and/or caregivers (Weiss and Lonnquist 1994:125).

Self-help groups have been found effective primarily in enhancing the psychosocial aspects of illness experience for those afflicted with disabling chronic disease (e.g., improved psychological well-being and coping strategies). But these groups also influence treatment adherence decisions and to some extent may reduce pain and physical impairment (Trojan 1989).

SENSE OF COHERENCE

See **Salutogenesis**.

SEX RATIO

In a given population, the ratio of the number of males to the number of females. For some applications, a sex ratio might be computed for specific age intervals.

Sex ratios are used by demographers and economists to assess the effects of gender distribution on biological processes, such as fertility, mortality, and morbidity, as well as social processes such as migration, marriage, labor force participation, and retirement.

SICKNESS

A social state signifying an impaired social role for those who are ill. *See also* **Sick role**.

SICK ROLE

The set of patterned expectations that define the norms and values appropriate to being sick, both for the individual and others who interact with the person (Cockerham 1995:142). The concept originated over forty years ago with **Talcott Parsons** (1951), who defined specific obligations and privileges of a patient. There are four basic components in Parsons's sick role concept; namely, that the sick person (1) is exempt from normal social roles, (2) is not responsible for his or her illness, (3) should try to get well, and (4) should seek technically competent help. Inherent in this concept is the notion that exemption from normal roles requires legitimation from a physician as the authority on what constitutes illness; that some curative process apart from personal willpower is needed to recover; and that exemption from usual activities involves an obligation to get well that includes a further obligation to seek help from a physician. The merit of the sick role is its extrapolation of the general norms and values appropriate to being sick, both for the sick person and others who interact with that individual.

In subsequent decades Parsons's model of the sick role has been criticized for its asymmetrical, physician-centered approach, for its disregard of sociocultural variations in sick role performance and socioeconomic restraints on seeking medical care, and its disregard of the effects of disease severity (West 1984). Parsons's model is highly regarded as a starting point for understanding illness behavior, but it is inadequate even as an ideal configuration of how individuals may always be expected to behave when ill.

Parsons's concept of the sick role is considered a significant event in the development of medical sociology. Parsons was one of the most important theorists in sociology during the 1950s and 1960s, and he was the first major theorist to consider problems of health and illness. Parsons's sick role concept called attention to medical sociology as a discipline at a time when the field was becoming established. *See also* **Parsons, Talcott.**

SICK ROLE LEGITIMATION

The process by which other social actors recognize and respect an individual's adoption of the sick role, thus allowing the individual exemption from normal task and role obligations (Wolinsky and Wolinsky 1981:231). An individual may seek, from family members and a lay-referral network, provisional validation of the sick role with *temporary* exemption from role duties. Subsequently, the individual may seek formal, institutional legitimation by visiting a physician. The success of individuals in obtaining sick role legitimation, and the patterned processes by which legitimation is sought, vary according to background, health attitudes, and previous health seeking and service utilization variables (Wolinsky and Wolinsky 1981).

SOCIAL CONTROL, MEDICAL

The sanctioned, institutionalized means by which medical personnel, especially physicians and psychiatrists, secure adherence to, or police, social norms in an effort to eliminate or minimize deviant behavior. Medicine is an institution of social control, and its personnel are agents of social control.

Especially from the standpoint of labeling theory and critical sociology, the significance of institutions of social control is not only that their agents sanction behavior but also that they define what constitutes appropriate behavior (Conrad and Schneider 1992:7–8). Similarly, from a historical-social constructionist approach, moral and normal behavior, and therefore, deviant behavior are defined for a given period of time within the cultural and political contexts of a society. Accordingly, it is widely argued that, as science has increasingly functioned to legitimate behavior in American society, the influence of medicine as an institution of social control has increased in the past half century at the expense of religion and government; to wit, social control is an important dimension of the medicalization of society (Conrad and Schneider 1992:17–37). *See also* **Medicalization.**

SOCIAL MEDICINE

The study of the social causes and consequences of health and disease, including the manner in which society responds to sickness. Social medicine is a broad field, embracing the social and behavioral sciences, along with the humanities, in the analysis of the relationship between society, health, and medicine. Subject areas include but are not limited to examining the role of medicine as a social institution; the social effects of medical knowledge; social origins of health and disease morbidity; health lifestyles; social and political philosophies underlying health care delivery systems; societal norms, values, and ethics pertaining to medical practice; the culture of medicine and health; and the social history of medicine. The goal of social medicine is to produce knowledge enabling health practitioners and policy makers to make informed and effective decisions reflecting the social and cultural realities of the people they serve.

The term *social medicine* was introduced by the French physician Jules Guérin, who urged his colleagues to help create a new society following the Revolution of 1848 (Rosen 1979). The revolutionary movement of 1848 began in Paris and spread throughout much of Europe, with the aims of establishing more egalitarian societies and replacing monarchies with constitutional forms of governments. In France, Guérin suggested that social medicine should be organized as a field for medical doctors involving "the coordinated study of the relation of social life and institutions to patterns of health and disease, and the provision of appropriate measures (medical or otherwise) to deal with the problems study would reveal" (Susser, Watson, and Hopper 1985).

These ideas gained favor among many leading German physicians and influenced Rudolf Virchow, noted for his work in the development of cellular pathology, to declare in 1848 that "medicine is a social science and politics is nothing by medicine on a grand scale" (quoted in Rosen 1979:29). Virchow and his circle of colleagues formulated a program of action based on the recognition of society's obligation for the health of its citizens, the need for the scientific investigation of the social and economic factors that foster disease, and a demand that steps taken to combat disease must be social as well as medical. The overall direction of the program was toward establishing a system of reforms guaranteeing state support for the health and welfare of the total population, especially the socially and economically disadvantaged.

However, the notion of social medicine as a revolutionary concept and means of social and medical reform ended with the defeat of the 1848 Revolution by military force and the emancipation of peasants in Central European countries where serfdom had remained legal. Although Virchow and his supporters remained true to their ideals, Rosen (1979) explains that the role of social medicine was largely limited to influencing reform in public sanitation. It was not until 1911 when Alfred Grotjahn, a German physician, published a book *Soziale Pathologie* [*Social Pathology*], that major attention was once again given to the study of disease from a social viewpoint. Grotjahn formulated a concept of social hygiene suggesting the use of social sciences to investigate and determine how health and life expectancy, especially that of the lower class, could be improved. He was unable to advance the sociological study of health problems, given the level of scientific expertise and focus on formal theoretical work in sociology in Germany at the time, but his ideas had wide influence on the rebirth of social medicine in Central and Eastern Europe (Rosen 1979).

The influence of Grotjahn and other like-minded physicians, along with recognition of the link between social conditions and disease, led to the development of social medicine as a medical specialty in Europe. Social medicine in Europe is primarily a form of preventive medicine involving the application of public health measures to large populations. In Great Britain and North America, social medicine did not evolve into a specific type of medical practice. Rather, what constitutes social medicine in Europe is carried out largely by specialists in preventive medicine and public health, while the social aspects of health and illness are largely studied by medical sociologists and medical anthropologists. Social medicine does exist as a particular field of study in Canada at McGill University in Montreal and in the United States at Harvard University, the University of North Carolina at Chapel Hill, and the University of Alabama at Birmingham. The most complete account of the history of social medicine is found in George Rosen (1979).

SOCIAL READJUSTMENT RATING SCALE

See **Stressful life event.**

SOCIAL SUPPORT

Subjective feelings of belonging and being loved, accepted, cared for, and needed by family members and friends. Social support has been found to be an important variable in the development of feelings of well-being and the relieving of symptoms and tension. Numerous studies have shown that the social support rendered by families and friendship networks helps reduce the potentially harmful effects of stress on the body and mind (Ensel and Lin 1991; Gore 1989; Haines and Hurlbert 1992; Loscocco and Spitze 1990; Matt and Dean 1993; Mirowsky and Ross 1979; Noh and Avison 1996). Social support tends to function as a buffer or intervening variable between an individual and his or her sense of stress. Persons with the strongest levels of social support typically report fewer health problems than those with little or no support. Consequently, social support is an important variable in stress research.

SOCIALIST MEDICINE

A system of health care delivery in which health care is a state-provided public service (Field 1989). The state controls, organizes, and allocates health care directly to all citizens free of charge. What all socialist medical systems have in common is that they (1) directly control the financing and organization of health services in a socialist (communist) economy, (2) pay providers directly, (3) own all facilities, (4) guarantee access, and (5) ban private care. Socialist medicine was a major feature of communism, under which no private practitioners or insurance companies were allowed. Communism collapsed in the former Soviet Union and in Eastern Europe during 1989–1991 and communist socialist medicine has found itself in a state of transition whose final form has yet to be determined. Only a few nations, primarily China and Cuba, still practice communist socialist health care delivery.

Countries like Canada and Great Britain have *socialized*, not socialist medicine. The principal difference is that socialized medicine is a state-supported consumer service in a capitalist—not socialist—economic system. *See also* **Social medicine**.

SOCIOECONOMIC STATUS (SES)

A person's overall position within a system of social stratification. Socioeconomic status typically consists of measures of income, occupational prestige, and level of education and not only reflects a person's economic circumstances but also accounts for differences in status that are not necessarily based on money or property. Although each dimension of SES is interrelated, each reflects somewhat different influences on health and illness. Income reflects spending power, housing, diet, and quality of medical care; occupation measures prestige, responsibility, physical activity, and exposure to unhealthy work conditions; and education indicates skills for acquiring positive social, psychological, and economic resources (Winkleby et al. 1992:816). Persons with the highest education tend to have the best health, and those with the lowest education tend to have the worst health.

SOCIOLOGY IN MEDICINE

The sociologist in medicine is a sociologist who collaborates directly with the physician and other health personnel in studying the social factors that are relevant to a particular health disorder (Straus 1957). This phrase was coined by Robert Straus (1957) to distinguish applied sociologists ''in medicine'' from theoretical scholars who conduct the sociology ''of medicine.'' The work of the sociologist in medicine is intended to be directly applicable to patient care or to the solving of a public health problem. Some of the tasks of the sociologist in medicine are to analyze the etiology, or causes, of health disorders; the differences in social attitudes as they relate to health; and the ways in which the incidence and prevalence of a specific health disorder are related to such social variables as age, sex, socioeconomic status, racial/ethnic group identity, education, and occupation. Such an analysis is then intended to be made available to health practitioners to assist them in treating health problems. Thus, sociology in medicine can be characterized as applied research and analysis primarily motivated by a medical problem rather than a sociological problem. Sociologists in medicine usually work in medical schools, nursing schools, public health schools, teaching hospitals, public health agencies, and other health organizations. They may also work for a governmental agency like the U.S. Department of Health and Human Services or the Centers of Disease Control and Prevention in the capacity of biostatisticians, health planners, administrators, and other positions. *See also* **Sociology of medicine**.

SOCIOLOGY OF MEDICINE

The sociology of medicine deals with such factors as the organization, role relationships, norms, values, and beliefs of medical practice as a form of human behavior (Straus 1957). The emphasis is on the social processes that occur in the medical setting and how these contribute to our understanding of medical sociology in particular and to our understanding of social life in general. The sociology of medicine shares the same goals as all other areas of sociology and may consequently be characterized as research and analysis of the medical environment from a sociological perspective. Thus the sociology of medicine can be characterized as primarily motivated by the solution of sociological problems rather than medical problems. Although some sociologists of medicine are employed in health institutions, the majority work as professors in the sociology departments of universities and colleges.

SPIRITUAL HEALERS

See **Faith healers; Folk healers.**

STIGMA

An attribute that is deeply discrediting. According to Erving Goffman (1963:3) there are three main forms of stigma: (1) abominations of the body, such as various types of physical deformities; (2) blemishes of individual character, such as sexual deviance, alcoholism, and so on; and (3) races, religious groups, and nationalities with minority status in a given society. Labeling theory provides the framework for understanding the interactive processes of stigmatization. *See also* **Labeling theory; Stigmatized risk group.**

STIGMATIZED RISK GROUP

A category of people at risk of disease(s) generally perceived to be the consequence of willful deviant behavior. Stigmatized risk groups include, for example, intravenous drug abusers and homosexuals, who are at high risk of contracting AIDS. Sickness is a form of deviance in that it interferes with a person's ability to carry out normal roles, but sickness affords its victims freedom from blame. (*See* **Sick role.**) Stigmatized diseases, such as substance abuse conditions, sexually transmitted diseases, and eating disorders, confuse the issue of willfulness and culpability. As a result, the disease, or behaviors that prompted it, may be seen as sin or crime. The association between the illness and deviant behavior stigmatizes those who exhibit either and evokes calls for moral retribution and punishment, rather than treatment. Stigmatized risk groups are sometimes portrayed as deserving of their pain and suffering and unworthy of care and treatment, and this can lead policy makers to ignore the group, as has been suggested was the case in the early days of the AIDS epidemic (Shilts 1987).

Public health outreach to stigmatized risk groups is complicated by the moralistic nature of stigmatized disease. Ethical and political dilemmas arise in the confrontations between, for example, the public health and religious communities. As in the case of AIDS, prejudicial societal responses not only harm the stigmatized risk group, but place all others at greater risk. Persons with symptoms of a stigmatized disease, may be led to fear of retribution that causes them to avoid seeking appropriate care, even when they have not participated in what the society has defined as deviant behavior. They can also find themselves without jobs or insurance once their status is known. Such avoidance behavior puts others at risk because unknowingly infected persons can spread a disease to others. *See also* **Acquired immunodeficiency syndrome (AIDS); Avoidance**.

STRAIN

See **Stress**.

STRESS

A heightened mind-body reaction to stimuli inducing fear or anxiety in the individual. Stress typically starts with a situation that people find threatening or burdensome (Pearlin 1989). Examples of stressful situations include divorce (Aseltine and Kessler 1993; Booth and Amato 1991), unpleasant work conditions (Pavalko, Elder, and Clipp 1993), widowhood (Umberson, Wortman, and Kessler 1992), and caregiving to frail elderly family members (Pearlin et al. 1990). The study of socially induced stress, that which results from the pressures of daily living, or especially from the pressures of burdensome roles such as caregiving to family members with Alzheimer's disease, is a major area of sociological research. For example, a substantial number of recent research articles published in the *Journal of Health and Social Behavior* are dedicated to this and related topics. Coping behavior, how persons cope with stress, not so much individually, but with the support of family members and others, is the process examined in sociological studies of stress and stress-related illness. *See also* **Coping behavior and processes; Stressful life event; Stressor, social**.

STRESSFUL LIFE EVENT

A stress-inducing change in one's life with the potential to cause or contribute to physical illness, psychological distress, or disruption of social relationships. Life events research does not focus on one particular life event (for example, exposure to combat) and claim that it is more stressful than another life event (for example, unemployment). Rather, it is generally based on the assumption that the accumulation of several events in a person's life eventually builds up to a stressful impact. However, what types of events, in what combinations, over what periods of time, and under what circumstances promote stress-induced health problems is not at all clear at the present time.

An important area of contention in life events research, for example, is the issue of whether any type of change in one's life, either pleasant or unpleasant, produces significant stress or whether stress is largely a result of unpleasant events only. Considerable evidence supports the idea that any type of environmental change requiring the individual to adapt can produce a specific stress response (Cockerham 1995; Selye 1956). However, most research clearly comes down on the side of unpleasant events as being of prime importance. The frequency and rate at which stressful life events are experienced also affect the potential for distress.

Life events research entails serious problems of accurately measuring the presumed relationship between stress and particular life experiences. The most influential instrument at present is the Social Readjustment Rating Scale developed by Thomas Holmes and Robert Rahe (1967). This scale is based on the assumption that change, no matter how good or bad, demands a certain degree of adjustment on the part of an individual: the greater the adjustment, the greater the stress. Holmes and Rahe have carried their analysis one step further and have suggested that changes in life events occur in a cumulative pattern that can eventually build to a stressful impact. Thus, the type of change does not matter as much as the extent to which change disrupts normal patterns of life.

The Holmes and Rahe Social Readjustment Rating Scale lists certain life events that are associated with varying amounts of disruption in the life of an average person. It was constructed by having hundreds of people of different social backgrounds rank the relative amount of adjustment accompanying a particular life experience. Death of a spouse is ranked highest, with a relative stress value of 100; marriage ranks seventh, with a value of 50; retirement tenth, with a value of 45; taking a vacation is ranked forty-first, with a value of 13; and so forth. Holmes and Rahe call each stress value a ''life change'' unit. They suggest that as the total value of life change units mounts, the probability of having a serious illness also increases, particularly if a person accumulates too many life change units in too short a time. If an individual accumulates 200 or more life change units within the period of a year, Holmes and Rahe believe such a person will risk a serious disorder.

Although used extensively and found to measure stress and life events about as well or better than other scales, the Holmes and Rahe Social Readjustment Rating Scale nevertheless contains some serious flaws. The scale does not adequately account for differences in the relative importance of various life events among ethnic and cultural subgroups. Also some events, such as divorce, can be regarded as a consequence of stress instead of a cause. For example, events such as ''change in sleeping habits,'' ''change in number of arguments with spouse,'' ''sex difficulties,'' and ''fired at work'' may result from stress rather than cause it. This situation confounds the relationships being measured.

Furthermore, as R. Jay Turner and William Avison (1992) discovered, life events that are successfully resolved may not be stressful. That is, it may be the case that mastery of an event provides a buffer to stress because successful resolution constitutes a personally meaningful positive experience. This situation, as Turner and Avision explain, can substantially counterbalance the stress associated with the event.

Obviously, life events research is in need of more extensive development. The relationship between stress and life events as a precipitating factor in causing or contributing to the onset of physical and mental disorders is a highly complex phenomenon and not easily amenable to a simple cause-and-effect explanation. Nevertheless, considerable progress has been made in improving measures of stressful life events, and work in this regard continues today.

STRESSOR, SOCIAL

Stimuli generated from social situations which provoke stress. Leonard Pearlin (1989) suggests two major types of social stressors: life events and chronic strains. First, there is the stress of life events like divorce, marriage, or losing one's job. Second are chronic strains, which are relatively enduring conflicts, problems, and threats that many people face on a daily basis. Chronic strain includes role overload, such as the strain associated with work and being a parent (Simon 1992) or trying to advance one's career over the life course (Pavalko, Elder, and Clipp 1993).

It also involves conflicts within role sets, like those between husbands and wives (Aseltine and Kessler 1993; Booth and Amato 1991); interrole conflict, in which a person has too many roles; role captivity in which a person is an unwilling incumbent of a role like being trapped in an unpleasant job or marriage, or role restructuring in which a person changes relationship within roles. As Pearlin (1989:245) observes, role strains can have serious effects on individuals because the roles themselves are important, especially when they involve jobs, marriage, and parenthood.

SUBCULTURE

A group of people who have developed beliefs, norms, morals, customs, and practices that differ from those prevailing in the wider society. In medical sociology, many early studies (Freidson 1960) identified the presence of a lay subculture among socially and economically disadvantaged persons whose norms and values concerning scientific medicine conflict with those of the middle and upper classes. These disadvantaged persons, lodged in the lower class, were skeptical of modern medicine and tended to delay seeking professional care until other remedies, like folk medicine, failed. Cultural barriers to health care utilization are less prevalent in the United States today because of a reduction in financial barriers due to Medicaid and Medicare. The current situation in the United States and Western Europe finds the lower class utilizing physician services to a much greater extent than in the past (Cockerham 1995).

SUPPORTIVE HEALTH CARE ORGANIZATION

See **Ancillary health care organization.**

SYMBOLIC INTERACTION

A major theory in sociology, developed by George Herbert Mead (1863–1931), which maintains that people define their social reality and then act on the basis of those definitions. Mead, in his best-known work, *Mind, Self, and Society* (1934), explains that human beings have the capacity to think and decide on their own how they should act in particular situations. Therefore, it is individual perceptions of situations that guide behavior and allow people to choose what they want to do; it is not the case that large-scale or macro-level social processes drive people to act in ways that are not necessarily of their own choosing. Social reality is constructed by individuals interacting with one another on the basis of shared symbolic meanings communicated through language. Social change is caused by people changing their perceptions and definitions of situations.

The essential message of symbolic interaction theory is that people are not robots responding automatically to social stimuli, but are creative beings constructing the reality of their everyday life on the basis of their definitions of situations. Symbolic interaction theory gained prominence in the 1960s and 1970s as an alternative to functionalist theory. It has been used extensively in medical sociology, especially in studies of patient-physician interaction, the professional socialization of medical and nursing students, and mental health. For example, the most famous study of medical students, *Boys in White* (1961), conducted by Howard Becker and his associates at the University of Kansas, utilized a symbolic interactionist framework of analysis. Symbolic interaction has had great influence on studies of mental patients and provides the foundation for labeling theory, a major approach to explaining deviant behavior. *See also* **Labeling theory**.

T

THERAPEUTIC AGENDA

The tendency for physicians to encounter patients with the narrow objectives of diagnosing and treating disease at the risk of ignoring the psychosocial aspects of patient management (Allman, Yoels, and Clair 1993).

Physicians acquire the therapeutic agenda in their training and subsequent experiences. In their training, physicians are taught to follow in medical encounters a systematic diagnostic format which ascertains chief complaint, present illness, past (medical) history, family (medical) history, social history, (total body) systems review, physical examination, other investigations (procedures and tests), diagnosis, and (treatment) plan (Waitzkin 1991:27). Of the ten steps in this agenda, only one, the social history, focuses on the patient's social context, and even the line of inquiry followed here is likely to be directed toward explaining visible symptoms.

The biocentric nature of the therapeutic agenda, causes physicians to disregard the larger concerns of patients, to appear authoritarian, and to ignore discussion of preventive health behavior and psychosocial aspects of health. In contrast, the patient's agenda may include a desire for autonomy and self-direction in treating their condition and a larger focus on health as a continuing psychosocial as well as biological/physical process. The lack of correspondence in their views of the situation leads to much miscommunication and patient dissatisfaction. Over the last decade, about 600 articles per year have analyzed and commented on dissatisfaction in physician-patient relationships and miscommunications in medical encounters (Allman, Yoels, and Clair 1993:29).

THOMSONIAN MEDICINE

A popular health movement of the early nineteenth century advocating the medical philosophy and methods of Samuel Thomson (1769–1843), that all disease had one general cause, that of being ''cold,'' and could be cured through methods that regenerate heat within the body. Thomson's remedies were botanic (plant based) as opposed to mineral, and his method involved consumption of vegetable solutions spiced with hot plants, such as red peppers, along with hot baths (Starr 1982:51; Thomson 1829).

Thomson patented his system of treatment and freely sold rights to its use, claiming by 1839 to have sold them to over 100,000 families. His adherents not only religiously used his system, but adhered to his medical and social ideologies. From a sociological standpoint, Thomsonianism sparked a social movement among the working and farming classes, as botanic social societies held conventions and published journals. Especially in northeastern and midwestern United States, Thomsonians were a formidable challenge to the authority and control of ''regular or orthodox physicians,'' those claiming to have jurisdiction over scientific medicine. Their lay ideology portrayed the dominant order as an undemocratic ''literary aristocracy'' comprised of priests, lawyers, and doctors who substituted ''arcane professional learning'' for common sense and used their political authority to exploit the masses (Starr 1982:51–54; *Thomsonian Recorder* 1832:123). The development of this **medical sect** coincided with the development of religious sectarianism on the American frontier (Starr 1982:95). *See also* **Medical sect**.

TOTAL INSTITUTION, MENTAL HOSPITAL AS A

Erving Goffman (1961:xiii) described the mental hospital as a ''total institution,'' which he defined ''as a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life.'' The central feature of the total institution, which includes prisons, monasteries, homes for the blind, and military camps, is a breakdown of privacy barriers normal to most people. All aspects of life are conducted in the same place under the same authority and in the immediate company of others who are treated alike and who do the same thing together. All phases of activities are scheduled to fulfill the aims of a rational plan supposedly designed to meet the official goals of the institution, which in the case of the mental hospital is therapy and/or custodial care. The goals of the institution, therefore, are the determining factors in shaping the social life that takes place within its walls (Cockerham 1996:243).

TRANSMISSION AGENT

''Any mechanism by which an infectious agent is spread from a source or reservoir to a person'' (Benenson 1985:456). Transmission may be direct from one person to another through casual contact (coughing, touching) or intimate contact (sexual intercourse). Transmission may also be indirect via vehicle-borne contact (contaminated inanimate objects, water, food, blood products) or vector-borne contact (insect transmission). (See Benenson 1985:457–458.)

U

UNDESIRABLE LIFE EVENTS
See **Stressful life event**.

UNORTHODOX THERAPY (MEDICINE)
A pejorative term used to refer to medical services or practitioners, who practice without certification of the American Medical Association. *Alternative medicine* and *alternative practitioner* are less value-loaded terms denoting non-M.D. practitioners. *See also* **Alternative health care practitioners**.

UTILIZATION
See **Health care utilization**.

V

VECTOR

See **Transmission agent.**

VOLUNTARY ORGANIZATIONS, AGENCIES

"Organizations established on the basis of common interests, whose members volunteer or even pay to participate" (Schaefer and Lamm 1995:161). Such organizations include churches and community service agencies such as the American Red Cross and United Way. Traditionally, the medical service system in the United States has relied on voluntary assistance, especially in fund-raising, but also in the direct provision and finance of medical services for the poor and for the victims of misfortunes such as natural disasters.

W

WORLD HEALTH ORGANIZATION (WHO)
United Nations organization that sponsors research and publishes reports on health problems in order to improve the health of the world population.

Z

ZERO POPULATION GROWTH (ZPG)

A state of stability in population size and growth, that occurs when the number of deaths in a population is equal to the number of births and migrants.

Zero Population Growth is typically computed as a demographic projection, stipulating a target year in the future. Recent projections mark the year 2040 as a point of ZPG for the United States, with an absolute decline in population growth expected thereafter (Spencer 1989). But such long-term projections of population growth are speculative because migration rates are susceptible to political and economic changes.

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