

3rd Edition

An Introduction to the
SOCIOLOGY
of **HEALTH**
and **ILLNESS**

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INTRODUCTION

- Diseases are socially produced and distributed – they are not just a part of nature or biology.
- The key variables shaping the production and distribution of diseases are class, gender and ethnicity, and the ways in which professional groups define conditions as diseases.
- Medical knowledge is not purely scientific, but shapes and is shaped by the society in which it develops.
- Sociologists, depending on their model of society, develop different explanations of the social shaping and production of disease. Marxists emphasize the role of class; feminists the role of patriarchy; Foucauldians the way society is administered by professionals; and those focusing on ethnicity, the impact of racism.

Sociologists study health and illness not only because they are intrinsically interesting, and go to issues at the centre of human existence – pain, suffering and death – but also because they help us to understand how society works. For sociologists the experience of sickness and disease is an outcome of the organization of society. For example, poor living and working conditions make people sicker, and poorer people die earlier, than their counterparts at the top of the social system. Even when there are improved living conditions and medical practices, but inequalities based on class, gender and ethnicity are not tackled, the differences between the rich and the poor persist and widen. Disease and inequality are intimately linked. The outcome of the unequal distribution of political, economic and social resources necessary for a healthy life is the social gradient of health. Those at the top of the social system are healthier and live longer while those at the bottom are sicker, do not live as long, and die more from preventable disease and accidents. These links between social factors and health and disease are the focus of this book.

This book demonstrates the relationship between social structures and the production and distribution of health and disease in modern society. Specifically, it examines the impact of class and the role of the medical profession, gender and

ethnicity on the production and distribution of disease. It argues that there is no simple relationship between biological and individualistic explanations of what causes sickness and disease. Furthermore it demonstrates that medical knowledge is not disinterested, objective, scientific knowledge, but is both shaped by and shapes the social structures within which it is embedded. Following some scene setting for the principles of the sociology of health, and of the social and political climate that is shaping our understanding of the causes of health and disease, the book reviews Marxist, Parsonian, feminist and Foucauldian approaches to health, as well as examining the data on the impact of ethnicity on health.

In modern Western societies it is usually assumed that health differences are biologically caused or that individual lifestyles result in people becoming sicker and dying earlier. The argument of this book is that there is little evidence that disease is caused by purely biological factors, operating separately from social organization. It is also the argument that individual lifestyle choices are socially shaped, and that a focus on them as an explanation of the cause of disease misses the social factors involved in producing individual actions. Rather, there are a wide range of mediating social factors that intervene between the biology of disease, individual lifestyle, and the social experience shaping and producing disease. These range from standards of living and occupational conditions, to socio-psychological experiences at work and at home, of men's and women's social roles, and of hierarchical status groups based on ethnicity. These factors, in turn, have to be seen against the background of the overall patterns of inequality that exist within specific societies. This includes whether or not there is a political commitment to reducing inequality and providing a social environment that prevents sickness and disease – of guaranteeing housing standards, food standards and conditions of employment, as well as enhancing lifestyles that increase health and longevity. Put simply, the impact of income inequality now appears to be central to the continued existence of inequalities in health. As Wilkinson (1996) has shown, countries with low relative differences between the richest and the poorest are the healthiest.

Sociology, Genetics, Social Mobility and Lifestyle

Sociologists argue that our understanding of the social production of disease is not helped by explanations:

- that focus solely on genetics at the expense of the social environment;
- that claim that the sick are poor because they experience downward social mobility;
- that fail to recognize that lifestyle choices are shaped by social factors.

In our daily life, three dominant representations of the causes of disease, especially in the media (the newspapers, medical docudramas and TV soaps), stand out. The first of these is the genetic explanation. Genetic explanations regularly feature in

articles and programmes in which claims are made that there is a genetic cause for obesity, drug addiction, alcoholism, divorce and homosexuality, to mention just the most common. There is, however, no evidence for a genetic contribution to what are cultural practices, nor any scientific justification for the negative moral evaluations of them that are couched in the language of medical science. These conditions are clearly culturally specific and professionally defined – not ‘facts’ of nature. Furthermore, there is little that can be done about even those diseases for which there *is* genetic evidence for their origins. Short of undertaking a eugenicist or genetic planning experiment, the knowledge of genetic predisposition does not help either individuals or policy makers to deal with disease. In fact, by reducing the explanation of the individual’s condition back to a lowest common denominator of biology, the genetic explanation systematically excludes a sociological explanation, and functions to deflect our attention from the ways in which social life shapes our experience of disease. Between the genetic predisposition for a specific disease and its development lie the intervening variables of politics, economics, gender and ethnicity. It is these variables that must be taken into account in explaining the transformation of a ‘genetic risk’ into a social reality.

A second common assumption is that the sick experience downward social mobility, while the healthy experience upward social mobility. This is an extension of what is presumed to be Darwin’s argument about the survival of the fittest. There is no support for this argument in the literature. The sickest are certainly in the poorest sections of society, but they are sick because they are poor, not poor because they are sick. Where sickness and downward social mobility intersect, it is in those conditions where political, cultural and social practices already discriminate against the individual – the single mother, the disabled, the differently coloured and those with AIDS.

The third dominant explanation for the existence of disease, in what should otherwise be healthier societies, is that people adopt a lifestyle that makes them sick, and are therefore individually responsible for their condition. The lifestyles explanation claims that freely made bad choices about diet, smoking and exercise make people sick. Again, there is very little evidence that individual effort at this level will achieve much in the way of a healthier society. Moreover, all the major studies, brought together in this book, show that good lifestyle choices are overwhelmed by wider structural variables in determining health and illness. Lifestyle actions do not account for more than a minor part of the variation in health status. Even if they did, since they are unevenly socially structured rather than individually chosen, they are the outcome of inequality rather than the cause of it.

For sociologists of health these three explanations have two common features. They make the claim that when individuals become diseased it is a problem of the individual’s own body and of their unique biology. Put another way, these explanations individualize and biologize the explanation of disease. Often they are combined into explanations that blame individuals for lifestyle choices that

they are biologically incapable of coping with, because of their genetic make-up. This 'over-determined' individual and biological explanation is very common in societies based on racialized status groups.

BOX 1.1

ABORIGINALITY, LIFESTYLE AND GENETICS – OBSCURING SOCIAL PROCESSES

In Australia, it is claimed that Aboriginal people have higher rates of diabetes because they freely choose bad Western foods such as potato chips, soft drinks and alcohol, for which they are genetically not 'programmed'. Thus their health problems read as the following equation. They choose poor foods (therefore it is their fault) + they are genetically not capable of processing Western food (the fault of their individual biology) + they are lazy or indifferent about their health (the fault of their culture). The conclusion, which policy makers informed by this way of approaching the problem then reach, is that it is the Aborigines' problem that they are sicker and die sooner, and that there is little or indeed nothing that can be done about it.

A sociological account, on the other hand, directs attention to the political and economic shaping of lifestyles available to subordinate populations, and to the way in which racism systematically destroys the beneficial aspects of an Indigenous population's culture.

The Sociological Perspective

Sociologists, on the basis of empirical research, demonstrate how the interactions of class, of professional interests, of power, of gender and of ethnicity enter into the formation of knowledge about and treatment of a sickness or disease. They demonstrate the social production and distribution of diseases and illnesses. Sociologists show how diseases could be differently understood, treated and experienced by demonstrating how disease is produced out of social organization rather than nature, biology, or individual lifestyle choices. While sociologists make no claim to being biological scientists they do make the claim that biological knowledge can be sociologically explained, to show that our knowledge of health and disease is created in a political, social and cultural environment. There is no pure, value-free scientific knowledge about disease. Our knowledge of health and illness, the organizations of

the professions which deal with it, and our own responses to our bodily states are shaped and formed by the history of our society and our place in society.

Since sociologists do not accept the medical model of disease and illness as simply biological events, they then examine the social functions of medical knowledge. That is, they examine the way medical and biological explanations of disease function in our society. Medical knowledge is produced in and reflects structural features of society. It explains as 'natural' what, from a sociological perspective, are social phenomena. Why the working class is sicker and dies earlier, why women are diagnosed sick more than men, and why ethnic groups do not receive the services they need – these require a sociological explanation and not a biological one. Medical explanations obscure and paper over the social shaping and distribution of disease, disease categories and health services.

Postmodernity and Sociology

The arguments of the sociologists of health are particularly important in the current economic and political climate. There has been a major restructuring of the labour market in the Western capitalist economies, with a decline in industry and, associated with this, of trade unions and class-based political movements. There has been a resurgence of the philosophy of liberalism – that the state should not be involved in the provision of welfare services, and that individuals should take more responsibility for their own lives. The economic changes are sometimes summarized in the term 'postmodernity' – that we have moved beyond organized capitalism, and into a new era in which consumption rather than production is the key to social life. Some sociologists have celebrated these changes. The claim is that we now live in a postmodern world, freed of the old structures of industrial capitalism and the bourgeois nuclear family. For Ulrich Beck, these changes mean that people 'will be set free from the social forms of industrial society – class, stratification, family [and] gender status' (Beck, 1992: 87). Identity has become fluid and negotiable, separated from 'social structures', which are now claimed to be just a figment of the sociological imagination. For some theorists the discovery of the body, linked to these weakened structures, has led to the argument that we construct our bodies as we see fit. Anthony Giddens, for example, emphasizes the openness of the body, and of individuals to shape it: 'We have become responsible for the design of our own bodies' (Giddens, 1992: 102). Similarly, Bauman (1992) has argued that both our sociological knowledge and the world that we live in are uncertain, ambivalent, deregulated and insecure. The stable basis of our identity has gone, as have the certainties of social science knowledge. At the core of these changes, according to Bauman (1998), is a transformation from a culture of production, in which hard work, thrift and self-discipline held sway, to a world of hedonistic indulgence. Rather than hard work resulting in savings and social prestige, we are rewarded with 'free sex', designer drugs and 'life in the fast lane'.

BOX 1.2

**MODERN SOCIETY MAY HAVE CHANGED –
BUT KEY SOCIAL STRUCTURES PERSIST**

It is the argument of this book that there is little evidence that social structures of class and gender, of ethnicity and of inequality have stopped shaping people's lives. Industrial capitalism may have changed its appearance, and patriarchy may no longer be the bulwark of women's oppression, but they both still structure health and illness, and distribute disease unequally through the population. In the area of health and illness individuals have not been freed from the structures of patterned inequality, nor have their choices increased. In fact, society has become more unequal, and the poor sicker.

Sociological Approaches to Health and Illness

Different sociological perspectives on society give rise to different accounts of the role of medical knowledge, and of the social causes of disease. They are also based in different sociological models of society, in part complementary, in part contradictory. Marxist approaches emphasize the causal role of economics in the production and distribution of disease, as well as the role that medical knowledge plays in sustaining the class structure. Parsonian sociology emphasizes the role of medicine in maintaining social harmony, pointing to the non-market basis of professional groups. At the same time, its critical sociological edge is maintained by the way it highlights the social control function of medicine in enforcing compliance with social roles in modern society. Parsons' work both contradicts Marxism – by highlighting the importance of the non-economic sphere of society – but also adds to it in providing a description of the sick role as a social role that is shaped by the social strains of modern society. Thus Parsons is both conservative and critical at the same time.

Foucault, too, highlights the social role of medical knowledge in controlling populations, and like Parsons emphasizes the diffuse nature of power relationships in modern society. Also, like Parsons, he sees the professions, especially the helping professions, playing a key role in inducing individuals to comply with 'normal' social roles. For Foucault, modern societies are systems of organized surveillance with the catch being that individuals conduct the surveillance on themselves, having internalized 'professional' models of what is appropriate behaviour. Marxist feminists identify the ways in which class and patriarchy interact to define the subordinate position of women in society and the central role that medical knowledge plays in defining women as childcarers and housewives. Foucauldian feminism, on the other hand, is more alert to the ambiguities of women's roles, and the way that women

TABLE 1.1 *A simplified overview of the sociology of health*

Theory	Model of society	Cause of disease	Role of the medical profession
Marxist	Conflictual and exploitative	Putting profit ahead of health	To discipline and control the working class; and provide individualized explanations of disease
Parsonian	Basically harmonious and stable set of interlinked social roles and structures	Social strain caused by meeting the demands of social roles	Rehabilitate individuals to carry out their social roles
Foucauldian	A net of power relations, with no one dominant source – administered surveillance	‘Diseases’ are labels used to sort and segregate the population to make it easier to control	To enforce compliance with ‘normal’ social roles; and to ensure that we internalize these norms
Feminist	Exploitative and repressive of women through patriarchy	Carrying out the social role enforced on women by patriarchal men; the medicalization of a woman around her reproductive life cycle	To enforce conformity with patriarchal norms of femininity and motherhood

can challenge their medicalization. However, on balance, medical knowledge – especially as it is manifest in self-help movements and health self-surveillance – is deeply pervasive. Feminist Foucauldians argue that large parts of the women’s health movement have been incorporated into a patriarchal net of self-surveillance. Sociologists who focus on ethnicity present a picture of society as ‘racialized’, as operating with a scientifically discredited notion of race to justify the exclusion and subordination of people of different skin colour or ethnic identity.

Thus there are competing models of society as harmonious or conflictual, as a set of structures ‘doing things’, or of individuals voluntarily complying with their social role, and of the sometimes complementary, sometimes competing, role of class, gender and ethnicity in structuring unequal health outcomes in society.

Political Economy and Marxist Approaches

Researchers in the materialist and Marxist traditions have produced one of the most powerful sociological accounts of the production of disease and its social pattern of distribution. These approaches emphasize the determining role of economic interests in both producing disease and in shaping the way it is dealt with. Marxists argue that medicine serves a key function in capitalist societies: it blames the victims of diseases (caused by the capitalists’ pursuit of profit) for their own condition. Furthermore, the very way in which disease is treated is itself an aspect

of capitalist society. The medical profession acts as an agent of social control of the working class, individualizing and depoliticizing disease, and controlling access to the sick certificate. High-cost, technical ‘fixes’ are pursued, which do not heal people but do produce enormous profits. Medicine in a capitalist society reflects the characteristics of capitalism: it is profit-oriented, blames the victim, and reproduces the class structure in terms of the people who become doctors (generally male, privately educated upper-middle-class students), or nurses (generally lower-middle-class women). Access to health services also reflects class inequality.

Parsonian Sociology of Health

An alternative analysis of medicine is provided by Talcott Parsons, who argued that modern societies, while having a capitalist economy, have noncapitalist social structures. He argues that the medical profession is one such structure. Medical professionals are motivated by factors other than making money, such as caring for their patients. They perform a key noneconomic function by acting in the interests of the whole community, treating individuals specifically for their disease, without passing judgement on them, and utilizing the best of scientific knowledge. They are, if you like, a balance to the fly-wheel of competitive capitalism in which the market would otherwise run over individuals. At the same time, Parsons goes on to make the important point that medicine is a major institution for controlling deviance in modern societies. It is not just a benign institution based on scientific care, but acts to check the deviant tendencies of individuals, who otherwise might try to escape their social roles. Parsons argues that the strains of modern life may be so great as to drive people into the sick role to escape their normal responsibilities, and this tendency needs to be checked. So while he has a more favourable perspective on medicine than the Marxist, he still sees it as performing a social function that is beyond its claim to be the purely scientific treatment of disease. Parsons’ analysis shows how the medical profession acts to control motivated deviance and provides an account of illness as a response to social strain. Parsons’ concept of the sick role is a very useful concept for problematizing the idea of disease as natural and biological, but is limited in its focus on acute illness episodes. Overall, Parsons’ ‘consensus’ focus on modern societies as stable is not as true as it appeared to him, writing in the 1950s. Neither is his picture of the altruistic workings of the medical profession as persuasive as it might once have been.

Foucault’s Sociology of Health

It is with the development of the category of disease – the product of the professionalization of medicine – that Foucault is concerned. Michel Foucault calls attention to another important aspect of modern society: it is an administered society, in which professional groups define categories of people – the sick, the insane, the criminal, the deviant – on behalf of an administrative state. For Foucault, medicine is a product of the administrative state, policing normal

behaviour and using credentialled professionals to enforce compliance with the 'normal'. Modern society is a version of Max Weber's Iron Cage, in which the profession (and its disease categories) provide a totalizing surveillance of citizens. Foucault also makes the important point that most of us, most of the time, have internalized these norms of behaviour and rarely require the services of the helping professionals. As will be seen, his argument raises serious questions for the Marxist and the feminist positions. For feminists, modern society is patriarchal and men wield power over women, who are forced to comply with men's definitions of how they should appear and perform. However, Foucault's theory of power emphasizes its diffuseness and the willingness of most of us – men and women – most of the time to comply with societal norms. Equally, Foucault's argument challenges Marxist accounts that focus on power as centralized in the hands of the capitalist class. For Foucault, power is not the property of any one group, whether based in class relationships or patriarchy. The usefulness of Foucault's position is the way in which he historically locates medical knowledge, especially allowing for the development of the sociology of the body. By showing how the body is historically constructed, Foucault has been appropriated and extended by feminists who show that it is the construction of gender-specific bodies that needs analysis.

Feminist Approaches

It is the case that the Marxists overlook the ways in which contemporary life is not always shaped by economic factors; that Parsons does not go very far in documenting the 'strains' of social life; and that for all his interest in bodies, Foucault does not discuss gender. Feminist sociology seeks to extend and develop especially Marxist and Foucauldian sociology. Feminists' key argument is that the way in which we are socialized into masculine and feminine social roles will have a determining effect on our health and illness. They argue that medicine plays a vital role in enforcing conformity to these social roles, and is especially targeted at women. This is because controlling women's ability to reproduce is central to a patriarchal society. It is no accident, the feminists argue, that almost all the medical attention paid to women is around their reproductive organs and their life cycle as it relates to their ability to have children. In many cases, the diagnoses and treatment of women as diseased are no more than thinly disguised social norms of women's appropriate social roles, especially their role as mother. There have been powerful accounts of the role and function of modern medicine growing out of an intermingling of Marxism and feminism. Marxist feminists have argued that the origins of capitalism, patriarchy and medicine are intertwined. The need to guarantee the legitimacy of offspring to allow for the inheritance of capital meant that the medical profession played a crucial role in the control of women. In contemporary capitalism, the profession performs the function of legitimizing the domestic role of women in the 'private' sphere, converting (into a 'fact' of nature) women's mothering and nurturing roles. It thus guarantees the rearing and nurturing of the next generation of workers at minimum

cost to capitalists. It also makes women responsible for a larger part of the health care of the unprofitable sectors of the population – children and the aged.

Feminist reactions to the way in which medicine ‘medicalizes’ their bodies have raised crucial issues at the centre of sociological explanations of disease. On the one hand, to explain women’s experience of a capitalist patriarchy as ‘disease’ provides them with an explanation of the way in which they are oppressed. For example, arguing for the existence of premenstrual syndrome as a disease provides an account of their stress that has a social legitimacy. On the other, to transform their social experience into a biological explanation leaves them powerless in the face of male medical practitioners’ definitions of them as diseased.

Bringing the Approaches Together

There is no definitive cause of inequality in health and in the patterns of disease distribution. Class, patriarchy and bureaucratic and professional surveillance intermingle with each other in shaping the contents of medical knowledge and the individual’s experience of health and disease. In addition to class and gender, as a result of the massive migratory processes since the end of the Second World War, ethnicity has also become a major variable in the experience and distribution of disease. In some cases being from a migrant ethnic group is a positive factor, while in others it operates negatively. What interests sociologists is how ethnicity intersects with gender and class, so that those who are from low-status ethnic positions find themselves members of the working class, and if they are women, suffer from the triple impact of skin colour, class and gender. The patterning of health inequality is a dynamic one and at different times class, gender and ethnicity will have greater or lesser impact. It is to understanding this constantly changing structuring of inequality in health that sociologists are most interested in making a contribution.

BOX 1.3

SOCIOLOGY, SCIENCE AND MEDICINE

The assumption that unifies sociological accounts of sickness and disease is a rejection of behaviourism, the claim that we passively respond to environmental factors, as a model for human action. Health and disease are cultural products, and individuals as social agents react to, transform and are shaped by the experiences of health and disease. There is no one-way determination from nature and biology through to the individual and society. Rather, for sociologists, it is the structures of society that shape who will get sick, how they experience their condition, how they will be diagnosed and treated, and how they will recover. What looks like ‘natural behaviour’ is, in fact, the

product of social interaction. Ours is a culture that gives privilege to those who claim to be 'scientists'. However, sociologists are sceptical that science – whether of the medical sort or any other sort – exists in any independent sense from the social relationships which produce it. Science is itself a social product, determined in its content and shaped by broader social variables, and in the case of the analysis of medicine in this book, by professional interests and by class, gender and ethnicity.

Integrating the analysis of modern medicine in terms of the different sociological approaches outlined above – the analysis of the Marxists, the Parsonians, the feminists and Foucauldians – we can make a number of statements which lie at the heart of a sociological analysis of medicine. Modern medicine, and the explanations of the individual, the body and our understandings of disease it produces, is the outcome of the development of modern bureaucratic society, and the interplay of the structuring of life chances based on gender, class and ethnicity.

Medical knowledge and medical practices are not distinct from the social: medical knowledge is socially produced knowledge. The boundaries and activities of the medical profession are not defined by natural objects, nor biological realities given independently of social life; they are the outcome of political and economic struggles around the negotiated realities of the body and disease. Consequently, the claim that technological and scientific knowledge underpin medicine's claims to professionalism and autonomy has to be seen as the successful mobilization of resources to become a profession, and not the cause of professionalization. In support of this claim, witness the way in which professional groups redefine knowledge to protect themselves from boundary encroachment. For example, the medical profession has deskilled the use of the stethoscope as it passed into usage by nurses.

Medicine acts as a cosmological system in modern society – historically replacing religion – and provides answers to central questions to do with the relationship of nature to society, of the individual to society, and of the impact of such social variables as class, ethnicity and gender on our individual biographies. It provides in the language of science what are, fundamentally, socially informed and value-laden explanations of our life chances, and acts from a sociological perspective as a system of social control. It makes inequality based on class, gender and ethnicity look natural and inevitable.

From a sociological perspective, biology is not itself the overriding factor in the development of a disease. Rather, it is the prevailing social and economic conditions that allow disease to develop which must be accounted for (Canguilhem, 1988; Stern, 1927; White, 1991a; Zinsser, 1935). Sociological accounts of health and illness have developed against the background of a sociology of knowledge that emphasizes the ways in which 'nature' is socially produced, and the ways in which the claim to understand nature is a political and social process. Furthermore, given that germs do not speak

for themselves, it is our interpretation of events that leads some conditions to be categorized as diseases (White, 1992). As Rosenberg puts it: 'Meaning is not necessary but negotiated ... disease is constructed not discovered' (Rosenberg, 1989: 2).

In addition to the sociology of knowledge, historical epidemiology has played a large part in the development of health sociology. Thomas McKeown (1979) demonstrated very clearly that medicine and its scientific practices contributed very little to the transformation of the health of the population in the nineteenth century. In fact, he estimated that medicine contributed about 1 per cent to the overall decline in the mortality rates of the nineteenth century. Rather, he argued that what made the difference were the social and political factors of improved housing, nutrition and sanitation (see also White, 1999).

Conclusion

This book presents an overview of the development of the sociology of health, which highlights some of the key conceptual underpinnings of the sociology of health in Chapter 2 developing the work of Émile Durkheim in the sociology of science, and a survey of the development of the sociology of health in Chapter 3. It also reviews recent changes in the social and political environment that have meant a resurgence of the individualistic approach to health and illness, as well as putting individuals and communities more at risk of disease and early death, in Chapter 4. The materialist and Marxist (Chapter 5), the Parsonian (Chapter 6), the Foucauldian (Chapter 7), and the feminist accounts of the social functions of medical knowledge (Chapter 8) are presented, while Chapter 9 provides an analysis of the intervening role of ethnicity in the experience of sickness and disease. In Chapter 10, the conclusion, I draw these perspectives together in the context of the suggestions of the World Health Organization about the social requirements for a healthy society. It also draws together the theme of the book: that social structures cause sickness and disease and that individualistic explanations or solutions to health inequalities are of limited value. Indeed, individualistic and lifestyle explanations contribute to the ongoing inequality of society and to the unequal distribution of sickness and disease down the social system.

Summary

- The 'commonsense' understandings of the cause of disease portrayed in our culture – especially the idea that lifestyles are freely chosen – individualizes and obscures the way in which disease is socially produced.
- The commonsense understanding of medicine as the application of 'objective' 'scientific' knowledge to a purely biological body obscures how diseases are produced in structures of inequality that are social – be they based on class, gender or ethnicity.

- **At the centre of all sociological accounts of medicine is the argument that medical knowledge performs social functions independently of whether it cures and heals – to discipline the working class, to enforce compliance with social roles, to administer and categorize individuals, or to ensure that women conform to their feminine roles.**
 - **Medical knowledge and practices are social accomplishments, and not the inevitable outcome of science or nature.**
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Discussion Questions

1. Different theories of society produce different accounts of the role of medicine in modern society. Compare and contrast two of the theories outlined in this chapter.
2. What does it mean when sociologists argue that diseases are social products and not just biological facts?
3. Can you think of conditions that were once thought of as normal but now require medical intervention?

Further Reading

- Conrad, P. (ed.) (2001) *The Sociology of Health and Illness: Critical Perspectives*. New York: Worth. A very good collection of articles which highlight the sociological, political, economic and gendered relations of modern medicine.
- Freund, P. and McGuire, M. (1999) *Health, Illness and the Social Body*. Englewood Cliffs, NJ: Prentice Hall. A very good textbook, using mainly American data, overviewing the social relations of disease.
- Germov, J. (ed.) (2005) *Second Opinion: An Introduction to Health Sociology*. Melbourne: Oxford University Press. A collection of articles covering a range of health topics and issues related to the class, gender and age dimensions of health and wellbeing, with a chapter dedicated to nursing and sociology.
- Marmot, M. (2004) *Status Syndrome: How Your Social Standing Directly Affects Your Health and Life Expectancy*. Oxford: Bloomsbury. A detailed exploration of factors contributing to the social gradient of health.
- Turner, B. S. (1995) *Medical Power and Social Knowledge*. London: Sage. Explores the sociology of health in a way that advances sociological arguments about changes in contemporary society.
- Turner, B. S. (2004) *The New Medical Sociology: Social Forms of Health and Illness*. New York: Norton. Explores how society makes us sick, examining macro-processes such as globalization, risk, economic deregulation and technological change.