# S/A 4071: Social/Cultural Aspects of Health and Illness:
# Class 16: Medical Knowledge & Medicalization 1

* Today we begin examining the construction of the "scientific" knowledge claims & practices of medicine. Are there social/cultural influences? Effects? Interests served?

## Medical & Scientific Knowledge:
## Historical & Cross Cultural Context

* Positivism (the "hard science" approach) claims objectivity, precision, certainty, & law-like generalizability independent of social influences. Is this accurate?

* Kuhn (1962) the development of science included cultural categories

* Freund & McGuire (1991): the value assumptions of medicine:

- mind-body dualism
- physical reductionism
- specific etiology
- the machine metaphor
- regimen & control

* Manning & Fabrega (1973): medicine's biologistic view of the body:

- organs/systems/functions are identifiable/discrete/observable
- normal bodily functioning same for all unless disturbed
- people's sensory experiences are universal
- disease/its experience don't vary from culture to culture
- boundaries between body/self/other are obvious & shared
- death=the body's ceasing to function
- bodies should be seen objectively

* Sociological research challenges all of these assumptions:

- observation depends on available technology, theories of body
- much research on "normal" person done on males
- cross-cultural/linguistic studies show experience arises out of language
- disease to one culture may be normal in another
- contagious diseases raise issues about bodily boundaries
- definition of death problematic given life-support technology
- objectivity is impossible due to cultural values/assumptions of medicine

## Medical Science & Practice: A Gap in Values:

* A gap exists between published research & medical practice. Attempts to bring researchers/practitioners together (CDC's) have little impact

* Montini & Slobin: this reflects distinct value differences between researchers & practitioners:

- expectations of certainty vs. uncertainty/probability
- evolutionary time for developing conclusions vs. clinical timeliness re: patients' needs
- aggregate measures vs. individual prescriptions
- scientific objectivity vs. clinical experience
- constant changes vs. standards of treatment

* Medical science & medical technology: relationship? ($) The introduction of new technologies often done before full evaluation (e.g. breast implants, IUD's, electronic fetal monitoring, etc). Linked to:

- key societal values
- government policies
- reimbursement strategies
- economic incentives

* McKinlay & McKinlay: 7 stages in the career of a medical invention:

1. A promising report
2. Professional/organizational adoption
3. Public acceptance & state endoresement
4. Standard procedure & observational reports
5. Randomized controlled trial
6. Professional denunciation
7. Erosion & discreditation (note: rigorous evaluation typically done later, not before)

## Medical Science Reinforces Gender Role Stereotypes

* “Objective” medical science often reflects fundamental cultural & socio-structural beliefs:

- Findlay: obstetrics/gynecology journals of the 1950's reflected current views of women and “the desire for children of the normal woman,” while “abnormal” women had reproductive problems
- Martin: menstruation described in negative terms/ spermatogenesis as positive

## The Sociology of Medical Practice

* Medical knowledge/practice are profoundly shaped by the social characteristics of both patients & doctors:

- doctors prefer younger to older patients (the latter often given tranquilizers regardless of diagnosis)
- ethnic minorities less often referred to specialists, more likely to be served by doctors in training & placed on a ward, less likely to be admitted to hospital (unless involuntarily), & receive less

aggressive treatment than others
- lower class patients given poorer prognosis & less state of the art treatment
- female doctors less likely to dominate interactions with patients/spend more time with them

* Cultural variations in medical practice: diagnosis & treatments vary among allopathic practitioners when presented with the same symptoms in different countries (e.g. English caution vs. American aggressiveness; German focus on the heart; French on the liver)

* Class resistance to medical knowledge: ("medicalization from below")

-Balshem (1991) found lower class resistance to lifestyle education/health promotion: suspicion that pollution to blame for high cancer rates
-Calnan & Williams (1992) in most cases, only a minority of laypersons would unquestioningly accept medical diagnoses. Variations by class, gender, age & health categories

* Medical knowledge becomes popular knowledge: disease-mongering by pharmaceutical companies in the media:

- promotion of new "diseases" following synthesis of new drugs
- inaccuracies in magazines, newspapers, billboards, radio & TV (esp. Womens magazines)
- inaccuracies in health information on the internet
- misunderstandings by audience
- social-psychological & disease status affect both health behavior & use of the media for information
- journalists writing articles may misunderstand their sources
- nevertheless, the media may have considerable influence on health related behavior for various reasons (e.g. inexpensive/use

of celebrities)

## Doctor-Patient Communication

* Doctor-patient communication reflects social structure & culture:

- doctors ignoring questions & focusing on success of treatment to maintain control
- ward rounds as organizational strategy to maintain topic monopoly/head off questions
- specialty differences in training re: same conditions reinforces differential treatment recommendations
- increased openness & ambiguity re: female sexuality reflected in "sensitive" interactions that still serve to reinforce "delicate & notorious" character of female sexuality in encounters with male doctors (may impact on STD's, unwanted pregnancies, etc.)

* So, again, how objective is the positivist model of medicine? Does a focus on the social construction of medical knowledge make more sense?