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CROSS-CULTURAL

66 The Social Structure of Medicine

TALCOTT PARSONS

Talcott Parsons, one of the most influential U.S. sociologists during the twentieth century, contributed greatly to the development of structural-functional analysis. In this selection, he examines the significance of health and illness within a social system, with particular attention to the social roles of physicians and patients.

A little reflection will show immediately that the problem of health is intimately involved in the functional prerequisites of the social system. . . . Certainly by almost any definition health is included in the functional needs of the individual member of the society so that from the point of view of functioning of the social system, too low a general level of health, too high an incidence of illness, is dysfunctional. This is in the first instance because illness incapacitates for the effective performance of social roles. It could of course be that this incidence was completely uncontrollable by social action, an independently given condition of social life. But insofar as it is controllable, through rational action or otherwise, it is clear that there is a functional interest of the society in its control, broadly in the minimization of illness. As one special aspect of this, attention may be called to premature death. From a variety of points of view, the birth and rearing of a child constitute a "cost" to the society, through pregnancy, child care, socialization, formal training, and many other channels. Premature death, before the individual has had the opportunity to play out his full quota of social roles, means that only a partial "return" for this cost has been received.

All this would be true were illness purely a "natural phenomenon" in the sense that, like the vagaries of the weather, it was not, to our knowledge, reciprocally involved in the motivated interactions of human beings. In this case illness would be something which merely "happened to" people, which involved consequences which had to be dealt with and conditions which might or might

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not be controllable but was in no way an expression of motivated behavior.

This is in fact the case for a very important part of illness, but it has become increasingly clear, by no means for all. In a variety of ways motivational factors accessible to analysis in action terms are involved in the etiology of many illnesses, and conversely, though without exact correspondence, many conditions are open to therapeutic influence through motivational channels. To take the simplest kind of case, differential exposure, to injuries or to infection, is certainly motivated, and the role of unconscious wishes to be injured or to fall ill in such cases has been clearly demonstrated. Then there is the whole range of "psychosomatic" illness about which knowledge has been rapidly accumulating in recent years. Finally, there is the field of "mental disease," the symptoms of which occur mainly on the behavioral level. . . .

Summing up, we may say that illness is a state of disturbance in the "normal" functioning of the total human individual, including both the state of the organism as a biological system and of his personal and social adjustments. It is thus partly biologically and partly socially defined. . . .

Medical practice . . . is a "mechanism" in the social system for coping with the illnesses of its members. It involves a set of institutionalized roles. . . . The immediately relevant social structures consist in the patterning of the role of the medical practitioner himself and, though to common sense it may seem superfluous to analyze it, that of the "sick person" himself. . . .

The role of the medical practitioner belongs to the general class of "professional" roles, a subclass of the larger group of occupational roles. Caring for the sick is thus not an incidental activity of other roles though, for example, mothers do a good deal of it—but has become functionally specialized as a full-time "job." This, of course, is by no means true of all societies. As an occupational role it is institutionalized about the technical content of the function which is given a high degree of primacy relative to other status-determinants. It is thus inevitable both that incumbency of the role should be achieved and that performance criteria by standards of technical competence should be prominent. Selection for it and the context of its performance are to a high degree segregated from other bases of social status and solidarities. . . . Unlike the role of the businessman, however, it is collectivity-oriented not self-oriented.

The importance of this patterning is, in one context, strongly emphasized by its relation to the cultural tradition. One basis for the division of labor is the specialization of technical competence. The role of physician is far along the continuum of increasingly high levels of technical competence required for performance. Because of the complexity and subtlety of the knowledge and skill required and the consequent length and intensity of training, it is difficult to see how the functions could, under modern conditions, be ascribed to people occupying a prior status as one of their activities in that status, following the pattern by which, to a degree, responsibility for the health of her children is ascribed to the mother-status. There is an intrinsic connection between achieved statuses and the requirements of high technical competence. . . .

High technical competence also implies specificity of function. Such intensive devotion to expertness in matters of health and disease precludes comparable expertness in other fields. The physician is not, by virtue of his modern role, a generalized "wise man" or sage—though there is considerable folklore to that effect—but a specialist whose superiority to his fellows is confined to the specific sphere of his technical training and experience. For example, one does not expect the physician as such to have better judgment about foreign policy or tax legislation than any other comparably intelligent and well-educated citizen. There are of course elaborate subdivisions of specialization within the profession. . . . The physician is [also] expected to treat an objective problem in objective, scientifically justifiable terms. For example, whether he likes or dislikes the particular patient as a person is

supposed to be irrelevant, as indeed it is to most purely objective problems of how to handle a particular disease.

. . . The "ideology" of the profession lays great emphasis on the obligation of the physician to put the "welfare of the patient" above his personal interests, and regards "commercialism" as the most serious and insidious evil with which it has to contend. The line, therefore, is drawn primarily vis-à-vis "business." The "profit motive" is supposed to be drastically excluded from the medical world. This attitude is, of course, shared with the other professions, but it is perhaps more pronounced in the medical case than in any single one except perhaps the clergy. . . .

An increasing proportion of medical practice is now taking place in the context of organization. To a large extent this is necessitated by the technological development of medicine itself, above all the need for technical facilities beyond the reach of the individual practitioner, and the fact that treating the same case often involves the complex cooperation of several different kinds of physicians as well as of auxiliary personnel. This greatly alters the relation of the physician to the rest of the instrumental complex. He tends to be relieved of much responsibility and hence necessarily of freedom, in relation to his patients other than in his technical role. Even if a hospital executive is a physician himself, he is not in the usual sense engaged in the "practice of medicine" in performing his functions any more than the president of the Miners' Union is engaged in mining coal.

As was noted, for common sense there may be some question of whether "being sick" constitutes a social role at all—isn't it simply a state of fact, a "condition"? Things are not quite so simple as this. The test is the existence of a set of institutionalized expectations and the corresponding sentiments and sanctions.

There seem to be four aspects of the institutionalized expectation system relative to the sick role. First is the exemption from normal social role responsibilities, which of course is relative to the nature and severity of the illness. This exemption requires legitimation by and to the various alters involved and the physician often serves as a court of appeal as well as a direct legitimatizing agent. It is noteworthy that, like all institutionalized patterns, the legitimation of being sick enough to avoid obligations can not only be a right of the sick person but an obligation upon him. People are often resistant to admitting they are sick and it is not uncommon for others to tell them that they *ought* to stay in bed. The word generally has a moral connotation. It goes almost without saying that this legitimation has the social function of protection against "malingering."

The second closely related aspect is the institutionalized definition that the sick person cannot be expected by "pulling himself together" to get well by an act of decision or will. In this sense also he is exempted from responsibility—he is in a condition that must "be taken care of." His "condition" must be changed, not merely his "attitude." Of course the process of recovery may be spontaneous but while the illness lasts he can't "help it." This element in the definition of the state of illness is obviously crucial as a bridge to the acceptance of "help."

The third element is the definition of the state of being ill as itself undesirable with its obligation to want to "get well." The first two elements of legitimation of the sick role thus are conditional in a highly important sense. It is a relative legitimation so long as he is in this unfortunate state which both he and alter hope he can get out of as expeditiously as possible.

Finally, the fourth closely related element is the obligation—in proportion to the severity of the condition, of course—to seek *technically competent* help, namely, in the most usual case, that of a physician and to *cooperate* with him in the process of trying to get well. It is here, of course, that the role of the sick person as patient becomes articulated with that of the physician in a complementary role structure.

It is evident from the above that the role of motivational factors in illness immensely broadens the scope and increases the importance of

the institutionalized role aspect of being sick. For then the problem of social control becomes much more than one of ascertaining facts and drawing lines. The privileges and exemptions of the sick role may become objects of a "secondary gain" which the patient is positively motivated, usually unconsciously, to secure or to retain. The problem, therefore, of the balance of motivations to recover becomes of first importance. In general motivational balances of great functional significance to the social system are institutionally controlled, and it should, therefore, not be surprising that this is no exception.

A few further points may be made about the specific patterning of the sick role and its relation to social structure. It is, in the first place, a "contingent" role into which anyone, regardless of his status in other respects, may come. It is, furthermore, in the type case temporary. One may say that it is in a certain sense a "negatively achieved" role, through failure to "keep well," though, of course, positive motivations also operate, which by that very token must be motivations to deviance. . . .

The orientation of the sick role vis-à-vis the physician is also defined as collectively-oriented. It is true that the patient has a very obvious self-interest in getting well in most cases, though this point may not always be so simple. But once he has called in a physician the attitude is clearly marked, that he has assumed the obligation to cooperate with that physician in what is regarded as a common task. The obverse of the physician's obligation to be guided by the welfare of the patient is the latter's obligation to "do his part" to the best of his ability. This point is clearly brought out, for example, in the attitudes of the profession toward what is called "shopping around." By that is meant the practice of a patient "checking" the advice of one physician against that of another without telling physician A that he intends to consult physician B, or if he comes back to A that he has done so or who B is. The medical view is that if the patient is not satisfied with the advice his physician gives him he may properly do one of two things. First he may request a consultation, even naming the physician he wishes called in, but in that case it is physician A not the patient who must call B in, the patient may not see B independently, and above all not without A's knowledge. The other proper recourse is to terminate the relation with A and become "B's patient." The notable fact here is that a pattern of behavior on the part not only of the physician but also of the patient, is expected which is in sharp contrast to perfectly legitimate behavior in a commercial relationship. If he is buying a car there is no objection to the customer going to a number of dealers before making up his mind, and there is no obligation for him to inform any one dealer what others he is consulting, to say nothing of approaching the Chevrolet dealer only through the Ford dealer.

The doctor-patient relationship is thus focused on these pattern elements. The patient has a need for technical services because he doesn't—nor do his lay associates, family members, etc.—"know" what is the matter or what to do about it, nor does he control the necessary facilities. The physician is a technical expert who by special training and experience, and by an institutionally validated status, is qualified to "help" the patient in a situation institutionally defined as legitimate in a relative sense but as needing help. . . .

CRITICAL-THINKING QUESTIONS

1. Does Parsons understand illness as a biological condition, that is, "something that happens to people"? What are the social elements in health and illness?
2. According to Parsons, what are the distinctive characteristics of the social role of the physician?
3. What are the major elements of "the sick role"? In what respects does Parsons view the social roles of physicians and patients as complementary? Can you see ways in which they may be in conflict?