

This model, by denying difference, takes away from the disabled an important part of their identity.

- **Impairment or disability?:** The model argues that the former is a creation of bodily difference while the latter is socially created. However, by focusing on impairment the social model argues that physical and mental differences are actually *more* significant than the medical model suggests.
- **Only and always disabled?:** By arguing that society is the cause of disability, the model assumes that individuals are either disabled (and always will be) or they are not (and never will be). However, many people experience impairment in less dramatic terms, often moving through 'different states of ability' (as with gradual loss of eyesight with age).

OCR examination questions

- 1 Identify and explain two ways in which disability can be seen as socially constructed. (17 marks)
- 2 Identify and explain two ways in which mental illness is related to gender. (17 marks)
- 3 Identify and explain two ways in which mental illness is influenced by ethnicity. (17 marks)
- 4 Outline and evaluate the view that disability is socially constructed. (33 marks)
- 5 Outline and evaluate interactionist views of mental illness. (33 marks)

The role of health professionals in society

Sociological explanations

We've referred at various points to the role played by **medical professionals** in areas like the diagnosis and treatment of illness and impairment. In this section we will examine their role in more detail, from a range of sociological perspectives.

Functionalism

For functionalists society is seen as a **social system**, organised around a general **value consensus**, where the constituent parts (**institutions** such as the family, education and health) contribute to the overall maintenance and reproduction of the system. In this respect, functionalists generally consider healthcare in terms of two types of role:

- *the general role* played by the health institution in the overall social system
- *the specific individual roles* that need to be performed within the institution for it to successfully function

These two types of role are important because societies can only function successfully if individuals are prevented from following their own self-interests; people must be encouraged to cooperate and behave in ways that are reasonable, consistent and broadly predictable. We will consider these roles further in the following subsections.

The role of health systems

For [Parsons \(1937\)](#) the role of any institution is defined by four **functional prerequisites** — the things that must happen if it is to successfully play its part in society:

- **Goal attainment:** People must be given goals to achieve and some way of moving towards their attainment. For the health system, these goals might include curing the sick or caring for those who cannot be cured.
- **Adaptation:** There needs to be some way for people to achieve institutional goals and this might include setting up a system of:
 - people — such as health professionals (surgeons, doctors and nurses)
 - places — health facilities such as surgeries, hospitals, care homes and hospices
- **Integration:** People have to be motivated to achieve health goals. Examples might include:
 - **Economic motivators** such as a **career structure** for health professionals: Doctors and consultants in Britain, for example, are among some of the highest income earners. Average annual GP earnings, according to the [Health and Social Care Information Centre \(2011\)](#), are currently £97,500. The lower-paid nursing staff enjoy significant levels of **social status** compared to employees with similar salaries.
 - **Cultural motivators:** For functionalists, an important integrating mechanism is the **collective orientation** of health professionals — the idea that they put the interests of the community and patients above their own interests. Doctors, for example, take the **Hippocratic Oath** (under which they promise to act **ethically**), undergo years of rigorous training and have their competence monitored by the General Medical Council. In addition, doctors belong to the British Medical Association, a professional association that sets out standards of behaviour, ethical practices and so forth.
- **Latency:** This represents a way of managing **conflicts**. All institutions develop rules of behaviour, and ways of rewarding conformity and punishing deviance. The General Medical Council, for example, has the power to remove doctors from the medical register, which means they are no longer allowed to practise medicine (60 doctors suffered this punishment in 2007).

Functional prerequisites

- G**oal attainment
- A**daptation
- I**ntegration
- L**atency



Identify and explain one way in which health professionals are motivated to achieve healthcare goals.

The role of health professionals

For the health system to perform its general social role of returning the ill to health, roles within this institution need to be carefully specified and their relationship managed. One way of organising health roles is through **hierarchies** of knowledge and power. The system is kept moving towards its goals through a top-down organisation whereby those who occupy the most **functionally important** positions (doctors and consultants) are given the most power and receive the greatest rewards.

In addition, health professionals play an important **gatekeeping role** that operates on two levels:

- **Primary care:** Dixon et al. (1998) note that access to care is filtered through a hierarchy of levels, with an initial gatekeeping role played by the GP; this involves making an initial diagnosis and then a decision about whether the patient should be referred 'up the system' to specialist practitioners. This role, Forrest (2003) argues, is designed to ensure healthcare services are matched to healthcare needs.
- **General care:** The broader gatekeeping role involves making decisions about whether individuals should be officially defined as 'sick', and therefore exempt from their usual social responsibilities.

A further aspect of the professional role is the idea of **universalism**: the sick are treated ethically and equally, regardless of cultural characteristics such as class, gender and ethnicity, on the basis of their health needs. In return for the patient's trust, doctors are required to act in the interests of the patient, with the objective of returning them to health. Ethical behaviour is paramount in this relationship, not simply because it is a dependent one (where the health professional is dealing with vulnerable individuals) but also because health professionals are given powers over patients (to examine them, record and distribute personal information about their condition and so forth) based on the idea of trust.

Overall, therefore, the roles of the healthcare system and professionals within that system are seen in terms of their functional organisation to fulfil certain **needs and purposes**. For society to function in a stable and orderly manner, institutions such as work, education and the family need healthy individuals, and the purpose of the health system is to ensure this need is met.



Identify and explain one aspect of the professional healthcare role.

Evaluation

- **Functional importance:** The high incomes and statuses of doctors and consultants are justified on the basis that they are objectively more functionally important to the health institution, but we can only judge this value subjectively. Nursing staff, for example, are functionally important too — since the system couldn't function without them — but they have much lower pay and status than doctors.

- **Dysfunctions:** As we've seen, [Ilich \(1976\)](#) argues that health professionals can perform their roles dysfunctionally by actually making people ill (**iatrogenesis**).
- **Social closure:** Some argue that professional bodies (such as the BMA) and regulators act as a 'closed shop' to protect professional interests (such as high incomes) by limiting entrance into the profession, rather than serving the public interest. This suggests the system is not necessarily meritocratic and therefore not necessarily functional.
- **Alternatives:** The assumption that the current organisation of health systems around a biomedical model is functional means that alternative models of health are seen as dysfunctional.

Marxism

The focus for Marxist perspectives is on **conflicts** surrounding the role of health professionals, based around two ideas:

- Capitalist societies are class societies based around the fundamental conflict between a ruling and a subject class. The underlying logic of this relationship is the pursuit of (private) profit based around competition and social and economic inequalities.
- A ruling class has a clear interest in ensuring a fit and healthy workforce that can be exploited for **profit**, especially if the workers themselves effectively pay to maintain their health — through income and consumption taxes to fund the collective approach of the NHS, or private health insurance to fund the individualistic approach of the US healthcare system.

The key idea, for Marxists, is that in capitalist societies the role of health professionals is shaped by conflicts across three dimensions: economic, political and ideological. These are discussed below.

Economics: medicine as production and consumption

[Bambra et al. \(2005\)](#) argue that in capitalist societies health is a commodity — something to be bought and sold — and the role of health professionals is to service this market. The area of greatest profitability is not community protection and prevention but individual cure.

The argument here is that the major improvements to general public health in any society (as measured by things like average life expectancy) occur through a series of relatively simple measures — such as the provision of clean water — and once these are achieved there is a diminishing rate of return and profit on 'medical improvements'. Only by switching the focus to 'individual cures for individual ailments' can profits be continually created — and this is where, [Navarro \(1989\)](#) argues, '**corporate medicine**' comes to the fore.

For large corporate interests to exploit medical care for profit — through drug sales, the provision of private insurance or servicing the needs of a national health service — they need to develop relationships at all levels of health provision: from dealing directly

with governments, through research and development that produces new products for sale to health professionals, to advertising that reaches directly into the hearts and minds of consumers.

Thus the economic dimension promotes a **biomedical model** of health, with the belief that higher levels of individual health are achievable through better drugs or improved surgical techniques. It also promotes the **ideology** of healthcare as something to be bought — both as a society, through building hospitals, organising health services and the like, and individually, through the consumption of a vast range of health products, from ‘cold cures’ to slimming pills.

Politics: medicine as social control (part 1)

For Marxists, health professionals play key roles in:

- > creating healthy workers who are a continued source of profit
- > controlling definitions of health and illness
- > deciding who is ill and who is healthy
- > defining new disorders (which can be treated by new and profitable drugs)

In general, therefore, the **gate-keeping** role played by health professionals is a form of ‘**soft policing**’ — making the day-to-day decisions about individual health and illness that contribute to the continued operation of capitalist society. Healthcare professionals are locked into this political and economic system through high salaries and the high statuses that come with increasing **specialisation**; certain groups, such as surgeons and consultants, are able to place a very high value on their knowledge and skills precisely because of the individualisation and **commodification** of medical services. (‘Commodification’ refers to the process of turning something into a commodity — something that can be bought and sold.)

The political role of healthcare professionals, and specifically those who occupy senior roles in the **medical hierarchy**, is a powerful one. This professional group sits at the centre of an important relationship: they hold the trust of the general public (those whom they nominally serve) and they are courted by corporations seeking to provide medical services to both individuals and governments. Navarro (1989) argues that the power of health professionals stems from their **monopoly control** over two areas:

- > **The production of medical knowledge**: Health professionals have created a system of training and registration that restricts entry into the profession.
- > **The provision of health services**: Only suitably trained, qualified and registered staff are allowed to administer these services.

This control has, in turn, shaped two processes: the **social organisation** of medicine, and the **division of labour** within medical institutions. Both processes, Marxists argue, have been shaped in the interests of healthcare professionals rather than the interests of the people they nominally serve.

Ideology: medicine as social control (part 2)

Althusser (1972) argues that medicine is an **ideological state apparatus**: the means through which people are socialised to accept a range of ideas beneficial to a ruling class. These include the idea that health is an individual, not a collective, problem, and the belief that curative medicine is superior to all other forms. The real causes of ill health, such as poverty and social inequality, are obscured by this ideology.

Navarro (1979) suggests that health professionals, because they are involved in promoting these ideas, are **ideological agents of social control**. 'Health' is promoted as the outcome of **individual lifestyle choices** (concerning diet, exercise and so forth), **random chance** or **individual weaknesses** — whereas, for Marxists, it should be seen as the result of unequal **life chances**, the long-term effects of **economic exploitation** and the willingness of a ruling class to promote its interests (and health) at the expense of the majority of workers.



Identify and explain one way in which medicine is a form of social control.

Evaluation

- **Left functionalism**: Some forms of Marxism simply replace the functionalist idea that the role of health professionals benefits society as a whole with the idea that they provide various benefits to a ruling class.
- **Capitalism**: By focusing on the 'general logic' underpinning capitalist societies (the pursuit of private profit), Marxists underplay the many significant differences between such societies. Health provision in America, for example, follows very different principles from that in Britain. Turner (1987), from a Weberian perspective (see below), argues that we need to understand the **diversity** of medical systems in capitalist societies.
- **Professional roles**: Marxism overplays the role of healthcare professionals as **agents of social and ideological control**. We could argue, for example, that professional medicine plays a key role in protecting the public from harm by insisting on the proper scientific scrutiny of the claims made by corporations and pharmaceutical companies.
- **Health**: The advances made in medical science are important and beneficial to large numbers of people who would otherwise experience greater suffering.

Weberian approaches

Weberian approaches focus on the relationship between **social structures** and **social actions**. They seek to understand how the nature of organisational structures influences the behaviour of individuals and groups within those structures — and, for our current purpose, how **social status** is negotiated within organisations. In particular, this approach explores the idea of professional status as a means of protecting the self-interests of doctors as an **elite group** of medical practitioners.

Weber (1905) argued that the development of modern societies was influenced by the concept of **rationalisation**. Ideas about organising behaviour **efficiently** and **productively** to achieve certain organisational goals, such as providing medical care for the greatest number of individuals, are implemented through:

- > **institutions** — such as work
- > **practices** — the various roles people play within an organisation

In modern societies, **rational organisation** is generally expressed in terms of **bureaucracy**, an organisational form that Ritzer (1996) describes as follows:

- > **Large-scale**: It involves big, complex institutional structures.
- > **Goal-orientated**: It exists to achieve certain clearly defined aims.
- > **Rule-orientated**: 'People have certain responsibilities and must act in accord with rules and written regulations.'
- > **Hierarchical**: It is arranged in levels, with those at the top (and at each successive level) having more power, influence and importance than those lower down.

A further key feature noted by Borthwick et al. (2009) is that **status** within bureaucracies is **achieved** (through particular merits and demonstrations of knowledge and skills) rather than **ascribed** (given).

If we combine these elements of bureaucratic organisation in relation to the British health system, we can understand the role of healthcare professionals as part of a **hierarchical status system**. The object of interest, for Weberian sociologists, is how and why certain groups achieve, maintain and enhance status within an organisation. We therefore need to understand professional groups within the health system as **status groups**, primarily organised to protect the standing and interests of their *members*. This is achieved by doctors in two ways: **specialisation** and **status hierarchies**.

Specialisation

Status groups stake out clear areas of knowledge, skills and expertise. These need to be exclusively owned by a group if they are to restrict entry and, in consequence, raise their status and income. One way to do this is through the increasing **specialisation** of the medical role (neurologists, paediatricians, urologists and so on). By raising the level of expertise, healthcare professionals create **barriers** to professional entry by:

- > claiming exclusive knowledge
- > increasing the need for long and expensive training
- > establishing monopoly practices

These barriers are complemented by a range of practices designed to consolidate the exclusive and economically valuable status of healthcare professionals:

- > **strict regulation**, preferably by a 'neutral' organisation such as the state (and the General Medical Council, in Britain), that requires alternative medical practices to pass strict tests to be admitted into the medical canon

- **self-governance** by a professional association (such as the British Medical Association) which sets standards to keep all members of the status group in line
- **specialised training** and testing, through university degrees and medical doctorates that exclude all but a small minority of potential entrants, while enhancing the claim to exclusive knowledge and skills

This does have certain advantages for those dealing with professional groups — for example, a patient can expect to be treated **ethically** and have their health assessed **objectively** by someone who has attained an objectively defined level of medical competence. However, professional status within an organisational hierarchy also has wide-ranging benefits for those playing the professional role. These include **privileges**, as [Allsop and Saks \(2002\)](#) note, such as the ability to:

- set their own behavioural and ethical rules
- define standards of competence
- define exclusive areas of practice

Bureaucratic organisation combines with claims for professional expertise to create, for Weberians, a very effective system of **professional closure**. [Alexander \(2005\)](#) characterises this as a form of **social exclusion**: by restricting and controlling their membership, a group creates an artificial shortage of expertise which is then translated into a range of rewards (such as high levels of status, power and income) exclusively enjoyed by the group members.

Social closure has the additional advantage of making it difficult for **alternative** forms of medical knowledge and expertise to develop. Professional closure is based on a biomedical model of health that is the basis of health professionals' claim to exclusive knowledge and skills. If this model is effectively challenged, then so too is the professional claim to closure.

Status hierarchies

In their day-to-day interaction with patients and other, competing healthcare professionals, especially nursing staff, doctors must work to maintain their **status** against the claims of these groups. [Stein \(1967\)](#) initially noted how doctors and nurses played an elaborate 'game' designed to protect the doctor's status while acknowledging that much of the day-to-day care of patients was done by lower-status (and much lower-paid) nurses:

One rarely hears a nurse say 'Doctor, I would recommend...'. A physician hearing a recommendation of that nature would gape in amazement at the effrontery of the nurse... Nevertheless...nurses make recommendations of more import every hour and physicians willingly and respectfully consider them.

When Stein et al. (1990) revisited 'the **doctor-nurse game**', they found that their relationship had evolved. This was partly a result of nurses seeking to enhance their own status by restricting entrance through higher educational qualifications and by creating a new range of professional roles that edged into the territory once exclusively occupied by doctors. Radcliffe (2000), however, takes a different view:

For all the jostling for position over the past 20 years little has changed. This is primarily because the power in the relationship is mediated by the patient. If in doubt ask the patient who is in control. The public may love its angels but it holds its medics in awe.

In a similar vein, Foucault (1973) notes the power of the **clinical gaze**. The medical institution and senior health professionals (as a powerful group within that institution) exercise **power** through their **moral authority** over patients: they have the ability both to explain problems, such as illness, and to provide solutions to those problems.



Identify and explain two ways in which status groups protect the standing and interests of healthcare professionals.

Evaluation

Criticisms of the Weberian approach turn on how we interpret the concept of professionalism. While this status clearly confers advantages on those who have it, it also provides benefits for those who require medical services:

- > trained and competent medical staff
- > ethical behaviour governed by a code of conduct strictly policed by both professional associations and the state
- > higher standards of behaviour and care

Barriers to entry can also serve the public by ensuring that those who offer medical services are properly qualified and that the service has been tested and assessed as effective, or at least not harmful.

Alternatives to the biomedical model, such as homeopathy or aromatherapy, may find it difficult to break into the health service, although, as we will see, it's not impossible. On the other hand, bureaucratisation and professionalism ensure that competing medical claims have to be scientifically assessed.

Preventative medicine, at least in the British healthcare model, has assumed increasing significance in recent years. It's difficult to see how this could occur if, as the Weberian approach claims, it's not in the interests of professional status groups to promote anything other than a curative approach to medicine.



Feminism

Feminist perspectives have focused on two ways in which women are **marginalised**: within the medical profession, and as objects of medical attention.

Women and the medical profession

The **historical origins** of female marginalisation within the health profession are traced, by writers such as Ehrenreich and English (1972), to women's role as 'healers' in the Middle Ages (the fourteenth and fifteenth centuries in particular). The developing, male-only medical profession used accusations of witchcraft against female folk-healers to 'remove the competition'.

Contemporary perspectives on male domination emphasise the following aspects:

- **Vertical segregation**: The medical profession is characterised by distinct layers of power, income and authority, with the higher level (doctors and consultants) overwhelmingly male and the lower level (nursing staff) overwhelmingly female.
- **Professional closure**: This results in female exclusion from the higher-status positions.

Female voices are marginalised further by the need to defer to male professionals of higher status even in situations where their greater everyday knowledge, experience and skills mean that they have more understanding of patient care and needs.

Women as objects of medical attention

A second strand to feminist arguments concerns male medical control over female bodies and minds.

In terms of **bodies**, one area of concern is the '**medicalisation of childbirth**': it is argued that women are subjected to a range of processes, from hospital deliveries to Caesarean operations, that owe more to the convenience of health professionals than to the interests of the women involved.

Medical interventions in areas of specifically female life, such as menstruation, pregnancy and childbirth, were once handled privately, within the family. The extension of male medical influence into these areas is interpreted as a desire to both control female behaviour and extend medical practice into profitable areas of the marketplace.

There is also concern about control over female **minds**. Across both class and ethnic categories, women suffer higher levels of mental disorder than men. Feminists suggest two explanations for this:

- Health professionals are more willing to classify (or **label**) females as mentally ill because of **patriarchal** notions of 'female fallibility', such as the idea that women are more prone to common mental disorders simply because they are women.
- The causes of female illness, both mental and physical, are **social**, not medical. The dual roles of women in contemporary societies, as both paid employees and unpaid domestic workers, place greater stresses and strains on women's minds and bodies.

These two ideas are bound up in the concept of **medicalisation** — the idea that healthcare professionals are more likely to use medical labels for behaviour that deviates from conventional norms about how women are supposed to behave. As [Busfield \(1996\)](#) puts it, there is an assumption that ‘Men are bad; women are mad’.

One further aspect of feminist concern relates to **informal care** within family groups. The argument here is that major responsibilities for both physical and mental healthcare are increasingly passed on to women by the medical profession. While women do most of the additional work, they receive little help, credit or financial remuneration.



Identify and explain one way in which women are marginalised by the healthcare profession.

Evaluation

While feminism makes a significant contribution to our understanding of the role of healthcare professionals by highlighting a range of ‘**malestream biases**’ within the medical profession, this approach has attracted a range of criticisms. There are significant doubts about two major areas of feminist argument: historical developments and contemporary society.

In terms of **history**, there has been dispute over the feminist claim that the female ‘healing role’ was taken over by men, and specifically by a male medical profession, as the result of a deliberate (and literal) witch-hunt. [Burns \(2003\)](#), for example, argues that the picture in England was more complicated than feminists have suggested. When the state wanted witches persecuted, medical authorities were often invoked in evidence against them; however, in periods when witches were not officially persecuted, medical authorities were often used in their *defence*. More significantly, Burns argues that by the seventeenth century, when a coherent medical profession began to emerge, there was ‘a remarkable succession of increasingly radical physician *opponents* of witch-hunting’.

Other criticisms concern feminist analysis of **contemporary society**. While the medical profession, especially at the highest levels, has historically been male-dominated, it doesn’t necessarily follow that this is still the case. A recent report by the [Royal College of Physicians \(2009\)](#) notes that women:

- > made up 57% of acceptances for medical school
- > are likely to become the majority of NHS GPs by 2013
- > are likely to become the majority of all NHS doctors sometime after 2017
- > accounted for over 60% of specialist training acceptances into general practice, paediatrics, public health medicine, and obstetrics and gynaecology

Another criticism concerns the focus on **patriarchy**. Rather than seeing medical power in patriarchal terms, an alternative is to see it in **class** terms. Since lower-class males, for example, suffer similar experiences to women at the hands of health professionals, we should see healthcare in terms of **professional power**, whether wielded by men

or by women. This then becomes the central way of explaining health inequalities, the medicalisation of deviant behaviours and the like.

The rise of complementary/alternative medicine

In this section we will discuss complementary and alternative medicine, considering the ways in which they present a challenge to conventional medicine. We can note first that complementary and alternative medicine are defined less in terms of the *type* of medical treatment or service being provided and more in terms of their *relationship* to the **dominant form** of medical practice in society (the biomedical model).

Complementary medicine

'Complementary medicine' refers to treatment or services used *in conjunction with* (as 'a complement to') conventional forms of medicine. They normally belong to one of three types (although, in practice, they may be combined):

- **Mind and body practices** include:
 - **acupuncture** — a traditional Chinese medical practice that uses very thin metal needles inserted into the skin, for example to relieve pain
 - **meditation** techniques such as yoga
- **Natural products** include a variety of herbal medicines and vitamins used as dietary supplements. **Probiotic** foods (such as yogurts) are probably some of the most well-known.
- **Body-based practices** involve a range of manipulative techniques designed to relieve conditions such as back pain. Two common examples are chiropractic services and massage.



Acupuncture is gaining popularity in Western countries

Alternative medicine

'Alternative medicine' refers to treatment or services used *in place of* conventional medicine. Some of the best-known or most widely used are the following:

- **Homeopathy**: This involves treating illness using the principle of 'like cures like': a substance that would cause illness in a healthy person is used, in very minute doses, to treat someone who is ill, on the basis that the 'harmful' substance stimulates the body's natural defence mechanisms.
- **Naturopathy**: This is again based on the idea of stimulating the body's natural defence mechanisms to prevent and overcome illness. It uses diet and exercise,

discourages 'unhealthy practices', and employs various forms of natural therapy to 'remove the barriers to self-healing'.

- **Aromatherapy:** This uses 'essential oils' (plant extracts) as a way of altering people's health.

? Identify and explain one difference between complementary and alternative medicine.

Complement or challenge?

It may seem obvious that, by definition, complementary medicine does not threaten the conventional medical model while alternative medicine does. However, the situation is not quite so simple. Despite their differences, complementary/alternative medicines (CAM) challenge conventional forms of medicine in three ways, which we can consider under the headings of causality, organisation and treatment.

Causality

CAMs can be distinguished from conventional Western forms of medicine in terms of the way each views the relationship between **mind and body**. Conventional biomedicine separates 'the mind' from 'the body' when treating illness. The mind (or how people feel) is seen as having no direct impact on health; the focus is on the search for, and treatment of, the **physical causes** of ill health. The emphasis is generally on cure rather than prevention, although this depends to some extent on the nature of different health systems.

CAM represents a challenge to conventional medicine in that it generally takes a different view of mind and body. It argues that the mind and the body are connected, such that when the two are working 'in harmony' the body's natural defence mechanisms are enhanced; this gives people greater protection against disease and greater ability to recover from illness. Rather than focusing on symptoms and locating causes in particular parts of the body, this view adopts a **holistic approach** to treatment — one that looks at the 'whole person' (mind, body, emotions and 'spirit') as a way of understanding and treating ailments.

Organisation

Alternative medicines in particular present a challenge to conventional forms of medicine in terms of the relationship between practitioners and patients:

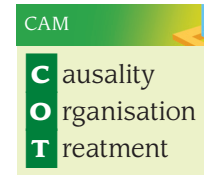
- **Conventional medicine** is **bureaucratically** organised and involves a clear, formal separation between the practitioner (doctor) and patient — the latter requires the former to cure their illness. Partly because of the focus on physical causality, the doctor is not particularly interested in the patient beyond any factors (diet, lifestyle and the like) that might impact on treatment and recovery.
- **Alternative medicine** emphasises **holistic** treatment (treatment based on an understanding of the 'whole person'). In this approach, the treatment of the *person*

is as significant as the treatment of the *ailment*. This means that the relationship between practitioner and patient is non-bureaucratic, less hierarchical and less formal.

Treatment

As we've suggested, one way CAM challenges conventional biomedicine is through a focus on holistic (mind and body) treatment. This, in turn, produces a range of specific differences in the way health and illness are treated. While conventional medicine focuses on the use of various, mainly synthetic, drugs and invasive surgical practices (such as heart surgery), CAM focuses on the idea of 'natural drugs' and non-invasive methods.

The two approaches are not inevitably opposed. Conventional medicine, for example, frequently uses naturally-occurring drugs, such as quinine for the treatment of malaria and opiates for pain relief. It also uses 'alternative techniques', such as massage, as part of its overall healthcare package. However, many alternative forms of medicine are philosophically opposed to synthetic drug treatments and invasive surgical techniques.



Identify and explain one way in which alternative medicine challenges the power of healthcare professionals.

The empire fights back

One arena in which the 'alternative challenge' to conventional medicine has been played out in recent times is the **scientific testing** of CAM claims to be a valuable alternative to conventional treatments. We will consider two aspects of the 'alternative challenge': the opposition between 'natural' and 'artificial' medicine, and the issue of effectiveness.

Natural versus artificial medicine

One of the criticisms levelled at alternative approaches such as homeopathy is that the label 'natural' is subtly confused in the mind of the consumer or patient with 'good'. This involves the idea that if something 'occurs naturally' it is automatically beneficial. The reverse, of course, is also the case — anything 'unnatural' (such as a synthetic drug) is, by definition, 'bad'. Conventional medicine points out that something natural is not automatically beneficial or harmless, just as something synthetic is not automatically harmful. The death cap mushroom, for example, is a 'naturally occurring substance' that, if consumed, can cause death (the clue is in the name).

Effectiveness

Homeopathy is one of the largest and most popular alternative medicine practices. It involves a market worth, [Sample \(2008\)](#) reports, '£38m in 2007 and expected to reach £46m by 2012'. It has been subjected to a range of scientific testing:

- [Linde et al.'s \(1998\)](#) review of a large number of clinical tests found no evidence that homeopathy was an effective treatment 'for any single clinical condition'. However,

they did conclude that homeopathic treatment had some beneficial effects as a **placebo**, as many people reported feeling better after treatment. (A placebo is a treatment which has no inherent therapeutic value, but can have a beneficial effect simply as a result of a patient's belief in the treatment.)

- > Ernst et al.'s (2007) review of the evidence for the effectiveness of homeopathy in the treatment of children and adolescents similarly found little difference between the effects of homeopathic treatment and placebo treatments. They concluded that, while homeopathy was largely harmless, it carried the danger of 'delaying effective treatment or diagnosis'.
- > Ernst (2010) concluded that, while there are currently around 200 clinical trials of homeopathic medicine, 'the totality of this evidence fails to show that homeopathic remedies work'.

Despite the lack of scientific validation of the clinical effectiveness of complementary and alternative medicine, there is little doubt it has become established as part of the **cultural health system** — the overall system of healthcare, conventional and alternative — in British society. Siahpush (1998) suggests three reasons for this:

- > dissatisfaction with the health outcomes of conventional medicine, for example when there are unpleasant side-effects of conventional drug treatments or when conventional treatments have failed
- > dissatisfaction with doctor–patient interaction and relationships, for example among those wanting greater involvement in their diagnosis and treatment
- > the existence of value systems (such as 'New Age' beliefs) that fit with the philosophical underpinnings of alternative medicine

OCR examination questions

- 1 Identify and explain two reasons for the growth of alternative medicine. (17 marks)
- 2 Outline and evaluate the functionalist view of the role of health professionals. (33 marks)
- 3 Outline and evaluate the view that health professionals have too much power in the contemporary UK. (33 marks)
- 4 Outline and evaluate sociological views on the role of medical professionals in society. (33 marks)