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THEORETICAL PERSPECTIVES ON MEDICINE AND SOCIETY

INTRODUCTION

In this chapter, the major fields of scholarship and research in the humanities and social sciences that have examined the social role of scientific medicine in western societies are reviewed for the theoretical developments which have occurred since the mid-20th century. Particular attention is paid to the emergence of social constructionism as a dominant perspective appropriate for engaging in inquiries into the sociocultural dimensions of medicine, health and illness. The chapter begins with a discussion of the concept of discourse, an important theoretical and methodological concept that has been adopted throughout many of the social sciences and humanities. Then follows a detailed account of the sociological tradition and the three major theoretical perspectives that have been used to analyse medicine, health and illness: functionalism; political economy; and social constructionism. The insights offered by the fields of anthropology, history, cultural and media studies and studies of science, technology and space in terms of what they have to offer for the analysis of medicine and embodiment are then explored.

DISCOURSE AND THE 'LINGUISTIC TURN'

All areas of the humanities and social sciences have experienced a heightened interest in language and discourse over the past three decades or so. There has been an increasing preoccupation with recognizing and understanding the role of language

in constituting and maintaining social order and notions of reality (Atkinson, 1990; Howarth, 2000; Jensen, 1991; Lehtonen, 2000). The linguist de Saussure was the first to develop semiotics, or the science of signs, and apply it to the explanation of the structure of language. Barthes' (1973) application of the methodology of semiotics to popular culture in the 1960s was a major step in the analysis of the meaning produced in such hitherto neglected cultural texts. Subsequent approaches to the critical scrutiny of the products of mass and elite media either have grown out of, or have been strongly influenced by, the insights into language and culture provided by early semiotic theory. The breakthrough in theoretical approach was the fact that semioticians thought of people as 'spoken by, as well as speaking, their culture: spoken through its codes and systems' (Hall, 1980: 30).

The poststructuralist concept of *discourse* marries the structuralist semiotic concern with the form and structure of language and the ways in which meaning is established with an understanding that language does not exist in a social vacuum. Discourse, in this usage, can be described as a pattern of words, figures of speech, concepts, values and symbols. A discourse is a coherent way of describing and categorizing the social and physical worlds. Discourses gather around an object, person, social group or event of interest, providing a means of 'making sense' of that object, person, and so on (Parker, 1992; Parker and the Bolton Discourse Network, 1999). All discourses are textual, or expressed in texts, inter-textual, drawing upon other texts and their discourses to achieve meaning, and contextual, embedded in historical, political and cultural settings. Common to most strands of discourse analysis is a concern with the way in which discourse is organized in terms of abstract principles, the view that discourse is an active means of communication used purposively and strategically to achieve desired ends, and an interest in the perspective of the actual communicators.

It is recognized that an integral and intertwined relationship exists between discourses – the way we speak or visually represent phenomena – and practices – the actions and activities surrounding these phenomena. For example, the ways in which the maternal body and the foetus are described, visually represented, and treated in western societies tend to make an explicit separation between woman and foetus which is not evident in some other cultures. Debates over abortion in popular and legal settings, accusations made against women for smoking or drinking alcohol while pregnant, the training of medical students in obstetrics and gynaecology, the use of ultrasound that represents the foetus as an image separate from the maternal body, colour photographs in books and popular science magazines that show the foetus in the womb, seemingly floating in space, the way that people speak of the foetus as having a potential gender and name before birth, all serve to reinforce this division between mother and foetus. Practices constitute and reinforce existing discourses, and vice versa.

The examination of texts is central to discourse analysis and other forms of interpretive research. Indeed, it is becoming recognized in all areas of social research that texts are important items of analysis as sensitive barometers of social process and change (Fairclough, 1992; Jensen, 1991; Lehtonen, 2000; Potter and Wetherell, 1987). Any communication which is verbal is considered a text worthy of study for

the identification of discourses. For scholars interested in medical discourses, texts to examine may include medical textbooks, hospital records and admission forms, popular self-help manuals, novels, television programmes about health issues, articles in medical and public-health journals and popular newspaper or magazine articles, blogs, websites and social media pages as well as the transcripts of conversations between doctors and patients or interviews between researcher and subject. When applied to sociocultural analyses of medicine, the analysis of discourse has the potential to demonstrate the process by which biology and culture interact in the social construction of disease, and the ways in which western culture uses disease to define social boundaries.

THE SOCIOLOGY OF HEALTH AND ILLNESS

As it first developed in the anglophone world, medical sociology (as the sub-discipline was first named and which term is still preferred in the United States), or the sociology of health and illness (the term preferred in Britain and Australia), was primarily concerned with systematic empiricism using the measurement of objective variables deemed quantifiable. Early in its development, in order to be accepted as a quasi-scientific discipline applied to a scientific discipline (that is, medicine), medical sociology adopted largely positivist values which to some extent are still evident, although more so in the United States than Britain and Australia. As a result, often medical sociology could best have been described as a derivative of social medicine rather than as a sub-discipline of critical sociology (Jordanova, 1983; Mechanic, 1993; Scambler, 1987). Accordingly, in line with the assumptions of the model of scientific medicine itself, for much of the history and development of medical sociology and the sociology of health and illness the biological, human anatomy conception of the body has remained unchallenged (Armstrong, 1987a). That is, until social constructionism, in train with the impact of poststructuralism and postmodernism and the ascendancy of feminist and Foucauldian critiques of medicine, began to reassert itself as an influential approach in the early 1980s.

There have been three dominant theoretical perspectives in the history of the sociology of health and illness: functionalism, the political economy approach and social constructionism. Variants of all three are currently in circulation in scholarship in the sociology of health and illness. However, it is clear that since the 1970s functionalism and, to a lesser extent, the political economy approach have been on the wane, while the social constructionist perspective continues to prosper.

FUNCTIONALISM

The functionalist approach to the sociology of health and illness views social relations in the health-care setting as products of a consensualist society, in which social order and harmony are preserved by people acting in certain defined roles and

performing certain functions. It is interested in the processes by which doctors and other health-care professionals carry out their everyday work, and how people cope with illness and disease. The classic functionalist position is to view illness as a potential state of social 'deviance'; that is, a failure to conform to societal expectations and norms in some way. Illness is considered an unnatural state of the human body, causing both physical and social dysfunction, and therefore must be alleviated as soon as possible.

Functionalists argue that feelings of stigma, shame and vulnerability accompany many illnesses. Therefore the role of the medical profession is to act as a necessary institution of social control, or a moral guardian of society, using its power to distinguish between normality and 'deviance' as the Church once did. The maintenance of social order is thus the basis of functionalist theorizing on the nature of illness and the medical encounter, with medicine being viewed as an important mechanism to control the potentially disruptive nature of illness.

The leading scholar in the application of functionalist theory to medicine was the American sociologist Talcott Parsons. His explanations of the demands and function of the 'sick role' and its implications for the doctor–patient relationship and discussion of the social aspects of the institution of medicine as a profession were influential in the sociology of health and illness in the 1950s and 1960s. According to Parsons and his followers, a person afflicted with serious illness is physically disabled and thereby forced to rely upon others, and hence is deviating from the expectations of social roles. Parsons argued that conforming to the norms of the sick role legitimates such deviance. He described the major components of the sick role: ill persons are exempted from the performance of social obligations which they are normally expected to fulfil; they are not blamed for their condition, and need not feel guilty when they do not fulfil their normal obligations; however, ill people must want to try and get well – if they do not, they can be accused of malingering; and being sick is defined as being in need of medical help to return to 'normality' – the sick must put themselves into the hands of medical practitioners to help them get well again (Parsons, 1987[1951]).

The patient is therefore placed in the role of the socially vulnerable supplicant, seeking official verification from the doctor that she or he is not 'malingering'. The role of the doctor is seen as socially beneficent, and the doctor–patient relationship as inherently harmonious and consensual even though it is characterized by an unequal power relationship. Parsons argues that patients often unconsciously view doctors as parental figures, investing their need for support and help in doctors and reverting back to the dependence of childhood. The sick role and the power differential between patients and doctors work to deal with this dependency productively and in ways that allow patients to cast off their dependency and eventually re-enter the world of the well. They are therefore mechanisms by which society deals with the potential threat of people harbouring a motivation to avoid responsibility by allowing themselves to become and remain ill (Lupton, 1997a).

While Parsons' work was ground-breaking in elucidating the social dimension of the medical encounter, the functionalist perspective has been subject to criticism based on its neglect of the potential for conflict inherent in the medical encounter.

There appears to be a streak of implicit moralism in Parsons' ideas relating to the potential of people to become 'malingerers' by claiming illness (Lupton, 1997a). Critics argue that the functionalist position typifies patients as compliant, passive and grateful, while doctors are represented as universally beneficent, competent and altruistic (Turner, 1995). On the contrary, critics assert, the conflict of interest between patient and doctor is expressed over a struggle for power, which may be explicit or implicit, and involves negotiation and manoeuvre at every step in the encounter (Gerson, 1976; Strong, 1979). It should be taken into account that doctors and patients have different, and often conflicting, interests: doctors, to perform their duties of the professional in the medical workplace, seeking to earn a living and progress in their career; patients, to alleviate the physical pain or discomfort that is disrupting their lives. Furthermore, it is argued, there are organizational constraints in the medical setting and external factors influencing the behaviour of doctors and patients when they meet in the medical encounter which go beyond the dynamics of the sick-role model. Both the doctor and the patient have relationships outside the medical encounter which affect their approach to the encounter.

As I noted earlier, the functionalist approach has become unfashionable in medical sociology and the sociology of health and illness, largely because of the critiques outlined above. Despite this, it still has important things to say about the emotional relationship between the doctor and the patient, and the needs and drives, both conscious and unconscious, which underpin it (Lupton, 1997a; Williams, 2005).

THE POLITICAL ECONOMY PERSPECTIVE

The political economy approach developed as a critical response to functionalism in the context of larger changes in social thought occurring in the 1970s, particularly Marxist views on the capitalist economic system. Also known as critical structuralism, the approach was a dominant intellectual movement in the 1970s and early 1980s, and remains influential in the sociology of health and illness. Under this perspective, good health is defined in political terms not only as a state of physical or emotional well-being but as 'access to and control over the basic material and nonmaterial resources that sustain and promote life at a high level of satisfaction', meaning that 'a key component of health is struggle' (Baer et al., 1986: 95).

For political economists, ill, ageing or physically disabled people are marginalized by society because they do not contribute to the production and consumption of commodities. Other marginalized groups, such as women, people from non-English-speaking backgrounds, non-whites, the aged, the unemployed and members of the working class, tend to endure greater social and economic disadvantage than those from privileged groups, have restricted access to health-care services and suffer poorer health as a result (see, for example, critiques by Ahmad and Jones, 1998; Estes and Linkins, 2000; Manderson, 1998).

From this perspective the institution of medicine exists to attempt to ensure that the population remains healthy enough to contribute to the economic system as

workers and consumers, but is unwilling to devote resources for those who do not respond to treatment and are unable to return to the labour market. Medicine thus serves to perpetuate social inequalities, the divide between the privileged and the underprivileged, rather than ameliorate them. Political economy writers comment on the cultural crisis of modern medicine, in which health care under capitalism is perceived as largely ineffective, overly expensive, under-regulated and vastly inequitable.

For writers such as Freidson (1970), the high status of the medical profession and the faith that is invested in its members' abilities to perform miracles has resulted in other social problems being inappropriately redefined as illness. He contended that as a result of the widening of medical jurisdiction, more social resources have become directed towards illness, and the medical profession's power and influence increased markedly in the 20th century, with little scope to question its activities or use of resources. This 'medicalization' thesis was adopted by other political economic critics, including Zola (1981) who saw medicine as becoming a major institution of social control, superseding the influence of religion and law as a 'repository of truth'. Illich (1976) argued that modern medicine was both physically and socially harmful due to the impact of professional control over medicine, leading to dependence upon medicine as a panacea, obscuring the political conditions which cause ill-health and removing autonomy from people to control their own health: 'Such medicine is but a device to convince those who are sick and tired of society that it is they who are ill, impotent, and in need of technical repair' (1976: 9).

Like the functionalists, political economists see medicine as a moral exercise, used to define normality, punish deviance and maintain social order. Where the two approaches differ is that the latter school of thought believes that this power is harmful rather than benevolent and is abused by the medical profession. The political economic critique questions the values of scientific medicine and focuses on the identification of the political, economic and historical factors that shape health, disease and treatment issues. Scholars claim that the capitalist economic system has promoted a view of health care as a commodity, in which the seeking of profit is a major influencing factor, and that therefore the relationship between doctor and patient is characterized by conflict and the clash of differing interests and priorities. They argue that western medicine attempts to narrow the cause of ill-health to a single physical factor, upon which treatment is then focused. Medical care thus tends to be oriented towards the treatment of acute symptoms using drugs and medical technology rather than illness prevention or the maintenance of good health. Political economists suggest, however, that the causes of ill-health are more diffuse and are related to socioeconomic factors which are themselves the result of capitalist production, for example: over-processed foods treated with chemicals; pollution; stress; alienation; and occupational hazards (McKee, 1988).

Political economy commentators have written extensively about the state's failure to acknowledge the role of environmental toxins resulting from industry in causing illness, to regulate the activities of multinational corporations to create healthier environments, or to take steps to control the production, marketing and advertising of unhealthy commodities such as alcohol and tobacco (for example, Breslow,

1982; Doyal, 1983; Epstein, 1978, 1990; Russell and Schofield, 1986; Syme and Alcalay, 1982). They see a symbiotic relationship existing between capitalism and health care: capitalism produces health needs which are treated in such a way as to obscure their origins and demands the consumption of commodities to secure the healing process, which in turn supports the capitalist system of production (Navarro, 1976; Renaud, 1978). The proposed alternative is a socialized system of health care, in which the state provides care for all free-of-charge and alternative, non-biomedical methods of health-care delivery such as natural therapies are accepted as valuable.

There are thus two major facets to the political economy approach. The first largely accepts that biomedicine is a politically neutral 'good' and seeks to provide more and better medical services to the underprivileged, while the second, more radical critique has questioned the value of biomedicine itself and highlighted its role as an institution of social control, reinforcing racism and patriarchy (Ehrenreich, 1978). However, both approaches conform to the 'use/abuse' model of medical knowledge, which tends to accept the neutrality and objective validity of medical knowledge itself, but questions the use to which it is put in the interests of doctors and the wider capitalist system, often retreating into 'doctor-bashing' (Jordanova, 1983).

Political economists have traditionally viewed medical knowledge as serving the interests of the ruling classes rather than as politically neutral. They therefore tend not to engage in a philosophical analysis of medical knowledge, but rather seek to identify the interests which it serves (Jordanova, 1983). Their critique sometimes seems contradictory: for example, medicine is typically criticized for being both overly expansionist and exclusionist (of the underprivileged), and illness is seen as being caused by both deprivation and medical domination (Gerhardt, 1989).

The political economy perspective has been criticized for ignoring the micro-social aspects of the doctor–patient relationship (Ehrenreich, 1978). For many writers from this perspective, the doctor–patient relationship is represented as the equivalent of the capitalist–worker relationship, in which the former exploits the latter. In this conceptualization, an individual who is ill may be reduced to 'a specimen of societal processes', his or her suffering not acknowledged as the focus of the doctor's wish to help, and emphasis upon structural societal change may detract from the plight of current cases needing immediate attention (Gerhardt, 1989: 350). Furthermore, the political economy perspective calls for a mass social movement to change dependency upon medical technology, decommodify medicine, challenge the vested interests of drug companies, insurance companies and the medical profession, and redirect resources towards ameliorating the social and environmental causes of ill-health (Ehrenreich, 1978; Gerhardt, 1989). For some sociologists, such a call may seem idealistic and unrealistic, particularly given the symbiotic relationship between capitalism and medicine (see, for example, Renaud, 1978).

The political economy approach has also been criticized for its unrelenting nihilism; its tendency to fail to recognize that advances in health status and increased life expectancy which have occurred over the past century, associated with improvements in the human diet, reforms in sanitation and the supply of clean water, a rise in standards of housing, better contraceptive technologies and

progress in medical treatment and drug therapies, are intrinsically linked to the requirements and demands of the capitalist economic system (Hart, 1982). It has been further argued that while political economists tend to be highly critical of patterns of health status and inequality in capitalist societies, they fail to fully recognize that socialist states are no more successful in reducing inequalities, and indeed that the overall health status and access to health care of the populations of such societies have historically been worse than that of populations of capitalist societies (Turner, 1995).

Nonetheless, this approach remains an important perspective on the social aspects of health and illness, especially in its focus on highlighting the political and economic dimension of health states. Without this perspective, the social structural reasons for disparities in patterns of ill-health across populations would not be identified and challenged. Continuing problems of access to health care and the larger environmental and political issues surrounding the question of why certain social groups are more prone to ill-health remain important points of discussion for the political economy approach. Many sociologists of health and illness remain concerned with and committed to drawing attention to these issues, particularly as great disparities continue to exist between the health states and access to appropriate medical care of people of high socioeconomic advantage, for example, and those who are disadvantaged, and between the populations of the developed and developing countries (see, for example, several of the chapters in Moss and Teghtsoonian, 2008 and Zoller and Dutta, 2008). The research conducted by political economists of health has been important in challenging the status quo, developing more equitable health-care policies and assisting the work of those seeking to act politically to improve the health of members of disadvantaged groups.

SOCIAL CONSTRUCTIONISM

The perspective of social constructionism began to receive increased expression in the sociology of health and illness and the history of medicine in the 1980s, and it remains a dominant approach in contemporary research and scholarship. In the 1980s and 1990s, poststructuralist and postmodernist approaches were important in building upon earlier writings adopting a constructionist approach. Foucault's works were most influential during this time, and have now stimulated a large body of research (see, for example, Armstrong, 1983, 2002; Fullagar, 2009; Lupton, 1995, 1997b, 2008; Petersen and Bunton, 1997; Petersen and Lupton, 1997; Rose, 2007; Turner, 1995; Weir, 2006). Postmodern scholars such as Kristeva, Derrida, Cixous and Deleuze and Guattari have also been employed to theorize relevant issues (see particularly the work of Fox, 1993, 1997, 1998, 2002; Fox and Ward, 2006, 2008; and the essays in Rudge and Holmes, 2010).

Social constructionism is an approach which questions claims to the existence of essential truths. What is asserted to be 'truth' should be considered the product of power relations, and as such is never neutral but always acting in the interests of

someone. The social constructionist perspective argues, therefore, that all knowledge is inevitably the product of social relations, and is subject to change rather than fixed. Knowledge is seen not as a universal, independent reality but as a participant in the construction of reality. Human subjects are viewed as being constituted in and through discourses and social practices which have complex histories. Thus the examination of the ways in which the 'common-sense knowledge' which sustains and constitutes a society or culture is generated and reproduced is a central interest.

This approach is certainly not new in the history of sociological theory (see, for example, scholars in the sociology of knowledge field such as Berger and Luckmann, 1967). Yet the growing predominance of poststructuralist and postmodernist analyses of issues surrounding concepts of reality and bodily experiences in the humanities and social sciences has given renewed vigour and intellectual interest in its application to the area of the sociology of health and illness after a long period of marginalization. These new areas of interest have also brought into the social constructionist perspective the somewhat previously neglected consideration of issues of power relations at the macro-level, thus incorporating some of the concerns of the political economy perspective. It is predominantly this modified version of social constructionism that this book adopts to illuminate medicine as culture.

The primary focus of social constructionists is examining the social aspects of biomedicine, the development of medico-scientific and lay medical knowledge and practices. The social constructionist approach does not necessarily call into question the reality of disease or illness states or bodily experiences. It merely emphasizes that these states and experiences are inevitably known and interpreted via social activity and therefore should be examined using cultural and social analysis. According to this perspective, medical knowledge is regarded not simply as an incremental progression towards a more refined and better knowledge, but as a series of relative constructions which are dependent upon the socio-historical settings in which they occur and are constantly renegotiated.

In so doing, the approach allows alternative ways of thinking about the truth claims of western medicine, showing them to be as much social products as is lay knowledge of medicine. Such a project has brought together sociologists, anthropologists, philosophers and social historians interested in the cultural assumptions in which western medicine is grounded and the practices that sustain it. The feminist movement has led the way in devoting attention to the ways in which medical and scientific knowledge is used to privilege the position of powerful groups over others. It has developed a trenchant critique of the 'biology as destiny' ideology which has frequently been adopted in the medical context to deny women full participation in the public sphere.

There are a range of political positions taken by scholars adopting the social constructionist approach (Bury, 1986; Williams S., 2006). Some view medical knowledge as neutral, while others emphasize the social control function of discourses, arguing that such knowledge and its attendant practices reinforce the position of powerful interests to the exclusion of others. However, social constructionist scholars generally avoid viewing power as being wielded from above and shaped entirely by the forces of capitalism, recognizing instead a multiplicity of interests and sites of

power. The notion that medicine acts as an important institution of social control has remained, but the emphasis has moved from examining medical power as an oppressive, highly visible, sovereign-based power, to a conceptualization of medicine as producing knowledge which changes in time and space. Those adopting the social constructionist perspective argue that medical power not only resides in institutions or elite individuals, but is deployed by every individual by way of socialization to accept certain values and norms of behaviour.

While the social constructionist perspective is currently rather fashionable, particularly in Britain, Australia and continental Europe, it is not a universally accepted perspective in sociology, a discipline that has traditionally been characterized by antipathy between competing paradigms (the political economy perspective versus the functionalist school, for example). Constructionist analyses have been criticized for: concentrating upon medical discourse at the macro-level; for making broad generalizations and avoiding a detailed examination of the micro-context in which discursive processes take place (such as the everyday experiences of people); for their insistence that discourses have general social effects, regardless of social class, gender or ethnicity; and for not recognizing human agency and the opportunity for resistance (Outram, 1989; Shilling, 1991; Turner, 1996; Williams, S., 2006).

Critics of the social constructionist approach have argued that the approach, like all others influenced by the poststructuralist movement, can descend into relativism and nihilism if taken to its logical conclusion – that all knowledge is a social product, and that therefore the insights of social constructionist analyses are themselves to be questioned. How are the claims of social constructionist analyses to be justified, if they themselves are contributing to discourses that provide certain ways of seeing the world which are not necessarily any more valid or reasonable than other ways? These kinds of objections have dogged the relativist constructionist project since its emergence in sociology. So too, critics have argued that social constructionism tends to ignore the material reality of embodiment in its focus on the discursive construction of illness, disease and other bodily ills (Bury, 1986; Williams, S., 2001, 2006).

However, in response it may be argued that the intellectual purpose of social constructionist scholarship is to highlight these very difficulties, and that therefore their own analyses should not be regarded as attempts to define 'truth' but as alternative versions of events which may be placed against other versions and perspectives for comparison, and judged on their fruitfulness for insight rather than their verisimilitude (Nicolson and McLaughlin, 1987). All researchers need to be aware of the assumptions upon which their analysis is founded; in this poststructuralist age, such reflexivity is almost mandatory. As Nicolson and McLaughlin (1987: 117) argue: 'Far from relativism being an "abyss" to be avoided, proper standards of sociological scholarship imply and demand that sociologists of knowledge be methodologist relativists. Anything less unnecessarily detracts from the scope and power of sociological inquiry.'

The social constructionist approach need not be uncompromisingly relativist. Indeed, as I noted above, despite the contentions of their critics, very rarely is it claimed by those adopting the social constructionist perspective to examine aspects

of medicine and illness that fleshly experiences are simply 'social constructs' without a reality based in physical experience. Most social constructionists acknowledge that experiences such as illness, disease, disability and pain exist as biological realities, but also want to emphasize that such experiences are always inevitably given meaning and therefore always understood and experienced through cultural and social processes. Furthermore, social constructionism is not politically nihilistic if it is recognized that exposing the social bases of medicine, health care and illness states renders these phenomena amenable to change, negotiation and resistance. At their most political, social constructionist perspectives may be brought to bear to challenge the inequalities that exist in health-care provision and health states, as critics from feminism and disability studies have done, for example.

MEDICAL ANTHROPOLOGY

Like many other disciplines and sub-disciplines in the humanities and social sciences, over the past three decades the projects of medical anthropology and medical sociology/sociology of health and illness have come closer together, to the extent that it is difficult to identify the boundaries separating them. Anthropological research aids a cross-cultural understanding of orientations to health care which may differ from the traditional biomedical model, including the lay health beliefs of ethnic minorities living in a western culture (Kleinman et al., 1978; Littlewood, 1991), and provides a comparative perspective against which the western medical system may be examined. Due to its tradition of participant-observation ethnographic research in small-scale societies, anthropology has developed sophisticated analytic tools to document and understand the meanings of communicative processes in the medical setting (Lazarus, 1988; Leslie, 2001).

Medical anthropologists have traditionally been concerned with the interpretation and lived experience of illness. They recognize that the culture within which a patient is operating influences the illness experience, although 'culture' when used by anthropologists in this context often refers to ethnicity or race. This approach views disease and illness as 'a form of communication – the language of the organs – through which nature, society, and culture speak simultaneously' (Scheper-Hughes and Lock, 1987: 31). Although the major focus of western anthropologists has been upon studying small-scale, rural, underdeveloped cultures rather than the large, urban, late-capitalist cultures in which they themselves have been encultured, recent scholarship in medical anthropology has begun to examine the health beliefs of western society. DiGiacomo (1992: 132) has termed this process 'Anthropologizing the West'.

However, the work of scholars and researchers in medical anthropology has sometimes suffered from their close links with biomedical practice and their need to appear institutionally 'useful'. In their avoidance of the social criticism perspective for fear of losing access to the health arena, medical anthropologists have often supported powerful ideologies supporting medical assumptions and neglected the

macro, socioeconomic perspective for a more politically neutral micro-level of analysis. Clinical anthropologists have sometimes been expected to act as cultural translators or public relations personnel in health-care settings rather than as analysts and critics of the social and political structures in which biomedicine is embedded. While going well beyond the biomedical model of understanding illness, and questioning notions of medical epistemology in relying upon empirical evidence in which symptoms are regarded as the objective expression of bodily disorders, medical anthropologists' project of exploring the cultural construction of illness has often been positioned as a tool of doctors for the better diagnosis of patients' ills and enhanced understanding of their experiences of illness. Non-western culture's medical beliefs have sometimes been viewed as 'superstitions' and anthropologists have sought to encourage compliance of these cultures with biomedical practices (Gordon, 1988a; Leslie, 2001).

As a result, medical anthropology scholarship and research sometimes portrayed the patient as a constellation of 'unknown' meanings, which it was up to the doctor to 'decode', using the elicitation of patients' narratives as the method of inquiry as opposed to the use of tests. Biology was considered essentially universal, while culture was considered as external to disease and biology (Gordon, 1988a: 28). While placing emphasis upon the sociocultural nature of illness, such an approach also tended to imply that 'folk illness' was an inferior version of 'real' biomedical illness as diagnosed and treated by doctors and described in medical textbooks and journals. An example is the comment of Stoeckle and Barsky (1981: 233, emphasis added) that '[f]olk and *primitive* beliefs persist today, even in the attributions offered by the modern "well-educated" patient, not only in those of the less educated, ethnic minorities'.

Since the 1960s, however, the political economy approach and social constructionism have begun to influence medical anthropology research and scholarship in the anglophone world. A perspective drawing upon both approaches, entitled 'critical' or 'interpretive' medical anthropology, began to challenge old ways of research and thinking (Baer et al., 1986; Leslie, 2001). Several areas of research interest for critical medical anthropologists have been identified that are also relevant to medical sociologists and historians. These include the following:

- the social production of medical knowledge;
- the functions of medicine and public health in social control;
- the importance of consciousness and agency in health-related behaviours and beliefs;
- the relation of health and medical language to power;
- the identification and labelling of disease;
- the contestable nature of medicine and disease as biomedical realities;
- and the meaning of the illness experience (Singer, 1990).

As this list demonstrates, recent critical approaches are interdisciplinary, incorporating political economy concerns with the structural economic features of society and how they impinge upon health status, with a social constructionist interest in epistemology and language use, as well as an interest in the experiential aspects of the

medical encounter. From this perspective, the human body is understood both as a product of biology and of social and cultural processes; simultaneously totally biological and totally cultural (Guarnaccia, 2001). These concerns are identical with sociological and historical approaches that adopt a social constructionist perspective. As such, in this book I draw extensively on research generated by medical anthropologists.

THE HISTORICAL DIMENSION

Until the mid-20th century, in the attempt to maintain some semblance of legitimacy for medicine and public health the history of medicine tended more towards the hagiography of medicine in viewing scientific medicine as enlightened, ever progressing and triumphant (Brandt, 1991; Wright and Treacher, 1982). However, as in the sociology and anthropology of medicine, recent social histories of the ways in which society has responded to disease and illness have taken a more critical constructionist approach. The history of medicine has therefore moved towards medical sociology and anthropology, and vice versa, for one of the most important features of social constructionism as adopted in medical sociology and anthropology is its recognition of the historical nature of medical knowledge.

History provides a perspective which is able to show, as does the cross-cultural perspective offered by anthropology, that the conventions of western biomedicine are no more 'scientific' or 'objective' than medical systems in other cultures or in other times. The historical perspective provides a chronological approach, a sense of continuity as well as change, and an ability to interweave different levels of interpretation in its analysis of medical and public-health issues and events (Berridge and Strong, 1991). It also allows an insight into social issues which, by highlighting their historicity, demonstrates that the taken-for-granted features of the present should be challenged: 'We use the past to shake confidence in the "obvious" appearance of medicine today; not in order to sanctify it as has so often happened in histories of medicine' (Wright and Treacher, 1982: 2).

Without the historical perspective, the beliefs and behaviours of people in response to health issues often appear inexplicable, irrational and self-defeating. Such accounts are valuable in providing an important perspective upon contemporary western society's responses to health threats and diseases. They are particularly useful for casting light upon the reasons why certain responses occur; why, for example, some diseases are stigmatized and provoke widespread fear and moralistic judgements; why certain kinds of imagery and rhetorical devices continue to enjoy resonance in the mass media's coverage of medical matters; why current health policies succeed or fail.

The historical writings of Foucault have been a major impetus to the reshaping of histories of medicine. Such classics as *Madness and Civilization* (1967), *The Birth of the Clinic* (1975) and the three volumes of *The History of Sexuality* (1979, 1986, 1988) have called into question the 'truths' of historical interpretations and shown

how networks of power produce medical knowledge and medical experiences. Thus, for example, in *Madness and Civilization* Foucault argued that the definitional and diagnostic processes developed in psychiatry as it emerged as a system of medical knowledge in the 17th and 18th centuries produced mental illnesses by labelling some behaviours as normal and others as abnormal, requiring treatment. Mental illness was therefore presented by Foucault as socially constructed, while he portrayed psychiatry as a system of knowledge exerting disciplinary power upon the bodies and minds of those who were defined as 'mad'. This was a perspective considered radical for its time, but it was taken up by members of the anti-psychiatry movement in the 1970s as part of their critique of contemporary ways of dealing with mental illness (Armstrong, 1997).

As noted above, Foucault's writings have proved highly influential and iconoclastic not only for historians but also for writers and researchers in sociology and anthropology. The Foucauldian perspective has inspired radically different ways of viewing the role played by medicine, in particular seeking to identify the discourses that shape ways of thinking about and acting upon the human body and the relations of power that are inextricably part of the medical experience. It is a perspective that is vital to the concerns of this book.

CULTURAL STUDIES AND MEDIA STUDIES

The fields of cultural studies and media studies are primarily concerned with documenting and explaining the processes of producing and circulating meaning through the channels of the artefacts and practices of mass culture. Scholars interested in such everyday contemporary western activities as people's use of the mass media and computerized information technologies, food preparation and consumption, table manners, dress, notions of style and taste have gone beyond the traditional sociological concern with organizations, the economy and public life to examine the rules, norms and symbolic meanings underlying social interaction in the domestic sphere and the reproduction of daily habits in everyday life (see, for example, the work of Bourdieu, 1984; Douglas, 1974, 1984; Fischler, 1986, 1988; Mennell, 1985; Murcott, 1983, 1993). Such studies bring together the concerns of the sociology of knowledge and the sociology of culture in ways which provide fascinating explanations of how such seemingly individual characteristics as a person's physical appearance, style, eating and exercise habits, taste, manners and bodily deportment are not merely personal idiosyncrasies but are highly influenced by sociocultural norms linked to social class, gender and ethnicity.

The theoretical base and empirical research produced by the fields of cultural studies and media studies offer important insights into the sociocultural aspects of medicine. Cultural studies is an interdisciplinary area that originally developed from the sociology of culture (Williams, 1976) and has incorporated literary theory, film studies, Marxist, linguistic and psychoanalytic theory to examine not only the products of elite cultural endeavours, such as the opera, fine art, theatre and

literature, but mass-produced commodities and the products of the popular mass media. Media studies is the term commonly used to describe a sub-field of cultural studies which is concerned exclusively with people's use of and interactions with the mass media. Revealing the meanings conveyed by cultural products and identifying the ways in which audiences take up and interpret these meanings is the unifying area of interest for all of the different approaches utilized in cultural studies (Fiske, 1992; Hartley, 2011; Turner, 1990).

Until recently, the cultural and media studies approach had rarely been adopted to analyse medicine or public-health institutions and practices. Yet, as writers in the fields of cultural and media studies have argued for decades, people construct their understandings of the world from their interaction with the mass media as well as from their personal experiences and discussions with others. This is important to recognize for anyone interested in the social and cultural meanings of medicine. The mass media portray aspects of medicine, health care, disease, illness and health risks in certain ways. Many people first learn about new medical technologies and therapies, or the latest research into the link between lifestyle factors and health status, via the mass media. Medical dramas and documentaries represent doctors, nurses, patients and diseases in defined archetypal ways that promote certain meanings for their viewers. Increasingly, too, the internet has become an important source of information about health and medicine for lay people, and avenues for people to recount their experiences of illness and medical care, including blogs, social media applications such as Facebook and Twitter and websites that provide medical information and advice.

These cultural products are all potential areas of research for those interested in how the meanings surrounding health, illness and medicine are constructed and reproduced, and how these meanings contribute to people's experiences. The study, therefore, of the ways in which medical practices and institutions are represented in the mass media and via computerized information technologies and the reception of such representations by audiences is integral to interpretive scholarship attempting to understand the sociocultural aspects of medicine and health-related knowledge and practices (Bunton and Crawshaw, 2006; Gwyn, 2002; Lupton, 1992, 1999a; Lupton and McLean, 1998).

Thus, for example, the news media were vital in conveying information and constructing certain meanings around a condition that was unheard of until the early 1980s – HIV/AIDS. It was via the news media that lay people first learned about this new condition, and it was via the news media that certain archetypes of those social groups deemed most 'at risk' from HIV infection were represented. At first HIV/AIDS was portrayed as affecting gay men only, and the sociocultural meanings portrayed in news accounts constructed the condition as a product of 'deviant' sexual practices, accompanied by the stigmatizing of people with HIV/AIDS and moral discourses blaming these people for their illness. By the late 1980s, news media in western countries began to report on the threat to heterosexuals of contracting HIV, and the condition began to be represented as associated with promiscuity for both heterosexuals and gay men, again with associated victim-blaming and moral censure. People infected with HIV via blood transfusions, in contrast, were portrayed

as 'innocent victims' who did not deserve their fate (Lupton, 1994a). Cultural and media analysts were central both in identifying the meanings emerging from the news media in their reportage of HIV/AIDS and in researching how audiences of these news reports responded to the news coverage they had viewed. There is a plethora of other material constantly emerging from the mass media and the internet that can serve as sources for similar kinds of cultural analyses.

STUDIES OF SCIENCE, TECHNOLOGIES, PLACE AND SPACE

The interdisciplinary field of science and technology studies is interested in the production of scientific knowledge as a social construction, and as such, some scholars within this field have devoted their attention to examining the production and reproduction of biomedical knowledge and practices. Science and technology studies is a multidisciplinary field, incorporating elements of sociology, anthropology, cultural studies, political studies and history. Medical geographers, too, have begun to turn their attention towards the technologies of biomedicine, interested in the social, political and economic contexts within which scientific knowledge and technologies are produced and utilized in western medicine, with a particular focus on spatial or physical aspects. From the perspectives of such researchers, what is considered 'human', 'healthy' and 'normal' is increasingly becoming defined through the biotechnologies that are produced and used as part of the system of western medicine.

One influential perspective within science and technology studies that has also been adopted in medical geography is actor network theory (ANT), an approach which has recently been adopted to examine scientific technologies within biomedicine by some researchers. ANT, as originally espoused by Bruno Latour (see, for example, Latour, 1987, 2005) examines how scientific methods, technologies, processes and knowledge are developed and given power as explanatory phenomena. These methods, technologies, processes and knowledge are viewed as not external to social and cultural processes, but rather as constituted in and through such processes. From the perspective of ACT, medical researchers, the developers of medical technologies and those who use medical knowledge and devices as part of their work, are viewed as competing to present their version of reality as the most valid. The 'allies' that they conscript to do so may include not only human actors but also non-human actors such as facts, equipment and other scientific objects and economic resources. Together, these allies form a network of knowledge production.

A particular feature of ANT, therefore, is its insistence on the agency of non-human actors in a network of knowledge production. While other social and cultural analyses of science may emphasize the meanings and actions of humans, ANT places the non-human firmly at the centre of any understanding of meaning making. A medical technology, for example, is viewed not as a passive object invested in social meaning by human actors, but as an actor in its own right, which itself

shapes social relations. Both human and non-human actors are referred to in the ANT literature as 'actants', to denote their equivalent status as agents of meaning. This use of the term 'agency' when describing non-human actants, however, does not presuppose that such actants have intentionality. It is rather to emphasize that material objects, or ideas, are important components of the way in which scientific knowledge and practices – including those of western medicine – come into being and operate.

In the case of medicine, these non-human actants that form part of a network of knowledge may include medical and laboratory equipment, pharmaceutical therapies, mechanical aids such as walking frames, artificial limbs, heart pacemakers or wheelchairs, and the ideas that underpin these actors. ANT researchers are interested in how these actors operate with human actors such as health-care professionals and their patients, or medical researchers, to form a network in a constantly shifting pattern of social and material relations (Hadders, 2009; Mol, 2002; Timmermans and Berg, 2003). Thus, for example, there may said to be a network constituting the medical care for a condition such as high blood pressure, which includes medical professionals, the scientists and pharmaceutical companies developing drugs for the condition, the patients diagnosed with the condition, the drugs they take, the lifestyle modifications they are urged to make, the technologies used to monitor patients' health such as the instruments used to measure blood pressure, other technologies used to produce the drugs, the advertising companies that produce the ads to market the drugs to doctors, and so on. ANT is interested in how these actants interact with each other to 'translate' a technology into everyday use.

Extending the example of high blood pressure, new drugs are developed based on the research of scientists and the instigation of drug companies, which are then promoted in certain ways to particular doctors. Doctors may or may not choose to adopt these drugs; their patients may take them, reject them or forget to take them. There is nothing particularly predictable or stable about how this new technology, a high blood pressure medication, is translated into the lives of the patients for which it was developed. But the technology itself is an active agent in the network of knowledge and practice that surrounds the treatment of high blood pressure, whether or not it is adopted as a therapy by individual patients.

Sociologists of health and illness were initially slow to recognize the relevance of ANT to their field, despite the increasing importance of scientific technologies as a component of medical care. One of the earliest uses of ANT to examine a medical technology was an analysis of metered dose asthma inhalers to treat child asthma (Prout, 1996). This study showed how these medical devices shaped the ways in which doctors interacted with their patients and the behaviour of the patients themselves. The inhalers only allow a certain dose of the drug within to be inhaled at a time, thus restricting how much of the therapeutic agent (a gas used to dilate the bronchial tubes in the lungs to ease breathing) the patient may take in. Thus, although patients had the autonomy to self-administer the drug, which they could keep at home, the device had a built-in mechanism to control their intake. Patients had to be instructed in how to use the devices, to achieve competency in self-administering doses of the drug away from medical supervision. A large proportion had difficulty using the

devices according to the technical instructions they were given, or chose to attempt to use the device differently. Such technologies, therefore, may be seen to act to shape people's behaviour by their design, but importantly, are themselves shaped by human intervention, both in the way they are designed by their manufacturers but also via the manifold ways they are used.

The spaces that medical workers and patients inhabit and move through are also part of the technological environment. Medical geographers have often used the concept of space in their work, while thus far it has been taken up only in a small way in the sociology of health and illness body of research. Space is seen from this perspective as comprised not only of physical features but also auditory and sensory phenomena. Some writers use the concept of 'territories', derived partly from the work of Deleuze and Guattari (referred to earlier in this chapter) to describe features of space and the interactions between human and non-human actants that take place within, through and between spaces. This notion of territoriality views space as a dynamic and fluid concept, which is continually made and re-made through the actions of and relations between human and non-human actants (Greenhough, 2010; Tucker, 2010).

Bodies are territorialized through these relations, or shaped and structured in certain ways that influence how they look, behave and feel, both consciously and subconsciously (Fox and Ward, 2008). Thus, for example, the body and emotions of the patient entering the space of the medical clinic are territorialized by features of that clinic: the technologies used to examine the body, the doctor's touch, demeanour and words, the drugs that may be prescribed. But so too is the space of the clinic and its other inhabitants shaped by the patient's presence within it. Once that individual leaves the clinic, the space becomes reshaped by other interactions of human and non-human actants as part of a continual state of change.

It may be argued from this perspective that some spaces and places may be described as 'therapeutic', or having a healing function for at least some of the people using them, while others have the opposite effect. Those interested in 'therapeutic landscapes' investigate hospitals, clinics and other institutional health-care settings, exploring their physical, social and symbolic systems of organization (Andrews and Evans, 2008; Greenhough, 2010; Smyth, 2005). Particular spaces and places may be regarded as therapeutic in their own right, quite apart from the kind of medical care that is offered therein. Such aspects as the architecture of a space, or the natural surrounds, the amount of light available, the artworks therein, for example, may all contribute to personalizing the space and providing a sense of well-being that ill people may experience when in the space. So too, particular spaces or objects may be more or less conducive to use by people who are disabled or weakened by illness, or may be more available for use by people from some socioeconomic backgrounds compared with others. On a broader scale, spatial dimensions become important when examining the ways in which, for example, pharmaceuticals and medical care are distributed globally, with less wealthy nations often receiving far less access to these than economically advantaged nations, or how national borders may be defended against infectious diseases (Greenhough, 2010; Kearns and Moon, 2002).

As research generated by writers from science and technology studies and medical geography demonstrates, an important aspect of medicine as a social and cultural product is the ways in which scientific technologies are developed, taken up and translated into everyday employment by the people involved with their use. Technologies have an increasingly major role to play in health-care delivery, and as such, they are often integral to the experiences of those practising scientific medicine and those receiving care. Spatial dimensions are also important to consider when investigating people's experiences of illness and health care.

CONCLUSION

I have argued in this chapter that there is much to be gained from an eclectic perspective that approaches the same research problem from different theoretical and methodological angles, while at the same time maintaining an awareness of the disciplinary traditions and rationale of the different approaches. I have shown that analysing medical phenomena can now be approached from a number of disciplines and perspectives at different levels of inquiry. While there are important differences in the manner in which different disciplines, sub-disciplines and interdisciplinary fields approach the analysis of medicine as culture, what is common amongst all the perspectives discussed above is the acceptance that in modern western societies the institution of medicine has an important part to play in giving meaning to everyday lives, shaping the regulation of human action, the experiences of embodiment and the construction of subjectivity. As such, medicine is eminently worthy of attention as a topic of research and enquiry on the part of scholars in the humanities and interpretive social sciences.

Discussion Questions

1 Outline the main ways in which the three major perspectives in sociology used to analyse medicine, illness and disease – functionalism, political economy and social constructionism – differ from each other. Are there any similarities in the three perspectives that you can identify?
2 Choose a medical condition or disease – examples may be a type of disability, obesity, diabetes, a type of cancer, heart disease or any other that you can think of – and list the major discourses which are used to give meaning to this condition or disease. Have these discourses changed over time?
3 What kinds of medical technologies are used to deal with this condition or disease and how do these technologies shape people's experiences of it?
4 How do aspects of space and place affect people's experiences of this condition or disease?