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Sociology of Medicine for Whom?: Feminist Perspectives in a Multi-Paradigmatic Sociology of Medicine

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Reflexive Statement

My mother was a nurse, always called on when the neighbor's child fell out of a high chair, woke up with spots or red eyes or had a fever. But, like others with whom I've talked whose parents offer health care services, I learned to feel that sickness was a weakness. I grew to feel ashamed of being sick; to have to rationalize and justify my own indisposition or to ignore or hide it. Through this, I learned that sickness and health were not biological events only but were constructed out of a web of social relations and meanings. And I developed an interesxt in the social-psychological aspects of health and illness. Later, I was swept away with feminist awareness and concerns and asked myself in what ways women and men and health and illness intersected. From these experiences and my academic education came thoughts such as those explored in this paper.

Feminist Perspectives in a Multi-Paradigmatic Sociology of Medicine

This paper is intended to discuss the intersection of two sets of interests. On the other hand it is argued that sociology must acknowledge its' divergent roots. The traditions of the classic theorists Marx, Durkheim and Weber have spearheaded widely different schools in sociology (Ritzer, 1975; Boughey, 1978; Sherman, 1974; and Mullins, 1973). These schools are believed, by their firmest adherents, to be both theoretically and methodologically distinct from one another and incompatible. This tenet has considerable political influence. Publication, research monies, appointments, conference themes, and policy suggestions are firmly constrained by theory affiliation. The correct epistemological assumptions about the science of the social world lead one to belong to one group or another. One purpose of this paper is to clarify the multi-paradigmatic nature of sociology of medicine and to discuss some of the strengths and weaknesses of each paradigm.

The other interest that this paper is addressed to is women and the social sciences. A multi-paradigmatic sociology must include considerations of theoretical and methodological issues which have been raised by feminist sociologists, for example, (Millman & Kanter, 1975; Ehrenreich and English, 1978; and Roberts, 1981). Millman and Kanter (1975), have argued that a feminist consciousness would alter the course of conventional sociology. They distinguish six crucial changes: new non-sexist subject areas and models would be revealed; the focus on the public, official and visible, would be minimized in favour of the informal, invisible and private; the distinct social worlds of men and women would be recognized; sex itself would be taken into account as a factor in social behaviour; radical transformation and change rather than the maintenance of the social order would be emphasized; and new methodologies would emerge. Ehrenreich and English's work has reoriented analysis in the sociology of medicine to the consideration of the ways in which (both) health and medical definitions and institutions are constructs of sexist medical and sociological practice (see Clarke, 1983 for an examination of this phenomenon in a decade review of the literature on gender and illness). Roberts (1981) has directed our attention to feminist and non-sexist methodologies which advocate the necessity of taking both men and women into explicit account as subjects of study and as researchers:

> "Feminist research, then, is concerned not only with making women visible, but with theoretical and methodological issues, with problems of sexual divisions in the research team and the research process, and with the language of research findings and the ways in which these may be used when they are published" (1981:26).

Feminist scholars have looked beyond the order of sexism though, and examined similar bias with respect to the tendency to assume homogeneity amongst subjects and researchers with respect to racial or ethnic background, social class and sexual preference (personal communication with Deegan and Moore, 1984.

Women are the major producers and the major consumers of health care (Dougal, 1979). Their position in the health care system, however, mirrors their position in society. When women are the subjects of investigation, it is most often as patients rather than as doctors or nurses (Lorber, 1975). They are powerless, the deprived. The classification of women as sick is the result of a double jeopardy. They are diagnosed by white middle class and upper class physicians and classified by white middle class male sociologists (Blishen, 1969, 1976; Scully, 1980; Clarke, 1983). Women's work in the health care system is relatively ignored and they play comparatively powerless and economically deprived roles as nurses, nurse's aids and nurse's assistants (Navarro, 1975). A title given by Lorber to some work in this area is instructive, "Women and Medical Sociology: Invisible Professionals and Ubiquitous Patients".

Paradigmatic Analysis

The next part of the paper will describe each paradigm, an exemplary work in each paradigm and will offer a feminist critique.

Positivism

The fundamental assumption of the positivist position is that the purpose of sociology is to understand, using the techniques and methods of the physical sciences, how order in a society is maintained. Thus, the roles of men and women in the structured institution of medical care become worthy subjects of investigation. Knowledge is power because knowledge, in providing an understanding of the present, permits prediction to the future. Social order is to be explained and the future predicted by means of a series of if x then y statements. Two variable statistically verified and predictive relationships form the building blocks of this positivist edifice. All levels of analysis are encompassed. Theories of the middle range, micro and macro theories are appropriate. Talcott Parsons' (1951) work is the germinal work in the positivist paradigm. Theoretically, this work is labelled strucural functionalist. Often it is of such a high order of generality and abstraction as to be impossible to empirically investigate. For example, in the discussion of both the patients and the professions, Parsons ignores the relevance of sex, gender, class, race or sexual preference. Sickness is a role, played alike by persons of both genders, all classes, ethnic groups, all races, ages and all sexual preferences such that when people become ill, they adopt a specific sick role which has four features: (1) sick persons are not held responsible for their incapacity; (2) they are exempted from their usual role and task obligations; (3) they must want to leave the role and get well; and (4) they are obliged to seek and comply with technically competent medical advice (1951).

All of these conditions are assumed relevant to all. But, empirical literature (again, in a positivist tradition has shown that men and women, for instance) are likely to differ in some crucial ways, ways that are relevant to the sick role analysis. In the first place, women (particularly those of certain classes, ethnic and racial

background (Ehrenreich and English, 1978)) are widely believed by doctors to be more responsible for their own illnesses than men. They are believed to be victimized by their emotions and to be more likely to suffer psychosomatic illnesses. Their reproductive organs are felt to be the seat of unpredictable and irresponsible behaviour (Lorber, 1975; Ehrenreich & English, 1973; Chesler, 1973). Second, sick days, with or without pay, are not as easily available to women who work in jobs with hourly or low wages as large numbers of women do at present (McDonald, 1975; and Himelfarb and Richardson, 1982). Because of the relatively isolated nuclear family, it is difficult for a sick woman to receive exemption from everyday role and task obligations. There is often no one willing or able to take over. A woman in Koo's study of the health of Regionville described her situation as follows:

> I wish I really knew what you meant about being sick. Sometimes I felt so bad I could curl up and die, but had to go on because the kids had to be taken care of and besides, we didn't have the money to spend for the doctor. How could I be sick? How do you know when you are sick, anyway? Some people can go to bed most anytime with anything, but most of us can't be sick even when we need to be (1954:1).

The third and fourth aspects of the sick role require that patients seek technically competent help and want to get well. The problem with this is that women (who are more often patients) are required to pay to go to male middle-class doctors in order that their symptoms receive legitimations (Lorber, 1975) as sickness. Thus, they are expected to accept the male definition of their experience and believe that it can be categorized rightly as "depression" or "menopause", for instance. There is another difficulty, too. Women are expected to suffer from psychogenic illness but yet they are required, says Parsons (1951) to want to get better. This is a double bind because psychogenic diseases are said to result from desire to be ill.

It is, thus, clear that Parsons' theory ignores some differences between men and women. Extrapolating from this, it can be seen that the theory ignores all manner of crucial demographic differences such as class, race, ethnicity, sex preference and age which to various extents serve to repudiate the value of such a construct.

Activism

The essence of the activist paradigm is the radical approach to social change. Change is ubiquitous: it is an historical, present and future reality. All of the history of societies can be seen as the history of exploitation. Its temporary resolution through the adoption of a new economic system is followed by another, different exploitive system. Injustice with an ethnic, racial, economic, sexual base has been the inevitable and true historical fact.

Classic radical statements of women and illness are made by Barbara Ehrenreich and Deidre English (1973a, 1973b, 1978). They argue that the medical system is strategic to women's oppression.

"Medicine's prime contribution to sexist ideology has been to describe women as sick, and as potentially sickening to men" (1973:5). The bio-medical model of the contemporary health-care system reinforces fundamental inequality and injustice in society. They state that women of different economic positions and racial and ethnic background were not equally and similarly oppressed by the medical care system. The historical distinctions in the causes and kinds of illness which befell women of each of the working class and middle class were each described. Class determined the medical categorization, diagnosis, prognosis and treatment. Upper class women lived lives of ease and leisure. Working class women lived lives full of heavy, dirty and hard work. Upper class women were viewed as naturally, inherently ill. Believed too delicate for work, emotionally labile, physically fragile, upper class women were the major consumers of the services provided by the physicians of the nineteenth century. This idle, sickly woman was, it is argued, ultimately a product of the economic system. She was an ornament designed to decorate and announce her husband's successful affluence by her leisured indolence. It was considered absolutely appropriate that a woman of this class would break down under such stress as a quarrel with a servant, or a falling out with a girlfriend. Indeed, all female functions and organs were believed to be inherently sick but the root cause of all sickness was an inadequacy in the reproductive system. The theoretical explanation for the frailty of women was the principle of the "conservation of energy" which asserted that each human body had a given quantity of energy to be used. Since a woman's purpose was procreation, the reproductive organs were cherished and rested for their proper function. The obvious conclusion was that higher education or outside careers were not advisable for the middle and upper classes.

Lower class women were thought distinctly different both biologically and socially. Working class women were strong and immune to disease. They had to work. Employers did not give time off for pregnancy or recovery from childbirth or menstruation. The wives of these same employers often retired to bed on all these occasions (1973:47). Working conditions were atrocious; they were filthy, ill-kempt, kept in dangerous repair, devoid of sanitation, with the minimum of light and fresh air and infested with vermin. They worked ten or more hours a day only to return home to housework, childcare and "wifeing" in crowded tenements. Likened to oxes or other sturdy animals they were considered the unhealthy carriers of dangerous and contagious diseases.

These works further a feminist analysis because they illustrate the manner in which the very conceptions of women of different social classes and racial and ethnic backgrounds embody sexist medicalizing. And, in doing so, they infer that change is not only a possible but a necessary fact of social life. What this paradigm tends to neglect is the analysis of a situation from the perspective of the subject of study.

Naturalism

The commitment of the naturalist sociologist is to portray the meaning of the social world from the perspective of the subjects of study. The three premises of symbolic interaction are that: "Human beings act toward things on the basis of the meaning that things have for them; meanings are derived from, or arise out of social interactions that one has with one's fellows; these meanings are handled in and modified through an interpretive process used by the person in dealing with the things he encounters (Blumer, 1969:2).

"Some Social Meanings of Tranquillizer Use" by Ruth Cooperstock and Henry L. Lennard (1979), illustrates this approach. Positivist sociologists know that minor tranquillizers, especially the benzodiazepines, have become accepted as the appropriate remedy for a variety of types of problems of living, both by physicians and by the population at large (Dunnell and Cartwright, 1972). A number of studies have shown that the prescribing of psychotropic drugs is not random - but that women, older women in particular, are more than likely the recipients (Cooperstock and Lennard, 1979).

What the naturalist is concerned with, however, is the context in which the tranquillizer use comes to be both meaningful to users and prescribers. Data for this study were gathered through 14 group interviews with 68 participants and 24 lengthy letters from individuals who could not participate. Major themes emerged and were repeated in the group discussions. Tranquillizers were used by women to enable them to handle difficult marriage; to continue in the nurturing role which they believed they ought to perform; or to handle anger and resentment directed at a spouse which they felt powerless to express more directly. Since the advantage of this perspective is that the data are themselves presented, let us let them speak for themselves.

> I take it to protect the family from my irritability because the kids are kids. I don't think it's fair for me to start yelling at them because their normal activity is bothering me (336).

Role conflict was sometimes the explanation for the use of tranquillizers.

> "I would like to be off in Australia somewhere, writing, you know, do only my work. But having to stop the writing to get supper on, it irritates me. And there are so many irritations during the day but I cannot change the situation because of my family" (337).

Many women reported beginning to use mood-altering drugs when their children were born. Almost consistently, when women returned to work their tranquillizer use diminished or terminated.

> And then I realized that I'd better get some of this pressure off at some point. I was afraid I was going to kill my kids...(338).

> It turned out we couldn't have children so we adopted ... And with the adoption of the first child, I was dilirously happy ... And then I adopted a second child very quickly after the first, and she was a holy terror. She screamed from the moment we brought her into the house and she never stopped screaming (339).

Sudden personal loss and the strains of adapting to a new role initiated tranquillizer use for many. Unresolved conflicts served to necessitate the continuation. Males in the sample tended to speak of their tranquillizer use with respect to the strains and stresses of their occupational roles. A minister found his symptoms arose when he changed jobs.

> I changed jobs about five years ago from a preaching ... job to a human relations job. It's competitive stuff. And about six months later, I started having some ... psychosomatic induced dizziness, a sense of you're about to pass out (340).

As the authors point out, this approach to the study of tranquillizers makes it patently obvious that the biomedical explanation of use is in itself inadequate. Through a refocus in methodology away from the quantitative, naturalist sociology is pertinent to a new model of sociology in which women are not made the object of a study but the subjects in the sociological art of knowing (Smith, 1976). What this paradigm tends to ignore is the social structural aspects of meaningful social life.

Discussion and Conclusion

The purpose of this paper has been to describe and illustrate the fundamentals of a multi-paradigm approach to sociology, and with reference to medical sociology. That the three paradigms are distinct in their fundamental views of the nature of social reality and in their decision as to the proper methods and theories, has been explained. There is a long tradition in the sociological literature dating back to Durkheim, Marx and Weber for these three major paradigms; positivism, activism and naturalism. Each is appropriate for somewhat different questions, methods and levels of reality. Together they comprise a more complete, complex and thorough explanation of the social world.

A more specific intention of this particular paper has been to describe the image of and the methods and theories for studying women in the context of health care in each of the three paradigms. To this end, a prototypical manuscript from each of the three paradigms was described and critiqued. Some advantages and disadvantages of each were pointed out.

Each model has strengths and weaknesses. Through positivism, a systems level of discussion with a clarification of causal processes is possible. Evidently positivism, as described, suffers however from an inadequate attention to sex, sex preference, class, ethnicity and race as either explanatory or dependent variables. Activism provides a critical and radical examination of the social action of individuals, groups and societies. It assumes injustice and exploitation. It neglects to explore the personal meanings of injustice, however, and attempts to designate those men and women who do not recognize their exploitation or exploitedness as suffering from false consciousness. The naturalist perspective provides, in rich and intimate language, the details of the experience of women. It tends to neglect, however, the provision of an adequate conceptual or methodological recognition of the existence of a level of social reality before and above the individual social actor.

To thoroughly incorporate the principles of feminist analysis (described by Millman and Kantner, 1975; Roberts, 1981; Smith, 1976), all three paradigms are necessary. They interweave to form a variegated mesh which is more complete because it is more multi-faceted. Medical sociology has been dominated by a positivist approach. This has meant that the emphasis has been placed on the existing society and has taken for granted the structures and values of the existing society. It has also meant that outside attempts at an objective analysis has been stressed at the expense of the subjective meaning to the social actors; that private worlds have been neglected in favour of public worlds; that the potential for a radically altered future has been dismissed in the face of the overwhelming reality of the present; that formal arrangement and structures have been described with the loss of the informal; that male language, models and methods have been utilized to the detriment of women and that sex, race, ethnicity, class and sex preference have not often been taken into account as factors in behaviour, even though they may be among the most important explanatory variables.

A second drawback of a reliance on positivism is methodological myopism. Numerous studies have documented the need for a multi-methods approach in sociology. As Denzin says, "No single method is uniformly superior; each has its own special strengths and weaknesses. It is time for sociologists to recognize this fact and to move on to a position that permits them to approach their problems with all relevant and appropriate methods, to move on to the strategy of methodological triangulation (1978:339)." Methodological triangulation can take many forms. A combination of multiple data collection methods, multiple data types, analytic styles, observers and theories in the same investigation is advocated. Thus, social reality is approached from numerous vantage points in respect to both theory and method.

A sociology of medicine that begins by (1) noting, describing, analysing and questioning the existing structures which perpetuate this sexism; and (2) acknowledging the importance of women's experience will go a long way in correcting it. These two conditions may be met by a dynamic, dialectic use of multi-methods and multi-theories

addressed to an exploration and explanation of the same problem. A conscientious effort at triangulation could be sueful in several ways. Observing, describing, analysing and challenging the taken-for-granted structure may lead to the imporvement of existing conditions for women both in the world and in the substantive discipline of sociology of medicine.

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