1. Introduction to Medical Sociology

Dr Fiona McGowan  (f.mcgowan@imperial.ac.uk)

1. Explain the difference between illness, sickness and disease
2. Explore definitions of health
3. Outline different theoretical perspectives
4. Summarise the changing medical and social context

Lecture Notes

- **Disease:** the medical conception of a pathological abnormality diagnosed by means of signs and symptoms
- **Illness:** the subjective interpretation of problems that are perceived as health-related, i.e. the experience of symptoms
- **Sickness:** the social organisation and performance of illness/disease, i.e. the “sick-role”
  - People feel ill (illness) → seek medical advice from doctor → diagnosis (disease) → treatment → legitimises illness and role of patient (sickness/“sick-role”)
  - One can be ill/suffer from disease without adopting the sick role
  - Illness/disease involves suffering, but does not require complaint
  - Disease may exist without subjectively experienced symptoms, e.g. cancer in remission

Health Definitions

- State of harmony with nature and the environment
- Absence of disease (medical definition)
- Complete state of well-being
- Functional adequacy

Humoral Theory

- Galen; Four natural elements relating to four humors of the body
  - Water (Phlegm)
  - Air (Blood)
  - Fire (Yellow bile)
  - Earth (Black bile)
- A unity of the 4 elements links the person (microcosm) to the world (macrocosm) i.e balance of the individual and their environment.
- Balance of the 4 humors = health
- Imbalance of the 4 humors = ill-health

World Health Organisation (WHO)

“Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”

This is criticised as simplistic, and not functional for everyday life
General Household Survey

*Sees health as multi-faceted, and measures it through...*

- Self report of health and long-standing illness/disability
- Curtailing of normal activities by illness/activity
- Contact with GP or as hospital out-patient
- Number of days treated in hospital
- Use of glasses/contact lens; own teeth; when had eye test; when had dental check.

*For >65 years old, health is seen as functional and is measured in terms of...*

- **general capability** (sight, hearing, managing stairs, getting around the house, managing own affairs)
- **personal care** (getting in and out of bed, dressing & undressing, cutting own toenails, washing hands and face, getting to toilet)
- **independence within the home** (preparing hot meal/snacks, making cup of tea, washing up, vacuuming, cleaning inside windows, screwing up tops, standing on a chair)
- **mobility outside the home** (walking down the road, using public transport, doing household shopping)

Lay perspectives of health include functional ideas i.e. whether a person is able to live a normal life and fulfil key roles. Health 'taken for granted' until illness occurs.

**NOTE:** it is very difficult to define health; it is more the impairment/absence of health which is discussed

**Key Theoretical Perspectives**

- **functionalism**
  - social consensus + stable social systems- with specific roles for each person
  - sickness as deviance from this stability
  - responsibilities of doctor and patient
- **conflict (Marxist) perspectives**
  - social divisions and conflict
  - power of the medical profession
  - inequalities in health as product of capitalism.
- **interactionist perspectives**
  - medicine is processes of negotiation and adjustment to reach a consensus and restore harmony.
- **interpretivist understandings**
  - how patients experience and understand health and illness
  - biographical and cultural contexts
  - medicine as processes of interpretation and experiences of the social aspects of illness.
- **Feminism**
  - gendered nature of healthcare systems
  - gendered patterns and experiences of illness
  - role of women as carers and guardians of the health of others.
- **post-structuralism/post modernism**
  - rejection of grand theory
  - interest in discourses; crisis of legitimation; fragmented world; fragmented identity;
  - medicine as surveillance
  - consumerism
  - new understandings of the body
  - reflexive response to risk.
Changing Context

- Changes in the patterns of illness – esp. relative growth in the chronic illness.
- Technological developments - e.g. bio-technology.
- Growing emphasis on health as distinct from the treatment of disease.
- Changes in the economic & social structures of society – e.g. production → consumption.
- Rising costs of health care – repeated restructuring of NHS; emphasis on effectiveness.
- Disillusionment with western medicine?
- Emergence of the ‘expert patient’?

Current Interests

- Social patterning of (health &) illness.
- Lay health beliefs & sources of knowledge.
- Changes in the doctor-patient relationship.
- Meanings of illness – strategies of adjustment.
- Impact of new technologies.
- Lay interpretations of & responses to risk.
- Sociological understandings of the body.
- Ethical debates – accountability; responsibility; quality of life.

2. Social Stratification/Health Inequalities

Dr Fiona McGowan (f.mcgowan@imperial.ac.uk)

1. Explain the concept of social stratification
2. Summarise different types of power and advantage associated with social position and how this is measured
3. Describe how socially structured inequality is evident, e.g. living and working conditions
4. Explain how these inequalities are reflected in health status
5. Describe the psychological and social consequences of poverty; and the medical conditions which may be associated with it

Lecture Notes

What is meant by social stratification?

The hierarchical ordering of a society’s members, whether by caste, class or estate. Social status refers to honour or social standing within the community. A social class is a stratum whose members objectively share certain characteristics which may be income, life-style or ownership of productive wealth.

- concept refers to different layers or social groups which are arranged – on top of one another – in human societies.
- Layer upon layer of social groupings and the study of social stratification is how these groups relate to one another.
- SOCIAL STRUCTURE: The broad arrangement of elements or units (eg. stratification; kinship) within a particular type of society.
- Groups usually found to relate unequally
Groups – often based on class, but also possible to identify stratification based on age, gender, religion, caste, ethnicity.

Consider how these change/are maintained over time, and their impact on life, health etc

### Karl Marx

- All societies ‘class’ based
- Class relationships embedded in production relationships, patterns of ownership and control
- Capitalism – bourgeoisie / proletariat
- One class grows wealthier whilst exploiting the labour of class which owns nothing
- Unequal, division of power and exploitation

### Criticisms

- Not all societies are class based
- Not the most basic social division, e.g. feminism
- Insensitivity to systems of stratification other than those based on class
- Failure to take gender / ethnicity into account
- Lack of explanation for growth of middle class
- No consideration of class consciousness

### Max Weber

- Alternatively viewed a class group as a label for a grouping of individuals who shared certain common economic characteristics
- Concerned with the exercise of power and organisation of domination
  - Three main dimensions:
    - social class
    - social status
    - authority/ political power
- Usually related but can vary independently, e.g. unskilled workers usually have little political status

### Differences

<table>
<thead>
<tr>
<th>Marx</th>
<th>Weber</th>
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<tbody>
<tr>
<td>• unilateral approach</td>
<td>• multi dimensional</td>
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<tr>
<td>• Classes born out of production of goods – at the same time worker is exploited commercially and alienated from himself</td>
<td>• Allows for analysis of both class and non class bases of inequality.</td>
</tr>
<tr>
<td>“The worker mortifies his flesh and ruins his mind.” (Karl Marx)</td>
<td>• Allows for other (non economic) factors that influence power and domination – gender, ethnicity</td>
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### Class

The demise of class?

- Is class compatible with recent social and economic changes?
- decline in manual work
- shift to a service economy
- higher employment of women
- individual citizen viewed as consumer rather than producer

*for research purposes, we look at a more precise definition of class*
REGISTRAR- GENERALS SOCIAL CLASSES (RGSC’s)

<table>
<thead>
<tr>
<th>Class Number</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>I</td>
<td>Professional</td>
</tr>
<tr>
<td>II</td>
<td>Managerial</td>
</tr>
<tr>
<td>III (non manual)</td>
<td>Skilled non manual</td>
</tr>
<tr>
<td>III (manual)</td>
<td>Skilled manual</td>
</tr>
<tr>
<td>IV</td>
<td>Semi-skilled manual</td>
</tr>
<tr>
<td>V</td>
<td>Unskilled manual</td>
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Now we use the National Statistics Socio-economic Classification Analytic Classes

- 1. Higher managerial and professional occupations
  - 1.1 Large employers and higher managerial occupations
  - 1.2 Higher professional occupations
- 2. Lower managerial and professional occupations
- 3. Intermediate occupations
- 4. Small employers and own account workers
- 5. Lower supervisory and technical occupations
- 6. Semi-routine occupations
- 7. Routine occupations
- 8. Never worked and long-term unemployed

Social stratifications can be used to predict patterns of mortality, obesity etc, e.g. mortality gap has widened since the 1930s. In fact, there is a widening social class gap in health.

Health Inequalities in Britain

- Socio economic gradients exist for commonest causes of long-standing illness and disability – highest rates among routine workers
- Class gradients
  - rates of obesity
  - neurotic disorders
  - neonatal, infant mortality, low birth weight,
- Differentials in life chances persist into adulthood

Dimensions of Inequality

- Richest 1% own 21% country’s total personal wealth. Richest 10% over half
- Poorest 50% own approx 7%
- The wealth that is owned by the majority of the population is used to guarantee the necessities of life, whereas the wealth of the rich also brings with it social power.
- Benefits – disproportionately go to those who earn more
Poverty

Relative poverty – refers to a standard of living below that which is considered normal or acceptable.

“\textit{The resources are so seriously below those commanded by the average individual or family that they are in effect, excluded from ordinary living patterns, customs and activities}”

Three main groups:
- Those employed on low wages/ casual/ routine work
- Disabled, long term sick, elderly retired
- Unemployed, single parent families

Living Conditions
Homes of low income families likely to be:
- lacking basic hygiene amenities
- in poor repair
- No central heating
- Less basic goods ‘consumer durables’
- lacking gardens
- overcrowded

Working Conditions
- Routine workers hourly rate
- Work a greater number of hours
- Work shifts – overtime, shift payment, production bonus
- Income varies from week to week
- Greater risk of redundancy

Medical Consequences

<table>
<thead>
<tr>
<th>Childhood</th>
<th>Adulthood</th>
<th>Old age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor maternal nutrition</td>
<td>- Health hazards from maximising income</td>
<td>- Reflect immediate problems and accumulation</td>
</tr>
<tr>
<td>Low birth weight / premature birth</td>
<td>- hazardous jobs ‘danger money’</td>
<td>- of past effects</td>
</tr>
<tr>
<td>Poor nutrition during childhood</td>
<td>- Overtime / taking second job</td>
<td>- Malnutrition</td>
</tr>
<tr>
<td>Inhibits normal growth and development</td>
<td>- Poor health &amp; safety conditions</td>
<td>- Hypothermia</td>
</tr>
<tr>
<td>Lack of hygienic facilities</td>
<td>- Physical exhaustion</td>
<td>- Increased vulnerability to chronic/ acute illness</td>
</tr>
<tr>
<td>Damp housing – respiratory problems</td>
<td>- Risk of accidents</td>
<td>- Social isolation – mental illness</td>
</tr>
<tr>
<td>Poor educational record</td>
<td>- Disrupted family life</td>
<td>- Risk of accidents</td>
</tr>
<tr>
<td>Lack of play facilities</td>
<td>- Vulnerability to depression</td>
<td>- Institutionalised care</td>
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<tr>
<td>hinders psychological development</td>
<td>- Psychological effects – low self esteem</td>
<td></td>
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<tr>
<td>Risk of accidents</td>
<td>- Feelings of failure and shame</td>
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“\textit{...The longer people live in stressful economic and social circumstances, the greater the physiological wear and tear they suffer, and the less likely they are to enjoy a healthy old age}” Wilkinson and Marmot, 2003
3. The social determinants of disease

Dr Samantha Murphy (s.l.murphy@open.ac.uk)

1. List and be able to illustrate the three pathways by which social factors can affect health.
2. Explain the conceptual and methodological problems involved in investigating the psycho-social pathway.
3. Describe studies which illustrate the range of solutions to these conceptual and methodological problems.

Pathway one: Physico-chemical

“Direct physico-chemical effect on the body of environment hazards such as air pollution, residential cold and damp, occupational fumes and dusts, physically arduous work and inadequate nutrition”

Hazards impact our health, and make us ill. Environmental hazards include:

- **Air pollution**—tends to be in particular areas, therefore affects particular social groups. Research shows these groups tend to be of a lower socio-economic status
- **Poor living conditions**—damp, cold (link with health, e.g. childhood asthma). Social housing is often poorly constructed (~300,000 households). Social housing is also sometimes associated with mental health problems
- **Occupational hazards**—e.g. “black-lung”- workers in industry exposed to harmful chemicals, e.g. coal miners and their families
- **Hard physical labour**—may affect treatment, i.e. patients working in hard physical labour will unlikely to be able to rest
- **Poor nutrition**

Pathway two: Behavioural

“Social circumstances conditioning behaviours which effect health, such as self-medication with ‘drugs of solace’ (tobacco; alcohol), dietary preferences (salt, saturated fats), habits of physical exercise (motor car; elevator) and use of medical services (immunisation; contraception)”

Behaviours are learnt through socialisation.

- Primary socialisation= family
- Secondary socialisation= school, workplace etc

Behaviours are also learnt from media, books, TV etc. Behaviours include:

- **‘Drugs of solace’**—smoking is twice as common in manual/routine households as in professional household, peer/family pressures. Drinking- higher socioeconomic groups tend to drink more prevalently, men are more likely to go over recommended units (thoughts about masculinity)
- **Dietary preference**—women with higher income tend to have lower BMI, HABITUS: the particular disposition we learn from, related to our class
- **Physical exercise**—is it safe to go jogging in the local area? How expensive is it to join a gym?
- **Use of medical services**—women are more likely to see their GP than men; concept of masculinity? Lower socioeconomic groups- less likely to see your GP within first 12 weeks of pregnancy which increases risk of having a stillborn

Pathway three: neuro-endocrine

“Stress (physiological response to environmental stressors) mediated via the autonomic nervous system and the hypopheseal-pituitary-adrenal axis; social stressors eg. self-restraint, threat”
• Biological pathways connect low social status to specific diseases through the autonomic nervous system, i.e. we experience stress and have a physiological response
• ANS controls heart rate, contraction, constriction of blood vessels (among other things)
• Disturbance to it can, therefore, cause health problems

**Stress Research**

**Difficulties in stress research**
- **Difficulty of defining stress**
  - eg. the need to distinguish between stress (physiological state) and stressor (environmental event); eg. subjective variation.
- **Difficulty of measuring stress**
  - biochemical measures (blood cortisol levels, urinary excretion of adrenaline and corticosteroids) have good validity but are expensive and invasive, so tend to be limited to small numbers
  - situational measures (assumed characteristic of specific social situations) are inexpensive and non-invasive, so practical for large numbers, but their validity is vulnerable to subjective variation.
- **Difficulty of conceptualising stress**
  - is stress uni-dimensional (more or less stress) in relation to health; or is the important factor the degree of balance between stress and social support?

**Examples of stress research**
- **Comparative study of time-stressed work systems**
  - Biochemical and uni-directional
  - piece-work compared with fixed wage; assembly line work compared with batch work
  - measured urinary excretion of stress hormones and oxygen consumption.
  - Higher stress hormones levels under piece work and assembly line work
  - O₂ consumption stable

- **The Whitehall Study**
  - Situational and uni-dimensional
  - Study of work stress (job characteristics established by a national survey) and myocardial infarction
  - Results: inverse social gradient in mortality from CHD, i.e. Shift work and monotony associated with MI risk

**WHITEHALL II**
- designed to test the hypothesis using the ‘job strain’ model
- hypothesises that risk of CHD outcomes related to psychosocial demand and low control of choice in life (i.e. with work etc)
- Results: Low control associated with increased incidence of CHD

- **Quantitative figure of Life events**
  - Situational and uni-dimensional
  - Life changes disrupt individual lives
  - Rests on the premise that disruption can be quantified
  - 43 life events on what is known as the Holmes and Rahe stress scale ((eg. death of spouse = 100; moving home = 20)
  - Based on retrospective date
  - Rahe interested on whether this could be used to predict illness
  - Results: moderate ability to predict illness
- **Brown and Harris: The Social Origins of Depression**
  - Situational and stress-support balance
  - Provoking agents (life events) plus vulnerability factors (lack of a confiding relationship) increase risk of clinical depression in women.
  - Provoking agents more common among clinically depressed (present in 58% of depressed and 19% of not depressed).
  - Women differ in their vulnerability to provoking agent
  - The vulnerability factors (mother dead; young children; no paid employment; no confiding relationship with husband/partner) do not produce depression on their own, but they increase the risk of depression when a life event occurs.
  - Symptom formation factors
    - Determine the severity and loss of the depressive illness
    - Illness more severe if over 50 and history of previous depression

- **Determinants of 3-year survival after myocardial infarction**
  - Situational and stress-support balance
  - 2320 interviews with male survivors of acute myocardial infarction
  - Individually, both life stress and social isolation increased mortality risk and risk of second MI
  - In combination, high life stress and high social isolation were associated with a quadrupled mortality risk

**NOTE:** Biochemical and situational measures produce consistent results. Stress-support balance is stronger than stress alone.

### 4. Doctor-Patient Relationship

**Dr Samantha Murphy (s.l.murphy@open.ac.uk)**

#### Learning Objectives

1. List, explain and illustrate six ways in which the quality of communication between doctor and patient can affect the doctor’s clinical effectiveness.
2. Describe the Szasz-Hollender typology, as amended by Friedson; and list, explain and illustrate three factors which, in addition to the patient’s clinical status, may influence the type of doctor-patient interaction.
3. List six common sources of misunderstanding between doctor and patient which may introduce confusion into a consultation

#### Lecture Notes

**Communication**

Communication between two people is most likely to be successful when two conditions are present:

- **One person is not more powerful than the other**
- **Both people have the same objective**

- The doctor is likely to be in a more powerful position than the patient; having professional knowledge social status, and gate-keepers such as receptionists and secretaries.
- The patient is the supplicant, may have waited a long time for the appointment, may feel humiliated by embarrassing confessions or undress and may be heavily out-numbered eg. during a ward round
• The patient will be concerned mainly with their own symptoms; and their perspective will be coloured by the material, cultural and inter-personal context in which their symptoms have developed.
• The doctor will be concerned with their whole work load i.e. the present patient plus all the other patients waiting to be seen; and their perspective will be coloured by their professional training and socialisation.
• In consequence, successful communication during a consultation can be difficult to achieve. Doctors need to understand these problems, because successful communication can influence their clinical effectiveness.

Clinical Effectiveness

The quality of communication between a doctor and patient influences the exchange of information between them and the patient's satisfaction with the doctor; both can affect the doctor's clinical effectiveness.

➤ Information exchange:
  - Accuracy and completeness of the diagnosis
  - Physiological response to therapy, e.g. Egbert's experiment on communication, lowering of anxiety and the need for analgesia and speed of recovery after surgery
  - Practicality of the treatment regime

➤ Patient Satisfaction
  - Effectiveness of therapy, e.g. placebo effect
  - Compliance with medical advice e.g. 30% of prescribed drugs are either not taken or taken incorrectly; non-compliance with preventative advice is higher still
  - Future illness behaviour and the doctor’s effectiveness as a medical educator

Balance of power

Historically power has shifted between doctor and patient; as medicine becomes more specialised, shift of power towards doctor. However medical paternalism clashes with patient autonomy, therefore the power shifts back towards patient. The balance of power between doctor and patient depends upon:

➤ Patient’s clinical status

The Szasz-Hollender typology, as amended by Friedson, describes four clinical levels:

- unconscious or anaesthetised
- acutely ill
- managing a chronic disease
- healthy patient requesting assistance

Each has a correspondingly appropriate DPR:

- activity-passivity/paternalistic
- guidance-co-operation
- mutual participation

➤ Setting of the consultation

- number of staff present
- whether patient undressed or in bed
- patient alone
- depends whether GP, Hospital, surgeon etc
- symbols of authority- white coat, stethoscope etc
Social distance between doctor and patient
- Doctors are members of social class I and the majority of consultations are with working class patients.
- Inverse Care Law: the lower class you are, the less time you get with GP

NHS vs. Private consultations
- Fee-paying patients often feel more confident; and doctors may be more concerned to remain of service to these patients.

Negotiation
- Doctors have tended to prefer guidance-co-operation
  - Paternalistic style
  - High level of physician control
  - Doctor-centred
- Patients prefer mutual participation
- Both doctors and patients have strategies for shifting the balance of power in the direction they desire. The doctor can indicate lack of time and emphasise greater knowledge. The patient may display emotion e.g. sob or cry; and make unfavourable comparisons with other doctors.

New Models of Doctor-Patient Interaction

Consensus
- Social expectations brought to encounter
- Patient understands experience and knowledge of doctor, so accepts the doctors role as legitimate

Conflict
- Marxist
- Personal/social agenda of patient contrasts with biomedical agenda of doctor

Negotiation
- Acceptance of conflict, but willingness to work towards resolution

Contractual
- Based on recent changes, i.e. the shift of power away from doctor, where management of ill-health is a joint affair

The expert patient
- recognize, monitor and respond to symptoms;
- Manage acute episodes and emergencies;
- Use medications;
- Adopt appropriate aspects of lifestyle including healthy diet, exercise and relaxation, and not smoking;
- interact appropriately with health care providers;
- Seek information and using community resources, i.e. the internet

Sources of conflict and confusion

Non-verbal communication
- Positioning
- body space
- body language
- eye contact
- spacing between Doctor and patient
Language
- The problem is not so much technical terms, which most doctors have the sense to avoid, but words shared by the lay and medical vocabularies which are given different meanings by each (e.g. stomach, constipation), i.e. professional language

Expectations
- Doctors can confuse patients by expecting them to recognise which symptoms need a consultation, but, once in the consultation, expecting them to behave as though they have no medical knowledge and becoming threatened or dismissive when such knowledge is displayed.

Uncertainty
- Doctors are often doubly uncertain: they don't know something and they don't know whether it is their personal ignorance or the state of medical science which is to blame.
- They may also pretend uncertainty to avoid telling the patient bad news.

Doctor’s role
- Doctors may regard their job as diagnosing and treating disease.
- Patients, in addition, may expect them to legitimise sickness, give access to medical and welfare benefits and provide emotional support.

Medical seriousness
- Doctors tend to assess the seriousness of an illness in terms of the likelihood of death or permanent disability, while patient tend to do so in terms of disruption to their lives.
- This difference in perspective can lead to disagreement about what is an emergency

5. Origins and Development of the NHS
Dr Fiona McGowan (f.mcgowan@imperial.ac.uk)

1. Outline the development of Healthcare in Britain and explain why the NHS was created and the principles on which it was based
2. Summarise the main problems encountered by the NHS since 1948

- The NHS as a hierarchy (1948-79): Top-down, command and control planning model
- The NHS as a market (1979-97): Market mechanisms
- The NHS as a network (from 1997): Collaboration, partnership and trust

Background: Organisation and funding of healthcare

19th century:
- Hospitals for the poor.
- Private practise for the affluent.
- Development of friendly societies and Insurance companies; Entitled those covered to GP ’Panel’ paid for

20th century:
- 1911 introduction of National Health Insurance for manual workers aged 16-65
- This did not include wife/ children – excluded dependents, limited to GP services.

Hospital system:
- Voluntary hospitals
  - large London teaching hospitals and cottage hospitals
  - Funded by charities / public subscription
- Patients referred by counsellors and had to be deserving poor
- Staffed by consultants.
  - Municipal (local authority) hospitals
    - infirmaries/extensions of the workhouse
    - Provision for deserving poor – old, chronically sick, mentally infirm – asylums, sanatoria (isolation hospitals – TB)

*Health care problems:*
  - Financial barriers to care
  - Hospital care not included in NHI
  - Uneven distribution of specialists, beds and GP’s/ wide variations in all services
  - Lack of coordination between local authority services, voluntary hospitals and GP’s
  - Financial crisis – especially in voluntary hospitals – shortage of equipment and skilled staff.
  - Wide variation in standards

*Why a National Health Service?*
  - Growing consensus for collective provision
  - Influence of the idea that health is a right
  - Effect of World War 11
  - Need for social reform
  - Five giants – want, disease, ignorance, squalor, idleness- Beveridge Report 1942

→ *NHS: July 5th 1948*
  - Free medical care at point of delivery
  - Comprehensive; Cradle to grave (All population covered)
  - Equitable service- all citizens entitles and taxation not insurance based

*Expenditure and the organisation of the service*

*Contributions to rising costs*
  - Changing demographic structure of the population
  - Technological advances in healthcare
  - Public demand

*Development*
  - By 1950s charges for prescriptions, dental and optical services introduced. First shift away from founding principle of free services for all.
  - Through the 1960s – a period of relative affluence and economic optimism, concern about NHS spending continued.
  - 1974: Labour government - reform by reorganisation – ‘consensus management’
  - 1982-87: Managerial Reform- Replacement of consensus management, Limited list of drugs of proven clinical effectiveness, Competitive tendering for support services
  - 1988: NHS review - Focus on issues relating to financing and organisation rather than scope and priorities of NHS
  - 1990: NHS and Community Care Act- Professional accountability, Management hierarchy, Development of general practice
The internal market 1991

- District Health Authorities main purchasers
- Major acute hospitals and other NHS providers became ‘Trusts’
- GP fund holders
- Non-emergency hospital outpatients
- Diagnostics
- Pharmaceutical care
- Aim was to bring benefits of competition and efficiency without jeopardising initial principles

- **Professional Accountability:**
  - Medical audit (systematic analysis of the quality of clinical care) made compulsory in hospitals and general practice.
  - Hospital consultants had clinical time commitments in NHS set out in job descriptions.
  - General managers involved in appointment of new consultants and in the allocation of merit awards, i.e. a Management hierarchy
  - Increased changes towards private sector management model. Health authorities became managerial bodies akin to the boards of directors of private companies

- **Management hierarchy**
  - Increased changes towards private sector management model
  - Health authorities became managerial bodies

- **General Practice**
  - New contract in 1990
  - Preventative activities
  - Degree of competition between practices
  - Cost-effectiveness of services
  - Changes to capitation payments
  - Activity targets
  - Subsidies to employ additional staff
  - Indicative prescribing budgets

*Impact*

- Incentives too weak and constraints too strong
- Increase in administrative and management costs
- Equity – but ‘two-tier’ system in GP
- Altered the operating culture of the NHS and balance of power between managers and health care professionals and hospital providers and GPs
- Exposed long standing issues – e.g. rationing
- No obvious indicators that the internal market system had damaged standards of patient care – less waiting times due to negotiations, public dissatisfaction initially fell in the 1990’s as more money was put into the NHS but resumed its steady upward trend in the later 90s.
- Regarding choice and responsiveness to the demands of the patient – there was little evidence of change and that the pts had been allowed to express their ‘voice’ even though (fundholding) GPs were supposedly acting on patients’ behalf.
6. Current Dilemmas facing the NHS
Dr Samantha Murphy (s.l.murphy@open.ac.uk)

Learning Objectives

1. Summarise the arguments leading to the reform of the NHS
2. Explain why markets and commissioning were introduced into the NHS and the possible impact of these
3. Explain why the founding principles of the NHS are increasingly compromised- comprehensive, Equal, Free? Or increasing selectivity?

The New NHS: 1997

- Purchaser-provider separation maintained
- Fundholding replaced by Primary Care Groups / Primary Care Trusts
- National Institute for Clinical Excellence National Service Frameworks
- Commission for Health Improvement / Commission for Healthcare Audit and Inspection
- National Performance Framework / Targets

The third way
- Citizenship rights
- Balance of social responsibilities of individual and the state
- Not only rights but also responsibilities

Today’s NHS

- Patient’s rights more upheld
- Citizens hold professionals to account- shift from paternal role
- Patients as consumers of healthcare
- Increase usability Accessibility and becoming ‘user-friendly’, e.g. NHS Direct/NHS Walk-in Centres/Waiting lists/ Choose and book

The NHS Plan- 2000

- Increased investment in the NHS
- More staff and hospital beds and a wider range of performance targets
- Modernisation Agency to spread examples of ‘best practice’
- CHAI assess the performance of NHS Trusts
- Targets and ‘star’ ratings
- Greater autonomy and allocation of part of a discretionary performance-related fund
- ‘Concordat’ with private sector that encouraged NHS purchasers to use spare capacity more cost effectively
- Positive support for public-private partnerships
- Stronger incentives for full time work in NHS and tighter restrictions on simultaneous work in public and private sectors
- Clinical competence
- Greater involvement of clinicians in design of services
- Powers and resources transferred to PCTs
NHS 2010-2015

- 5 year plan to reshape NHS, high quality care in a financial environment
- Meet demand of aging population and lifestyle diseases
- Shift towards pluralism and renewed focus on prevention

Selectivity of the NHS

No longer: free, comprehensive and equitable?

- **Cost** pass onto patients e.g. early introduction of prescription charges, informal carers in the community, top up fees, private sector, commercial care e.g. nursing homes
- **Private-public partnership** (better access for some?), diversification of the NHS. There is always some commercial element to the NHS e.g. pay-beds. The growing partnership undermines the founding principles.
- **Rationing**: (‘resource allocation’) at:
  - Group level: ‘postcode lottery’ in treatment; NICE to counteract this
  - Individual level: refusal to treat e.g. by age, lifestyle
  - Level of clinical judgement: implicit rationing

The future of the NHS

- The NHS is simultaneously criticised and supported by patients and the public at large
- Different opinions on the future as to whether it is sustainable given the recent increases in funding or whether there will be a continued crisis in terms of funding and a need to become more pluralistic and diverse in terms of sources of funding and responsibility for delivery but with a high degree of fairness in financing and access
- The NHS is seen as:
  - liberated: people centred, pluralistic
  - brand name: privatised, for profit etc

7. Illness and behaviour

Dr Zaina Al Kanaani (z.al-kanaani@imperial.ac.uk)

1. Explain the difference between the clinical and symptom icebergs; and illustrate each with the results of a study
2. Define illness behaviour and explain its relationship to the iceberg phenomenon
3. Explain what is meant by the lay referral system; list, explain and illustrate three characteristics of a person’s lay referral system which may influence whether they consult a doctor
4. List, explain and illustrate three aspects of the organisation of medical care which may influence the likelihood of consulting a doctor.

Illness and consulting a doctor

- Illness is not sufficient for consultation of a doctor. Sometimes disease present without pain, symptoms etc e.g. cancer, but they do require seeing a doctor.
- Doctor patient disagreement on what is necessary for a consultation- this is known as TRIVIA
- Iceberg of disease: diseases which do not reach a doctor.
Iceberg of disease

Clinical iceberg: the proportion of disease in the community which is not taken to a doctor and accumulates within the population, e.g. SE London screening study

Symptom iceberg: the proportion symptoms experience by a community which are not taken do a doctor, e.g. Morell & Wade - 1 in 37 symptoms were presented to a doctor

Medical seriousness

SE London screening study

- 2000 people between 40 and 64 yrs old
- Minor diseases-53% unknown
- Serious diseases (potentially life threatening/incapacitating)- 44% previously unknown
- Symptoms are common, patients have to select which to present to a doctor

Illness behaviour

The ways in which symptoms are perceive, evaluated and acted upon by a person who recognises some pain, discomfort or other signal organic malfunction, i.e. how patients decide whether to consult

Factors influencing Illness behaviour:

- Age
- Sex
- Social class
- Ethnic origin
- Marital status
- Family size
- Nature of symptoms (Mechanic’s variables- how do they influence our decision to see a doctor.)
- Individual’s personal and social circumstances (Zola’s triggers- what makes them see a doctor )
- Perceptions of costs and benefits- whether we believe it is worthwhile

Mechanic’s variables

- If the symptoms are visible and recognisable, e.g. rash
- How serious do we perceive the symptoms to be, e.g. dizziness vs. mild headache
- How much does the symptom disturb your lifestyle, i.e. interfering with every day activities e.g. work
- How often does the symptom appear, i.e. increased frequency increases likelihood to see doctor
- Pain threshold
- Familiarity of the disease, e.g. colds- often go get cold medication

These are more to do with the specific patient

Zola’s triggers

- Family crisis- e.g. a death from cancer will increase awareness
- Interference with social activities- i.e. with your normal role in society, e.g. not being able to work. This increases pressure from people around you to see a doctor and return to work.
- Interference with physical activities, e.g. with an exercise regime, sport etc
- Deadline- people will often set a deadline to see a doctor, e.g. if this pain continues for 5 days...will go see a doctor

These are more to do with the environment surrounding the patient
More factors influencing illness behaviour.

- **Characteristics of a lay referral system:**
  - **expectations** - of the people that surround you to whether you go to a doctor, personal perception of symptoms
  - **disruption** - how much your illness is disturbing your referral system, e.g. not being able to go to work
  - **culture and structure** - i.e. the bigger and more tight-knit the community, the more advice is given, therefore less likely to see

- **Access to healthcare facilities**
  - i.e. how close the GP surgery is, whether a walk-in surgery is nearby – the physical distance of a patient from medical care. Also the ease of access.

- **Available of alternatives**
  - e.g. self-medication, herbal remedies, acupuncture, patient support groups, websites etc.
  - This also depends on people’s attitudes to medicine

- **Doctors attitudes**
  - whether the doctor has enough time allocated for the patient, their behaviour during consultation. Also found that Doctor’s that don’t identify triggers of visit (i.e. Zola’s triggers), patient is less likely to follow treatment plan.

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**8. Sick role and stigma**

Dr Zaina Al Kanaani ([z.al-kanaani@imperial.ac.uk](mailto:z.al-kanaani@imperial.ac.uk))

**Introduction**

- Parsons- first to describe the sick role
- Illness: unwilled social deviance (prevents normal role performance temporarily)
- Society response to illness
- Sick role is the cultural response (social mechanism) in order to ensure a functioning society

**What is expected from the different roles?**

**Patient: Sick Role**

- Allowed to give up some activities- depending on the nature and severity of the condition
- Deserve care

BUT, it is also expected that the patient:
- Must get well as quickly as possible
- Should seek professional health

**Doctor: Professional Role**

**Rights**

- Examination and insight to intimate area physically and personally
- Autonomy and authority

**Obligations**

- High degree of skills and knowledge
- Act in the interest of the patient, e.g. PCC (patient centred care)
- Objective and follow professional practise

By giving the doctor the responsibility for assigning the sick role, Parsons described them as GATEKEEPERS TO THE SICK ROLE
Paraon’s Theory

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For patients:</strong></td>
<td></td>
</tr>
<tr>
<td>Removes fear of punishment for sickness</td>
<td>RIGHT 1: temporarily relieved of normal responsibilities- but not all relieved of responsibility, e.g. parents</td>
</tr>
<tr>
<td>Allows time to recover</td>
<td></td>
</tr>
<tr>
<td><strong>For doctors:</strong></td>
<td></td>
</tr>
<tr>
<td>Enhances recovery for illness</td>
<td>Doctor as gatekeeper</td>
</tr>
<tr>
<td></td>
<td>Dr values may conflict with patient- ethical issues</td>
</tr>
<tr>
<td></td>
<td>maintaining confidentiality- issues can be very sensitive to patients</td>
</tr>
<tr>
<td></td>
<td>difficulty in determining severity of symptoms</td>
</tr>
<tr>
<td></td>
<td>relying of patients report- does the patient actually need time off?</td>
</tr>
<tr>
<td></td>
<td>clinical and managerial issues</td>
</tr>
<tr>
<td></td>
<td>difficult to translate population EBM (evidence based medicine) to individual patients</td>
</tr>
<tr>
<td><strong>For society:</strong></td>
<td></td>
</tr>
<tr>
<td>Controls deviance- people adopting sick role without being sick</td>
<td>RIGHT 2: not held responsibility for this deviant behaviour, and therefore not punished. Some people are held responsible- is it medical or moral? Also what happens with chronic disease-patients may want to get better?</td>
</tr>
<tr>
<td>Maximise role performance (assume normal social roles as soon as possible)</td>
<td></td>
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</tbody>
</table>

Deviance

- Illness: deviance from normal social roles
- Deviance conditions: conditions that set their posessors apart from “normak” people
- Results in marking them a socially unacceptable, inferior (mental illness, severe burns, deafness, AIDS)
- Diagnosis may result in rejection from society- attaches STIGMA to the patient

Stigma

- The situation of an individual who is disqualified from full social acceptance
- Enacted: discrimination by others on grounds of being imperfect
- Felt: internalized sense of shame, fear and discrimination
- Doctors role: diagnosis of disease → stigma
- Shame/guilt leads to delay in seeking treatment

Stigmatised conditions:

- Physical disability
- Mental disability
- Mental illness
- Facial disfigurement
- Epilepsy
- HIV/AIDS
- Leprosy
- TB
- Cancer
Discredited & Discreditable

- Discredited: visible and widely known
- Discreditable: not obvious and not widely known
- Different strategies to manage social interactions and embarrassment

Discredited

- Have to cope with awkward situations
- Davids’ 3 stage process: Tension management when meeting strangers
  1. Fictional acceptance- polite acceptance of stereotype
  2. Breaking through- realisation stigmatized person is normal
  3. Consolidation- maintaining this perception
- Advantages of Davids’: openness/honesty
- Disadvantages: difficult for patient to accept stereotype, social skill, effort required by patient

Discreditable

- “information management”
- Advantages: passing as normal
- Disadvantages: anxiety as always have to make cover stories and have to decide when to tell, Distress because fear negative reactions
- Goffman’s dilemma: to display or not to display, to tell or not to tell, to lie or not to lie, and in each case, to whom, how, when and where

Collective Response

- Spend time with fellow sufferers
- Advantages: support, normalisation, avoids tension and information management
- Disadvantages: group isolation, identity defined by condition- reinforcing differences

9. Role of Medicine
Dr Samantha Murphy (s.l.murphy@open.ac.uk)

1. Describe the chain in all-cause, infectious disease and non-infective mortality rates in England and Wales during the century after 1850
2. List, in order of prevalence, the diseases which made the main contributions to the fall in infectious disease mortality
3. List, explain and illustrate the four factors which contributed to the fall in infectious disease mortality; explain McKeown’s reasoning in assigning relative importance to them
4. Describe and assess critically the implications for the role of medicine which McKeown drew from his conclusions

Demographic transition

- The change in a population from having high mortality and high birth rates to having low mortality and low birth rates is called ‘the demographic transition’.
- The demographic transition occurred in Britain between the mid-nineteenth and mid-twentieth centuries. It started slightly later in other developed countries, and most Third World countries are presently in the middle of it.
In England & Wales, the crude mortality rate fell from 24 per 1,000 in 1850 to 14 per 1,000 in 1960. The birth rate began to fall in the latter part of the nineteenth century; importantly, before effective contraception became available.

McKeown’s observation

- McKeown analysed British death certificates (number and causes of death) since the mid-nineteenth century.
- Death certification started in 1837 and, after initial teething problems, was reasonably reliable by 1850. The reason for introducing the census of birth and death rates was the increasing population so that the Government could keep track.
- Compulsory Registration of all births and deaths was introduced in 1883.
- McKeown noticed that the fall in mortality during 1850-1960 was mainly due to a fall in infectious disease deaths. In 1850 the crude death rate due to all infectious diseases was 12 per 1,000; in 1960, 2 per 1,000. In contrast, the death rate due to non-infectious causes remained constant at approximately 12 per 1,000. So, explaining the fall in the death rate due to infectious diseases is a key part of understanding the demographic transition.

The most important causes of infectious disease deaths during the demographic transition were:
- tuberculosis
- enteric fevers (diarrhoea, dysentery, cholera, typhoid);
- respiratory infections (bronchitis, pneumonia, influenza);
- childhood infections (scarlet fever, measles, whooping cough, diphtheria).

McKeown’s analysis

Current understanding of infectious diseases suggests four possible causes for the fall in their mortality rate:

- Decreased virulence
  - A decrease in the virulence of the infecting micro-organism may have been part of the explanation for the fall in deaths due to scarlet fever
  - implausible as a general explanation because:
    1) why should the virulence of all the infectious diseases reduce at the same time?
    2) why has the virulence of none of the infectious diseases subsequently increased?

- Medical measures
  - Prevention vs cure
  - VACCINATION undoubtedly contributed to the fall in mortality from smallpox, and diphtheria anti-toxin was sometimes effective against diphtheria. Their combined effect on total mortality, however, was small because by 1900 smallpox and diphtheria were not among the most prevalent causes of death.
  - E.g. Diphtheria: 1890- 800 per mil deaths- causal organism identifies. 1900- 900 per mil deaths- antitoxin first used in treatment. 1940s- 300 per mil deaths- National immunization programme introduced
  - IMMUNISATION AND ANTIBIOTICS are medicine’s main weapons against infective disease. However they did not become available until the late 1940s (diphtheria immunisation and the early sulphonamides were discovered in the 1930s but did not become widely available until after the start of the NHS), by which time some 75 per cent of the fall in infectious mortality had occurred.
  - EFFECTIVE MEDICAL MEASURES AFTER WWII helped to eliminate most of the remaining infectious disease deaths, but they became available too late to have been responsible for the main part of the improvement.

- Decreased exposure
  - A series of measures by central and local government helped reduce individuals’ exposure to infections.
Sanitary reforms (separating drinking, cooking and washing water from the sewage system), Factory Acts, slum clearance and tuberculin testing of milk all helped to break the chain of infection.

These measures were most effective against water-borne and vector-borne infections, and would have had little effect on the air-borne infections (tuberculosis, measles, whooping cough) which were responsible for the majority of deaths.

- **Increased host resistance**
  - increased host resistance must have been the main cause of the fall in deaths due to infectious diseases, because the other possible explanations could only have had a small effect.
  - increases in living standards, particularly improved diet, were probably most important.
  - Decreased exhaustion, for women due to fewer pregnancies and smaller families and for men due to a shorter working week would also have contributed.
  - explanation is plausible because of the effect of nutrition and exhaustion on the immune system eg. different mortality rates from measles in malnourished and well nourished populations.

McKeown concluded that the four explanations were in the following order of importance:

1. increased host resistance
2. decreased exposure
3. medical measures
4. decreased virulence

**Implications of his analysis**

- McKeown’s work on the fall in British mortality rates has influenced World Health Organisation policies on health in the Third World and British policies on the NHS.
- thought the NHS should place more emphasis on health promotion and disease prevention and less on attempts at cure, which rarely succeed.
- He advised that medicine should focus on safe birth and painless, dignified death and favoured increased status for medical specialities which offer care rather than the hope of cure.
- His views remain controversial. Opponents argue that medicine has changed in the past thirty years and point to 'cure' successes such as peri-natal mortality, renal transplants, childhood leukaemias and trauma surgery.
- Sociologists think that McKeown did not consider differences between social classes, but rather focused on behaviours
- Supporters of McKeown reply that such breakthroughs are welcome but there are still exceptions; and point out that we have yet to estimate the size of clinical medicine’s contribution to the recent increases in life expectancy at middle age.
- Despite the controversy, certain reasonably safe implications can be drawn from McKeown's work
- WHo do focus on prevention rather than cure, as well as the current NHS policies, e.g. 5 a day. So this can be seen as based in McKeown’s analysis

**Health of populations**

A population’s mortality rate and its main causes of death reflect its standard of living and way of life. Access to medical care is part of the standard of living, and medicine can affect mortality, but other aspect of the standard of living are the main determinants of population health.

**Prevention**

Medicine’s most effective interventions are preventive. These may be clinical eg. immunisation or involve the profession in campaigns for social change eg. sanitary reforms in the nineteenth century and smoking cessation today.
Medical care
Medical care may not be the main determinant of a population's health, but it makes an enormous difference to a person's experience of being ill. This suggests that the patient's experience should be at the heart of medicine.

In practical terms, this means that certain aspects of medicine become more important: eg. understanding the effect of disease on patients’ lives; ensuring that treatment regimes are practical for the patient; paying as much attention to the side-effects of drugs as to their therapeutic effects; provision of terminal care - all of which require good communication skills. It means also that patients who are not going to recover, such as the handicapped and elderly chronic sick, should no longer be neglected because they are medically uninteresting.

10. Death, dying and bereavement
Dr Samantha Murphy (s.l.murphy@open.ac.uk)

1. Describe what social factors might contribute to a person’s risk of untimely death.
2. Outline how death has been medicalised and how this has now led to the growth of the medical specialism palliative care.
3. List the various uses of the dead body.
4. Outline how the medicalisation of death has brought new ethical dilemmas to the fore.
5. Ask whether or not bereavement is now being brought in the realm of medicine.

Social Patterning of Death

- **Gender**: different for men (78) and women (82.1):
  - Difference in health behaviour
  - Health seeking behaviour
  - Masculinity as dangerous to your health
  - Women as biologically the stronger sex
- **Class**: higher for higher social classes
  - Stillbirths: death after 28 weeks-pregnancy. Higher social classes appear to have fewer stillborns.
  - Positive correlation

Statistical analysis of mortality rates

**Importance**
- Improve public health
- Establish links to behaviour and disease, e.g. Richard Doll; smoking and lung cancer links
- Influence service delivery; specific health interventions for specific groups

**Problems**
- Depends on the accuracy of the data
- Subjective opinion
- Sensitivity of the cause of death; more sensitive causes of death may be left off medical records
- Not taken seriously by the clinician?
- Classifying occupation of the deceased might have to be obtained from family etc
- Data from certificates then has to be coded for a statistical summary
Death

Medicalisation
- The increasing intervention of medicine into our lives
- The medicalisation of death is the intervention of medicine into the experience of death and dying; beginning with the introduction of death certificate - death must be registered, documented and explained

Dying
- Legal definition in the UK: does not exist
- Biological vs. Social death
- Diagnosis of dying is a medical judgement
- The prospect of dying impacts medical treatment
- If diagnosis of “dying” is made too early, can cause unnecessary distress
- If diagnosis of “dying” is made too late, the access of end-of-life services is restricted
- The process of dying is neither absolute nor predictable, although the diagnosis is made by clinicians

Problems with considering Death
- Western medicine is “cure-orientated”, therefore death is to be avoided, resisted or postponed
- Seen as a failure of medicine
- Most deaths occur in hospital, therefore, death has been “sequestered”

Palliative Care
An approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems; physical, psychological and spiritual

Rise in palliative care
- Improved pain control and symptom relief
- Rise of the hospice movement to deal with TOTAL PAIN
- Total pain as physical, emotional, spiritual and psychological
- 1980s; palliative care becomes a medical speciality

Ethical Implications
- Respect for autonomy
- Beneficence
- Non-malificence
- Justice
- Involvement of medicine in death; assisted suicide, euthanasia, withholding/withdrawing treatment, organ donation
- Heart-beating donation: death is determined by brainstem inactivity. This has been criticized as difficult to prove “brainstem death”.

Study Guide Notes

Death as the great leveller?

Death has often been described as the great leveller – it is one thing that both rich and the poor can be assured of experiencing. However, while this is so, the social location of an individual has an influence over the timing, the
place and the cause of death. Statistics show us that women live longer than men and that the higher the social location the individual is in, the longer they are expected to live. Moreover, particular ethnic groups live longer than others. This leads us to ask what social factors are present that protect some people rather than others.

**Medicalisation of death and the ethical context of death and dying**

Since the introduction of death certificates that required the cause of death to be identified on the death certificate, medicine has played an increasing role in the individual experience of death. Death has moved from the home into the hospital and hospice (the sequestration of death); life-saving measures are used by doctors to prolong life or to save it and people are now diagnosed as ‘dying’. The dying person may decide to donate parts of their body so other people can live, thus the dead body can be seen to be commodified, that is, turned into an object of exchange. As such, medicalisation has brought with it particular questions and ethical dilemmas that medics, ethical committees and lay people have to grapple with: