

**Structural Functionalist view of Health:Disease and Illness;
The Organization and Functioning of The Modern
Healthcare System.**

&

**The Doctor-Patient Relationship: Shift in Balance of Power
in Doctor-Patient Relationship**

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Structural Functionalist View Of Health: Disease And Illness; The Organization And Functioning Of The Modern Healthcare System.

1.0 INTRODUCTION

Functionalism addresses the societal whole with respect to functions of constituting elements of the society –like traditions, institutions, norms, and customs –and much exemplary like organ interactions within the human body (Boundless, 2013). Structural functionalism, or simply functionalism, is a substructurein construction of theories that sees society as a complex system whose parts work together to promote solidarity and stability –an approach of viewing the society at a macro-level, which is a broad focus on the social structures that shape society as a whole. This approach looks at both social structure and social functions. Functionalists argue that a sick individual is not a productive member of society; therefore this deviance needs to be checked –instituted on the role of professional medical personnel. Between 1940 to 1950 was the peak influence of structural functionalism but this saw a decline in 1960s as it was substituted with conflict-oriented approaches concentrated in technologically advanced nations and thereafter –with structuralism which is also seen in other parts of the world.

2.0 PERSPECTIVES

The structural-functionalist perspective focuses on how illness, health, and health care –affect –are affected by changes in other aspects of social life (Mooney et al 2002).This theoretical perspective stresses the essential stability and cooperation within modern societies. Social occurrences are conceptualized with regards to the functions they perform in sustenance of the society. With reference to biological analysis of the human body, the society is like a biological organism in which the whole is seen to be formed by interconnected and integrated parts –an integrated system aided by dominated accord of important norms and values. The result of rules learning is manifested in the roles an individual plays through the socialization, and thus, the integration factored by the nature by human behaviour. The use of this concept is bathed with sick role and illness behavior.

According to the structural-functionalist perspective, healthcare –a social institution –functions to maintain the well-being of individuals in the society and, consequently, of the social system as a whole (Mooney et al, 2002). Illness is dysfunctional since it limits performance of societal members, and thus to cope with societal changes due to illness, the society assigns a temporary and unique role “sick role’ to those who are ill (Parsons, 1951). This role assures that societal members receive needed care and compassion when ill, with an expectation to seek competent medical advice, adhere to the prescriptions, and return as soon as possible to normal role obligations.

Structural-functionalists explain the high cost of medical care by arguing that society must entice people into the medical profession by offering high work-benefits –and the absence of this hinders the incentives for individuals to undergo the rigors of medical training or the stress of being a physician. Therefore sustenance of the society through roles is factored –positively by health –and negatively by illness.

3.0 THEORITICAL CONTRIBUTORS

3.1.0 Emile Durkheim (1987)

Contributed through his work on the theory of suicide –stating that suicide is caused by factors as

1. Integration or strength to which individual is part of the society: leading to
 - i. egoistic suicide: due to lack of integration in the society, for example people living in isolation –alone compared to those who live with family.
 - ii. altruistic suicide: due to too much integration in the society, for example members of the armed forces were said to have greater suicide rates than civilian personnel as they were too strongly integrated into a united body.
2. Regulation or degree of external constraints: leading to
 - i. anomic suicide: due to low regulations in the society, For example an unexpected death of a family member is sudden social change which can cause Anomic suicide.
 - ii. fatalistic suicide: due to too much regulations in the society

The merit of this concept is that it shows the capability of lager society to create a stressful situation where people are forced to respond to condition not of their own choice, and thus aiding the understandingof not only the social dimensions of suicide, but also the recognition that

macro-level social events –like economic meltdownwhich can affect health in a number of ways through stress; and that the effect of stress can be mitigated through social support.

3.2.0Talcott Parsons (1951)

Parsons is considered as father of medical sociology because of his description of “Sick Role” theory which greatly changed the discourse of medical sociology. He did the first theoretical concept by utilizing the work of Durkheim and Weber within the parameters of classical sociology to come-up with propositions of the sick and their respective social roles outlining normative pattern of normative physician utilization.

This theory described the role of a sick person as opposed to the role of a healthy person. He defined ‘sick role’ as a motivation of a patient neither mentioning the role of doctor nor the role of other medical institutions He argued that being sick means that the sufferer enters a role of "sanctioned deviance". This is because, from a functionalist perspective, a sick individual is not a productive member of society. Therefore this deviance needs to be policed, which is the role of the medical profession.

In the functionalist model, Parsons argued that the best way to understand illness sociologically is to view it as a form of deviance that disturbs the social function of the society. The general idea is that the individual who has fallen ill is not only physically sick, but now adheres to the specifically patterned social role of being sick. "Being Sick" is not simply a "condition"; it contains within itself customary rights and obligations based on the social norms that surround it. The four (4) propositions comprising of ‘two rights of a sick person’ and ‘two obligations’; and a conclusion of three (3) versions of the sick role as shown below:

Propositions:

1. Rights

- i. Exemption from normal social role responsibilities. For example, a minor chest cold "allows" one to be excused from small obligations such as attending a social gathering. By contrast, a major heart attack "allows" considerable time away from work and social obligations
- ii. Privilege of not being held responsible for being sick and thus needs care.

2. Obligations

- i. Desire to get better.

- ii. Obligation to find help and follow advice from the doctor. For example, many people believe that people with mental illness should adhere to prescribed medications in order to be functional members of society or to be entitled to receive benefits

Versions:

1. Conditional legitimate: person(s) with temporary sickness e.g. cold, pneumonia etc.
2. Unconditional legitimate: person(s) with incurable sickness and the sick is not seen as responsible for it e.g. cancer etc.
3. Illegitimate: person(s) with stigmatized sickness and the sick is held responsible e.g. HIV/AIDS (human immunodeficiency virus infection / acquired immunodeficiency). For example, in patients with lung cancer, who are often assumed to have developed the disease because they smoked and other form of self-inflicted cancers. Likewise, people who do not cooperate with treatment plans may be criticized for failing to fulfill their duties to get better. Other examples are stammers, epilepsy etc.

4.0 CRITICS OF THE FUNCTIONALIST PERSPECTIVE

According to Stolley (2005), critics argue that the functionalist perspective on medicine applies only to some conditions and some people. For example, it does not apply to acute illness such as the measles or the common cold. However, it does not adequately address chronic illness. Current medical capabilities might slow the decline or stabilize the condition of people with disease such as heart disease, arteritis, or Alzheimer's disease, without the current ability to cure them. Thus, the perspective does not fit reality. No matter how people try to get well, or how much their doctor try to make them well, that outcome will not occur.

Critics also charge that health care system does not function optimally because of the profit motive that is sometimes at odds with the function of providing health care (Stolley, 2005). Some people want to get well but cannot afford the things that are more likely to make that happen. Expensive or experimental technologies are not available to all who might benefit from them. The functional view also encourages the medical profession to be in charge of treatment, leading some critics to argue that it does not adequately support growing interest and knowledge

of patient who want to make an active role with their physicians in directing their own health care.

5.0CONCLUSION

Structural functionalism, with its emphasis on value consensus, social order, stability and functional process at the macro-level of society, had a short-lived period as the leading theoretical paradigm in medical sociology. Although the principles much diminished in explaining illness-disease of patient to doctor, the structures are still very much present in the functioning of a health care institutions -in terms of division of labour and organisation.

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The Doctor-Patient Relationship: Shift in Balance of Power in Doctor-Patient Relationship

1.0 INTRODUCTION

Shift in Balance of Power between Doctors and Patients analyzes the changing public perception of the physicians in modern times with specific focus on the evolution of the doctor-patient relationship. According to Furst (1998), she stated that a radical shift in power has occurred from –the 19th nineteenth century, when the patient's wishes and social position have limited pressure – to the present, when technology and specialization have significant pressure on the power bestowed upon the doctor.

Shift in Balance of Power between Doctors and Patients takes as its thesis the notion that the shift of power from patient to doctor is directly related to the increase of scientific knowledge which led, in turn, to a change in the locus of medical practice from the domestic sphere to the hospital and laboratory. Also there have been power changes due to healthcare reform mainly as seen in helping people stay healthy instead of only caring for the sick

In recent years there has been a shift in patients' attitudes towards healthcare and healthcare practitioners, which has resulted in patients desiring more empowerment within medical consultations. For example, social change through the rise of movements like feminism has given people more autonomy. Also, society is becoming increasingly relaxed, with the formal boundaries between the professional and lay person's views which is factor not only by the healthcare reforms, but also the internet age, among other factors.

In part, this change in attitudes has led to patients' increasingly viewing healthcare as a 'preventative' process, rather than purely a 'curative' process. In some respects this empowers patients, making them responsible for their own health outcomes. However, it also shifts the dynamic towards a consumerist approach –the patient needs a service –in a preventative market the patient becomes consumer. The need for appointments that are not 'cure driven' means that health care providers have to attract patients to use our service and such health care providers are in a 'buyers' market. 'Even the term 'healthcare provider' is part of this shift –creating a different attitude to patient's services through patient empowerment.

Traditionally the ‘practitioner knows best’ (paternalism) or ‘practitioner-centred’ consultation has been the norm. Indeed, within medical profession this is how most of them have been taught to examine patients. The patient attends health care Centre for an examination with a particular problem, and the practitioner spends the rest of the consultation ‘information gathering’ through various tests in order to give the patient advice. This type of consultation has little reference to exploring patients’ beliefs, expectations and fears. The practitioner is endowed with all the power and the patient is left as the supplicant. However, with changing patient attitudes this type of consultation becomes less appropriate. A practitioner-centred approach can lead to consultations that are both ineffective and dissatisfying to both patient and clinician. Indeed, there is a growing need to adopt a more ‘patient-centred’ approach which allows the patient to have some power within the consultation. Unfortunately this change can lead to clinicians feeling helpless, frustrated and threatened by their lack of control.

2.0 THE POWERFUL DOCTOR

Traditionally, the doctor is presumed to be more powerful in that he can influence the patient in terms of advice and medical treatment (Stoeckle, 1987). A variety of theories of power exist that might be relevant in this context. For example, Foucault’s (1980) relational power describes how power is in every relationship and thus also in the doctor-patient relationship. Lukes’ (2005) three-dimensional viewpoints referenced the ability to shape wants and needs in power role aspect. Looking at the doctor-patient context more specifically, for Broom (2005) the doctor’s greater medical knowledge compared to the patient is central factor of the power position –since the patient has no option but to trust the accuracy of the doctor’s diagnosis and recommendations (S. Christmann, 2013). Arising from the patient’s need for the doctor’s help, trust is not only referred to as one of the central pillars in this relationship, but also as being inseparable from the patient’s vulnerability, ‘in that there is no need for trust in the absence of vulnerability’ (Hall et al., 2001). The patient’s oftentimes urgent need for medical care in combination with a lack of medical knowledge may even enhance the doctor’s perceived power (Hall et al., 2001). Parsons (1951) describes a reciprocal relationship between doctors and patients which implies a ‘functional consensus’ or functional agreement of the relationship –characterized by the rights

and obligations of the doctor and patient being complementary to each other ‘in the common task of returning the patient to normal’ (Stoeckle, 1987).

3.0 LIMITS TO THE DOCTOR’S POWER AND THE MORE ACTIVE PATIENT

Researches have illustrated the possibility of a more active patient in the relationship with his doctor which limits the physician’s power in the relationship, these ‘ideas about the relation began with the recognition that the patient might, in turn, influence the doctor’ (Stoeckle, 1987), leading to an understanding of the relationship as involving negotiation and conflicts.

According to Szasz and Hollender (1956), the individual patient, depending on his specific physical condition, may well influence the relationship with his doctor in terms of treatment. For example, patients suffering from chronic illnesses may –through participation, avoid or adhere to treatments. Haley (1963) concludes that the patient is not always the inferior actor in the relationship. As opposed to this concept, Scheff (1968) argues that the doctor-patient encounters are in fact negotiations and further stating that the doctor is always one up in influencing the patient in the kind of illness or treatment he thinks is proper (Stoeckle, 1987).

Others see a redefinition of this relationship in the direction of patients being more and more comparable to consumers seeking medical aid of doctors as ‘providers’ (Reeder, 1972; Haug & Sussman, 1969). The actual limitation of the physician’s power to act is described through the lens of the patients’ social networks and choice possibilities –providing certain control over the doctors (Freidson, 1960). These arguments on the patient as consumer are taken up by more recent research such as Eysenbach and Köhler (2002), Eysenbach and Diepgen (2001) or Anderson et al. (2003) in the context of the Internet’s influence.

Despite these conflicting notions about the power relationship between doctors and patients, the fact still exists that medicine requires very accurate and very specific knowledge cannot be denied, which suggests a knowledge divide between patients and doctors.

4.0 EXPERT AND LAY KNOWLEDGE

However, knowledge in the medical context is not necessarily restricted to expert knowledge: while the patient is likely to lack medical expert knowledge, he is likely to be equipped with so-

called lay knowledge. According to Pearce (1993), own experiences as well as cultural factors play into the creation of knowledge in individuals, such that ‘people draw on many different aspects of their environment and their daily lives to construct medical “truths”. So ‘lay knowledge differs from expert knowledge in the sense that it has an ontological purpose’. According to Williams and Popay (1994), in the health context, lay knowledge is rooted in the experience of illness.

Vis-a-vis the ‘traditional ‘medical model’ which reflects the perceived lack of relevance of such experiences’, lay knowledge would challenge the ‘objective’ and science-based expert knowledge of medical professionals: most importantly, it questions to what extent the ‘objective’ expert knowledge permits a proper understanding of health problems in the ‘new modernity’.

5.0 INFORMATION AND THE DOCTOR-PATIENT RELATIONSHIP

In general, patients have less medical (expert) knowledge, a considerable amount of research has focused on the question of whether providing patients with more medical information – leading to ‘informed patients’ as described by Kivits, (2004 & 2006), among others – would change their relationship to their doctor. Studies have observed a more powerful and autonomous patient when he is equipped with more medical and health information, as it contributes to his knowledge.

Nevertheless, it remains contentious whether, and to what extent, increased information results in increased knowledge in the sense of medical expertise or rather lay knowledge, and whether both knowledge types stimulate power (Kivits, 2004; Prior, 2003). Within this context, the impact of online information is the focus of this section.

The rise and development of Information and Communication Technology (ICT), and the Internet specifically – leading to ‘Information Age’ – has increased the importance and relevance of questions related to information gathering. According to Hardey (2001), it ‘is collapsing the boundary fences around previously carefully guarded information domains that form the basis for professional monopolies such as in medicine’.

Being available over distances, anytime and from basically everywhere, the Internet facilitates patients’ increased and easy access to information about issues like their health conditions,

diagnosis or treatments and medical decision-making. Constant updating of –and cross-linkages between the different webpages further support a very flexible information search process.

For example, the increasing use of social media allows the active contribution of Internet users to online content in that it fosters the production and sharing of information among patients on forums, communities, blogs, and network sites. In that sense, social media are understood as Internet-based applications ‘that allow the creation and exchange of User Generated Content’.

Thus a power change towards the patient as a result from the impact of the patient’s greater information – gained through online sources.

However, the role of quality information raises the question of how relevant the quality of online health information is for the evaluation of its impact on the doctor-patient relationship. Many studies point to the oftentimes poor or at least questionable quality of online information. Low barriers to publishing, the anonymity of content producers and publishers, and low rigor in moderating and filtering online content are some of the central elements that contribute to the quality problems (Goldberg, 2010; Mittman & Cain, 2001).

Moreover, patients’ information search skills are found to be limited: most often they make use of general search engines when looking for health information, misspelling medical terms and considering the first page of search results only (e.g. Morahan-Martin, 2004).

6.0 POWER IMPACT

Specifically, online health information leads to a changed decision-making model with regard to medical issues like treatment options, with a greater influence on decision-making on the part of patients (Cullen, 2006; Morahan-Martin, 2004, Dolan et al., 2004).

However, according to Rice and Katz (2006) ‘literature overwhelmingly indicates that the increase in patient health-seeking behavior does not necessarily lead to patients desiring to replace or challenge their physician. Neither does it appear that online health information will replace reliance on physicians’. Wald et al. (2007) find that more informed patients are more likely to develop a sense of partnership and collaboration with their doctors. As Kivits (2004) observes, in the consultation situation, patients rarely confront their doctors with the health information they researched, as they are aware of not being medical experts.

Nevertheless, others emphasized that the more engaged patients no longer follow the doctor's suggestions. Due to dissatisfaction with the doctors' accessibility, information and communication, patients look up the information themselves and possibly refuse to follow their doctors' advice. The shift from the exclusive focus of medicine from curing to preventing illnesses supports this point. The patients' information gathering would result in a 'reversed information gap', implying a relationship, in which doctors can no longer tell well informed patients what to do.

7.0 SHIFT FROM THE BIOMEDICAL MODEL TO THE PATIENT EMPOWERMENT MODEL OF CARE

Health care providers need to surrender the need for control and involve patients in making care decisions and exert control over his/her health needs. In comparison of the traditional biomedical model of care with an empowerment model of care, the latter illustrates the kind of shift in thinking required to allow empowerment to take place.

In the past, patients were supposed to be compliant (obedient) with a health care professional's directives—the biomedical model. In this model, when a treatment plan fails, it is often the responsibility or the fault of the patient.

Persuasion and manipulation (coercion) are the primary communication strategies for attempting to make patients manage their illnesses. Experience has shown that these strategies are simply not efficient, especially for patients with chronic diseases.

In the empowerment model, the term used is adherence. Adherence implies a contract between patients and providers in whom joint responsibility is taken for achieving agreed-upon outcomes. In the empowerment model, health care professionals respect the patient and assist the patient in making decisions in ways that have meaning to the patient.

Patient autonomy is seen as relational rather than independent. Patients are encouraged to act autonomously through shared information and mutual collaboration in decision making. Understanding how patients view their illnesses and treatment has been shown to be positively related to treatment adherence and produces better outcomes.

8.0 CONCLUSION

Medical knowledge has long been used in clinical practice for professionals. The shift/or balance of power to include patient is aimed at patient empowerment -intended to enable patients to make judgements about their own illness and to be fully responsible members of the healthcare team. Patients are seen as experts of their illness and health care professionals as experts on the medical conditions and management resources. Combining both and sharing the expertise could achieve the intended platform for managing illness.

For example patient' participated-knowledge of medication could help to prevent medication errors --which result in many deaths yearly and significant damage to patients' health, -will create a market that demands and supports safety.

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