

## PART

**1**

# Social Factors and Illness

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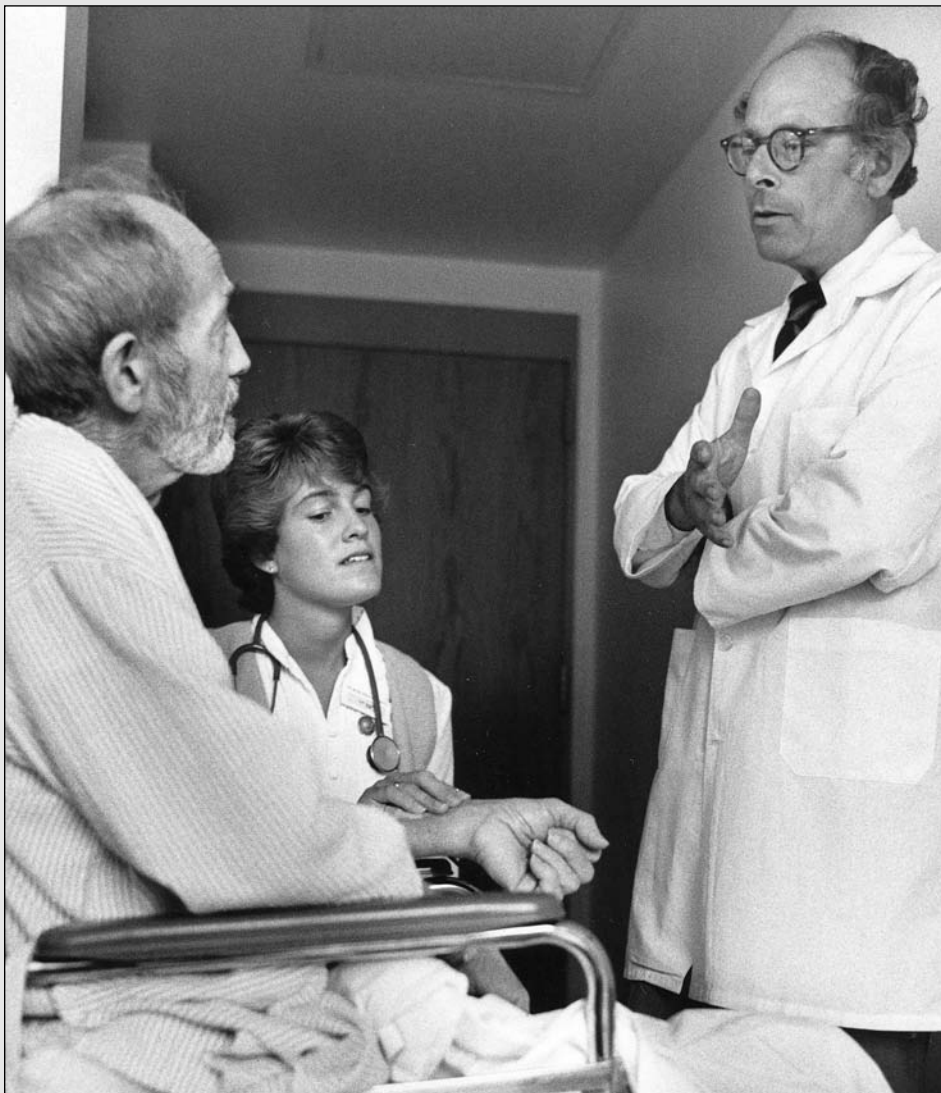
Illness is a fact of life. Everyone experiences illness sooner or later, and everyone eventually must cope with illness among close friends and relatives.

To the ill individual, illness can seem a purely internal and personal experience. But illness is also a social phenomenon, with social roots and social consequences. In this first part, I demonstrate the role social factors play in fostering illness within societies and in determining which groups in a given society will experience which illnesses with which consequences.

Chapter 1 introduces the sociological perspective and illustrates how sociology can help us understand issues related to health, illness, and health care. In the subsequent chapters, I discuss the role social forces play in causing illness and in determining who gets ill. Chapter 2 provides a brief history of illness in the Western world; I describe how patterns of illness have changed over time and assess the relative roles of social factors and medical advances in those changes. I then look at the social sources of illness in the contemporary United States. In Chapter 3, I investigate how four social factors—age, sex and gender, social class, and race or ethnicity—affect the distribution of illness in the United States and explore why some social groups bear a greater burden of illness than others. Finally, in Chapter 4, I describe the very different pattern of illnesses found in poorer countries and how social forces—from the low status of women to the rise of migrant labor—foster illness in these countries.

## CHAPTER 1

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## Introduction

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*In 1996, at the age of 46, my friend Lara learned she had breast cancer. Once her doctor concluded from Lara's mammogram (a form of X-ray) that a lump in her breast seemed cancerous, events followed in quick succession. The next day, a surgeon removed a piece of the suspicious lump for testing. A few days later, Lara learned that the lump was cancerous. That week, she got her affairs in order and signed a "living will" specifying the circumstances in which she would want all treatment stopped and a "medical power of attorney" giving me legal authority to make medical decisions for her if she physically could not do so herself. These two documents, she hoped, would protect her from aggressive medical treatments that might prolong her suffering without improving her quality of life or chances of survival.*

*Two weeks after the initial tests, her surgeon removed the rest of the lump as well as the lymph nodes under her arm (where breast cancer most often spreads). The surgery went well, but the subsequent laboratory tests showed that the cancer indeed had spread to some of Lara's lymph nodes.*

*Yet in many ways, Lara was fortunate. Her breast cancer was detected at a relatively early stage, giving her about a 65 percent chance of surviving for at least five years. Although she had no husband or children to turn to, her friends proved uniformly supportive. She received health insurance through her employer and had no fears of losing either her job or her insurance.*

*Nevertheless, cancer changed Lara's life irrevocably, making it, at times, a nightmare. Having breast cancer shook Lara's faith in her body and changed her sense of her physical self. At the same time, her illness threatened her relationships with others. Despite the supportive responses she received from friends and co-workers, she nevertheless feared they would drift away as her illness continued or that she would chase them away with her all-too-reasonable complaints, worries, and needs.*

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*Although she had far better health insurance than many Americans have, her debts for items not covered by insurance nonetheless mounted. In addition, she had to spend hours fighting her insurance company to obtain relaxation training and expensive but effective antinausea drugs to cope with chemotherapy's side effects. Yet the chemotherapy made her so ill she often found it difficult to function, let alone fight her insurance company. In addition, chemotherapy proved so toxic that it damaged her veins with each painful intravenous treatment. As a result, her doctors suggested inserting a semipermanent plastic tube into her chest wall so they could instead administer the chemotherapy through the tube. Although doing so would have reduced her pain, Lara rejected the suggestion because she felt that, with this sign of her illness physically attached to her body at all times, she would truly become a cancer patient, rather than someone for whom cancer was merely one part of her life.*

*After a year of surgery, chemotherapy, and radiation, Lara's physical traumas ended, although it took another year before she regained her former energy. Although her future remains uncertain, to date she is free of any signs of cancer.*

### **The Sociology of Health, Illness, and Health Care: An Overview**

Lara's story demonstrates the diverse ways illness affects individuals' lives. It also demonstrates the diverse range of topics that sociologists of health, illness, and health care can study. First, sociologists can study how social forces promote health and illness and why some social groups suffer more illness than others do. For example, researchers have explored whether working conditions in U.S. factories help explain why poorer Americans get certain cancers more often than wealthier Americans do. Similarly, sociologists can study how historical changes in patterns of social life can explain changes in patterns of illness. To understand why rates of breast cancer have increased, some researchers have studied the impact of women's changing social roles, and others have studied the impact of political forces that promote increased meat consumption. Second, instead of studying broad patterns of illness, sociologists can study the experiences of those, like Lara, who live with illness on a day-to-day basis—exploring, for example, how illness affects individuals' sense of identity, relationships with family, or ideas about what causes illness. Third, sociologists study how social factors affect health care providers. Some sociologists have analyzed how the status and power of different occupations have shifted over time, and others have investigated how power affects interactions between health care occupations (such as between doctors and nurses). Still others have examined

interactions between health care workers and patients, asking, for example, how doctors maintain control in discussions with patients or whether doctors treat male and female patients differently. Finally, sociologists can analyze the health care system as a whole. Sociologists have examined how health care systems have developed, compared the strengths and weaknesses of different systems, and explored how systems can be improved. For example, some have studied how U.S. health insurance companies can make it difficult for people like Lara to get needed care, explored why European countries do better than the United States at providing health care to all who need it, and examined whether European health care policies could work in the United States.

The topics researched by sociologists of health, illness, and health care overlap in many ways with those studied by health psychologists, medical anthropologists, public health workers, and others. What most clearly differentiates sociologists from these other researchers is the **sociological perspective**. The next section describes that perspective.

## The Sociological Perspective

Using a sociological perspective means focusing on social patterns rather than on individual behaviors. Whereas a psychologist might help a battered wife develop a greater sense of her own self-worth so she might eventually leave her abusive husband, a sociologist likely would consider therapy a useful but inefficient means of addressing the root causes of wife abuse. Most battered wives, after all, do not have the time, money, or freedom to get help from psychologists. Moreover, even when therapy helps, it takes place only after the women have experienced physical and emotional damage. The sociologist would not deny that individual personalities play a role in wife battering, but instead finds it more useful to explore whether social forces can explain why wife battering is much more common than husband battering, or why battered wives so often remain with abusive husbands. Consequently, whereas the psychologist hopes to enable the individual battered wife eventually to leave her husband, the sociologist hopes to uncover the knowledge needed by legislators, social workers, activists, and others to prevent wife abuse in the first place.

As this example demonstrates, using the sociological perspective means framing problems as *public issues*, rather than simply *personal troubles*. According to C. Wright Mills (1959: 8–9), the sociologist who first drew attention to this dichotomy:

*[Personal] troubles* occur within the character of the individual and within the range of his immediate relations with others; they have to do with his self and with those limited areas of social life of which he is directly and personally aware. Accordingly, the statements and the resolutions of troubles properly lie within the individual as a biographical entity and within the scope of his immediate

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milieu. . . . [Public] issues have to do with matters that transcend these local environments of the individual and the range of his inner life. They have to do with the organization of many such milieux into the institutions of an historical society as a whole.

For example, whenever a child dies from leukemia, it is a tragedy and a personal trouble for the child's family. If, on the other hand, several children in a neighborhood die of leukemia during the same year, it could suggest a broader public issue such as toxic contamination of the neighborhood water system. A sociologist would be likely to look for such a pattern, and to explore why, for example, polluting industries are more likely to build factories in poor, minority neighborhoods than in affluent, white neighborhoods. The sociological perspective, then, departs radically from the popular American belief that individuals create their own fates and that anyone can succeed if he or she tries hard enough.

The sociological perspective can help us identify critical research questions that might otherwise go unasked. For example, in the book *Forgive and Remember: Managing Medical Failure*, sociologist Charles Bosk (2003: 62–63) described a situation he observed one day on “rounds,” the time each day when recently graduated doctors (known as residents) and more senior doctors jointly examine the patients on a service, or ward:

Dr. Arthur [the senior doctor] was examining the incision [surgical cut] of Mrs. Anders, a young woman who had just received her second mastectomy. After reassuring her that everything was fine, everyone left her room. We walked a bit down the hall and Arthur exploded: “That wound looks like a walking piece of dogshit. We don’t close wounds with continuous suture on this service. We worked for hours giving this lady the best possible operation and then you screw it up on the closure. That’s not how we close wounds on this service, do you understand? These are the fine points that separate good surgeons from butchers, and that’s what you are here to learn. I never want to see another wound closed like that. Never!” Arthur then was silent, he walked a few feet, and then he began speaking again: “I don’t give a shit how Dr. Henry [another senior doctor] does it on the Charlie Service or how Dr. Gray does it on Dogface; when you’re on my service, you’ll do it the way I want.”

Dr. Arthur and the residents he supervised undoubtedly viewed this situation as a personal trouble, requiring a personal solution—the residents seeking to appease Dr. Arthur, and Dr. Arthur seeking to intimidate and shame the residents into doing things the way he considered best. Similarly, depending on their viewpoint, most nonsociological observers probably would view this as a story about either careless residents or an autocratic senior doctor. Sociologists, however, would first ask whether such interactions among doctors occur often. If they do, sociologists then would look for the social patterns underlying such interactions, rather than focusing on the personalities of these particular individuals. So, for example, based on

his observations in this and other cases, Bosk discovered that cultural expectations within the medical world regarding authority, medical errors, and the importance of personal, surgical experience had enabled Dr. Arthur and the other supervising doctors to humiliate residents publicly and to set policies based more on personal preferences than on scientific data.

Whereas Bosk investigated health issues within hospitals, David Kirp used a sociological perspective to explore health issues in the community. For the book *Learning by Heart: AIDS and Schoolchildren in America's Communities*, Kirp (1989) observed half a dozen communities around the country to determine why they responded in such different ways to the presence of schoolchildren who had acquired immunodeficiency syndrome (AIDS). The following events occurred relatively early in the history of the AIDS epidemic, in Swansea, Massachusetts:

For the members of the Swansea, Massachusetts, school committee, habituated to brief and sparsely attended bimonthly meetings in the century-old red brick administration building, the evening of September 11, 1985, was an eye-opener. More than seven hundred people, almost all parents, filled the high school auditorium, the biggest meeting place in town.

The people of Swansea are usually polite in their dealings with one another, but these parents were in no mood for good manners. They demanded to know why their superintendent and their school committee had acted differently than every other school official in the entire country. Why had they allowed a thirteen-year-old boy with AIDS—a boy named Mark, known and liked by many of the people, but now fatally tainted in their eyes—to remain in school?

Why, the parents asked, had people they trusted—a school committee they had elected, most of whose members were natives of Swansea, and a superintendent who had been a fixture in their schools for nearly three decades—exposed their children to the bizarre terror of AIDS? (Kirp, 1989: 16–17)

As in the case of Dr. Arthur and his residents, we could view the Swansea furor simply as an isolated event caused, depending on one's viewpoint, by either an unthinking and arrogant school board or uneducated and heartless parents. Probably the school board and the parents saw the problem in these terms and therefore focused, respectively, on calming the parents or overturning the school board's action. By looking at the variety of ways communities responded to the presence of schoolchildren with AIDS, however, Kirp was able to identify a different set of issues—politics, power, and stereotypes—and of causal factors, such as how the media fostered fears and how popular beliefs about the meaning of illness bred bigotry against ill persons.

In sum, the sociological perspective shifts our focus from individuals to social groups and institutions. One effect of this shift is to highlight the role of power. *Power* refers to the ability to get others to do what one wants, whether willingly or unwillingly. Power is what allowed Dr. Arthur to treat his residents so rudely and allowed some school boards to override the

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wishes of their communities. Because sociologists study groups rather than individuals, the sociological analysis of power focuses on why some social groups have more power than others, how groups use their power, and the consequences of *differential* access to power (i.e., some having more than others), rather than on how specific individuals get or use power. For example, sociologists have examined why doctors as a group proved more successful than nurses did in obtaining the power to control their working conditions and how recent changes in the health care system have limited doctors' power. Similarly, sociologists have explored how *lack* of power exposes poor persons and disadvantaged minorities to conditions that promote ill health, while limiting their access to health care.

### A Critical Approach

Although the concept of power underlies the sociological perspective, some sociologists do not emphasize power in their research and writing. Instead, some sociologists essentially take for granted the way power is distributed in our society, examining the current system without questioning why it is this way or how it might be changed. For example, some sociologists have investigated whether lower-class persons are more likely than upper-class persons are to suffer mental illness without first questioning whether definitions of mental illness might reflect an upper-class perspective regarding socially acceptable behaviors or whether the same behaviors might more likely be defined as symptoms of mental illness when performed by lower-class persons.

Those sociologists, on the other hand, who do *not* take for granted existing power relationships and who instead focus on the sources, nature, and consequences of power relationships can be said to use a critical approach. Critical sociologists recognize that, regardless of how power is measured, men typically have more power than do women, adults more power than do children, whites more power than do African Americans, heterosexuals more power than do gays and lesbians, persons with socially acceptable bodies more power than do persons who are disabled, and so on. Critical sociologists who study health, illness, and health care have raised such questions as how this differential access to power affects the likelihood that members of a social group will be exposed to illness-producing conditions or will have access to quality health care.

Critical sociologists also emphasize how social institutions and popular beliefs can support or reflect existing power relationships. For example, many researchers who study the U.S. health care system have looked simply for ways to improve access to care or quality of care within that system, such as offering poor people subsidized health insurance or providing financial incentives to doctors who practice in low-income neighborhoods. Those who use a critical approach have asked instead whether we could provide better care to more people if we changed the basic structure of the system,



such as by removing the profit motive from health care to reduce the costs of care for everyone.

Similarly, critical sociologists have drawn attention to how doctors' power and authority enable them to frame our ideas about health, illness, and health care. Most basically, these sociologists have questioned the very terms *health*, *illness*, and *disability* and have explored whether such terms reflect social values more than they reflect objectively measurable physical characteristics.

In any sociological field, therefore, those who adopt a critical approach will ask quite different research questions than will others. Within the sociology of health, illness, and health care, this approach translates largely to whether sociologists limit their research to questions about social life that doctors consider useful—a strategy referred to as **sociology in medicine**—or design their research to answer questions of interest to sociologists in general—a strategy referred to as the **sociology of medicine** (Straus, 1957). Research using the latter strategy often challenges both medical views of the world and existing power relationships within health care.

To understand the difference between sociology in medicine and sociology of medicine, consider the sociological literature on patients who do not follow their doctors' advice. Because doctors typically define such patients as problems, over the years many sociologists, accepting medical ideas regarding what questions need asking, have sought to determine how to “bring patients to their senses” and increase their compliance with medical advice. In contrast, sociologists of medicine have looked at the issue of compliance through patients' eyes. As a result, they have learned that patients sometimes ignore medical advice not out of stubbornness or foolishness but because their doctors have not explained clearly either how to follow the prescribed regimens or why they should do so. In other circumstances, patients have ignored medical advice because they have concluded rationally that the emotional or financial costs of doing so outweigh the potential medical benefits. Similarly, whereas those practicing sociology in medicine have studied various aspects of the experience of *patienthood*, those practicing sociology of medicine instead have studied the broader experience of *illness*, which includes but is not limited to the experience of patienthood. The growing emphasis on sociology of medicine and on the critical approach has led to a proliferation of research on the many ways illness affects everyday life and on how ill individuals, their families, and their friends respond to illness.

## Chapter Organization

This textbook demonstrates the breadth of topics included in the sociology of health, illness, and health care. The text covers both micro-level issues (those occurring at the level of interactions among individuals and small groups) and macro-level issues (those occurring at the level of the society as

a whole). In Part One, I discuss the role social factors play in fostering illness and in determining which social groups experience which illnesses. Chapter 2 describes the major causes of preventable deaths in the United States and how they have changed over time, including both long-standing problems such as cancer and emerging problems such as severe acute respiratory syndrome (SARS) and drug-resistant tuberculosis. This chapter demonstrates how social as well as biological factors affect health and illness. Building on this basis, Chapter 3 describes how age, gender, social class, and race or ethnicity affect which Americans get ill with which illnesses. Finally, Chapter 4 explores the nature and sources of illness in the poorer countries of Asia, Africa, and Latin America.

Part Two analyzes the meaning and experience of illness and disability in the United States. In Chapter 5, I explore what people mean when they label something an illness, as well as how social groups explain both why illness occurs and why illness strikes certain individuals rather than others. This chapter also looks at the social consequences of defining behaviors and conditions as illnesses. With this as a basis, in Chapter 6, I first explore the meaning of disability and then offer a sociological overview of the experience of living with chronic pain, chronic illness or disability, including the experience of seeking care from either medical doctors or alternative health care providers. Chapter 7 provides a parallel assessment of mental illness, describing what people mean when they label something a mental illness, analyzing the relationship between social factors and mental illness, providing a sociological account of the diagnosis and treatment of mental illness, and exploring the experience of living with mental illness.

In Part Three, I move the analysis to a more macro-level perspective. Chapter 8 describes the basic outlines of the U.S. health care system and examines some of the current problems with that system. I begin Chapter 9 by suggesting some basic measures for evaluating health care systems and then use these measures to evaluate the systems found in Canada, Great Britain, the People's Republic of China, and Mexico. I conclude this chapter by asking what useful lessons the United States can take from these other countries and by assessing the prospects for health care reform within the United States. Finally, Chapter 10 examines several health care settings, including hospitals, hospices, nursing homes, and family homes, and provides a social analysis of the technologies used in those settings.

Part Four shifts our focus from the health care system to health care providers. In Chapter 11, we analyze how doctors have achieved both prestige and professional autonomy and the factors now threatening their position. The chapter also describes the process of becoming a doctor, the values embedded in medical culture, and the impact of those values on doctor-patient relationships. Chapter 12 describes the history and social position of various other mainstream and alternative health care occupations, including pharmacists, lay midwives, osteopaths, and Christian Science practitioners. Finally, Chapter 13 presents an overview of bioethics, the study of

ethical issues involved in the provision of health care. The chapter discusses how bioethics can inform sociological debate and how sociology can inform bioethical debate. (Reflecting the importance of bioethics to understanding health, illness, and health care, each of the preceding chapters also includes an ethical debate on a topic related to that chapter.)

The glossary at the end of the book defines all essential terms used in the book. The first time a term appears in the book, it is defined and set in bold-face type. In case professors assign the chapters out of sequence, each term also appears in boldface type (without a definition) the first time it appears in any subsequent chapter. In addition, “Key Concepts” tables throughout help explain particularly complex and important topics.

Each chapter ends with suggested readings, review questions, and a section labeled “Getting Involved” that identifies pertinent nonprofit organizations. The suggested readings were selected not only because of the materials they cover but also because they are exceptionally well written and interesting. The study questions are designed to provide an overview of the chapter. Readers who can answer these questions should feel confident that they understand the material. Finally, the “Getting Involved” sections are included both as sources of additional information and as potential means through which readers can become personally involved in working on the issues raised in the chapters. Updated web addresses for these organizations can be found at this textbook’s Student Book Companion Site (click Sociology of Health, at <http://www.thomsonedu.com/sociology>). To show readers how individuals can make a difference, each chapter also includes a boxed discussion on an organization that has fought successfully to prevent illness or improve the lives of those who experience illness or disability.

## A Note on Sources

### Printed Sources

This book is based primarily on data from three types of printed sources: medical journals, sociological journals and books, and government and United Nations statistics. Before readers can evaluate this book and the conclusions drawn in it, they need to know how to evaluate these sources.

The most influential medical journals in the United States are the *Journal of the American Medical Association* and the *New England Journal of Medicine*. The comparable British journals are the *British Medical Journal* and *Lancet*. These journals are most influential for several reasons. Each has been in existence for several decades, proving its worth through its longevity. Each has a large readership, indicating that doctors take them seriously enough to pay for subscriptions. Each accepts for publication only a small percentage of submitted manuscripts, so these journals publish only the best articles. Finally, each uses peer review, sending every submitted manuscript to two or more reviewers for evaluation before the editors decide whether to publish it.

Much of the medical research presented in this textbook comes from these sources or from the *American Journal of Public Health*, published by the major professional association in public health. Because it is a specialty journal rather than a general medical journal and therefore has a smaller audience, the *American Journal of Public Health* is not as prestigious as the top medical journals. However, the standards for publication in this journal are as high as for the top medical journals, and all health care professionals take seriously anything published in it.

The most influential sociological journals in the United States are the *American Sociological Review*, the *American Journal of Sociology*, *Social Forces*, and, to a somewhat lesser extent, *Social Problems*. By general agreement, the most important journal in the sociology of health, illness, and health care in the United States is the *Journal of Health and Social Behavior*. Many of the sociological articles cited in this book come from these sources. Sociologists widely respect these journals for the same reasons that doctors widely respect the *New England Journal of Medicine*.

Although all these journals—especially the medical journals—sometimes print articles based on only a few cases, most of the articles cited in this book draw on large samples. As a result, the conclusions presented in these articles are more likely to reflect trends among the population as a whole rather than to reflect individual idiosyncrasies. For the same reason, the most methodologically sophisticated articles use **random samples**. In a random sample, researchers select participants in such a way that each member of a population has an equal chance of being selected (such as drawing names out of a hat, or interviewing every fifth person listed on a class roster). When a sample is randomly selected, researchers can be fairly certain that the selected individuals will statistically represent the population as a whole. In addition, these articles typically use statistical techniques to **control** for the impact of extraneous factors on the observed relationships. For example, researchers studying the relationship between smoking cigarettes and lung cancer can use statistical techniques to control for the impact of smoky work environments. To do so, they would first divide the population under study into those who do or do not work in smoky environments. They could then see if smokers were more likely than nonsmokers were to develop cancer in one environment, both environments, or neither environment.

Finally, this book draws heavily on statistics collected by the U.S. government and by the World Health Organization (WHO), a branch of the United Nations. Because these statistics are collected by nonpartisan bureaucrats whose employment typically continues regardless of shifts in the political climate, rather than by groups with a particular political agenda, they are generally regarded as the most objective data available.

This brief discussion of sources suggests several questions readers should keep in mind while reading this book. First, ask if the data come from a reputable source. Second, ask whether the data were peer reviewed or in some

other way checked for quality or potential bias. Third, ask about the size and nature of the study's sample as well as whether the study controlled statistically for possible confounding factors. Fourth, ask what questions the researchers asked in collecting their data and what questions they *should* have asked. For example, countries that define infants who die during the first week after birth as stillborns will appear to have fewer infant deaths than will countries that define these as infant deaths. Finally, ask if the data presented are sufficient to justify the conclusions. If not, ask what additional data are needed to reach a firmer conclusion and how one might obtain that information from reputable sources.

### Internet Sources

In addition to using printed sources, I obtained some of the information used in this book through the Internet. The Internet can be an excellent source for current statistics and an efficient way of learning about many topics. However, the vast wealth of materials available via the Internet and the ease with which anyone can post on it make it crucial for users to evaluate these sources critically.

When evaluating materials garnered through the Internet, readers can use the same principles used to evaluate printed materials. Most important, users must determine whether a reputable source provided the information; most of the information used in this book and obtained through the Internet came from either U.S. government sources or the World Health Organization. The source of an Internet page is often apparent in its address. Internet addresses for government agencies usually end with *.gov* and addresses for educational institutions usually end with *.edu*. Nonprofit organizations, like the Sierra Club or the Muscular Dystrophy Association, usually have addresses that end with *.org*. Commercial sites, on the other hand, usually end with *.com*; this ending applies to sites run directly by businesses, such as General Electric ([www.ge.com](http://www.ge.com)), as well as to sites run by individuals who purchase Internet access from businesses (e.g., addresses ending with *aol.com*). For example, in evaluating information about different treatments for cancer, you should probably give more credence to information obtained from [www.healthfinder.gov](http://www.healthfinder.gov) (a site run by the United States government) or from [www.mayohealth.org](http://www.mayohealth.org) (run by the nonprofit Mayo Clinic) than to information obtained from a site that ends with *.com* and that might reflect either one individual's views or the views of a business that earns its profits by selling a particular treatment. Be aware, though, that any individual or company can obtain an ".org" address. And keep in mind that websites identified by search engines such as Yahoo and MSN.com are likely to be sponsored by drug companies or others with commercial interests to protect (Green, Kazanjian, and Helmer, 2004).

Unfortunately, Internet sources come and go rapidly, and addresses change constantly, making it difficult to provide a reliable list of useful

**Box 1.1** *Useful Internet Sources*

**H**ere are several online sources you may find useful when reading this book:

**www.healthfinder.gov:** Run by the United States Department of Health and Human Services, this site offers a wide range of health information, as well as an extensive set of links to other government and nongovernmental health-related sites.

**www.nlm.nih.gov:** This site provides access to both published and unpublished materials available at the National Library of Medicine, the largest medical library in the world.

**www.mayohealth.org:** Run by the Mayo Clinic, this site offers both consumer health information and the opportunity to email questions to physicians.

**www.who.int:** Run by the World Health Organization, this website provides a vast array of information about health, illness, and health care around the world.

**hippo.findlaw.com:** An invaluable compendium of information on health law, policy, and regulations. Although run by a for-profit organization, “hippo” is highly regarded in the health field.

**scholar.google.com:** This branch of the Google® search engine takes viewers only to scholarly journal articles, on health as well as other topics. An excellent starting point for finding reputable information on any topic.

Internet sites. Box 1.1 suggests some currently useful Internet sources for health issues that seem likely to remain stable for the near future. Readers can find updated addresses and additional sources at this textbook’s website (located under Sociology of Health, at <http://www.thomsonedu.com/sociology>).

## Suggested Readings

Mills, C. Wright. 1959. *The Sociological Imagination*. New York: Grove Press. The classic statement of the sociological perspective.

Schwalbe, Michael. 2004. *The Sociologically Examined Life: Pieces of the Conversation*. 3rd ed. New York: McGraw-Hill. Another excellent introduction to the sociological perspective.

## Review Questions

What is the sociological perspective?

How do the questions sociologists ask differ from the questions asked by psychologists or by health care workers?

What does this textbook mean by a critical approach?

What are some ways a reader can tell if a journal article or Internet website is a reliable data source?

## Internet Exercises

1. Try different Internet search strategies to find information about writing a living will. First, try one of the major search engines, such as Excite, Yahoo, or AltaVista, which you can probably access by clicking on the word *Search* or on a “search” icon on the main menu of your Internet browser. What kinds of information (quantity, quality, type) do you find? Then try using Metacrawler ([www.metacrawler.com](http://www.metacrawler.com)), which searches and combines results from other search engines.
2. If you searched for “living will,” you probably found a great deal of irrelevant information. (Your search was probably more productive if you searched for “living wills.” Can you figure out why?) To make your search more effective, you’ll need to learn how to perform “advanced” or “power” searches. Instructions for doing so, or tips for searching, probably appear somewhere on the web page for your browser. For example, in some browsers, to find web pages on living wills (rather than on every document about living that includes the word *wills*), you must search for “living+wills,” whereas in other browsers you would need to search for “living wills.” Do your search again, using proper syntax to specify your request. How does this affect your results?
3. Now try the same search, using Medline, the major online archive for medical and other health-related journals. You might be able to access Medline through your college library or its website. Otherwise, you will need to first search for and then connect to the Grateful Med website, the library of a major university, or the National Library of Medicine (a branch of the National Institute of Health). Check your screen, and see if it offers instructions for narrowing your search, power searches, or advanced searches. How does the information you get from Medline differ from the information you found using a web browser?
4. Finally, try looking for articles on living wills in InfoTrac® College Edition, a large online archive of scholarly articles available through Wadsworth Publishing at [www.infotrac-college.com/wadsworth](http://www.infotrac-college.com/wadsworth). (You have free access to InfoTrac College Edition this semester if your professor ordered it when ordering this textbook.) If you don’t find anything after searching for “living wills,” try searching for “right to die” or for “advanced directives” (a general term referring to legal documents specifying what types of medical care an individual would want in a given situation).