Journal of Innovative Research in Management and Humanities 1(1), October, 2010.
Maiden Edition
© Global Research Publishing, 2010.

Effects of Ill Health and Morality in the Sick Role Model *(pp. 33-42)*

Ogege Samuel Omadjohwoefe
Department of Sociology, Delta State University Abraka, Nigeria.
Correspondence Email:samtase@yahoo.com

Abstract: The paper focuses on ill health and the issue of morality against the backdrop of the sick role - a functionalist approach to ill health initiated by Talcott Parsons. A fundamental reality is that being ill, is an unpleasant experience and has disruptive impacts on a group or society. What the ill person needs most is not blame but supportive interaction with family members and assistance from medical experts for him to get better. But more often than not, rather than gets the support, the gatekeepers of the sick role model morally evaluate ill health, thus, making the sick person blameworthy by attributing his/her ill health to moral failings and irresponsible lifestyle. The paper argues that moral evaluation of people with ill health or victim blaming ideology invalidates the sick role model. This serve as a legitimization of the denial of the rights and obligations of the sick person as stipulated by the sick role principle. The implication is that the individual is abandoned at the mercy of illness while its disruptive effect on the group or society prevails. The paper suggests re socialisation programme for the gatekeeper of the sick role as a way out of the crisis of moral evaluation of ill health.

Key words: heath, ill health, morality, sick role

1 INTRODUCTION

Globally, ill health is an unpleasant and possibly a life threatening experience. The moment illness starts, the person is left with no option than to seek assistance from physicians and others to enable him or her get better. However, the extent to which the sick person seeks medical assistance is a function of his or her illness behaviour. Illness behaviour refers to the way in which symptoms are perceived, evaluated and acted upon by a person who recognizes some pains, discomfort and other signs of organic malfunction (Mechanic, 1986). In other words, reactions to symptoms, use of social networks in locating help, and compliance with medical advice constitute some of the activities that characterized illness behaviour (Segall, 1996).

Illness does not only involve the body, it also affects people's social relationship, self image behaviour, and effective social functioning. The psychological aspects of ill health are related in part to the biophysiological manifestations of illness but are also independent of them. The very act of defining something as an illness has consequences that are independent of any effect of biophysiology. The issue is compounded if the sick person is

denied attention and assistance. It is on this note that the functionalist approach to ill health centres on the sick role model.

Ill health generally has potentially disruptive consequence on group or society. It is in order to minimise the potentially disruptive consequences of ill health in a group or society that the functionalist, Talcott Parsons maintains that there should exists a set of shared cultural norms known as the sick role model – basic expectations of the sick person and those that interact with him/her. The sick role model among others, legitimates the deviations caused by illness and help the sick person to recover and resume his usual responsibilities in society. An important component of the sick role is that sick people are not to be blamed for their illness but must work towards recovery as quickly as possible.

However, today, physicians and other medical care givers draw a linkage between illness and morality. Consequent upon this linkage, they blame the patient's ill health and attribute it to moral failings. Beside the blame associated with moral failings, certain illnesses are defined as discreditable attribute. Most times, the physicians and other medical care givers morally evaluate the self worth of the sick person before and during diagnosis and treatment.

The paper charts a tour on the issue of ill health and morality. It situates its discourse within Talcott Parson's functionalist framework of the sick role normative principle. Finally it examines the implications of the moral evaluation for the victims and put forward recommendations that can ameliorate the negative effects associated with the moral evaluation of sick people.

2 THE CONCEPTS OF HEALTH AND ILL HEALTH

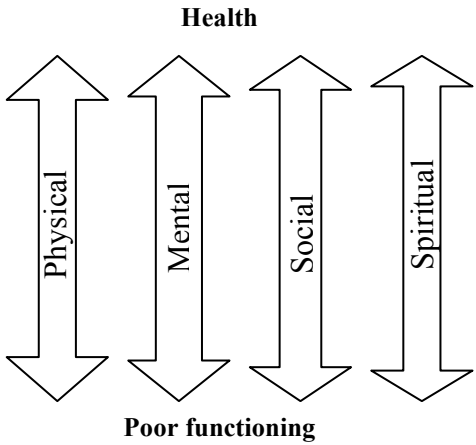
The application of science to medical diagnosis and cure was the major feature of the development of modern health care system. Disease came to be defined objectively in terms of identifiable objective signs located in the body.

The twin concept of health and illness are used by most people in everyday life without knowing exactly what health and illness refer to. A considerable divergence exists in views and understanding about the concepts and this is reflected in the academic debates about the nature of health and illness. Accordingly, the definitions of health and illness are polarized between those that rely upon objective and scientific criteria at one extreme and those that are based on the subjective awareness of individual on the other hand.

Traditional medical view has it that, there is something as a normal functioning of the body, which has a limited degree of variation (Turner, 1992). When operating within the normal boundaries of this variation, a person can be said to be healthy and when they are outside these normal boundaries, they are ill or their organs are diseased (Lawler, 1991and Shilling, 2003). Health therefore can be defined within this framework, as the absence of disease. At the other extreme, the World Health Organization definition of health is employed. WHO

(1974) defines health as not merely the absence of disease but a state of complete physical, mental, spiritual and social well being.

This positive approach to the understanding of health and illness acknowledges the concept of disease, but brings a much broader social element into the meaning. This implies that health is not just a physical state but also a wider sense of well-being, closely linked to our social surroundings (Armstrong, 1993), see the continuum of health and illness.



Source: (Fisher, 1996)

Figure 1: A Continuum of Health and Illness

The continuum is a portrayal of the definitional components of health and illness. From this continuum, it is rather out of place to think of people as either healthy or ill. It is more appropriate to think of them as healthier in some areas and less healthy in others. For instance, a certified mentally ill person may be okay in physical shape, while a person that is physically ill may be mentally healthy (Fisher, 1996).

Central to the variation in the definition of health and illness is the distinction between disease and illness. Eisenberg aptly distinguishes between illness and disease as;

> *Illness is experience of disvalued changes in states of being and social function… while disease is an abnormality in the structure and function of body organ and systems…. Illness is something that individuals experience as having unpleasant impact upon their lives and activities… while disease refers to abnormal*

*and harmful physical changes in the body (*Eisenberg, 1977).

It is possible therefore to have a disease and not to be ill, and to be ill and not to have a disease (Blaxter, 1990). For instance, in 1947 in South America, Spirochetes- a skin disease was so widespread and those afflicted were regarded as healthy and men who did not have the disease were actually discriminated against and even banned from marrying (Ackernecht, 1983). In a similar vein, women with hysteria (with it obvious symptoms as crying and sometimes laughing for no reason) were diagnosed as ill but not having a disease. Also, sufferers of myalgic encephalomyelitis (chronic fatigue syndrome) and Gulf war syndrome exhibit genuine debilitating symptoms yet medical opinion denied the existence of any objective disease (L' Esperance, 1977).

What is fundamental to sociologists is not the distinction between illness and disease, rather it is the poor social functioning of the person that has a disease or illness. It is the decline of the social functioning of the individual with ill health that determines whether the individual play the sick role. However, to play the sick role, the gate keepers; parents, significant others and physicians must certify it. They are the people who mediate between our feelings of illness and our claim of being ill.

2.1 Ill Health and the Sick Role Normative Model

The functionalist approach to the understanding of health and illness is derived from the work of Talcott Parsons. Functionalism is a dominant social theory in sociology. The theory has society as its basic unit of analysis. Functionalists view society as a system with interconnected parts which make up the whole. Its emphasis is the working together of the various units of society for the maintenance of society. There are basic needs known as functional prerequisites which must be meant for society to function effectively and harmoniously. The moment, the basic needs of any of the units is affected, society is disrupted and this move society to a state of disequilibrium (Parsons, 1951).

The genesis of Parsons analysis is that all social actions can be understood in terms of how they help society to function effectively or otherwise. When an individual is sick, he or she is unable to perform his or her social role or responsibilities effectively and this disrupts the effective functioning of society. Illness therefore is seen as a form of deviation and it has to be controlled in a way for the individual to retrace his/her steps to the path of 'conformity' so as to enable him/her perform his or her role again. According to Parsons (1990), this can only be achieved through adherence to the sick role normative principle.

Parsons sees illness as a social concept rather than a biological one. Being ill therefore means acting in different deviant ways contrary to the norms and culture of a given society. Thus, illness generally has a potentially disruptive consequence on a group or society. In other words, if society is to function effectively as a stable system, it becomes fundamental that people should be healthy for them to contribute substantially to society. Consequently,

illness is viewed as a form of deviant behaviour which must be controlled by society through the sick role normative principle.

The sick role normative principle is a set of patterned expectations that defines the norms and values appropriate for persons with ill health and for those who interact with them. According to Parsons (1951) the sick role normative principle has four elements: The elements or components of the sick role are:

- The person with ill health is not personally responsible for being sick. Illness is seen to be caused by forces beyond the individual's control. The sick person therefore cannot be blamed for his/her illness, but, have the right to be looked after by others. The sick role automatically absolves the person of any blame for his ill health.
- The sick person has the right to be legitimately excused from normal responsibilities and behaviour for instance the sick person should be exempted from certain duties either within or outside the home. Also behaviour that is not as pleasant or thoughtful as usual should be excused.
    - The sick person must as a matter of fact accept his condition as undesirable and so must want to get well so that they can return to take up the responsibilities he or she is exempted from on health ground. In other words, the sick role is considered a temporary role that a person must relinquish as soon as his or her condition improves sufficiently. Consequently, an individual who does not return to his or her regular activities and behaviour in a timely fashion may be labeled as hypochondriac or malingerers.
    - The sick person must actively seek to regain health by seeking the assistance of a medical expert and he (she) agreeing to become a patient. In order to occupy the sick role, the sick person must be prepared to receive the sanction of a physician or its equivalent that legitimates and validates his/her claim of illness. Confirmation of illness via expert opinion is a very crucial step in determining how family members and others relate with the person with ill health.

The first two components of the sick role are the rights of the person with ill health while the other two are his/her obligation. The right components of the sick lay emphasis on what the sick enjoys from those around him be it family members, friends or others. The obligatory components bother on what is expected of the sick person regarding his/her ill health.

The sick role normative model has the parents and medical experts as its primary gate keepers. They mediate between the feelings of illness and the individual's claim of being sick (Kendall, 2001). For instance, before a parent calls the school to excuse a child's absence, he/she decide whether the child is faking or has genuine symptoms serious enough to allow the child stay at home. A medical doctor's excuse or medical report actually

permits the sick person to play the sick role and at the same time deters the employers and others from invalidating the individual's claim of being sick.

2.2 Ill Health and Morality: A Negation of the (Parsons, 1951) Sick Role Normative Model

Although, ill health is a physical problem, most time, it is viewed in moral terms. Despite the dominance of the biomedical model over the traditional model in the understanding of ill health and the sick role principle, people most time establish a linkage between ill health and morality. People attribute ill health to moral failings. In otherwords, they lay blame for illness on the sick person (Helman, 1996).

Thus, the set of patterned expectations that defines the norms and values appropriate for persons with ill health and for those who interact with them are most times jettisoned on moral grounds. There are persons with ill health out there that receive blame for their ill health and are seen as responsible for their illness. People with lung cancer, obesity, being HIV positive and having AIDs are blameworthy because the illnesses are erroneously believed to be caused by their chosen lifestyle. For instance, people with lung cancer are blamed for excessive smoking, obesity for over eating, excess beer in take and lack of exercise. AIDS is linked to reckless sexual activity (William, 1971, Gillborn, and Hamnet, 2004). The overall picture is that illness that are blameworthy are attributable to moral failings on the part of the person with the ill health and therefore, the cause of their illness attributable to is their own wrong lifestyle (Crawford, 1991). This experience is an outright violation of the first component of Parsons' sick role which stipulates that a person cannot be blamed for his illness but, rather the person deserve the right to be looked after.

Apart from illnesses that are blamed on moral failings of the sufferers, certain illnesses also defy the sick role principle. For instance, sufferers of leprosy and epilepsy are vulnerable to discreditable responses from family and other members of society on moral grounds (Perlman 1977, Ewhrudjakpor 2004). Consequently, people that are supposed to look after them as the sick role normative model demands, relate with them on the basis of expectations derived from this impression and negative moral evaluations of the illness (Chalden, 2006). According to Goffman (1959) moral evaluation forms the basis for stigmatization of the person with ill health.

The morally evaluated discreditable illness such as epilepsy is fraught with a constant threat of grave medical crisis. The epileptic patient may go into convulsion and be killed in fire, pool of water or traffic accident (Temkin, 1971, Trimble, 1989, Scambler and Hopkins 1996). The crises need to be controlled by family members and friends in other to minimize the impact on the sufferer. On the contrary, the dictates of the sick role normative principle is rarely adhered to and the sufferer is blatantly denied his right to assistance. This experience is aptly captured by Utakan Diegbe:

> *Instead of getting the needed assistance from family members and friends, the epileptic is abandoned to cope with the crisis alone. During convulsion, non sufferers stay far away from the victim or even ignore him or her. Apart from this unnecessary abandonment people are also warned out of ignorance against touching the victim until he regains consciousness (Diegbe, 1999).*

Another area where people with ill health suffer from moral evaluation is in the hands of those responsible for dispensing professional medical services. This experience is mostly prevalent in public hospitals, where a significant percentage of patients are from the lower class in society. Their moral evaluation of the patient bothers on self worth or devaluation of the patients (Goffman, 1970). A common negative evaluation is drunkenness usually associated with men. They are more consistently treated as undeserving. They are frequently handled as if they were baggage. Those with lacerations are often roughly treated only for drunkenness and obvious surgical repairs without being examined for other pathology. No one believes their stories, their statements are ridiculed and they are treated in an abusive or jocular manner, and often ignored for long period (Gold, 2000). The reason for their behaviour is anchored on a simple moral syllogism that drunks do not deserve to be cared for or to be given good treatment (Belknap, 1996).

The moral evaluation is not reserved for only men. A common negative evaluation for women is pelvic inflammatory disease. This is not just a medical diagnostic category, but, by implication, a moral judgment especially for unmarried lower class women with difficult – to – diagnose abdominal pain or fever. Professional medical officials frequently make the erroneous assumption that their problem is as a result of dissolute sex life, unwanted pregnancy and perhaps veneral diseases, frequent abortions and consequent infection of the reproductive organ. Such patients are relegated to a group less deserving of prompt and considerate treatment (Cartwright, 1988, Hurley, 1991).

3 CONCLUSIONS

From the above discourse, the contention that currently pervades ill health issues is that of moral evaluation. The person with ill health is now seen as irresponsible in behaviour and other aspect of his/her lifestyles. Consequent upon this, he/she becomes blameworthy. Without any detailed diagnosis, it is assumed and concluded that based on the obvious symptoms, his/her ill health is as a result of his/her peculiar lifestyle. At times, certain illnesses are defined as discreditable attributes and on the basis of this, are stigmatized. At the institutional level, there are also negative evaluations from professional health care workers. Ill health is a complex issue that not only affects the individuals excellent social functioning but also that of society. That explains while Talcott Parsons came up with the concept of the sick role normative model – the set of patterned expectations that defines the norms and values appropriate for individuals with ill health and for those who interact with

them. Central to the sick role principle is that the person with ill health is absolved of blame for his illness and as a matter of right and obligation requires the assistance of those around him and the medical services of competent physicians.

The rationale behind the strict adherence to the sick role normative principle is to protect the individual as well as to help him/her recover quickly so as to resume his/her usual responsibilities. This by extension erases the disruptive effect on society thus bringing it back to a state of equilibrium. Regrettably, these expectations and values associated with the sick role are relegated to the background as a result of morality or what could be referred to as the victim blaming ideology.

The outright negation of the sick role normative principle serves as a legitimization for the denial of the rights and obligations of the persons with ill health. This has grave implications for the individual, group and society. At the individual level, the sufferer is faced with the problem of coping with medical crisis of the illness. This could prolong recovery and can eventually leads to unmerited death. For the group and society, while the illness is on the role played by the sick person is grossly affected. This by extension leaves society in a perpetual state of disequilibrium.

Finally, it is obvious that at both micro and macro level, the non adherence to the sick role normative principle has detrimental effects. One way out of the moral evaluation of illness is through resocialisation programme that are centered on conformity with the norms and values of the sick role normative principle. This will enable people with ill health enjoy their rights and obligation of the sick role so that their recovery is facilitated for them to take up their usual responsibilities for group and the stability of society.

There should be a general overhauling in values that emphasis moral evaluation of persons with ill health. Sick persons should undergo proper diagnosis devoid of moral sentiments. This will enable the gatekeepers of the sick role normative ensure that sick person is not treated as a misfit in society. It should be borne in mind that, anybody can be a victim of ill health. Also those who are healthy today can be ill tomorrow and verse versa.

4 REFERENCES

Ackernecht E.A. (1982). *A Short History of Medicine.* Baltimore M.D. Johns Hopkins University Press.

Armstrong D. (1993). *The Political Economy of the Body*. Cambridge: University Press.

Belknap A. (1996). *Human Experience in a Public Hospital*. New York: McGraw Hill.

Blaxter M. (1983). *The Causes of Disease: Women Talking*. Social Science and Medicine 17(1)

Blaxter M. (1999). *Health and Lifestyl.* London: Routledge.

Cartwright K.L. (1988). *The Medical Services in Public Hospitals.* Ormskirk: Causeway Press.

Chalden K. (2006). Stigma and Identity Question. New York: John Wiley & Sons.

Diegbe U. D. (1999). *Attitude of Urhobo People Towards Epileptic Patients. A Case Study of Ughelli North LGA*. A B.Sc Thesis, Department of Sociology. University of Calabar, Nigeria.

Eisenberg D.M. (1977). Disease and Illness: Distinction Between Professional and Popular Idea of Sickness Culture.
Medicine and Psychiatry Vol.4 Pp 3-19

Ewhrukjakpor C. (2004). *Knowledge and Attitude of Health Workers Towards Leprosy Patients in Delta State:* A Ph.D. Dissertation, Department of Sociology & Psychology Delta State University, Abraka.

Fisher S. (1996). *Understanding Health and Illness*. New Brunswick: Rutgers University Press.

Gillborn J.E. Hamnett B. (2004). *Blaming the Patient New Brunswick*: Aldine Transaction.

Goffman E. (1959). *Presentation of the Self in Everyday Life*. New York: Doubleday Anchor

Goffman, E. (1970). *Stigma*: *Notes on the Management of Spoiled Identity.* Harmondsworth: Penguin.

Gold R.L. (2000) *The Human Shape of Medical Service*. New York: John Wiley.

Helman B.C. (1996) *Ill Health and Morality*. New York; Shocken Books.

Hunt P. (1996). *Stigma: The Experience of Disability*. London: Geoffrey Chapman

Hurley R. (1991). *The Health Crisis of the Poor.* in Dreitzel (ed) The Social Organisation of Health. New York: Macmillan.

Kendall, D.E. (2001). *Sociology in Our Times*. Belment CA: Wadsworth Publishing Co.

L'Esperance J. (1977). *Doctors, Women and Nineteenth Century Society: Sexuality and Role* in Woodwards & Richards (eds) Health Care and Popular Medicine in Nineteenth Century England. London: Croom Helm.

Lawler J. (1991). *Behind the Screens: Nursing, Somology and the Problem of the Body*. Edinburgh: Churchill Livingstone.

Mechanic D. (1968). The Concept of Illness Behaviour. *Journal of Chronic Diseases*. Vol.7 Pp 3-9

Parsons, T. (1951). *The Social System*. Glencoe: Free Press.

Parsons, T. (1960). *Towards a Healthy Maturity*. Journal of Health and Social Behaviours, Vol. 1. Pp 51-57

Perlman, L.G. (1977). *The Person with Epilepsy: Lifestyle, Needs, Expectations*. Chicago: National Epilepsy League.

Scambler G. (2002). *Health and Social Change: A Critical Theory*. Buckingham: Open University Press.

Scrambler G.E. Hopkins A. (1996). Being Epileptic: Coming to Term with Stigma. *Journal Health and Illness* Vol. 8. Pp 7-14

Segall A. (1996). The Sick Role Concept: Understanding Illness. *Behaviour Journal of Health and Social Behaviour* (Vol 4) Pp 24-31

Shilling C. (2003). *The Body and Social Theory*. London: Sage.

Temkin, O. (1971). *The Falling Sickness.* Maryland: John Hopkins Press.

Trimble, M.R. (1989). *Chronic Epilepsy: Its Prognosis and Management*. Chrehester: John Willy and Sons

Turner B.S. (1992). *Regulating Body: Essays in Medical Sociology*. London: Routledge.

William R. (1971). *Blaming the Victim*. New York: Vintage Books