



Stability and change in disease prestige: A comparative analysis of three surveys spanning a quarter of a century



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ABSTRACT

In this paper, we present a comparative analysis of three survey studies of disease prestige in medical culture. The studies were conducted in 1990, 2002 and 2014 using the same research design. In each of the three rounds, a sample of Norwegian physicians was asked to rate a set of 38 diseases on a scale from 1 to 9 according to the prestige they believed health personnel in general would award them. The results show a remarkable stability in the prestige rank order over 25 years. The top three diseases in all three surveys were leukaemia, brain tumour and myocardial infarction. The four lowest ranked were fibromyalgia, depressive neurosis, anxiety neurosis and hepatocirrhosis. The most notable change concerns apoplexy (brain stroke), which moved from a rank of 33 to 29 and then to 23 over the three rounds. We argue that the stable pattern, as well as this change, substantiate the interpretation of previous research, i.e. that the prestige of a disease is affected by the localization of the affected organ or body part, the effect and style of its typical treatment, and the social attributes of the typical patient. Analysing physicians' shared evaluations of different diseases, the paper contributes to the cultural understanding of disease conceptions in medicine. Understanding these conceptions is important because disease prestige may influence decision-making in the healthcare sector.

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1. Introduction

Medical professionals rank disease categories in a prestige hierarchy (Album, 1991; Album and Westin, 2008), which is an order of regard or esteem (Nørredam and Album, 2007). The disease prestige hierarchy in medicine, therefore, expresses the unequal standing of diseases among physicians. Disease categories ranked at the top, such as myocardial infarction, brain tumour and leukaemia, are held in high regard, while those at the bottom, such as fibromyalgia and anxiety neurosis, are held in low regard. Notions of what is prestigious and what is not influence the aspirations of social agents (Bourdieu and Wacquant, 1992). Therefore, patterned differences in disease prestige are a significant aspect of medical culture, with likely effects on decision-making in the health services.

Systematic and comparative analysis in the related field of occupational prestige has shown patterns of valorisation to be very

stable over time (cf. Treiman, 1977). To our knowledge, there has been no systematic analysis of the stability of disease prestige hierarchies. Revealing the trends of stability and change in the rank order of disease categories will enhance our understanding of disease prestige in particular, and of evaluative patterns in medical culture in general. The aim of the present paper is a contribution to that end.

Our research question is: Does the disease prestige hierarchy change over time? To address this question, we compare survey data elicited at three different times (1990, 2002, 2014) spanning a quarter of a century. All three surveys were conducted using the same research design (sampling, data collection, questionnaire). Although data from the 1990 and 2002 surveys have been used in research publications (e.g. Album and Westin, 2008), they have not been systematically compared. The 2014 survey was conducted for the purpose of comparison across three rounds. Together, our data constitute a solid foundation for comparing temporal patterns of disease prestige.

In the remainder of the paper, we present the concepts of prestige and disease prestige, describe our method of study, and review and discuss the results.

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2. Concepts

2.1. Prestige

Prestige is a measure of regard or esteem (Nørredam and Album, 2007: 655). Together with power and economic resources, prestige is one of the three basic forms of social inequality, a concept that originated with Max Weber (1978). A related concept is stigma (Goffman, 1968; Link and Phelan, 2001; Scambler, 2009), which covers the lower end of the prestige scale. Today, prestige research can be seen as part of the emerging sociological subfield of valuation and evaluation (Lamont, 2012).

The prestige concept has five defining characteristics (Nørredam and Album, 2007; Johannessen, 2014). (1) Prestige is an evaluative concept. (2) It is cultural, depending on consensus, i.e. shared views (Zhou, 2005: 97–8), and “shared norms and values regarding the relative position of attributes in a hierarchy of value” (Treiman, 1977: 20). (3) It is relational: a category can only be evaluated in (implicit or explicit) comparison with other categories. (4) It is an autonomous principle of stratification, irreducible to the two other forms of social inequality (although they empirically affect each other) (Hatch, 1989), and (5) the prestige concept applies to all meaningful objects. Although this last characteristic has long been acknowledged at a theoretical level (Parsons, 1954: 386–92; Treiman, 1977: 19–20; Shils, 1968: 104–5), empirical research has hitherto focused almost exclusively on human agents (e.g. individuals or groups) as the unit of analysis, leaving the prestige of other objects, such as scientific journals and universities, to other media. The same tendency is found in research on social differences in medical attention and treatment – research on “good and bad patients”, predominantly focusing on individuals and their traits (Becker, 1993; Dingwall and Murray, 1983; Dodier and Camus, 1998; Jeffery, 1979; Kelly and May 1982; Lorber, 1975; Roth, 1972; Sudnow, 1967; Timmermans, 1998, 1999; Vassy, 2001). The notion of disease prestige runs counter to this analytical trend.

2.2. Disease prestige

Analysing the prestige of diseases, this paper treats diseases as cultural categories. As such, diseases convey connotations in the form of stories, images and identities. To talk about the meaning of diseases is, therefore, to talk about the associations that thinking about them can bring to the fore. For instance, talking about AIDS can make people think about a person's sexual practices and moral fibre, not just the state of his or her immune system (see Sontag, 1988). In other words, diagnoses are meaningful, and their meanings are not restricted to the “strictly medical”, neither for lay people nor for medical professionals. Disease categories can be ranked according to their prestige, because they have various and frame (Goffman, 1974) dependent meanings.

The idea that any object – ideational or material – can be more or less prestigious dates back to at least 1954, when Parsons wrote that “Stratification in its valuational aspect (...) is the ranking of units in a social system in accordance with the standards of the common value system” (1954: 388). Although he was preoccupied with the status of occupations, Parsons underlined that “care has been taken to use the very general term ‘unit’ as the ‘that which’ to which ranking evaluation is applied” (1954: 388). Parsons (1954: 386–92) therefore maintained that in principle, all units – including concepts and categories – can be stratified according to cultural value and meaning (Treiman, 1977: 19–22).

Later, Parsons (1958: 170) explicated, “Health and illness are not only ‘conditions’ or ‘states’ of the human individual (...). They are also states evaluated and institutionally recognized in the culture and social structure of societies”. In line with this, Canguilhem

proposed that diseases are ordered in a “vulgar hierarchy (...) based on the extent to which symptoms can – or cannot – be readily localized (...)”, and that diseases at the top of such a hierarchy were “more of a disease” (1991/1966: 39).

Hierarchies of disease categories have been studied empirically using the concept of *disease prestige* as a lens (Album, 1991; Album and Westin, 2008; Johannessen, 2014; Grue et al., 2015; Haldar et al., 2016). The concept was coined by Album (1991). During the course of fieldwork, he noted implicit evaluations in physicians' talk of diseases. Moreover, he discovered that, when asked, physicians could rate disease categories according to prestige. Inspired by the long-standing tradition of research on occupational prestige (Treiman, 1977) and medical specialty prestige (Matteson and Smith, 1977; Schwartzbaum et al., 1973; Shortell, 1974), Album conducted a survey in which he asked physicians to rate 38 disease categories according to the prestige they believed health personnel would in general award them.

The results showed that physicians were able to rate all 38 disease categories consistently, placing myocardial infarction, leukaemia and brain tumour at the top, and fibromyalgia, hepatocirrhosis, depressive neurosis and anxiety neurosis at the bottom. The same survey was repeated in 2002 (Album and Westin, 2008).

Based on interpretation of the survey results, extensive reading of the literature, qualitative interviews and informal conversations with physicians from several specialties in connection with ethnographic field work in a gastro-surgical ward, Album and Westin (2008: 186–7), suggested three sets of prestige criteria – or “deference entitlements” (Shils, 1968: 106) – that seem to structure disease rankings. The first is related to the disease and its typical trajectory. Non-self-inflicted, acute and lethal diseases with clear diagnostic signs, located in the upper part of the body, preferably the brain or the heart, are typically awarded high prestige. The second set of criteria is related to the typical treatment of the disease. Disease categories associated with active, risky and high technology treatment leading to a speedy and effective recovery are awarded high prestige. The third set of criteria is related to the typical patient with the disease. Disease categories associated with young patients, patients who accept the physician's understanding of the disease, and whose treatment results do not involve disfigurement, helplessness or other heavy burdens, are awarded high prestige (see Album and Westin, 2008; Johannessen, 2014 for more in-depth discussions).

Patients' illness concepts have long been conceptualized as cultural, as more or less shared understandings of bodily and social experiences. In our investigation of disease prestige, we treat physicians' disease concepts as cultural in exactly the same sense. In this, we follow Freidson (1970: 209), who remarked, “biological deviance or disease is defined socially and is surrounded by social acts that condition it”. Therefore, “The disease side of the disease/illness conceptual distinction is also ripe for social constructionist analysis, insofar as what gets labeled a disease or qualifies as biological is often socially negotiated” (Conrad and Barker, 2010: S68). Our study thus relies on a social constructionist view of medical knowledge (Armstrong, 2002; Arksey, 1994; Jordanova, 1995; Löwy, 1988; Nicolson and McLaughlin, 1987; Wright and Treacher, 1982), and of disease categories in particular (Aronowitz, 1991; Atkinson, 1995; Mol, 2002; Nicolson and McLaughlin, 1988).

3. Methods

3.1. Questionnaire

We use data from three rounds of questionnaire studies (conducted in 1990, 2002 and 2014) of how physicians rate disease

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