Medical Sociology and Social Theories of Health and Disease

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Introduction:

The relationship of sociology with medical knowledge from the beginning was not an easy task between two different scientific fields to produce knowledge of disease, health and health care. Rather, sociological intervention in the field of medicine was not acceptable by specialists in the medical field. However, with the development of social life and overlapping multiple factors in the emergence of diseases, their diagnosis and methods of treatment, the gradual opening of medicine to sociology appeared in an attempt to introduce some social factors in the interpretation of diseases, the role of the patient, the relationship between the doctor and the patient, and the formulation of some scientific approaches and theories. With the prosperity of the medical profession in late of 19^{th} century and the beginning of the 20^{th} century, which resulted in awareness of the importance of social factors in explaining disease, the impact of interpersonal relationships in treatment led to a conflict between traditional and modern medical thought, which was resolved towards adopting modern scientific trends that believe in the integration of sciences. On the one hand, sociologists had a prominent role in the appearance of a novel branch of knowledge in the field of sociology called medical sociology. Medical sociology deals with medical issues in society after studying the phenomena related to health and disease as they are social phenomena. This branch was prominent especially in the thirties of the twentieth century and the post second world war period due to the spread of chronic diseases and the increase in the proportion of the elderly in society, mentally ill and psychologically troubled people, and the handicapped, as well as the development of health services, the increase in specializations. A kind of diseases is in need to a psychosocial treatment before it can be treated medically. All of these factors pushed towards an integration not only between medicine and sociology, but also between medicine and other social sciences. Although medical sociology is newly emerging, the relationship between it and social theory began to develop rapidly,

making medical sociology distinct between the social and behavioral sciences related to health and disease. It has made tangible progress with regard to the interpretation of the social aspects of public health and health services and in developing advanced research designs, including the formulation of conceptual frameworks - the pattern of concepts, assumptions, expectations, beliefs and theories that underpin the research.

As for the main factors determining what is medical sociology, it was the institution of medicine and health care, the development of patterns of relations between the doctor and the patient, the diversity of health perspectives, the understanding of the influence of social factors on health, knowledge of the biological, psychological, social and cultural dimensions of health behavior, as well as the basic developments in the field of health technology and other factors in sociology. We will review the most prominent social theories such as functional constructivism, conflict theory and symbolic interactionism, poststructuralism and feminist theory that tried to explain changes in the social aspects of health and health care from different angles.

Before presenting these perspectives, it is necessary to first define four basic concepts of health, medicine, health care and medical sociology that fall within the interpretation of the topics. Health: It is the ideal state of a person's physical, mental and emotional and social structure where the person is free from any disability or disease.

Medicine: It refers to the social institution that seeks to prevent, diagnose and treat illness and promote health in its various dimensions.

Health care: It refers to the availability of medical services to prevent the spread of diseases and treat health problems. (Who, 2009)

Medical Sociology: The mechanics of medical sociology is defined as "the group of efforts aimed at developing sociological ideas within medical contexts, and at studying important application issues in relation to disease processes and patient care." Dr. Abdullah Muammar al-Hakimi defines it as "that branch of sociology that studies the process of social interaction within the medical institution, whether this interaction is between its workers and patients or between workers with each other, as well as the relationship between the patient and the master of the art of treatment even if he does not belong to a health institution It is also the branch that studies the social aspects related to health and disease "(Al-Hakimi, 2017).

First - structural and functional perspective:

Human society can be likened to a living being, in terms of the structure and functions that each of them perform. The perspective made some medical sociologists believe that disease, health and health institutions can be analyzed within the reference framework of the changing social pattern.

Parsons views society as a social system that contains sub-systems that have reciprocal relations with other systems, all of which work to achieve and maintain the balance of the general social order. Parsons believes that the deviation of a system from the standards and failure to perform its function leads to social deviation, which threatens the system to collapse. However, this deviation, in his view, can be corrected by mechanisms led by other sub-systems in the interest of resisting the deviation and returning the deviated system to its normal state to perform its function in such a way as to ensure the balance and social stability of the overall system.

Parsons made an outstanding contribution to medical sociology by formulating constructivist theory of structural Functionalism (Cockerham, 2007; 29). Parsons sought to analyze the behavior of individuals in the context of the major social systems influencing social interaction. His focus is on ill health in relation to its effect on the wider functions of society, which prevents people from fulfilling their social roles. Talcott Parsons defined disease or illness as a social phenomenon before it was a biological one. He defined health as meaning the individual's inferior ability to perform his usual social roles (Parsons, 1951). On the basis of this perspective, Parsons believes that the patient has roles to be played before his illness, and upon exposure to the disease those roles are disrupted. Accordingly, it becomes necessary to find a social mechanism that corrects any defect that afflicts members of society in order to restore them to their normal state. To explain this important issue, Parsons has developed a functional construct model that includes the concept of the "role of the patient."

The role of the patient and the association among the doctor and the patient:

One of the most consistent explanations for the behavior of morbidity in Western society is the concept of the patient’s role, inferred by Parsons in 1951. Although disease may be the result of infection or accidents, it becomes necessary for the patient upon contracting the disease to seek medical advice and cooperate

with physician. Accordingly, Parsons describes the role of the patient consists of four basic elements:

1- The infected man is exempted from his usual social roles

2- The infected individual burdens no responsibility for his illness.

3- The infected person should seek help to get rid of the disease.

4- The infected person must seek effective professional assist and collaborate with the doctor, however, the exception that the sick person gets from his usual social roles, requires proof of the validity of his illness with a certificate issued by the doctor supervising the treatment.

As a result, the patient and the doctor have an integral but not equal role relationship. The relationship is integrated because both the doctor and the patient need the other to fulfill the requirements of their own roles, and it is not equal because the doctor has supreme authority or directive power over the patient's behavior. Parson's concept of the role of the patient is a useful social approach to disease behavior because it depicts the relationship between the doctor and the patient within a frame of reference for social roles, attitudes and activities that make the two parties confront each other in a situation of illness. The role of the patient raises a set of regular expectations that define appropriate standards and values for the patient, for both the individual and others interacting with the sick person. Thus, the behavior of those involved is articulated in an interactive and predictable manner. Besides Parsons's contribution to the understanding of morbid behavior, he also describes the function of the medical profession as a form of social control. Parsons believes that impairment disrupts the functioning of society because it is a condition in which people can evade their social responsibilities. Some people even wish to preserve the role of the patient permanently in order to justify failure (Cole and Lejeune 1972). As well as exemption from the usual obligations and obtaining other privileges usually granted to the patient. For this reason, medicine becomes a mechanism by which the social system can restore patients to their normal state.

As for the doctor's role, it is focused on providing the best possible services to patients for their recovery and achieving a healthy life for all of them. This requires from him a high level of specialization, scientific practice and experience as well as taking into account the humanitarian aspects when dealing with patients. Parson's concept of the role of the patient has stimulated a number of researchers to

follow it and take different positions, including the positive and the negative. Nevertheless, the concept is still important as an ideal pattern that is conducted in the light of other studies.

Multiple models of patterns of social interaction between patient and doctor:

Hollander and Szasz (1965) tried to expand on Parsons' one-dimensional model by defining three types of therapeutic relationships between patient and physician: the negative-positive connection, directed collaboration, and mutual involvement. The doctor-patient relationship is not always characterised by collaboration; it may sometimes be characterised by conflict and antagonism. Fredson also identified three types of legitimacy for a sick person: Conditional legitimacy exempting patients completely, legality is unconditional exempting patients from their duties permanently and allowing them to obtain additional privileges because they are afflicted with diseases that cannot be cured quickly, and the illegality of relieving deviants from some of their usual obligations (Morgan, 1993). As the doctor belongs to the universal scientific reference system, Fredson underlined that the response to the sickness and the expectations of the ill person may change from one group to the next based on the varied cultural patterns of each of them and the patient belongs to the local reference system (Freidson, Eliot 1970).

Behavior of asking for professional medical services:

The behavior of asking for treatment is an issue based on the fact that some patients seek immediate help from doctors when symptoms appear while others hesitate or refrain from doing so, even though they are in the same condition. Despite, they are more inclined to seek medical help when their normal, functional organic treatment is more disturbed than they are affected by the nature of the side effects. Mechanic emphasizes that pathological experience is shaped by sociocultural and socio-psychological factors, regardless of their physiological or genetic dimensions or any other organic factors (Mechanic 1986). In order to shed light on these issues, we present Mechanics' disease behavior.

Disease behavior analysis:

Mechanics defines the disease behavior as a disease that worries its owner and raises his desire to know symptoms, evaluation of its contents, and identification of them by resorting to a doctor for the purpose of formal or popular treatment. (Mechanic1970).

Mechanics identifies ten factors influencing disease behavior.

1. Symptoms:

Several studies have shown a strong relationship between the severity of disease symptoms and the speed of seeking medical help.

2. Realize the severity of symptoms:

More serious diseases urge the owner to seek treatment more than others.

3. The extent of the disease disrupting social activities:

The more the disease affects social activities, the faster the patient seeks the necessary treatment, for fear of permanent disability.

4. Symptoms recurrence and persistence:

When the patient feels of continuing symptoms, he/she would rush to seek medical help.

5. The degree of tolerance towards the disease:

Individuals differ in their ability to withstand the pain of the disease. Some of them, when they notice any real signs of the disease, rush to search for a cure, while others refrain from doing so unless serious symptoms appear.

6. Evaluation criteria:

Disease response (especially psychological) depends on the evaluator's information and cultural assumptions. The individual's level of awareness, culture, and familiarity with medical matters affects the degree of motivation to seek treatment.

7. Motives for concealment:

There are types of diseases that make some individuals hide from others, including psychological disorders. The wife or husband, for example, conceals these symptoms from the other party for fear of the influence of the marital bond, or to avoid shame on the part of the other party.

8- Contradictory needs:

In some cases, the individual may resort to a balance between needs that may appear contradictory or conflicting, such as detailing the head of the family to continue his pension work to seek health care despite his critical illness, in order to ensure that he provides for his family members.

9- Alternative Interpretations:

Individuals surrounding the patient, especially in the case of psychological illness, resort to a set of different explanations for the disease. People often reduce the severity of the symptoms on the patient’s life. These interpretations may continue

for a long period of time, until his health deteriorates further, and they speed up, at that point, to seek treatment at the end of the day.

10. Access to treatment:

Access to treatment depends on its relative availability, accessibility, and benefit from it. The greater the difficulties encountered in obtaining medical service, the less reliance on it and the search for other sources for treatment. Barriers to accessing treatment include financial costs, time, effort, distance from the location of treatment, and more.

Sushman attempts to analyze disease behavior through the social patterns associated with seeking, and utilizing, medical care (Suchman, 1965). The stages of the illness response are divided into five categories by Sushman:

1- **Perception stage**

At this point, the patient observes the presence of organic pain or discomfort, as well as a shift in some bodily manifestations, such as a sensation of weakness, trouble comprehending and interpreting symptoms, and a sensation of dread and worry.

2- **Starting to enter the disease stage**

In this scenario, the patient seeks ways to ease his sickness via personal care and assistance from family, friends, and acquaintances.

3- **The stage of requesting medical care**

After exhausting all other options, the patient decides to seek scientific medical treatment rather than routine medical treatment at this point (folk medicine). He introduces himself to the treating doctor in order to carry out the appropriate procedures.

4- **The actual patient role stage**

At this point, the attending physician is responsible for providing health care and making treatment and health-related decisions for the patient. He engages in a complicated social interaction process with the patient, which may continue as a result of her and him disagreeing on diagnosis and therapy in terms of demographic factors. Other variables such as ethnic composition and gender class were also important. There are two influential studies in this field, namely Schuman (1965) and Koos (1954).

Sushman studied several ethnic communities in New York City place a high value on religious belief and accept contemporary treatment. He found that people of

high-ranking urban origins have scientific attitudes about modern medicine, while people belonging to local groups have popular or unscientific beliefs. Another approach to studying the behavior of seeking medical help is its association with social class. The important study here is Koos's study foe Reignville Health (Koos, 1954), where it was found that upper and middle-class people were more likely to perceive the symptoms that interest the doctor. The world is unable to seek medical help because of the cost, fear of doctors, and the relative need determined by age and the role of the sick person. Young, old and breadwinner people were more likely to receive medical treatment, along with age, gender, ethnicity, social class, other variables such as education, marital status, ability to pay, time, energy, and the effort required to get to the doctor have all been found to be important in some studies (McKinley, 1972).

Second: the theory of symbolic interaction

The proponents of the symbolic interaction theory of medical sociology have created an important new perspective on health and morbidity. For example, the owners of the symbolic interaction distinguish between the concepts of disease {disease} and illness} as the first refers to specific diseases that affect the human body, while the second indicates social implications Attributable to that disease, including experiences gained, social relationships, and patterns of behavior related to the patient. In essence, the perspective of symbolic interaction stems largely from the work of George Herbert Mead (Mead, J, H 1934) and Herbert Blumer (Blumer, H, 1969). The main issue of the owners of symbolic interaction is that the human soul is the result of the interaction existing between members of society.

Cooley (ch.1902) The Self-Reflective Woman Theory indicates that people have the ability to know themselves through the reactions of others. This social perspective influenced two famous scholars of symbolic interaction, namely: Anselm Strauss and Warving Goffman. Strauss's contributions are evident in his joint work with Goffman, Howard Baker and others in their study of medical school preparation (Becker, et al. 1961) Strauss achieved his breakthrough in theory and research methods in a number of fields, including his joint work with Claire on the social process of death and death in which he portrayed the suffering of patients before their death, and the negligence they encounter on the part of their caregivers of doctors and nurses. (Glaser and Straus, 1965, 1968).

He also collaborated with Howard Becker in the book Intruders (Becker, et al. Outsiders1963), and is the main thinker behind the theory of the adjective or stigma, which indicates that deviant behavior does not represent the real action, but rather is the result of others 'definition of deviation. This concept is particularly useful in medical sociology, as Thomas Schiff (Thamas Scheff, 1966) used it in his study of the mentally ill. He described the patient's psychiatric symptoms as behavior contrary to culturally recognized social norms. As for Goffman, who became a major theoretician in sociology in general, his work in research in medical sociology began by closely following the conditions of patients in the mental hospital. On the social status of people detained by institutions that exert heavy pressure on them, he also invented the idea of a theatrical perspective in sociology that depicts (life as a theater and people are represented on stage) and this perspective has been used in the field of medical sociology. Goffman distinguished himself by using the concept of stigma (Goffman, Stigma 1963), which in the context of psychiatry means stigma attached to people who are usually mentally ill or to people who are abnormal in their behavior in general. People who are stigmatized do not have full social acceptance, and they always strive to adapt their social identities to the general social milieu. Goffman identifies three types of stigma: behavioral, physical, and group stigma. The first represents deviations in personality traits such as mental disorders or drug and alcohol addiction. The second type includes external deformities of the body, leprosy, obesity or pathological thinness. As for the third type, it afflicts a person because of his belonging to a racist group, religion, or a certain people, as it is attached to foreigners according to tribal customs and traditions.

Goffman's influence can be seen in medical sociology in the search for medical confrontation, a situation in which two or more people meet face to face (Goffman, 1963). He emphasized that this should be a major field of social research. " He also stressed that sociology should focus on defining and understanding the rules and standards that govern any process of social interaction of any kind, including the process of interaction between doctors and patients, along with Strauss and Goffman, Freidson's books are the following: The medical profession (1970a) and occupational dominance (1970b)), medicine together (1975) are basic works in the field of medical sociology in which he deals with the analysis of the professional control of doctors, and the relationship of the doctor to

the patient. In his last book, he emphasized the professional social control practiced by doctors on one another and how this control affects improving the quality of doctors 'professional performance.

Third: the agrarian theory:

Conflict theory counts on the postulation that society is made up of competing groups for the sake of obtaining resources, power and prestige, that access to resources is inherently unequal, and that those with power seek to preserve their privileges. Thus, conflict theorists expect that social change will occur through revolution rather than Gradual social change. Karl Marx is considered the founder of conflict thought, and although he did not write explicitly about health and disease, his ideas influenced contemporary research on the political economy of health. The early writings of Frederick Engels on the deteriorating health conditions of the working class in England during the nineteenth century, and his joint work with Karl Merx, represent a critique of health and medicine during this period, representing one of the true social theories of illness and disease (1971 Engels.) At present, the World Health Organization has developed a health perspective in which it defines the role of social factors in health and disease (who 2009). In applying this approach to medical sociology, it leads us to the so-called "social determinants of health", whereby the health conditions of the population are viewed as being influenced by a combination of social, economic, psychological, environmental and cultural factors.

Recently, researchers' interest in this context has focused on formulating medium-term theories to explain the distribution of diseases, and include the four main theoretical frameworks:

1- Social psychological theory
2- The theory of social determinants of health
3- The political economy theory of health
4- The influence of culture on health and disease

1-Psychosocial theory:

The psychosocial framework directs attention to the social environment consisting of psychosocial factors resulting from human interaction, and includes class domination, social disintegration and rapid social change the marginal position in society, including social exclusion and social isolation. Cassel believes that these socio-psychological factors together explain the reason why certain

groups disproportionately afflict some diseases and not others (Cassel, J.1976) Thus, the psychosocial frame of reference directs attention towards internal biological responses to social interactions. It is focused on responses to stress and on people subject to stress in need of psychosocial resources (Krieger, Nancy 2001)

Poverty and its diseases:

The health status of individuals and the different groups and classes of society is commensurate with the socio-economic status of these groups, meaning that the health status is more deteriorating the more these groups are in a low socio-economic status and vice versa. Recent studies indicate that the psychological and social pressures that the poor are exposed to may increase the risk of many diseases, for example that chronic psychological stress resulting from living in an environment characterized by poverty and destitution increases the individual's predisposition to developing coronary artery blockage, depression and diabetes , 2010). Lupton believes that disease is due to deprivation and poverty (Lupton, 2003), which are two major causes of disease and ill health and are obstacles to obtaining the necessary health care. The relationship is also due to the link between health and other factors closely related to poverty, such as the lack of information and health culture related to appropriate practices to maintain health, such as smoking, alcohol abuse, and lack of movement.

Social determinants of disease

The social determinants of health are the economic and social conditions in which people live that determine their health, and the social and health services that they are able to obtain. The primary factors determining people's health are not medical treatments or lifestyle choices, but rather their different living conditions. These conditions are known as "social determinants of health". People's health is determined by income distribution, wealth, employment status, working conditions, health and social services they receive, and their ability to obtain quality education, food and housing, a social safety net, among other things. (Tuha Mikkonen et at).

3- The political economy theory of health

The owners of the political economy perspective of health emphasize that under capitalism, the relationships of individuals with the means of production are

important to understanding their social position in the social hierarchy as well as their potential to obtain wealth and enjoy healthy health. In their interpretation of health differences, they stress the essential role of those with power and influence in the distribution of scarce resources that constitute the quality and distribution of the social determinants of health. The basic assumption of this approach is that the economic and political institutions and the decisions that result from them impose economic and social privileges on certain groups and deprive other groups of them, and they constitute the main causes of social differences in health conditions (Link, BG 1996)

As for Harold Wetitzen, he saw the medical institution as a source of social strength for capitalists. And since the capitalist society is based on free economic competition, the race to control the health system brings enormous wealth to the owners of capital, which prompted the leaders of the health system to engage in the capitalist process. Thus, the health system, with all its practical technical and practical experiences, would inevitably come under the control of the capitalists (Waitzkin, H. 1986). There are other analyzes focused on addressing the social differences resulting from racial and gender discrimination and the ethnic composition of the population, in addition to male dominance, and its negative repercussions on health. Humanitarian social movements of a global nature have recently launched, addressing the threats to the fairness of the environment and the safety of the human race, arousing great interest in the joint decisions of Western governments in transferring pollution and poverty to poor countries and to degraded areas within rich countries, especially groups with population minorities, and among the most important sources: environmental pollution Globalization, global forced migration, wars, acts of violence, and more.

The effect of wars and conflicts on health:

Conflictionists were interested in studying the health impact of wars and violent conflict. The devastating effects of conflict on human health appear in direct injuries, ill health, and deaths resulting from deteriorating public health. The health consequences of violent conflict also include civilians and military personnel. The effects of wars also extend to environmental health, including environmental pollution, pesticides, atomic radiation, as well as exposure to the risks of infectious diseases in the destruction of the ecosystems of the neighboring regions.

4- The influence of culture on health and disease

Anthropologists emphasize that the causes of diseases, the ways of perceiving them and the methods of treating them differ according to the social and cultural environment of the group. In many primitive nations, it is believed that death, health and disease are due to the act of magic, envy, jinn, sorcery and others.

Fourth: Feminist theory of health:

Feminist theory is a different group of feminist social ideas and movements related to equality between the sexes politically, economically, socially, culturally, health and in all other aspects. In traditional societies, women are subordinate to men in terms of social, economic and cultural status, they are excluded from decision-making, and they have limited access to and control over resources, in addition to their limited mobility, and are often subject to threats and violence by males. Despite the progress achieved, societies all over the world, especially developing and backward societies, are still falling far short of the right of women in the basic stages of their lives, especially in adolescence and adulthood (WHO 2017)

Determinants of health

Over its history, public health efforts paid attention to what was thought to be the source of the most significant deaths, disease, injury and disability. In the late nineteenth and early twentieth centuries, public health focused in particular on the natural environment, enhancements in clean water, healthy housing, Public health promotion, workplace security and healthy nutrition have all contributed to improving health conditions and thus to a rapid increase in average life expectancy. In the last decade of the twentieth century, attention focused on the necessity of providing health care services, in order to prolong more years of life, especially life expectancy. In the current decades, research has increasingly shown the importance of the influence of social and economic factors in improving the health status of various peoples of the world.

The health status of people in the world:

Despite the progress made in the field of women's health, in all human societies, women still suffer from health problems in various stages of their lives, especially during adolescence and adulthood. These are the findings of the WHO reports. (Who, 2009)

The difference between women and men:

Women and men face several similar health challenges, but there are important differences as well. Women are generally older than men by about 5 years, given their biological and behavioral advantages. However, these advantages are almost eliminated in some regions, especially in some parts of Asia, due to discrimination against women to the point that their life expectancy at birth is shorter than the life expectancy of men, or almost equal, unlike in the rest of the world. Moreover, the longer life of women does not necessarily mean that they are in better health, as they face greater difficulties than men in obtaining the necessary health care, in addition to the deprivation of women from education and the low level of income and employment opportunities that limit their ability to take care of personal health.

Differences between countries in the world:

There are clear health differences between women due to the different living conditions in different countries of the world. Women in rich countries live longer and suffer from poor health only slightly, compared to women in poor nations. In rich countries, death rates for girls and women are very low, and most deaths take place after the age of 60. In poor countries, the picture is completely different: mean ages are shorter on average, mortality rates among children are higher, and most female deaths occur during adolescence and births.

Gender and health:

The World Health Organization notes that sex refers to biological characteristics such as the structural and physiological structure, that is, organ functions that distinguish men and women. As for gender, it refers to the differences in terms of the regional roles in each of them according to the culture of the society. Gender relations describe the standards, roles, values, attitudes, and expectations that guide people how to act, and determine the ways to deal with them in a particular society. Gender relations are not fixed but rather are different from one society to another and from place and time to another, because they represent social ideas and beliefs instead of biological facts.

Gender roles

Gender roles are the specific duties and responsibilities that men and women perform in society. And it has important functions to fulfill in determining gender relations.

Social determinants of differences of health between males and females

In traditional societies, the simplest form of social differentiation is based on gender in terms of the distribution of duties and responsibilities. Women are mainly responsible for household maintenance and domestic work, caring for the elderly, the sick and the helpless. On the other hand, men undertake the gainful work outside the home and manage the rights and duties of citizenship. Societies assign different values and status to these gender roles. In most societies, the types of activities performed by men are valued more than those performed by women. Although the work of women is no less important than the work of men, they are rarely evaluated in an accurate, fair and equitable manner.

In most societies, there are not only differences between the sexes but inequalities built into these social definitions of maleness and femaleness. Males are given preference over females in almost everything, and accordingly, the work that women do in the home, for example, is unpaid, because it is considered less important than gainful work. These differences have an impact on the health of both males and females. Economic inequality means that many women face difficulties in obtaining the basic requirements for a healthy life. Meanwhile, the specific nature of women's work may affect women's health as well. Doyal, j. 1996)) Domestic work and taking care of family members has resulted in reduced sleep hours and fatigue, which negatively affects the physical, mental and even emotional health of women. One study indicated that the potential impact of the role of home care on mental health could explain the higher rates of depression in women of reproductive age (Doyal, J. 1996).

It is worth noting that women in the world began to enter the workforce in increasing numbers after World War II, and despite this, their participation in the workforce of developing countries is still low. Moreover, most of this increase is confined to the temporary jobs. At present, the main businesses of women in developing countries are concentrated in the sectors of education, health and public services. The discrimination between males and females within the labor market is still widespread, and there are no equal employment opportunities with men, neither in hiring and promotion, income and job security, as well as senior administrative, executive and academic positions.

Male dominance and discrimination against women:

Women encounter several risks as a result of being subjected to inhumane treatment in providing health care, especially during pregnancy, childbirth and the postpartum period and at all other times. Moreover, women are also vulnerable to ill treatment in cases of deprivation of their liberty, even within immigration detention facilities or health institutions, because of their criminal identity and sexual orientation. Also, Women's bodies are abused for a variety of reasons, including cultural, political, and economic. The following are some examples of discriminatory actions that have an impact on women's and girls' health:

* Female circumcision, underage marriage and teenage pregnancy.

• Excellence in access to health care

Violence against women in the family, at school and at work

• Obtaining information and services for family planning and pregnancy termination

Discrimination and abuse during the birth of children in health institutions

• Neglect and abuse of adults, including health care institutions and adult care homes.

The role of the medical institution in the difference between the sexes:

The owners of the revolutionary feminist theory assert that the low status of women in society is due to two factors: male domination and meeting the needs of the capitalist system represented in the control of doctors and the medical establishment over women, as most centers of power are confined to the hands of doctors who use scientific knowledge as a means to control and control women's bodies. Doctors also control the production process, including contraceptives and reproductive technology, not to mention the commercial market for medicinal drugs. According to Friedson, the doctor has turned into a dealer and the medical establishment has become a tool of repression (1975 Friedson,).

Fifth: Post-structuralism theory

The French philosopher, Michel Foucault Michel, has a major role in the development of medical sociology, and his interest has concentrated on studying the connection among knowledge, power, and the imbalance of power it entails. In his famous book The Birth of Clinical Medicine (1994, 1973) Foucault distinguished two trends in his investigation of medical practice: human medicine and the medicine of social spaces. (1973 and 1994). The first classifies diagnoses

and treats disease states, and the second seeks to prevent the occurrence of diseases. Human medicine considered the human body to be a subject for medical study and intervention, while social space medicine used public health as a means of control and regulation by the civil and medical authorities, and so the bodies themselves became the scope of expert authority for the benefit of society (Armstrong 1987, Turner, 1952)). Foucault's assay of the body led to the emergence of a new discipline, the sociology of the body, which coincided with the emergence of Turner's book entitled body and society (Turner, 1996).

Another area of research is the social formation of bodies, ailments, and emotions. In medical sociology, the socio-structural approach is the closest to Foucault's analysis of the body as a result of power and knowledge. It is the investigation of the way in which people shape their appearances, from decorating, displaying and managing their bodies and assessing them socially. It is reported that social class has a great influence on how people behave and take care of their bodies. The other scientist who contributed to the development of medical sociology is Pierre Bourdieu. Among his many works, the Book of Discrimination (Bourdieu 1984) is the closest to medical sociology, in which he deals with the explanation of the different patterns of cultural practices between French social classes and their impact on health. He relates social practices to culture, social organization and power (Swartz, 1997). His analysis includes food habits and physical exercise that reveal the influence of class attributes on the various aspects of healthy life (Cockerham, 1999).

Bourdieu explains how negative healthy parenting patterns were the primary social determinants of the decline in life expectancy in every saying about this condition, and the case is for middle-aged men belonging to the working class. These men's living conditions and poor social status bred negative traits that drove them to engage in unhealthy behaviours such as a lack of interest in eating, alcohol abuse, smoking, and lack of physical activity. All of these variables have combined to create a lifestyle that is favourable to heart disease, with high death rates as a result, and thus, shortening the life expectancy in these countries. These behavioral patterns that endangered people's lives are criteria developed via the group's social interaction, and decided by the options accessible to them, which resulted in poor living circumstances and early deaths (Bourdieu, 1984)

Capital influences and stresses Bourdieu on the significance of social capital in affecting people's health via social cohesiveness and creating confidence in their souls and their desire to serve members of the same group Through the exchange of benefits, help, and the provision of medical services and social care to people in need, social capital has a variety of effects on health. It also has an impact on aspects that are linked to health concerns, such as quitting smoking, avoiding alcohol or addiction, and boosting participation in sports. It also has an influence on other social factors including education and employment, as well as lowering the effects of certain situations that cause psychological and social stress. Another key way through which social capital influences health is main group members' capacity and competence to conduct cooperative actions that promote health, instil good social standards, and prohibit health-damaging behaviour. Finally, social capital influences health through knowledge that is good to health, the promotion of healthy culture, self-hygiene, and the building of security for the local and communal environment (Bourdieue, 1964). The impact of social capital on individual and group health has been documented in several research, the most recent of which was conducted by the World Health Organization (Who, 2010). In the three primary areas of applied study, Anthony Giddens establishes the theoretical foundation for the sociology of health and morbidity: drug use advice, food choices, eating patterns, and long-term sickness. Gabe j. And Almeida j. Eds. (2015)

References

1: Al-Hakimi, Abdullah Muammar, 2017, in Sociology and Anthropology - Part 1, Manar Center for Social Studies.

2: Annandale, Ellen. (1998) The Sociology of Health and Medicine, Cambridge Polity Pres

3: Annandale, Ellen and J. Clark (1996). What is gender? The feminist Theory and the Sociology of Human Reproduction. “Sociology of Health and Illness” 18 (1):17-44

4: Armstrong, David. (1987) Bodies of Knowledge

5: Armstrong, David. (2015) An outline of Sociology As applied to medicine. El Sevier

6: Becker, Howard. (1973). Outsiders: Studies in the Sociology of Deviance. New York, Free Press.
7: Blumer, H. (1969) Symbolic Interactionism Perspective and Methods, ISBN
8: Bourdieu, Pierre. (1984) Distinction (Translated by Wice, Richard Harvard University Press)
9: Cassel,j. (1976). the contribution of social environment in host resistance, American journal of epidemiology 104 p,107- 23-
10: Cockerham, William. Medical Sociology (1981) International Review of Modern Sociology, Vo.11. No. 112, pp.231-250.
11: Cockerham, William. (2007) Medical Sociology and Sociological Theory, Published Online.
12: --------- (2013) Sociological Theory in Medical Sociology in the early Twenty First century.
13:Cooley, Charles (1902). Human nature and Social Order, New York, Scribner.
14: Dahrendorf, Ralf. (1959) Class and Conflict in Industrial Society – Stanford University Press.
15: Doyal, Lesley (1996) Sex, Gender and Health, A Preliminary Conceptualization Framework.
16: Durkheim, Emile. (1951(1897)) Suicide A Study in Sociology, Glenda Free Press.
17: Engels,F. (1971, 1845) the Conditions of the Working Class in England Oxford Blackwell publishing
18: Foucault, Michel. (1973) The birth of Clinic, London: Tavistock
19: Frierson, Eliot (1970) Profession of Medicine, New York. Dodd and Mead
20: ----------(1970) Profession of Dominance. Chicago Aldine
21: _____ (1975) Doctoring Together. New York Elsevier.
22: Gabe, j. and Almeida j. (2015) in; Collyer F. (eds.) Handbook of social Theory in health and Illness and Medicine .Palgrave Macmillan London.,
23: Glaser. Barney and Anselm Strauss (1965). Awareness of Dying, Chicago Aldine
24: Goffman, Erving, (1961) Asylums. Anchor. Stigma, Notes on the Management of Spoiled Identity, Englewood cliffs Prentice-Hall
25: Jaime Lumpias Wolff (2017). Health and development in the third world
26: Kasl, s.v. (1966). health behavior, Illness Behavior and sick role Behavior

27: Koos, Earl. (1954). The health of Regions Ville. New York Columbia University press.

28: Lorber, Judith (1997). Gender and the social construction of Illness, London, Sage

29: Krieger Nancy. (2001). Theories for social epidemiology in the 21st century, Eco social Perspective, International Epidemiological Association, great Britain.
30: McKinley, John. (1984). Issues in the Political Economy of Health and care. London Sage.
31: Mechanic, d. (1995). The Sociological Dimensions of Illness Behavior, Social Sciences and Medicine 41 9 1207-16
32: Metzner,c. (1965). Choice of health care plans, University of Michigan School of Public Health
33: Morgan,M. (1993). The doctor -Patient relationship
34: Navarro, Vicente (1986). Crisis, Health and Medicine: A social critique. London Tailstock.
35: Parsons, Talcott. 91951). The Social System, New York free Press.
36: Roemer, M, (1960) editor on the sociology of medicine. m. d. publication New York.
37: Schuman, Edward. (1965) Stages of Illness and Medical Care, Journal of Health and Human Behavior
38: Steve et al (2001). Sick Behavior as a New Target for drug deviant.
39: Szasz T. and Hollander, M (1956). A contribution to the Philosophy of Medicine, basic Models of the doctor _Patient Relationship. Journal of the American Association,
40: Thomas J. Schiff ,1966). Being mentally Ill, A sociological theory, Chicago, Aldine
41: Turner B. (1996). The body and Society of London Sage.
42: Twaddle A. (1969). Health Decision and Sick Role Variations: An Exploration, Journal of Health and social Behavior ,10:105-14.
43: Waitzkin Howard. (1971) Latent Functions of the Sick Role in Various Settings, Social Sciences and Medicine 5:45-75.
44: World Health Organization, (2009, 2010 Young, J. t. (2004). Illness Behavior a Selective Review and Synthesis

45: Zola Irving, (1966). Culture and Symptom, an analysis of Patient Presentation of Complaints, American Sociological Review 31:615-630