2

The Sick Role

1. An epidemic of influenza swept through town. Absenteeism was highest among students, followed by white-collar workers, and lowest among the blue-collar workers at the steel mill, especially those with least seniority.

2. [A newspaper excerpt] Policemen in the city today called in sick in droves as negotiations between the city and the police union broke down.

3. A 35-year-old secretary, who had never missed a day's work, became noticeably pale and seemed to have trouble walking but would not miss work to see a doctor. Since she lived alone, there was no one to be alarmed when she started vomiting in the evening or when excruciating pains kept her awake at night. She would, however, invariably show up at work with a smile on her white parched lips. Then, one day she did not come to work. She had died of massive stomach bleeding in the early hours of the morning.

4. [The late Senator Hubert Humphrey, on returning to the Senate after discovery of inoperable cancer] "I must believe that I am going to win this battle. . . . I have to do it, nobody else can. The doctors can't do it for me, although they can help."

5. A 25-year-old man was admitted to the hospital when he came to the emergency room vomiting blood. All tests were negative, and he was discovered stealing a test tube of blood from a technician's cart, whereupon he immediately walked out of the hospital. Two days later, he was admitted to another hospital in an adjacent city after coming to that hospital's emergency room vomiting blood.

6. [In a bedroom] "No, not tonight. I have a terrible headache."

7. Having been found incompetent to stand trial, the defendant was committed to the mental hospital.

SICK-ROLE EXPECTATIONS

Society assigns specific expectations to the ill person by virtue of his being ill. These expectations comprise what is known as the "sick role."

Talcott Parsons, a sociologist, formulated the sick role as consisting of four aspects. The first is an *exemption from normal social role responsibilities* (Parsons, 1951). The degree of such exemption is, of course, dependent on the nature and severity of the illness. This exemption, according to Parsons, is a right of the sick. In order to prevent abuse of this right (malingering), society also requires that this right be legitimized by others. The physician is most often the key person in this legitimizing process, both as a direct legitimizing agent and as a "court of appeal." The sick role may be assumed by some persons without having seen a doctor or having been recognized as ill (vignettes 2 and 6). In these instances, the legitimacy of the exemption from social responsibilities may be seen as tenuous; further, should such persons eventually seek medical help (after having assumed the sick role for prolonged periods without medical legitimization), the physician may be reluctant to grant legitimization. Thus, patients suspected of being "crocks" or "hysterics" tend not to be taken seriously by doctors even when their complaints might otherwise stimulate further investigation.

The second aspect of the sick role is *recognition "that the sick person cannot be expected by 'pulling himself together' to get well* by an act of decision or will. . . . He is in a condition that requires being 'taken care of.' His 'condition' must be changed, not merely his 'attitude.' Of course the process of recovery may be spontaneous, but while the illness lasts he can't 'help it.' This element in the definition of being ill is obviously crucial as a bridge to the acceptance of 'help'" (Parsons, 1951).

The third expectation is that *"the state of being ill is . . . undesirable . . . and the patient should want to 'get well.'"* According to Parsons, the first two elements of the sick role, the exemption from normal role responsibilities and legitimization of dependency on others, are contingent on the acceptance of the idea that the assumption of the sick role is an undesirable and unfortunate necessity that should be relinquished as soon as possible (vignette 4). Although the sick person cannot be expected to "pull himself together" to get well, he may be seen as responsible for his condition if he does not show motivation to get well, to get out of the sick role.

The fourth aspect of the sick role is the obligation—in proportion to the severity of the condition, of course—*to seek technically competent help,* usually from a physician, and to cooperate with him in the process of trying

to get well. It is here, of course, that the role of the sick person as patient becomes articulated with that of the physician in a complementary role structure.

Parsons attached great importance to motivational factors concerning the sick role, realizing that the privileges and exemptions of the sick role would give rise to attempts by some to assume the role for "secondary gain." The balance between the pull toward the sick role and the push toward relinquishing it is of utmost importance.

The sick role is considered to be a "contingent" role that anyone may assume regardless of his status in other respects.

In essence, then, the sick role consists of two rights and two obligations: the rights of exemption from normal responsibilities and the recognition that the ill person is not to blame for his illness, and the obligations to desire to get well and to seek competent medical help.

The sick role is seen as being "universalistic": generalized objective criteria determine whether one is or is not sick, and with what kind of sickness (Parsons, 1951).

When the physician recognizes a person as being ill, that person becomes a *patient,* legitimately assuming the sick role, exempted from normal responsibilities such as going to work, and expected to want to get well and to cooperate with the physician and other health-care personnel.

SICK-ROLE PERFORMANCE BY PATIENTS

The sick-role expectations are obviously shared by the doctors and other health-care personnel. The patients who fail to conform to the sick role are considered to be "bad" patients. When a patient fails to conform, the legitimacy of the illness itself is often questioned—that is, the patient may be suspected of malingering. An uncooperative patient may be denied continuation of hospitalization by premature discharge because the physicians become angry with him for not living up to the fourth expectation. A convalescing patient who repeatedly complains of minor symptoms is seen as not fulfilling the third expectation to regard the sick role as an undesirable one that should be relinquished as soon as possible. This may even tempt the physician to withdraw legitimization of the sick role from such a patient. Some patients, on the other hand, may foster approved prolongation of the sick role by being "good" patients, that is, by extreme cooperativeness (for example, even volunteering to participate in experimental procedures).

The way a person actually behaves when he becomes sick may be conceptualized as *sick-role performance.* Sick-role performance is influenced by socioeconomic and ethnic-cultural factors (vignette 1). Persons of deprived economic status might be reluctant to assume the sick role because of loss of income and increased financial hardship. For persons involved in industrial accidents, assumption of the sick role (for a legitimate injury) may mean prolonged exemption from work and secure income as long as the sickness continues. Students in training for careers may be reluctant to assume the sick role due to possible disruption of studies and delay in career achievement.

Personal experiences are also important in sick-role performance. Exposure to persons who have derived benefit from being sick may predispose one to seek out sick-role exemptions and secondary gains whenever the opportunity presents itself. For example, a friend of a patient who received a large compensation after an industrial accident may come to the doctor with exaggerated lingering symptoms of a minor injury. Patients who seem to want to prolong the sick role have often been exposed to and envied the prerogatives of persons who had been seriously ill for long periods of time.

Society's view of a particular illness also affects whether a person is more or less likely to be motivated to assume the sick role for the illness. Patients suffering from socially stigmatized illnesses such as venereal disease or mental illness may be reluctant to assume the sick role. Stigmatized illnesses (such as venereal disease and alcoholism) are not treated with neutral attitudes (as Parsons formulated), and they often carry an assumption of responsibility for the illness on the patient's part. Heterothetic presentation of symptoms (McWhinney; see Chapter 1) may be seen as an attempt on the part of the patient with emotional difficulties to assume some elements of the sick role.

The concept of the sick role as formulated by Parsons does not apply to all illnesses. Specifically, it is *inadequate* to deal with (1) minor illnesses, for which no exemption from normal social roles is granted and no requirement to contact the physician is made; (2) incurable illnesses, which require adjustment rather than a motivation to recover; and (3) legitimate "ill" roles that do not require continuing attention by a physician or exemption from normal responsibilities or motivation toward recovery, such as in the handicapped (Freidson, 1962). More recently, physicians are becoming more and more aware that many illnesses occur due to neglect on the part of potential patients of measures that would clearly be preventive. Such neglect may be active, such as smoking despite respiratory symptoms, or passive, such as not consulting a physician after

discovering a lump in the breast. In this sense, society's sick-role expectations concerning responsibility for illness may need revision.

Role-conflict problems are relatively frequent. For example, an elderly person may become very sick with a viral illness that usually runs a mild course. He may feel guilty if he assumes the sick role, and yet he may be chided by others if he does not.

We often see patients with incurable illnesses such as advanced cancer attempting to recover from the illness completely through the use of irrational methods of treatment and spending enormous amounts of money and energy in the attempt. This would be an example of conflict between the third and fourth expectations.

In psychiatric illnesses, there are divergent role expectations depending on the physician's orientation to the illness, with varying degrees of modification from Parson's sick role. A biologically oriented psychiatrist using mainly a medical model of psychiatric illness may legitimize the full assumption of the sick role for the mentally ill patient. On the other hand, psychiatrists with a more sociopsychological orientation may be reluctant to grant their patients exemptions from social role responsibilities and expect them to work at getting well through their own efforts assisted by the psychotherapist. Then, there are some who still believe that mental illness is a condition for which the patients are totally responsible, that they could "pull themselves together" if they really wanted to. This attitude contributes to the continuing stigmatization of mental illness and, consequently, the reluctance of the patients to seek help.

The sick role, like any other newly assumed role, requires a period of adjustment. In newly hospitalized patients, conflicts often arise between the patient and the staff because of the inability or difficulty of some patients to accept the sick role, which leads to the patient being perceived as uncooperative rather than inexperienced in the role.

The patient's personality has a major bearing on how he perceives and accepts the sick role (see Chapter 18).

SUMMARY

Society's expectations of a person who becomes ill constitute the "sick role." Parsons describes four components of the sick role: (1) exemption from normal role responsibilities; (2) recognition that the sick person cannot be expected to get well by an act of will or decision on his part; (3) definition of the state of being ill as an undesirable state;

and thus (4) the obligation to seek technically competent help from a physician.

As generalized social expectations, they are generally shared by both physicians and patients. The "sick-role performance," that is, how a patient actually behaves when he becomes sick, is determined by many factors besides the "sick-role expectations." These factors include the realities of economics, personal experiences with illness, the context of being ill, and the personality of the patient, to list a few. The sick-role performance of specific patients may be at variance with the sick-role expectations of society or of physicians, resulting in misunderstandings or conflicts between patients and health-care personnel.

IMPLICATIONS

For the Patient

The generalized sick-role expectations form the basis or "ground rules" for persons when they become ill. Thus, patients "know" that they can and should stay home from work in the presence of high fever and, if it continues, that they should go to the doctor; also, that they should take the medications prescribed by the doctor to get well. The sick-role performance of individual patients, however, is influenced by a number of individualized or class-dependent factors, including unique personal experience with illness or ill persons. Thus, some patients behave in ways at variance with the way they should behave according to society's expectations. For example, some patients may not seek help in the presence of serious symptoms (as in vignette 3); some may "assume" parts of the sick role as a means to a goal (e.g., the policemen in vignette 2), as an excuse to be exempted from normal role expectations (e.g., that of a spouse in vignette 6), or as a legitimate reason for such an exemption (vignette 7).

For the Physician

The physician should first *understand what his expectations are of the sick persons he is treating,* since they may influence his attitudes or generate prejudices concerning a particular patient. Then, the physician should attempt to understand the determinants of the patient's sick-role performance—the influence of socioeconomic class, personal experiences, contexts of the assumption of the sick role, and other factors. For example, did the patient delay seeking help (assumption of sick role) because

of economic reasons? Is the patient seeking certain aspects of the sick role (e.g., exemption from normal responsibilities) because of psychological needs (being unable to cope with a severe emotional stress)? *Many problem patients can be understood if the problem is analyzed in terms of the sick-role expectations of the physician and the sick-role performance of the patient.* For example, in vignette 5, we see a patient who is "addicted" to the sick-role performance, assuming it by deception. Part of society's sick-role expectation is that it is an "undesirable state" and should not be voluntarily assumed in the absence of illness. Physicians, in general, tend to be angry at such patients. However, once the physician recognizes that his anger is directed at the sick-role performance of the patient (not playing by the rules) and also that this performance gives him a sense of being "cheated" by the patient, he can recognize that the person's need to be hospitalized is itself an illness requiring treatment. With this perspective, the physician can then endeavor to understand the personal determinants of the sick-role performance of the patient, including the meaning of hospitalization.

For the Community and the Health-Care System

The generalized sick-role expectations as described by Parsons may be modified in specific communities and health-care systems. For example, in certain communities, the expectation that an ill person should seek professional help may not apply (e.g., a community of Christian Scientists). In certain hospitals for chronic or terminal diseases, the expectation of hoping to get well may not be appropriate. A community may have latent prejudice against certain minority members who do not share the sick-role expectations of the larger community. It may also show prejudice against persons who cannot fulfill the community's sick-role expectations when they become sick. For example, patients with chronic or terminal diseases or some geriatric patients often are not treated with the same degree of compassion and caring that more acutely ill persons receive in the community.

Generalized sick-role expectations of the community change as we become more aware that certain diseases might have been prevented but for the patient's inaction—for example, failing to stop smoking—or might have been precipitated by patients' actions—for example, becoming malnourished because of a dietary fad.

In understanding "problem" patients in a given health-care system, it is important to understand what the sick-role expectations of that system are and how they interact with the patient's sick-role performance. Many problems may turn out to be a conflict between the expectations

of the health-care system as to how patients should behave and the patients' expectations (determined by their own unique experiences) as to how they should behave and be treated.

REFERENCES

Freidson E: The sociology of medicine. *Curr Sociol* x/xi:3, 1962.
Parsons T: *The Social System.* New York, The Free Press, 1951.
Pilowsky I: The concept of abnormal illness behavior, *Psychosomatics* 32(2):207–213, 1990.

RECOMMENDED READING

Parsons T: *The Social System.* New York, The Free Press, 1951, chap X (Social structure and dynamic process: The case of modern medical practice), pp 428–479. This chapter by Parsons is a classic that lucidly formulates the concept of the sick role and the social expectations of the doctor's role; it also contains a thoughtful functional analysis of the institution of medicine. Very highly recommended.

Pilowsky I: The concept of abnormal illness behavior. *Psychosomatics* 32(2):207–213, 1990. A discussion concerning abnormal illness behavior as represented by hypochondriasis and "hysteria." The author proposes a classification scheme of certain abnormal illness behaviors, and reviews research findings associated with them.

Twaddle AC: The concepts of sick role and illness behavior, in Lipowski ZJ (ed): *Advances in Psychosomatic Medicine.* Vol 8: *Psychosocial Aspects of Physical Illness.* Basel, Karger, 1972, pp 162–179. This is a succinct summary of the concepts and controversies concerning the sick role and illness behavior. With extensive references.