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Sexism, feminism and medicalism: a decade review of literature on gender and illness

Abstract Do we really have a dependent variable in our study of the sex differences in illness and sex differences in the explanations for illness? The purpose of this paper, which reviews the literature in this area over the past decade, is to argue that because of both conceptual and methodological difficulties in the definition of health/illness, there are serious problems in the available analyses to date. Confusions between medical and lay definitions, mental and physical illness, illness *per se* and illness behaviour are among the issues raised with respect to the first issue: conceptual and definitional incommensurability. Proxy respondents, distinctions between males and females in illness experience, and improper rate calculation are among the issues discussed in the section concerning methodology.

Introduction

In a seminal article Constance Nathanson (1975) reviewed the literature published to that date, which explored the causes of sex differences in morbidity and mortality. That women have been regarded as more likely to be ill while men have been found to be more likely to have high rates of mortality is and was one of the most consistent findings in the literature dealing with sex, morbidity and mortality. Women's surplus in illness rates appeared in Nathanson's review to exist with regards to rates of mental illness, physical illness and use of health services. Much-repeated and yet infrequently tested explanatory models for this finding were thought to be the following:

(1) women report more illness than men because it is culturally more acceptable for them to be ill; (2) the sick role is more compatible with women's other role responsibilities; and (3) women have more illness than men because their assigned social roles are more stressful (Nathanson, 1975:57).

Nathanson's study is based on a large and growing literature concerned with the relationships between sex and morbidity and sex and mortality.¹

Despite the plethora of studies on sex and illness, one would have an exceedingly difficult task should one want to describe the differences

in the morbidity experience of men and women. When explanations as to the supposed difference are offered, the confusion mounts. The difficulty in describing the health situations of men and women arises from the lack of conceptual and methodological clarity in the very definition and measurement of morbidity and gender. A variety of theoretical and methodological limitations is responsible for the fact that the numerous empirical studies have not led to an increase in understanding the significant aspects of the distinct morbidity/mortality situations of men and women. Thus this paper will not present a summary of the findings from the last decade but rather will attempt to review first the conceptual and then the methodological issues which describe this literature.

The conceptualization of illness and gender

One major difficulty in the conceptualizations of illness and gender² is that social scientists have often accepted the categorizations of illness given them by the medical profession and the prevalent sociological versions of gender given them by this male-dominated discipline. This is a problem for two reasons. First, because sociologists have been willing to adopt the models of health and illness prescribed by the powerful medical profession and thus have ignored the unique contribution which the sociological imagination provides. Second, because one group of males (physicians) has dictated to another group of males (sociologists) interpretations of the experiences of women. One example of the implications of the first problem is in the distinction in the sociological literature between mental and physical illness. This distinction is a direct derivative of the specialities evolved by the medical profession. That this is not a necessary differentiation can be illustrated in two different ways. First, it is common for persons to talk about, to explain health, in a holistic manner. People often speak of the way in which particular stress has caused a headache, nervous stomach, sweating palms and so on. Second, there is a growing body of literature demonstrating the irreducible unity of the mind and body (see Herbert Benson, 1979, for example).

The problems which result from the fact that male doctors or male sociologists define women's experience has been amply demonstrated by a number of feminist scholars. Classic examples of this literature are provided in the work of Ehrenreich and English (1973, 1978). Ehrenreich and English argue, in this series of works which are based on historical research, that medicine has made a prime contribution to a sexist description of women as sick, particularly with respect to their

reproductive functions and their emotions, and as sickening to men. They demonstrate the ways in which attributing illness to women has served the interests of male doctors. As the authors put it, 'The myth of female frailty, and the very real cult of female hypochondria that seemed to support the myth, played directly to the financial interests of the medical profession'. In the late nineteenth and early twentieth centuries, the regular AMA doctors (members of the American Medical Association – the intellectual ancestors of today's doctors) still had no legal monopoly over medical practice and no legal control over the number of people who called themselves 'doctors'. Competition from lay healers of both sexes, and from what the AMA saw as an excess of naturopaths, osteopaths and other non-allopathic physicians, had doctors running scared. A good part of the competition was female; women lay healers and midwives dominated the urban ghettos and the countryside and in many areas suffragists were beating on the doors of medical school.

For the doctors, the myth of female frailty served two purposes. It helped disqualify women as healers but made women highly qualified as patients (Ehrenreich and English, 1973:23). Contemporary medical practice is based on these historical facts: women's illnesses now tend to be thought (by male doctors) psychogenic in origin, related to women's neurosis and to women's hazardous menstrual and reproductive cycles. Psychotropic drug use which predominates amongst women provides some evidence of the tendency of male doctors to see women's complaints as 'unreal'. Cooperstock and Leonard's (1979) study of the social meaning of the tranquillizer use has shown us how women (and men with somewhat different problems) use mood-altering drugs to help them cope with their unsatisfactory lives and relationships, roles and relationships which are structurally determined.

Women's reproduction and its prevention are major causes of the attendance of women at the offices of physicians. The medicalization of childbirth has generated a great deal of doctoring of women who in contemporary obstetrical practice are obliged by their doctors to have monthly, bimonthly and weekly check-ups during pregnancy and who are increasingly likely to be subjected to Caesarian sections, forceps deliveries and scheduled births.

The modern ob-gyn emphasizes surgery rather than primary care, a policy that promotes the financial and professional interests of physicians. The belief that female reproductive organs are expendable equipment, dangerous and dysfunctional outside of childbearing, continues to provide justification for aggressive surgical practices. . . . This is organizational deviance and it is institutionalized amongst ob-gyn doctors. (Scully, 1980: 233-4).

It must be noted here that the evidence is that the involvement of the male

doctor in what was once the work of the female midwife has not served the health of the mother or of the baby. Maternal and infant mortality figures which compare historical and societal rates of these variables note the prophylactic value of the midwife (Haire, 1972; Arms, 1975).

Recent research sponsored by the AMA has shown that the hysterectomy has become the most frequent operation in the United States and now outranks the tonsillectomy and the appendectomy, the former top surgical contenders (Scully, 1980:17). Equally disturbing is the 1977 editorial cited by Scully in the prestigious *New England Journal of Medicine*, which states that some physicians are recommending prophylactic mastectomies for women with precancerous breast disease even though the definition of 'precancerous' is indeterminate.

Currently, an increasing number of women are entering medical school. We might suppose that when more women become doctors medical care will change. Unfortunately, the effect of this change will be slow to come, because of the present overwhelming dominance of men, and masculine ideologies in the care and cure involved in medicine. That the dominant sex is embedded in the dominant institutional position with respect to health care (Navarro, 1975) has had significant implications for women's notions of their health, bodies and childbirth. Women from the same elite background as our contemporary cadres of male physicians would, in this view, be expected to adopt the values and social conduct of their class equals. Change, in this view, in the medical profession would require an increase in the number of persons of working-class background in medical school.

Indeed, women's illnesses and bodies are regarded as so unusual that a speciality has evolved designed specifically to deal with them (Ob.-Gyn.). Scully and Bart (1981) examined gynaecology texts published from 1943 to 1973 in the United States and noted persistent paternalistic and often condescending attitudes of doctors of this speciality towards female patients. One illustration of this is the following comment regarding women who work in the paid labour force,

The very recent widening of the sphere of feminine activities, with the assumption of the male function of protection and maintenance, has led to a further weakening of the reproductive urge, resulting in the modern 'smart' type — sexless, frigid, self-sufficient.

The acceptance of the notion that gender is coincidental with sex and that both are bipolar variables is another source of harrowing complications in understanding of the ways in which sex/gender leads to different sorts and levels of illness. The assumption has been that biological sex and sociological gender are each unitary concepts

(Tresemer, 1975). A biological male has been thought to be a social male and a biological female a social female. There are several problems here.

First, biological differentiation is not conclusive proof of gender identity. Boys without penises may become normal males; girls with penises but without uteruses may come to see themselves as female. Socialization, can, at times, reverse the disturbing effects of mixed physical characteristics (Eshleman and Clarke, 1978:35).

(See Eshleman and Clarke, 1978 for a more complete discussion of this.) Gender and sex, as many have agreed (see Clarke, 1978 and Eshleman and Clarke, 1978 for a further discussion), are not coincidental. Nor is it correct to think of either sex or gender as unitary concepts. According to John Money there are six crucial determinants in the distinction between male and female: (1) the chromosomes, (2) the hormone balance, (3) the internal genitalia, (4) the external genitalia, (5) the gonads, and (6) the sex of assignment and socialization. Congruity amongst all six elements generally leads to the development of a successful unitary gender identity in a person. Incongruity can lead to a sense of discomfort with the assigned gender, hermaphroditism, or a mixture of 'typically' male and female behaviours in one individual. The maleness and femaleness of these six qualities are not necessarily distinct; one's sex identity is determined by a combination (Eshleman and Clarke, 1978:32). That gender role is not coincidental with sex has been demonstrated in numerous ways, in for instance studies of androgyny, role-reversal, cross-sexuals, and transsexuality. Both gender and sex, as historically defined by male sociologists in male-dominated societies, are conceptually problematic.

Mental illness and gender

Let us turn now to the complexities involved in the meaning of illness and briefly discuss mental illness. Gove and Tudor (1974), define mental illness in an idiosyncratic way to exclude some of the kinds of problems which bring people into psychiatric treatment. They refine and exclude categories until the definition of mental illness refers to a single range of problems only – feelings, emotions or mental states.

A disorder which involves personal discomfort (as indicated by distress, anxiety, etc.) and/or mental disorganization (as indicated by confusion, thought blockage, motor retardation, and, in the more extreme cases, by hallucinations and delusions) that is *not* caused by an *organic* or *toxic* condition. (1974:69, my emphasis)

This definition is useful to their particular hypothesis testing; it allows them to support it. But it does not apply to the way that mental illness is defined by the lay population, by the mental health professionals, those who take censuses of mental illness data, nor to other sociological researchers (e.g. Smith, 1975; Dohrenwend and Dohrenwend, 1976). In addition, physicians have acknowledged women's feelings, moods and so on more than those of men. Women's illnesses are not taken seriously, and are not as likely to be seen as having a biological cause (see Diana Scully for instance, for a discussion of the ways that contemporary Ob.-Gyn. doctors see women's problems, 1980:94-100). Scully observed residents, interns and doctors who were specializing in Ob.-Gyn. for three years and was led to conclude, 'Residents were encouraged to suspect that many "female complaints", including menstrual pain, were psychosomatic' (p. 95).

As Dohrenwend and Dohrenwend declare (1976:1339), Gove and Tudor's (1974) definition 'excludes types of disorders that most experienced psychiatrists and clinical psychologists would include, while including symptomatic distress that experienced clinicians would exclude and combining disparate types of disorders that clinicians would not combine.' Dorothy Smith (1975) would disagree with both Gove and Tudor and Dohrenwend and Dohrenwend because of her view that available mental illness statistics are not a simple reflection of the experiences of wellness and illness in a population. Rather they indicate, in part, the distribution and availability of psychiatrists, beds in psychiatric hospitals, psychologists and other caregivers who have the power to label a caseload as either suffering from mental illness or not. She argues that the usual process of reasoning about mental illness goes something like the following: a situation causes stress; this leads to mental illness which then leads one to seek psychiatric assistance. This model assumes that mental illness is an objective social state which exists prior to treatment. She proposes a different model in which mental illness is not seen as a distinct disease or an entity. It is the last in a chain of events and results from a definition by the social control agencies involved.

Physical illness and gender

The problem is, of course, confounded when we remember that Smith is talking about a process whereby male psychiatrists control the behaviour of patients of different sexes on very different criteria. Definitional incommensurability is not only a characteristic, however, of the mental illness data but also of the physical illness data.

One distinction is between illness and illness behaviour. In this model researchers are concerned to differentiate between physical symptoms and the social behaviour which results from those symptoms. The primacy of the physical is felt to be irrefutable. Others would argue that this is a false dichotomy because human beings are social actors. As such they must continually construct social reality. The physical realm is not separate: it can only be known through social interpretation. From this viewpoint it does not make sense to speak of symptoms except as they are socially constructed. Illness behaviour and not illness *per se* as a physiological construct is the appropriate focus of analysis for the sociologist.

There are three strategies for measuring illness and illness behaviour. These include the self-perceptions of illness as indicated in an interview survey, an assessment made by a physician of the health of an individual and entered on medical records, and standardized clinical examinations (Mechanic, 1976). The first alternative gives an indication of the social experience of health and illness without necessary regard to its medical diagnosis or treatment. Self-report gives data on the meaning made of the experiences of health and illness in the everyday lives of respondents to the extent that this is possible within the constraints and limitations of social survey data. Physical assessment is based both on self-perception and on physiological complaints and, it appears, the biases of specific doctors. There is evidence, for instance, that physicians tend to do more extensive work-ups when men report symptoms than when women report the same symptoms (Armitage et al., 1979). As well, we know that people of different backgrounds (Zborowski, 1952) are more or less sensitive to the same symptoms, and thus present them differently to physicians. Perhaps the least vulnerable to social definition is the third technique for measuring illness, which involves direct physical measurements such as X-rays, blood pressure, blood and urine samples, electrocardiograms and so on.

However, in the same way that mortality rates are known to be affected by the biases of those who sign the death certificates, whether doctors, coroners, or others (Wilkins, 1970; Atkinson, 1971), it seems plausible to suppose that clinically defined measures of physiological characteristics and functioning are similarly in error. If records of an occurrence believed to be so objectively measurable as death are known to be susceptible to social construction it appears at least a possibility that other physiological measures and diagnoses are similarly fated to biases such as sexism.

In addition to the variability in the concept of illness which arises out of viewing it as a self-perceived, clinically diagnosed and/or laboratory-measured phenomenon, there are complex facets of illness

within each of these three categories. Thus self-perceived illness itself differs in many respects, from non-existent or unnoticed symptomatology, to mild and transitory, to serious but acute and limited, to chronic and debilitating, to chronic and terminal. It varies in the degree of painfulness, in the extent to which the illness is believed to be stigmatizing; in the extent to which it interrupts the everyday life of the person in other ways; in its contagion and resultant isolation; in the amount of stress it engenders in the person, and his or her family and other relations; in its treatability; in its social meaning; and in its usefulness or message, among other things. In these, and undoubtedly in numerous other ways illness is multifaceted and to some extent experienced differently by different people and differently by the same people at different times.

Even when illness is considered to be that which the physician labels as illness, variations in meaning abound. Clinician's diagnosis involves presence or absence, the degree, the severity or the extensiveness of impairment and specific diagnostic categories among other things.

A standard source for information on the health of the population of the United States of America is the *National Health Survey* which is a repeated questionnaire survey of a stratified random sample of households all over the USA. The health indices included are the following:

The incidence of acute conditions, number of acute conditions, restricted activity, bed disability and days lost from primary activity, direct acute conditions, overall days of bed disability, physician visits and discharges from shortstay hospitals (Nathanson, 1975:57).

As Nathanson suggests, 'Illness, disability and use of health services represent conceptually distinct aspects of areas in which comparability is limited.' In another review Verbrugge (1976), relying essentially on the same data source, defines illness in a more exclusive manner. Here she includes only rates of acute conditions, and chronic conditions, restricted activity days and bed disability days and limitation of activity, and of mobility due to chronic conditions (1976:388). Furthermore, each of these definitions is more specifically defined (e.g. an acute condition is one which began sometime during the two weeks prior to the interview and which involved either medical attention or restricted activity). Verbrugge begins with these rather general, if exclusive, categories from the *National Health Survey*. She then examines particular diagnostic categories such as infective and parasitic diseases, respiratory conditions, digestive system conditions, injuries, and other acute conditions (1976:390). Elaborating then on sex differences with this complex of dependent variables indicating illness,

Verbrugge is led to conclude 'that more females have a [chronic] condition but they are less severe than males' conditions', and, on the other hand, females are sicker from acute conditions because they stay in bed and restrict their activity more (p. 397). It seems, with these data at least, whether or not one finds a difference between men and women, and in what direction, depends on the diagnostic category (the definition of the dependent variable).³

Gove and Hughes (1979) attempt to examine sex differences in yet another version of illness, what they call 'real illness'. They attempt to deal with the supposition that the differences in male and female rates arise out of reporting (either to physicians or in survey research), not 'real' differences. Verbrugge (1976) and Mechanic (1976), for instance, have argued that the differences are not real but artifacts of the willingness of women to report illness. Verbrugge documents this assertion with some evidence (1977), as she finds that, disease by disease, the sex with the highest likelihood of morbidity is the sex with the highest rate of mortality. Unfortunately the data that Gove and Hughes bring to bear on this issue again define the dependent variable differently, i.e. the response to the question concerning overall general health, felt illness, inability to pursue normal activities and days in bed in the previous two weeks, and 'an index which combined indications of the different types of impairment that were weighed for severity and multiplied by the number of days of their occurrence' (1979:135). In addition, these authors distinguish between mental and physical illness and suggest that mental illness is causally prior to physical illness. To indicate mental illness, Gove and Hughes (1979) use a scale with some validity and reliability (according to two earlier studies in which Gove was involved). While they claim that they have chosen the particular items which were included in the scale so that it does 'not contain items that can be interpreted as physical symptoms of organic disorders', they have not documented this statement. It seems that in contradiction to what the authors believe, 'symptoms' described in the scale are often typical of the experiential component of an illness that is often manifest as physical illness (Benson, 1979). Thus their causal model is in serious jeopardy of suffering from the conceptual and operational overlap of the dependent and independent variables.

Confusions and contradictions abound amongst the concepts of the dependent variable. This is a serious drawback to the accumulation of knowledge. Illness is indicated by self-perceived symptoms presented verbally in a survey research study, by means of the medical records of clinical assessments by physicians who have been approached by lay people because they have seen themselves as ill and in need of treatment, or by physical assessment of specific physiological mechanisms

such as blood pressure, galvanic skin response, vision, cholesterol counts, and so on. Rather arbitrary distinctions are made between physical and mental illness. Physical illness is believed to be indicated by days in bed while mental illness is said to be suggested by a series of questions of mood state, or by (psychiatric) diagnosis. These distinctions may not be this clear, however. It seems that when people stay in bed they may be malingering, feeling symptoms of physical illness or those of mental illness such as depression.

Illness is clearly not a unitary concept. To treat it as if there is a clear referent is premature. We do not know enough about the social meaning of illness nor its aetiology accurately to differentiate physical from mental illness. Nor do we know enough about the sense in which days of bed disability, for instance, relate to hospital discharge rate to include them in the same category and call them both by the same name – illness. Additional problems need to be examined when we add other variables in the attempt to explain morbidity rates. It may be that rates of illness are different for men and for women not because men and women have a different proclivity for this ‘objective’ phenomenon but rather because illness means something quite different to the members of each sex. Days of disability and hospital discharge data could, for instance, result from accidents rather than illness. But accidents might not be considered relevant to respondents who are asked about their chronic or acute ailments. From another perspective it might be argued that accidents, incarceration, alcoholism and cigarette addiction (in which male rates are far larger than female), while not illnesses in the sense that they may not be reported as symptoms in a survey research interview, are nevertheless ‘illness’ in the sense that they are immediately tied to physiological malfunctioning in the body and, as well, may lead to other more debilitating symptoms and even death. Indeed, illnesses resulting from these behaviours are among the major causes of death for men (Lalonde, 1974).

The larger conceptual issue regarding gender has to do with the validity and efficacy of asking questions about sex differences and explaining these differences in terms of social roles. The problem with this is akin to the story of the blind man who felt the toe of the elephant and exclaimed on the basis of its size and the hardness at its front that it must be a mouse. We are explaining a minuscule and contextless behaviour when the social-structural, cultural and economic forces which move persons dialectically are ignored. Questions about sex and illness are ambiguous unless the social construction of the categories of meaning associated with all of sex, gender and illness are explored in their full social, political and economic surroundings. Social-role hypotheses look at the ways in which women’s roles, as

domestic labourers, wives, mothers, employers, employees and so on, are associated with different sorts and levels of health and illness. The assumption is that these roles have the same meanings, first, to different women and, then, to women and men; or that the context and the content of domestic labour is comparable across classes, cultural/ethnic groups, educational levels and so on. As Oakley has shown so clearly, even in the sphere of one occupation – housework – this is not the case (Oakley, 1974:61–78). Moreover, this argument ignores the fundamental fact that ‘the social situations of men and women today are structurally and ideologically discrepant, and the dominant value system of modern industrialized societies assigns greater importance and prestige to masculine than to feminine roles’ (Oakley, 1974:2).

Indisputably, the field of illness research is fraught with innumerable difficulties as the result of the lack of conceptual clarity with regard to the dependent and independent variables.

Methodological issues in the study of illness

Most research in the field of gender roles and illness is positivistic in its orientation. That is, for the most part, research is modelled on the natural and physical sciences: the search for universal causal laws of the if x then y variety; the belief in the possibility of value freedom in empirical observation and analysis; the assumptions of objectivity, replicability, comparability and generalizability characterize this research. All of these are aspects of the methodology which typify epidemiological studies such as those discussed in this paper. Innumerable books and articles have already been written in both a critical and in an accepting vein. A general examination of the methodology is not at issue here. There are particular methodological problems, however, in this health/illness literature.

Biases in health survey research data arising out of the relationship between the interviewers and the respondents have been documented by the US National Centre for Health Statistics (Nathanson, 1977:20). Apparently most information in this routine, recurrent survey is proxy. Approximately 80 per cent of the respondents are women who then give information about themselves, and about the men in their lives. There is a consistent bias which results from the use of proxy respondents. Proxy interviews generally understate the morbidity of the absent person (Nathanson, 1977:20). This could be a serious source of difficulty in the literature, particularly as the hypotheses of interest focus on the comparative rates of illness for men and women. If women are more likely than men to respond in the survey interview and if

people who respond tend to under-report the existence of a given phenomenon for those whom they are discussing, it follows that women will – simply as a result of the methodology employed – say that they suffer more illness than the men whose health they are reporting. Yet controls for this sort of bias are not generally forthcoming, nor are their effects widely understood.

The effects of the response characteristics of 'yeasaying' and 'nay-saying' and 'social desirability' have also been tentatively explored in this literature (Selltiz et al., 1976). Phillips and Segal (1969) have argued that the reason that the rates of mental illness are generally higher for women is that it is much more acceptable or more socially desirable for women to acknowledge symptoms of weakness or stress. This argument has been applied to the literature on physical illness as well. In fact, one of the major explanatory hypotheses offered – one with a good deal of credibility – is that women are reportedly more likely to be ill because they are more willing to express their disease or distress. Mechanic (1976), however, has argued the point and suggested that men and women are not differentially likely to relate symptoms but rather they are likely to relate different symptoms. Women are more likely to experience distress in terms of physical symptomatology while men are more likely to express distress through 'acting out'. That is, men have been more likely to smoke cigarettes, to drink alcohol, to commit violent crimes and so on. Survey research, in that it does not allow for these sorts of distress symptoms, is sexist in its very definition of illness and illness behaviour.

There are other methodological problems. First, the specific questions which are asked and taken to reflect illness vary from study to study. At times, a general question is asked to indicate whether the respondent believes that his or her overall health is 'poor' or 'good' (see Gove and Hughes, 1979). At times health is viewed as measured by specific symptomatology. In the same study, Gove and Hughes asked respondents whether or not they had had to stay in bed, were unable to do the things that they normally did, or did not feel well during the past two weeks. Gove and Hughes did not equate this variable with the general health variables described above, however, but rather called it functional impairment, a distinct additional aspect of the whole illness experience. Woods (1979), in her reports of morbidity, utilized a description of symptom complexes rather than individual symptoms. A list of possible complaints was read to each subject, who was then asked to indicate which of these had been experienced over the last four weeks. Subjects were then asked to group the symptoms they perceived to be related. It was thought that the person's perceptions of which complaints were related in what was termed a 'symptom complex' would be more

relevant to illness patterns and illness behaviour than isolated complaints. In this same study, illness behaviour was distinguished from illness and taken to refer to what subjects had done in response to the symptom complex, such as visiting a health professional, 'Putting down a usual activity, resting in bed, using nonprescription drugs, consulting the lay network, or visiting a health professional' (Woods, 1979). We have already discussed the definitions provided by Nathanson (1977) and Verbrugge (1976) in an earlier section of the paper. Muller defines health/illness exceedingly pragmatically. Health capital, as she terms it, should be based on a definition of health capital for women which is measured by reproductive efficiency and the experiences of women with regard to fertility, general health, employment and household responsibilities (1979:37). Questions range from single-item indicators to multiple-item indicators; from current health in the past two weeks to health in the past two months, to health in the last six months; from health/illness behaviour to health-care utilization rates, from acknowledgment of diagnostic categories, to no acknowledgment of diagnostic categories (cardiovascular and respiratory disease, scarlet fever, typhoid, smallpox, measles, whooping cough, and so on (Ortmeyer, 1979)).

It is difficult to know or to estimate the extent to which we can compare responses to questions which have been asked with such widely discrepant degrees of specificity. To what extent does chronic and/or acute illness refer to the same category of meaning? To what extent can a question of general health refer to the same social experience as a bout of influenza? To what extent do illness behaviours (what people do when they think they are sick) belong in the same reservoir of meaning as the feeling or acknowledgment of a symptom? To what extent do health-care utilization rates correspond to rates of experienced symptomology or to rates of experienced disability? All of these questions remain unanswered. The complexity that is involved in the measurement of physical illness is exacerbated in the realm of 'mental illness': in the first place, because a rather arbitrary distinction between mental and physical illness is made; second, because the measurements of mental illness also frequently vary markedly from study to study.

As was indicated earlier, most health data are gathered by women from women and this is the case whether or not the information is taken to be about men or not. Women have been interviewed out of convenience, since they are much more willing to be interviewed, easier to locate and thus less expensive (in terms of interviewing costs). Official rationales for interviewing wives only would point to the fact that wives know and understand the experiences of their husbands as readily as the husbands themselves. Wives are believed to be the chief caretakers of the well-being of their husbands and, in particular, in this

culture are expected to be responsible for the most intimate of the details of the lives of their spouses (feeding, cleaning clothes, and so on). This is an unfortunate assumption because as literature in family sociology has demonstrated, husbands and wives live with very different understandings of the same situations (Bernard, 1972). Discrepant world views and discrepant information seem to be more characteristic of the lives of husbands and wives than not. Saffilius-Rothschild (1970) reviews literature which notes that the range of discrepant responses is from 15 per cent to 30 per cent in one study to 23 per cent to 64 per cent in another study. In particular, it appears that women tend to under-report the illnesses of their husbands. While this phenomenon is of interest in itself and might well tell us more about the construction of the illness experience and label in a marital relationship, wives' answers should not be considered to be valid indicators of the health of husbands.

In addition, the calculation of an overall health score is not unproblematic. Whether or not all types of illness, disability, and health-care utilization figures should be given equal weight remains an open question. It assumes that all of these are of equal value in this complex illness experience we are attempting to study. Further, whether or not illnesses of different diagnostic categorization should be given equal or different weights is also debatable.

Another difficulty with data which are based on available statistics such as hospital discharge rate, first admission to hospital and so on is that they do not take into consideration the proportion of the population of the specific sex in question. That is, we may indeed discover that women are more likely to be admitted to hospital than men. This comparison, however, is unfounded unless we compare the number of women who are hospitalized to the number of women who are not hospitalized and the number of men who are hospitalized to the number of men who are not hospitalized. The independent variable is taken to be sex in this literature and it is the way in which sex affects the probability of illness that is at issue. Thus the percentages or the ratios must be based on the total in the category of the independent variable. The problem is that the best explanation for the greater likelihood of female illness may be that there are more women in the population than men. This problem is particularly noteworthy when we consider the combined effects of age and sex. Older people are more likely to use health services than younger people (Crandall, 1980). There are more older women than older men because women live an average of approximately seven years longer than men (Crandall, 1980; Eshleman and Clarke, 1978). These two facts taken together would lead us to expect that simply by virtue of population sex ratios,

older women would comprise a larger proportion of the sick population, not as a result of social factors but simply as the result of the population ratios.

The literature described must be evaluated from another perspective, as well. On the whole, it pays remarkably little attention to reproductive orders and disorders. Although hospital stays for delivery may be exempted when hospital bed and hospital discharge rates, for instance, are calculated, the ways in which the secondary effects of these medical experiences get counted in other health statistics are ignored. Moreover, it could be argued that the experiences of pregnancy, delivery and post-partum examinations sensitize women and indeed, iatrogenically induce in women illnesses (symptoms) which they might not otherwise experience. There is a way in which women's reproductive experiences contaminate the rest of the health experiences of women. There are other serious criticisms of the literature which has been reviewed here and these are epistemological and/or feminist in their orientation. All of the empirical literature criticized is positivist, or social factist (Ritzer, 1975). But as has been argued elsewhere (Clarke, 1981) reliance on positivism provides an inadequate and myopic view of the social world. Activism (Bougey, 1978) would provide us with a needed critical and radical examination of the social action of individuals, groups and societies. It assumes injustice and exploitation. It would include an analysis of the structural determinants of women's alienation, false consciousness, political and economic disenfranchisement and ill-health. The definitionist perspective would describe the subjective, everyday 'lived experience' (McBride and McBride, 1981). It would begin with a trust in the world views of women themselves as recorded by female sociologists.

To incorporate thoroughly the six principles of feminist analysis described by Millman and Kanter (1975) all three paradigms are necessary. They interweave to form a variegated mesh which is more complete because it is multi-faceted. Medical sociology has taken place in the existing society and has taken for granted the structures and values of the existing society. It has also meant that outside attempts at an objective analysis have been stressed at the expense of the subjective meaning to the social actors; that private worlds have been neglected in favour of public worlds; that the potential for a radically altered future has been dismissed in the face of the overwhelming reality of the present; that formal arrangement and structures have been described with the loss of the informal; that male language, models and methods have been utilized to the detriment of women and that sex has not often been taken into account as a factor in behaviour, (see Millman and Kanter (1975) for a fuller discussion of this phenomenon.)

Conclusion

As we have seen, illness is a multi-faceted, complex phenomenon which has been measured in a wide variety of ways in many different studies. Such variability limits severely our ability to generalize from study to study, to treat data as comparable or to establish firm conclusions. How can theory explain why one sex is more likely to be ill than the other when we are not at all sure what is meant by the very concept of illness? When we do not know whether men or women view the same things as symptoms of illness, when we do not know to what extent physicians diagnose the same symptoms differently in men and women, when we do not know about the differential effects on men and women of the hospital experience, how can we theorize about sex differences in illness? Nathanson has summarized the literature to find three possible theoretical explanations for the presumed differences in the morbidity rates of men and women. And yet, there is a way in which there can be no adequate, systematic theory-building as of yet because of the conceptual indeterminacy in the definition and problems in the measurement of illness and gender: that the explanations are to some extent contradictory is not surprising given the state of the research. To redress the imbalance, to turn the dubious conceptions of sex and illness which have been discussed herein on their heads, would demand significant reconceptualization and design in the empirical research in this area.

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Notes

1. The following is a list of major studies published in this past decade: Chesler, 1972; Crane, 1975; Dohrenwend and Dohrenwend, 1976, 1977; Ehrenreich and English, 1981; Gove, 1972, 1973, 1980, 1981; Gove and Hughes, 1979; Gove and Tudor, 1974; Mechanic, 1976; Nathanson, 1975, 1977; Radloff, 1977; Renne, 1971; Smith, 1975; Verbrugge, 1976, 1977, 1979; Waldron, 1976; Muller, 1979; Ortmeyer, 1979; Wallen et al., 1979. The critical evaluation which I will offer here is based on these studies.
2. Gender and sex refer to different aspects 'masculine and feminine'. Classification by sex is based on physiologically based properties primarily while classification by gender refers to social dimensions of action as either male or female. For a more complete discussion see (Tresemmer, 1975, Eshleman and Clarke, 1978). From this point on the paper will use the term gender when referring to the research which is being reviewed as it is the more appropriate term.

3. When Dohrenwend and Dohrenwend (1976) re-analyse the trends in sex and mental illness rates first established by Gove and Tudor (1974), they too find correlation reversals with different definitions. Dorothy Smith, reanalysing the Gove and Tudor (1974) findings but using Canadian data and comparing the sex and mental illness rates with different definitions of mental illness, came up with the opposite results.

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