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Talcott Parsons, the Sick Role and Chronic Illness

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Abstract

Parsons' sick role concept has become problematic in the face of the increased significance of chronic illnesses and the growing emphasis on life-style centred health promotion. Both developments de-limit the medical system so that it extends into the world of health, fundamentally changing the doctor-patient relationship. But as the sick role is firmly based on the reciprocities of a resiliently capitalist achievement society it still informs normative expectations in the field of health and illness. The precarious social position of chronic patients between being governed by and being consumers of medicine, I will argue, can only be adequately understood if one involves, as Parsons did, the moral economy surrounding health and illness.

Introduction

The sick role still is one of the most frequently invoked of Parsons' concepts. It is, however, mainly used as a 'negative referent' (Shilling, 2002: 625) rather than as an interpretative tool. The sick role is widely accepted as an historically adequate account of normative expectations around illness in the middle of the 20th century (Herzlich, 1973: 9), but the rise of chronic illnesses and the pathologization of everyday behaviours in health promotion has opened up medical fields which it no longer seems to cover. Even in the shrinking field of acute illnesses the sick role has been predicted to disappear soon due to marketization and patient empowerment (Bury, 1997: 106).

This apparent obsolescence, I will argue, can best be understood against the normative background of reciprocity and recognition at the heart of Parsons' thinking. In his medical sociology, as in his general theory, he was interested not so much in concrete behaviours as in the normative expectations structuring and structured by ordinary practices in capitalist societies (Parsons, 1964: 257ff.; Arluke, 1988: 176). Although those practices have changed considerably in the various transitions described under labels like 'post-Fordism' and 'the New Economy', both the success orientation of economic practices and the fundamental patterns of capitalist reciprocity and recognition (Varul, 2010) have remained intact and may even have become more accentuated (Gorz, 2005: 6). With this tension between a shrinking field of application and a persisting moral plausibility in mind, I will suggest that the obsolescence of the Parsonian sick role is not due to the marginalization of its field of application but to its expansion beyond its temporal and spatial boundaries. I will try to show that this approach can add to an understanding of the precarious social position of the chronically ill, and that it also highlights parallel expectations towards the healthy in what I will call 'chronic health'.

Acute illness and health in the capitalist moral economy

Parsons' starting point is his understanding of illness as deviance. Illness is the breakdown of the general 'capacity for the effective performance of valued tasks' (Parsons, 1964: 262). Losing this capacity disrupts 'loyalty' to particular commitments in specific contexts such as the workplace and the family. The assumed cause of disloyalties in the case of illness is not disregard of norms but inability to conform to them, a difference which constitutes the distinction between illness and immorality or crime (Parsons, 1964: 270). For the effect on the social system, however, it does not matter if and how deviance is motivated since in any case 'too low a general level of health, too high an incidence of illness, is dysfunctional' (Parsons, 1951: 430). This renders illness an undesirable deviance that requires normative rejection.

But system requirements do not translate smoothly into normative expectations in everyday social relations. It is more informative, therefore, to look at the web of reciprocities of role performances that make up the social system. Parsons (1951: 430) invokes a social contract in which society's gift of life is repaid by continued contributions and conformity to social expectations. As Gerhardt (1989: 17) points out, for Parsons '[a]ll social action is seen as exchange' entailing 'the relentless obligation to conform to others' role expectations'. A transgression against 'a going system of social relationships' therefore does not require 'positive disruption' – simple withdrawal is sufficient because it forces role partners 'to do without the benefits expected from a person's actions' (Parsons, 1951: 30f.). Illness is 'one of the most important withdrawal behaviors in our society' (Parsons, 1951: 31). As 'disturbance of the total person' it affects all the person's particular role performances. Failure in *all* particular roles amounts to total personal failure since the loss of 'approvals' (for specific role performances) adds up to a loss of 'esteem' (for the person as a whole) (Parsons, 1964: 266ff.).

The potential consequences of such a loss are severe because approval and esteem function as 'fundamental analytical basis of the place of moral sentiments in the institutionalization of the reward allocation systems of societies' (Parsons, 1951: 132). The need for approval by others is

built into the personality system's need disposition, reflecting the inescapable dependence on others' reciprocation (Parsons, 1951: 381). King (2009: 281ff), in his reading of *The Structure of Social Action*, points out that for Parsons this is more than just a matter of symbolic interaction: 'honour' and 'shame' accompanying conformity and deviance have consequences for the allocation of resources and for social membership. In *The Social System* this insight is watered down in a shift towards a more psychoanalytical perspective (1951: 38ff.), but it is still echoed in the norms of loyalty and solidarity which are rewarded by being 'in a position to "count on" the favorable attitudes of alter' (1951: 79). Failure to fulfil role expectations, disloyalty, therefore incurs the risk of social exclusion.

Parsons has tailored the sick role to US American achievement values, but it also applies to other capitalist societies to the extent that liberal labour and consumer markets are the central *loci* of social exchange. In these societies the 'absence of a definitive goal for the system as a whole' means that economic productivity becomes the most significant field of contribution to the common good (Parsons, 1964: 278). In this context health is crucial because it underlies the capacity for economic achievement. Defined as the ability to perform health is synonymous with what Marx called 'abstract labour power': the unspecified capacity to produce (Blane, 1987; Varul, 2004: 207ff.). In a later reflection Parsons (1978: 80) suggested a parallel between health and money. He may not have had this in mind, but if money is 'the socially recognized incarnation of human labour' (Marx, 1996: 107) and health the basic ability to work, money and health are convertible through the working body. Williams (2003: 38) relates this money-like health to Bourdieu's notion of 'physical capital', which is economically relevant in every occupation as all work is embodied (Shilling, 2005: 28ff., 73ff.; Hall, 1999: 607). In tune with the gendered division of labour of the 1950s, the body in Parsons' sick role is a male one, defined as controlled by a rational, purposive mind and oriented by it towards an income-generating performance. The female body here counts only in its biologically and emotionally reproductive role within the family (Parsons, 1956: 12ff.), which gains legitimacy only indirectly through the performance of

the reproduced male body. While the mind/body dualism and the requirement to control emotions must not be essentialized as masculine, and the “emotional” body not as “feminine” (Witz, 2000), it is the health of the rational producer – whatever the gender – that the Parsonian sick role seeks to restore. Ignoring much of the lived illness experience that often cannot be subsumed under the notion of “incapacity”, it nevertheless adequately reflects social legitimacies which until today privilege paid work.

The use of money as symbolic recognition and as material realisation of that recognition (Varul, 2010) enforces the existential nature of the anomie constituted by illness. In a society championing ‘universalistic achievement values’, tokens of *approval* for specific performances are the central element in the social reward system. Desisting from a holistic evaluation of the person, approval has an affinity to money which in turn very often is used to express the degree of approval and the importance of the valued action (Parsons, 1951: 132). In an achievement society *esteem* as more diffuse social recognition of the whole person is largely linked to general capacity, evidenced in its particular approved actualizations. Illness as a breakdown of capacity interrupts performance worthy of approval, most significantly in economic roles, and thereby threatens general esteem, which is largely (although not exclusively) expressed in financial resources. And because financial resources are ‘the basis of the availability of facilities for attaining *whatever* goals may seem most worthwhile’ (Parsons, 1964: 278) illness is not only a threat to social status in terms of respect (‘honour’) but simultaneously a threat to material status in a very immediate sense.

Being largely beyond the individual’s rational control (Gerhardt, 1989: 23) illness thus poses an unbearable prospect of abandonment and deprivation. The provision of an institutionalized bridge over periods of illness is therefore essential if mass loyalty in a modern capitalist society is to be maintained (Behrens, 1997). Because health is the ‘fundamental condition of achievement’, access to health services becomes ‘a central focus of the problem of justice’ (Parsons, 1964: 279), a cornerstone of the capitalist moral economy.

The sick role

The sick role is, for Parsons, one of the most important mechanisms of social control in capitalist societies. Yet, while health is vital for the economic system, the anomie of illness is controlled by non-economic means: ‘The “profit motive” is supposed to be drastically excluded from the medical world’ (Parsons, 1951: 435). In Durkheimian tradition Parsons sees the capitalist economy as an institutionally established field where interaction based on utilitarian motives is enabled by social arrangements that cannot themselves be utilitarian (Durkheim, 1933). The case of medicine has such a prominent place in his theoretical work because it excellently demonstrates this point. It is an institution that is oriented towards enabling individualistically calculated social action, but is in itself collectivity-oriented.

Substituting the multiplicity of everyday roles, the sick role bridges periods of incapability by establishing a single role that enables conformity within the deviance of illness. Loyalty to and efficient performance in the particular commitment of the sick role compensates temporarily for general incapacity. In what is best termed a ‘moratorium of reciprocity’ (to extend the application of Gerhardt’s [1987: 117] apt expression), the individual’s everyday obligations – and also their everyday rights – are suspended and replaced by a set of sick-role specific rights and obligations. The exemption from normal role expectations itself obviously is the most fundamental right. Other rights are the assumption of innocence and access to professional help. These rights are matched by complementary obligations.

The right to exemption is matched by an obligation to retreat from normal everyday life, both work and leisure, to isolate oneself from the world of the healthy. Parsons (1951: 437) points out that this obligation is often enforced by role partners (domestic, occupational etc.). The ill are to be ‘insulated’ as ‘disturbing element in the system’ (Parsons, 1964: 259). The ‘system’ needs to be protected not only from biological infection but also from motivational contagion (Parsons, 1964: 275f.) as without such protection the presence of people who receive sustenance and care

without making a productive contribution would destabilize the motivation of the healthy not to fall ill.

This concern with illness motivation originates from Parsons' premise that illness is not just 'situational' incapacity (1964: 269) but also 'normative' deviance (cf. Gerhardt, 1989). Although Parsons put a strong emphasis on the physical organism (Shilling, 2002: 625, Howson, 2005: 16) the body remains secondary, a mere object ultimately to be controlled by the rational mind. Illness in most cases is the failure of such control (Shilling, 2002: 626). In a Parsonian perspective, therefore, 'most illness, if not all, could be considered to be psychosomatic' (Lupton, 1997c: 567).

The assumption of innocence still makes sense, as the unavailability of motives makes an appeal to the sufferer's morale or even punishment dysfunctional. Part of the predicament of the ill person is that they cannot control those motives. Further, the motivational component of illness always exists alongside a conditional one – the body refusing to follow the mind – which cannot be tackled by a merely social control (Parsons, 1964: 335). In his reconsideration of the sick role (1978: 19) Parsons limits the notion of illness as deviance to the motivational component. Given the way the sick role is embedded in a capitalist moral economy it seems nonetheless appropriate to retain the notion of even purely physiological incapacity as deviant. Valuing contribution here is based neither just on one's potential (capacity), nor just on its motivated realization – the value of actualized labour power is qualified by what is socially defined as its relevant skill (Varul, 2010) – and so, too, are individual healths as different capacities.

Controlling the motivational side of illness is crucial in preventing sufferers from accepting their illness 'as a liberator' from the burdens of a stressful modern life (Herzlich, 1973: 130). The 'secondary gains' (exemption, attention and care) of the sick role must not be obtained without a price. In order to uphold commitment to social reciprocities while unable to fully take part in them, a secondary reciprocity is introduced. The weakened motivation to fulfil normal role obligations is replaced by a motivation towards recovering lost motivational energy. The

assumption of innocence can only be upheld if the sick person is seen to comply to the second obligation that comes with the sick role: the ‘obligation to “want to get well”’ (Parsons, 1951: 437). Compliance to this imperative is demonstrated by compliance to the obligations matching the right to professional help and social support: to actively seek professional help, to trust the physician and to follow medical advice. The doctor-patient relationship is set up to enable legitimacy-providing conformity within the deviance of illness.

The sick person may be allowed, to an extent and for a time, to regress into childlike dependency – but this permission comes with an equally childlike loss of autonomy (Gerhardt, 1991: 171f.). In order to achieve the collective goal of re-establishing health, the patient has to accept violations of personal and bodily integrity, treatments that come with discomfort and sometimes even considerable pain – ‘the burdens the physician asks his patients and their families to assume on his advice are often very severe.’ (Parsons, 1951: 442) The ill are not allowed to pick and choose treatment – they are not consumers deciding according to their individual preferences. ‘Shopping around’ is not an option (Parsons, 1951: 438f.).

The loss of autonomy is, paradoxically, informed by the high value placed on autonomy, ‘compulsive independence’ (Parsons, 1958: 345), in modern societies. Disease is a threat to autonomy as it disables social contributions which legitimize individual freedoms; and, of course, it impacts directly on autonomy by way of incapacitation. The renunciation of individual autonomy in the sick role is only tolerable because it is relinquished solely in order to fully regain it. As a strictly *transitional* role the sick role defines a spatially and temporally delineated world of illness (Parsons, 1978: 32).

Chronic Illness

Chronic illnesses – from the 1970s onwards more significant than acute illnesses - by definition exclude recovery. In this situation the sick role’s spatial and temporal containment of illness becomes untenable (e.g. Freidson, 1970: 234f.; Segall, 1976: 165). Parsons defended his concept

against such charges by stating that despite the failure to recover completely the sick role still makes sense as:

‘recovery is the obverse of the process of deterioration of health, that is, level of capacities, and in many of these chronic situations tendencies to such deterioration can be held in check by the proper medically prescribed measures based on sound diagnostic knowledge.’

(Parsons, 1978: 19)

He ignores, however, the implications of the achieved normality under the Damocles sword of impending crises and the effects of a regimen structuring everyday life with disciplines holding in check, but thereby also holding present, those recurring crises. For the chronically ill ‘their illnesses are either always with them or, if quiescent, potentially lurking just round the corner’ (Strauss and Glaser, 1975: 9).

For chronic patients the doctor-patient relation therefore never really ends; they remain dependent on, and therefore under the authority of, the medical system. Even in the case Parsons quotes as relatively easy to control (mild diabetes) the regimen has an infantilizing aspect: being told what and what not to eat (Cohn, 1997).

The indefinite extension of medical control and diminished autonomy follows the logic of the sick role concept under changed circumstances. Full capacity cannot be recovered however well the motivational component is controlled. The ‘dys-appearing’ body (Leder, 1990: 69ff.) refuses to disappear and gets in the way of daily routines, permanently disabling reciprocities that require a “‘social competence” [...] informed and coded by non-impaired carnality’ (Paterson and Hughes, 1999: 607). If health is understood as elasticity as a resource that enables adaptation to and absorption of new challenges (Canguilhem, 1988), an exhaustion of this reserve is the more disruptive the more fluid and flexible the world of work becomes.

There therefore is a strong incentive for ‘normalization’, a return to normal role performances in spite of persisting illness. In a society oriented toward ‘universalistic achievement values’ the permanent removal of members from relations of reciprocal efficiencies/loyalties is not an

option – neither would it be a tolerable prospect for the sufferers themselves. The sick role does provide specific approval confirming that the ill person is attestably doing ‘the right thing’; but being only *one* particular role, and one that includes the obligation not to perform in any other roles, it thwarts the acquisition of multiple approvals in diverse contexts which could add up to esteem. Continued inability to accrue esteem, in turn, will contribute to the erosion of socially embedded personhood, a ‘loss of self’ (Charmaz, 1983). Regaining the desired status as ‘valid adult’ (Charmaz, 2000: 282) requires, in capitalist societies, the acquisition of esteem through direct or indirect participation in the generalized reciprocity of economic exchange. Both the moral order of the social system and individual need-dispositions geared to autonomy and recognition lead to a

‘commitment to the attempt to recover a state of health or in the case of chronic illnesses or threats of illness to accept regimens of management that will minimize the current impairment of teleonomic capacity and future risks that the actual or presumptive illness may entail.’ (Parsons, 1978: 76)

Without the prospect of regaining full capacity, the ‘job’ of recovery becomes a life-time employment. The discipline of the sick role is partly replaced by self-disciplines of the chronic patient, a regimen consisting of treatments, diets and/or exercise which often is so demanding that it requires the reorganization of the entirety of everyday life towards it (Strauss and Glaser, 1975: 21ff.).

On re-entering social reciprocities the chronically ill are confronted with the competing expectations of an ongoing sick role and of normal everyday roles. On the one hand continued compliance to sick role expectations is essential in order to avoid sanctions both from a disapproving environment and, above all, one’s own body. Regained capacity often remains fragile and complete control is rarely won back. The very ability to engage in social relations is

put in question by a body that may no longer behave according to social expectations (e.g. Radley, 1994: 151).

By normalizing, the chronically ill become dual citizens in the world of illness and the world of health (Radley, 1994: 136). If illness is to be re-admitted, the danger of moral contagion must be minimized: The healthy public needs constant reassurance that it is not nice to be ill, that ill people carry a burden. Their narratives represent the abhorred (Radley, 1999), the unhealthy non-self (Crawford, 1994). Re-entering the world of health while still being ill therefore means that even where the ability to specific performances is regained, these are indexed as performed by a sick person. As Charmaz (2000: 284) points out ‘a woman who uses a wheelchair because of multiple sclerosis becomes a disabled mother, handicapped driver, disabled worker, and wheelchair dancer.’ This limits what can be achieved in normalization as already the effort to regain and maintain normal capacity makes one stand out. The membership in self-help groups, for example, may on the one hand facilitate normalization – but it can also entail engulfment in a community of illness (e.g. Crossley, 1998: 525).

Normalization further means that the ill person needs to be seen as not giving in to illness. Even where treatment evidently does not make any difference whatsoever, the normative expectation to comply remains (Freidson, 1970: 235; Jobling, 1988). If, as in the case of chronic back pain, it is difficult to get a regimen prescribed, this creates anxieties that ‘this lack of treatment could be seen as a sign that they were not really trying to get back to work’ (Glenton, 2003: 2247). Just as in the sick role of old, here too the *motivation* of wanting to get well in the sense of wanting to re-enter normal reciprocities is central. The unhealthy body must be shown to be driven by a healthy mind.

Welfare-to-work agendas such as the British “New Deal” programme (e.g. Roulstone, 2000) confirm such a continued hierarchical mind/body dualism by linking benefits to motivation. Motivation is also central in the Expert Patient Programmes (EPPs) with their emphasis on the

enhancement of ‘self-efficacy’, a psycho-therapeutic strategy to induce behavioural changes despite remaining limits set by an impaired body (Taylor and Bury, 2007: 32).

While compliance to sick role expectations is still required, it no longer offsets diminished contributions in normal roles. This is manifestly expressed in the loss of income that many chronically ill experience. Diminished capacity translates into less valued jobs and thus less approved specific role performances. The sick role is an institutional arrangement to bridge discontinuities – if there is no end in side, it turns into a slide down to whatever level of contributions can be expected in the future (Behrens and Dreyer-Tümmel, 1996: 195). The parallel between health as capacity and abstract labour power helps to understand this. Wage differentials for what is socially defined as different capabilities do not just show the extent of the realization of those capacities – capacity itself is the object of an indirect moral evaluation. The everyday meritocratic interpretation of economic rewards does not make a difference between effort, skills and talent as factors in achievement. Different capacities are reflected in different levels of reward, so that permanently diminished capacity is morally and materially sanctioned by diminished rewards.

Approval is then to be earned under the same or similar conditions as apply to the ‘healthy population’ and, subsequently, ‘the chronically ill feel themselves to be subject to the same normative judgments as the healthy’ (Radley, 1994: 157). The co-occurrence of sick role and normal roles in chronic illness means that

‘balances must continually be struck between doing too little and doing too much. If sufferers ignore symptoms and press on as normal, they risk being perceived as “reckless”. If they take great care of themselves, they run the risk of being seen as “invalids” or as “malingerers”.’ (Radley, 1994: 157)

Over-compliance on either side results in deviance on the other. To achieve normalization in the face of the permanent loss of normality, conformity to medical regimens must be oriented

towards enabling normal role performances. The classical sick role requires patients to dedicate *all* their efforts and time to prepare for normality *after* the sick role – full sick role compliance hence disables normalization *during* illness. For the chronically ill person, therefore, full sick role compliance turns into what Merton (1968: 238) described as ‘ritualism’ in the response to anomie: a response in which ‘one continues to abide almost compulsively by institutional norms’ but in doing so abandons the ‘culturally defined aspirations’ behind those institutional norms. ‘Illness as occupation’ (Herzlich, 1973: 130), is as detrimental to normalization as ‘illness as a liberator’.

The normative background of the Parsonian sick role thus contributes substantially to an explanation of the double expectations of conformity in normalization: the routine observance of a regimen, self-monitoring, crisis management as prolonged compliance on the one hand and the expectation to perform as far as possible in normal roles on the other. Regaining legitimacy by minimizing unreciprocated dependency (Charmaz, 1983: 188; S. J. Williams, 1993: 93) is a central motive in the reorganizing efforts towards a new normality.

Successful normalization leads to an erosion of the medical authority under whose extended influence it is performed. This erosion is commonly seen as an effect of the illness knowledge the chronic patient acquires by playing a greater part in managing their illness, being a participant in, rather than a mere object of, medical decision making (Bury, 1997: 100; Frank, 1995: 12ff.) – not to mention the obvious fact that the prolonged experience of illness in itself creates practical knowledge of it. For Parsons, medical authority is first and foremost based on, and justified by, the doctor’s exclusive access to expert knowledge. Consequently, Young (2004: 6f.) observes, as ‘the patient’s knowledge of medicine increases, the power differential between patient and doctor decreases, as does the dominance of physicians in the sick role relationship.’ While the internet is often presented as the major challenge to the knowledge-based authority of medicine (e.g. Shilling, 2002: 630) acute patients appear to be reluctant to educate themselves into competent rational consumers of medical services (e.g. Lupton, 1997b, Henwood et al., 2003). It takes

considerable time and skills to access, assess, and apply online medical information (Hardey, 1999), which is why online forums and 'patient online communities' (Josefsson, 2005) only unfold their potential as sites of exchange and production of knowledge in the long term, by *chronic* involvement.

Once actualized this potential minimizes a central characteristic of the sick role: the anomic helplessness of the ill and the insurmountable knowledge gap between physician and patient. Apparently, therefore, the applicability of the sick role concept ends here. Yet the patient's helplessness is not in itself an essential element of the normative setup of the sick role. Rather, what is required is the recognition of this helplessness, which is to be proven by seeking professional help. Therefore, as soon as it becomes possible at least partly to overcome this helplessness, the sick role occupant must reject total dependence on the doctor, actively search for information and engage in self help. The shift in the power balance between doctors and patients follows from a sick role requirement conformed to over a longer period of time and thus is not at all at odds with its normative background. To regain autonomy is one of its aims, and informed, knowledgeable patients are sharing it.

The emancipation from medical power, however, will always be incomplete. While the knowledge-based authority of the doctor over the chronic patient erodes, that of science-based medicine itself remains largely untouched. Much of patient organizations' energy is spent on campaigns to increase funding for bio-medical research and to make newly developed drugs available. As Crossley (1998: 524) puts it, they 'remain tied in the most fundamental fashion to the progress of medical knowledge'.

From a governmentality point of view one could say that this is a case of progression from direct power, from surveillance and punishment, to governing indirectly 'at a distance' (Rose and Miller, 1992: 180) – a shift from control to self-control, from discipline to the self-discipline of subjects into whose subjectivity the knowledge/power of the medical gaze has been inscribed (Lupton,

1997a: 99). The subject in this indirect regime makes free choices and is governed through the entailing accountability and responsibility for these autonomous decisions within the parameters of the facts about risks provided by 'governments, policymakers and institutions' (Nettleton, 1997: 266). In capturing this shift towards knowledge-instilled autonomous conformities governmentality studies develop on Parsons' (1958: 345) notion of 'compulsive independence'. The governmentality approach does not, however, tell us how such an infusion with independence through knowledge can produce socially conforming performances. Here Parsons' approach from the reciprocities of the sick role and its links to the recognition to be had from normal role performances is still relevant even after the sick role's alleged obsolescence. Governmentality studies do acknowledge that governing agencies tap into this need for recognition and inclusion in order to mobilize them for their own programmatic aims. But while taking parameters like 'self-esteem' and 'recognition' *into* account (Cruikshank, 1996), to account *for* them remains beyond the theoretical remit of a Foucauldian perspective that denies the role of legitimacy in the construction of social reality (Fraser, 1993). Yet, legitimacy and recognition play a crucial part in another important transformation through chronic illness.

There are two reciprocity arrangements providing legitimacy in the doctor-patient relationship. The first is the expectation that the doctor directs all efforts towards the patient's recovery, which is to be reciprocated by the patient's equally uncompromising success orientation translated into and expressed by compliance and trust. The second is a reciprocity of reciprocity moratoria: The patient is exempt from sanctions that would normally apply to those not conforming to everyday social roles. In return the patient desists from reciprocating violations of their psychological and physiological integrity that come with diagnosis and treatment (Gerhardt, 1987: 117). Both these reciprocities do no longer fully work in chronic illness: The doctor cannot promise full recovery and the total exemption from social roles is no longer sustainable.

In the absence of the prospect of full recovery it is now often for the patients themselves to decide what, in the end, is a desirable state to achieve because such states will always be trade-offs

between only relative gains in well-being and further suffering incurred by the treatment itself (e.g. Low, 2004). Without a perspective beyond illness the negotiation of, for example, side effects becomes much more significant in the ‘fine judgment about the costs and benefits (social as much as economic) of treatment’ (Bury, 1997: 126). In the face of the ‘ineffectiveness of medicine in treating chronic illness’ the patient can indeed become more of a sovereign consumer who is ‘making judicious use’ of ‘doctors and their drugs’ (Williams, 1993: 102). As medicine cannot keep its side of the bargain, patients are no longer bound to theirs and can begin to “shop around”.

The reciprocity of reciprocity moratoria, too, is thrown off balance. If a chronically ill person goes back to performing in normal roles, he/she thereby terminates the exemption and exposes her/himself to the same sanctions and rewards as a healthy person. As a consequence the doctor’s unquestioned exemption from scrutiny regarding physical and psychological injuries inflicted in the course of treatment is also terminated. Back in a role that is recognized as contributing in social exchange the “normalized” chronic patient is in a more empowered position vis-à-vis medical personnel whose right to order and prescribe can no longer be taken for granted. The power balance within the doctor-patient relationship is shifted as the patient regains the status of autonomous adulthood that had been suspended in the Parsonian sick role, which is thus obsolete. But its “spirit” survives as driving force behind this very obsolescence. This survival seems to indicate, as Charmaz (1983: 169) maintains, that ‘the traditional American emphasis on independence, privacy and family autonomy is still evident in the management of chronic illness.’ My argument so far would suggest that the moral economies of capitalist societies play a major part in the continuation of such normative expectations.¹

Chronic Health

There are striking parallels between what is promoted as healthy lifestyles and what is prescribed to chronic patients. Like them, the chronically healthy follow a regimen consisting in dietary

requirements (low fat, high fibre, five-a-day etc.), quasi-medication (vitamin supplements, herbal infusions etc.), exercise of an ascetic or ‘gymnastic’ (Bourdieu, 1978: 838f.) nature (yoga, jogging, etc.), and self-observation based on health knowledge (BMI, blood pressure, emotional balance etc.). Again, neo-Foucauldian approaches to health promotion, like those of Lupton (1995) and Nettleton (1997), capture the governmental inscription of such self-surveillance and self-disciplines into subjects. And again what they do not do, but what a Parsonian perspective does, is to acknowledge the embeddedness of those subjects in the moral economy surrounding health and illness.²

Parsons, of course, did not address lifestyle-centred health promotion which was only emerging in the 1970s, and at first sight he therefore seems to have relatively little in store to approach it. But, as Shilling (2002: 627) points out, the productivity ethos so central for Parsons is still behind much of contemporary health seeking – only that it is now joined by a consumerist ethos emphasizing the additional capacities of maintaining self-images and achieving pleasure (also cf. Crawford, 2000: 221). As Lupton (1994: 31) puts it, ‘self control and self-discipline over the body within and without the workplace have become the new work ethic’.

Parsons’ persistent relevance is particularly evident in the current promotion and pursuit of health as related to the significance of chronic illness. The most obvious link is the causal connection that is made between lifestyles and chronic diseases, since

‘... the prevalence of chronic diseases has meant that there has been an increased effort to find the risk-factors that lead to onset and, where possible, to persuade people to modify their lives to minimize the risk.’ (Radley, 1994: 137)

Once such a causal link is established, the sick role expectation of working towards recovery is extended to include working towards preserving health before illness occurs. As Greco (1993: 370) puts it, the ‘moral responsibility [that] has become associated with prevention [...] represents an extension of the duties Parsons described as those incumbent upon the sick-role.’

Parsons (1978: 76) already saw the social control of motivational deviance reaching into the behaviour of the still healthy, e.g. requiring them to avoid exposure to the risk of infection. Such quasi sick role expectations towards the healthy have now been extended much further.

Mobilizing citizens to combat potential disease is a governmental reaction against the rising costs of health care provision. But the obligation to avoid risks does not directly follow from their attestation. Health promotion to a large part consists in appeals – appeals to individual rational self-interest but increasingly also to individual responsibility towards others. The recent NHS anti-smoking campaigns are indicative of this: Not the fear of suffering in disease and dying is central but the guilt anxiety of letting down dependent family members. Appeals cannot create what they appeal to, in this case the moral economy behind the sick role: preserving health as general capacity is part of the social imperative of self-reproduction in the Durkheimian (1933: 399) sense that the ‘duties of the individual towards himself are, in reality, duties towards society.’ Where lifestyle choices are identified as pathogenic or “salutogenic”, making the right choices and being persistent in them becomes maintenance of status-securing capacity. Advertising for health preserving or enhancing products hence often plays to anxieties about losing the ability to meet role expectations (Varul, 2004: 164ff.). As Crawford (1980: 382) notes:

‘Not only do we experience the insecurity of imagined, future illness, the anxiety of worrisome prognosis, but also the insecurity of the deviant, the anxiety of not fitting in.’

While this applies to domestic as well as to public roles, the paradigmatic case (given the central role of money for approval in contemporary capitalism) remains the reproduction of labour power. So it is not surprising that some employers are tempted to arrogate the right to regulate, under the banner of a ‘new corporate health ethic’, into their employees’ private lives (Conrad and Walsh, 1992).

Beyond the mere obligation to maintain or even enhance capacity, health practices testify to the motivation to stay healthy. This, too, can be related to the increased significance of chronic illness

and its normalization. As Crawford (1987: 104) points out, the meaning of health shifts from the results of a healthy lifestyle to the lifestyle itself because ‘the more the achievement of health is defined as a moral project, the more people are likely to confuse means with ends’. This also works as a statement of immunity against motivational infection by the presence of chronic illness – a means of maintaining one’s identity as fully contributing and hence recognized member of society (Varul, 2004: 258ff.). The toleration of chronic illness and disability within the world of health is balanced out by a rejection of behaviours and attitudes that are suspected of being part of their aetiology – which in turn keeps reminding those who do not have “full health” of their otherness (e.g. Marks, 1999: 28)

Against this background, the similarity of regimens in illness management and health maintenance does not seem to be a mere coincidence. While the chronically ill have to display their refusal to give in to illness, engaging through such disciplines in constant rehabilitation not only in a physiological but also a moral sense, the chronically healthy engage in a similar display of motivation – moral prehabilitation as it were.

Further, a Parsonian perspective also can help to shed light on the limitations of the current lifestyle-centred health promotion. Like the chronically ill, the chronically healthy do not obtain any of the secondary gains of the sick role (Horn et al., 1984: 18), leading into an unbalanced reciprocity with no tangible reward for conformity – except perhaps a reduction in guilt anxiety. This also exposes the weakness of employers’ claims to a right to govern the health maintenance of their employees on the basis that this capacity is the foundation of the efficiency/loyalty that workers owe them in exchange for the material/symbolic approval which is the wage. As employees normally do deliver on the labour contract their capacity is proven by its actualization. Autonomy in social reciprocity is thus safeguarded, which prohibits control beyond this reciprocity so that there is no legitimacy for any attempt to govern reproduction. This also puts limits to the extent that government agencies can motivate and expect compliance.

Finally, just as ‘illness as an occupation’ constitutes deviant behaviour, so does health as an occupation. It focuses entirely on the maintenance of the capacity that is the basis of the acquisition of esteem – but capacity must be realized in concrete performances in order to earn approvals, which in aggregate build up esteem. Extreme ‘healthism’ (Crawford, 1980) celebrates capacity and refuses its actualization. Parsons’ enigmatic money/health parallel aims at this dilemma. Georg Simmel (1990: 218) understands money as a universal capacity, as ‘encircled by innumerable possibilities of use, as though by an astral body’. Like money ‘good health is an “endowment” of the individual that can be used to mobilize and acquire essential resources for satisfactory functioning as organism and personality’ (Parsons, 1978: 80). Without a physically, emotionally and mentally “working” (i.e. “healthy”) real body the “astral” body of financial resources is not only less freely deployable – this astral body tends to collapse with an incapacitation of the real body that sustains it. Like money or capital, health ‘in this meaning, would function only if it is “used” and not “hoarded”’ (Parsons, 1978: 80f.). The hoarder of health, like Simmel’s miser (1990: 242), relishes in the endless possibilities, the infinite potential that is implied in capacity, but is fearful of destroying this potentiality by its realization – and thus renders it worthless. Capacity (and therefore health) in itself does not yield any recognition (approval/esteem), it has to be actualized in specific and particular role performances (efficiency/loyalty). Not only does the astral body depend on the real body’s working – that working is only recognized through the accumulated approval – money - that is the substance of the astral body.

Conclusion

It is an intriguing question why Parsons’ special sociologies and prominently his medical sociology have proved to be so much more resilient than the general theory which they were supposed to illustrate. I would suggest that this is mainly because this illustration is firmly based on a much neglected current in Parsons’ thought: the attention given to reciprocity, recognition and its allocative consequences. His theorization of the sick role is rooted in needs for

recognition as they emerge from the exchanges (economic and non-economic alike) of ordinary life in capitalist societies, which links back to an everyday moral economy that is largely ignored in contemporary approaches. It is therefore better equipped to relate to empirical accounts of practices of living with chronic illness and of health consumerism than approaches that argue from the systemic needs of consumer capitalism, or approaches that focus on programmes rather than actual practices. Parsons acknowledges the emergence of role expectations in ordinary reciprocities and the need for recognition in a much more material sense than more recent revisitors (Honneth, 1995; Fraser, 2000). Rediscovering an earlier Parsons of reciprocity and recognition may add substantially to the debate on symbolism and materiality in relations of recognition and thus may prove to be of an ongoing relevance, a relevance that the 'structural-functionalist' Parsons of the sociology textbooks seems to have lost.

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¹ To the extent that those moral economies are relevant, they should generally apply beyond a US context. There are strong indications that the proposed perspective is one that is broadly applicable throughout advanced capitalist economies. Where welfare to work means that incapacity benefits are linked to proven efforts to regain employability, one can speak of a sick role writ large. Such moves have been made in countries with very distinct welfare cultures and health care systems (e.g. Dahl/Drøpping, 2001 for the Norwegian case and Barbier/Théret, 2001 for the French case). It is less applicable where the societal regimes of responsibility for the disabled and chronically ill remain with family networks and hence outside capitalist moral economies. Italy would be such a case – and the issue of health is conspicuously absent in the Italian version of welfare to work (cf. Boeri et al., 2000, Fargion, 2001).

² Again, there are indications that these patterns seem to be surprisingly similar across countries with otherwise distinctive healthcare systems (cf. e.g. Freeman, 2000: 74).