

Social Labeling Theory and the Physician

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This issue of *The Journal* includes an important paper by Kleinman dealing with the cultural meanings and social uses of illness. He makes a persuasive plea for the broad application of the biopsychosocial model in practice, teaching, and research in primary care. With regard to patient care, for example, the biopsychosocial model provides "a conceptual approach more adequate for a science of clinical care, since it seeks to unite clinical sciences' biomedical and social science basis. Whereas biomedicine has little to contribute to the study of physician-patient communication, the analysis of clinical reasoning, the study of help seeking, and the myriad of biopsychosocial issues that make illness behavior a crucial problem for clinicians, the biopsychosocial approach is a powerful way of bringing knowledge and research strategies from social science to help examine these and many other relevant issues."¹

Kleinman's paper serves to introduce physicians to a rich world of social science literature, which often has been regarded within medicine as "soft" and irrelevant to medical practice. A recently published book edited by Eisenberg and Kleinman, *The Relevance of Social Science for Medicine*,² is an excellent illustration of this kind of literature, which bears scrutiny and application by clinicians. For example, my interest has recently been drawn to the value of social labeling theory

in everyday practice, a subject likely to be foreign to many physicians.

The social labeling theory holds that the process by which the individual is labeled "ill" is determined by the individual's social position and society's norms instead of by accepted objectively defined signs and symptoms. The illness label is affixed to the patient as a result of a negotiation process involving the patient, the physician, the family, and others.³ The social labeling theory stands in sharp contrast to the biomedical model. Whereas the biomedical model attempts to link the patient's symptoms, signs, and course to a specific cause upon which clinical decisions are based, the social labeling theory "stands outside the doctor-patient interview and asks how the social context, the social roles and relationships, the application of the biomedical model of disease itself, influences what the doctor does and what happens to the patient."³

The social labeling theory raises many interesting and practical issues that are by no means irrelevant to patient care. The very definition of who is "ill" is a more complex question than may be immediately apparent. Definitions of illness may vary from one location, culture, or time to another. For example, only recently in many Western countries has what is called "alcoholism" been shifted from the category of "crime" to "illness." Mental illness in Ceylon, thought to be

due to supernatural causes, is not the responsibility of the individual so affected. Ceylonese culture strongly encourages early dropping of the sick role, and these patients become asymptomatic much more rapidly than in Western countries.³ Criteria for illness vary, even within the same society in response to nonobjective factors. As an example, the diagnosis and prognosis given by psychiatrists have been shown to depend partly on the social class of the patient, with lower class patients being given more serious diagnoses.⁴ Other issues related to labeling include the duration of a given label, who is responsible for labeling and delabeling, and by what process this should occur.

There are many serious potential problems of the labeling process in medical practice, mostly related to whether the correct label is applied in the first place and whether delabeling takes place at the appropriate time. The delabeling process is especially interesting, since it is affected by a number of influences quite unrelated to the biomedical status of the patient. Such factors as the social and economic position of the patient may affect the timing of this process or even whether delabeling occurs.³ The policies of the institution providing treatment may also affect this process; for example, hospitalized patients with tuberculosis who are cooperative and compliant with treatment have been shown to recover more slowly than nonconforming, "difficult" patients who are more aggressive in shedding their diagnostic

label.⁵ In addition, some labels are stigmatizing in a given society and may be difficult for the patient to discard even when symptoms have disappeared and the patient is "well." For example, one survey reported by the *New York Times* in 1979 showed that more than 80 percent of blue-collar workers and 50 percent of white-collar workers reported some kind of job discrimination despite the fact that they had been successfully treated for cancer.³

What does all of this mean for the clinician? Several conclusions seem warranted:

1. The biomedical model is useful insofar as it goes, but it has major limitations requiring the broader application of the biopsychosocial model.

2. Diagnostic labels need to be accurately applied through a process of negotiation leading to reasonable consensus between the patient's and physician's explanatory model of illness.

3. It is especially important to achieve timely delabeling, as a result of patient education and reassurance, in order to avoid the deleterious effects of the extended sick role.

4. The physician needs to be aware of his or her own role in the labeling and delabeling process and to understand the potentially powerful effects of some diagnostic labels.

5. And finally, physicians can learn much from the work of social scientists who have the opportunity to stand aside from the patient-physician relationship and bring fresh, useful perspectives to the study of this interaction.

References

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