May 6, 2021

Medical Anthropology (4) **Sick role (patient role) in detail**

- Sick role: **Social expectations** for the behaviors of a person diagnosed as suffering from a malady (eg. being excused from work or school). * In Japanese, *Byo-nin **Rashisa***（病人らしさ）. In Japan, *-rashisa* is implicit, but very strict social norm.
- Patient role: A special kind of sick role, **social expectations** for the behaviors of a patient diagnosed as suffering from a disease at any medical facility. Changing by not only the social context but also epidemiological situation. * In Japanese, *Kanja **Rashisa***（患者らしさ: Play your patient role! ＝ 患者らしくしなさい！）
- Parsons (1951) popularized the "sick role" and social analysis of illness behaviors and suggested that the sick role leads to exemptions from responsibilities and/or responsibilities
  - "Exemption from performing certain normal social obligations or responsibilities"
  - "Release, to a certain degree, from responsibility for one's condition and only peripheral responsibility for recovery if medical advice is followed"
  - "Temporary legitimization of the sick role and the expectations that the sick person has the obligation to recover and leave the sick role status as rapidly as possible"
  - "An obligation to comply and cooperate with medical orders"
- The experience of sickness (= the social response to one's experience of illness) usually follows distinguishable stages
  - Experience of symptoms
  - Assumption of the sick role
  - Medical care contact (~ as patient role)
  - Dependent patient stage
  - Recovery or rehabilitation stage
- Becoming sick is a social process, where the one's perception of and responses to "impaired well-being" are usually shaped by the behavior of significant others (incl. not only physician, but also family, friends, employers, and so on). Cultural, social and personal factors may affect the one's willingness to accept the sick role. Some don't want to accept the sick role (eg. alcohol abusers tend to deny their abuse), others like to accept it as release from obligations. "The social benefits of the sick role may make patients ambivalent, wanting to maintain their sickness rather than eliminate it because of beneficial effects"
  - Primary benefit: Attention and concern from others, especially beneficial for the people in marginal status with weak social support
  - Secondary benefit: Exemption from responsibility, including work. Sometimes a patient can alleviate blame for the one's fault as the result of malady.
  - Tertiary benefit: Others receive benefits from a patient's sickness (e.g., being a helper). (cf. MSBP: Münchausen syndrome by proxy)

MSBP（代理ミュンヒハウゼン症候群 in Japanese）

Bass C, Glaser D: Early recognition and management of fabricated or induced illness in children. Lancet, 383: 1412-21, 2014.

南部さおり: 代理ミュンヒハウゼン症候群. アスキー新書, 2010. (in Japanese)

Many changes have taken place in nomenclature since Meadow first described Munchausen syndrome by proxy in 1977,[1] including renaming to factitious disorder by proxy,[2] paediatric condition falsification,[3] fabricated or induced illness in the UK,[4] and medical child abuse in the USA.[5] In 2013, the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5),[6] introduced factitious disorder imposed on another (previously factitious disorder by proxy; panel 1).

***Panel 1*: Diagnostic and Statistical Manual, fifth edition, criteria for factitious disorder imposed on another, code 300.19[6] (International Classification of Diseases-10 code F68)**

1. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another; associated with identified deception
2. The individual presents another individual (victim) to others as ill, impaired, or injured. The perpetrator, not the victim, receives the diagnosis
3. The deceptive behaviour is evident even in the absence of obvious external rewards
4. The behaviour is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder

***Panel 2*: Illness fabrication and induction**

Erroneous reporting (fabrication) of medical history, symptoms, or signs by:

- Exaggeration
- Misconstruing of real events on the basis of mistaken belief about their meaning
- Reporting of actual events that only happen in the mother's presence (ie, situation specific events, therefore not a disorder located solely in the child)
- False reporting

There might or might not be an intention to deceive

Deception by use of hands

- Falsification of records or charts
- Interference with investigations and specimens (eg, putting blood or sugar in the child's urine)
- Interference with lines
- Inducing of signs or illness in the child by, for example, poisoning or overmedication (eg, laxatives, salt), suffocating, starving

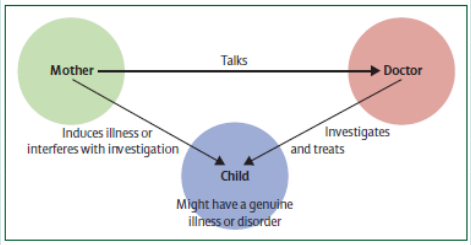

Figure: **The inter-relationship between mother, doctor, and child**

***Panel 3*: Explanatory mechanisms and motivations**

- Extreme anxiety leading to exaggeration of symptoms and signs to encourage the doctor to rule out or identify any treatable disorder
- To confirm (false) beliefs about a child's ill health (eg, developmental disorder, food allergy[7,22,23]), including beliefs held by caregivers with Asperger's syndrome and rarely with a delusional disorder)
- Wish for attention
- Deflection of blame for child's (usually behavioural) difficulties
- Maintain closeness to child
- Material gain

(The source of these texts, figure and panels is Bass and Glaser, 2014)

<Debate theme, for 13 May 2021>

Some patients at terminal stage tend to refuse their patients' role. When they lost hope to survive longer, they sometimes ignore the physician's indication and do what they want. However, the physician has to do their best to save the patient's life. Should the patient at terminal stage continue to play a patient's role?

- Proposition side: "YES"
- Opposition side: "NO"