Medical sociology

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CHAPTER 33

Medical Sociology

Guido Giarelli

The Canonic Narrative: Sociology *in* and *of* Medicine in its American Origins

Health and illness and the social relations and health care organizations coping with them relate fundamentally to both the individual human experience and the social structure of human societies. This explains their complexity and why they constitute an interdisciplinary field which no single discipline can claim to exhaust. Medical sociology is a subdiscipline trying to deal with these issues from a sociological perspective in relationship with the other social sciences (psychology, anthropology, demography, geography, history, economics) and the medical and natural sciences.

Following Merton's sociology of science, we can distinguish the *social identity* of a subdiscipline – its professional and institutional arrangements – from its *cognitive identity*, "in the form of its intellectual orientations, conceptual schemes, paradigms, problematics, and tools of inquiry" (Merton 1977: 5). Starting with the former, it should immediately be said that the peculiar character of the social identity of medical sociology is that it was shaped from two worlds – academic social sciences on one side and medicine and health care systems on the other. Given this fact, the origins of the discipline have been the subject of debate among scholars (Bradby 2012: 2–8).

The American roots of medical sociology lie in an inter-professional group composed of physicians, social workers, and a few sociologists who, in 1910, started a sociology section in the American Public Health Association. Among them were Charles McIntire (1894), who was the first to use the label "medical sociology," and Elizabeth Blackwell (1902) and James Warbasse (1909), who published two pioneering studies. But the time was probably not ripe for this type of specialized subdiscipline, and the section was dismantled in 1921. Sociology was not yet well developed in the American academic departments of that time, and this made any kind of differentiation in subject matter and methodology from the mother discipline unlikely.

It was not until the second postwar period that medical sociology fully emerged

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in the United States as a specialty within the sociological discipline. During this time, a growing number of sociologists entered medical settings, especially in the mental health field, as economic growth and progressive politics fostered governmental efforts to improve access to health care and the demand for sociological knowledge about it. At the same time medical schools transformed into scientific research centers supported by federal funds, especially by the National Institutes of Health. As a result, "the development of medical sociology as a subspecialty began not so much within departments of its own parent discipline or with the creation of a new department, but as a part of particular interdisciplinary programs in the university, like those in Yale's Institute of Human Relations, or by … a growing association with medical institutions, which always had higher priority for government support" (Bloom 2000: 17). Private sources of support remained important, especially foundations like the Russell Sage Foundation, Commonwealth Fund, Milbank Memorial Fund, and Rockefeller Foundation, in supporting the introduction of sociology and other social sciences into medical education and in stimulating professional organization. However, the rapid grow of federal support for research training in social sciences was most instrumental in the professional development of medical sociology.

During this period, even though they faced some resistance by physicians and health care organizations unfamiliar with the concepts and methodologies of sociology, medical sociologists were able to show the usefulness of their approach in fields such as mental health, especially in dealing with health inequalities (Hollingshead and Redlich 1958) and medical education (Merton et al. 1957; Becker et al. 1961). At the same time, within sociological departments prominent figures such as Parsons, Merton, and Hughes for the first time acknowledged the role of the medical institution within the general societal system, academically legitimizing the new subdiscipline (Parsons 1951). This gave rise to a new division within the subdiscipline, which started to emerge between those doing "sociology *of* medicine" in academic sociological settings, answering sociological questions for sociological audiences, and those doing "sociology *in* medicine" in health care contexts, using sociological perspectives to answer medically oriented questions for medical purposes (Straus 1957). Even though this dichotomy appears a bit schematic and not easy to operationalize, it captures an actual division of labor which characterizes the history of the subdiscipline in the Anglophone contexts and the consequent tensions between those medical sociologists doing theoretical work in non-medical academic setting and those doing their work in medically applied situations. The former often look at the latter with disdain, accusing them of "theoryless empiricism," and the latter charge the former as having elitist presumptions regarding their own possible contribution to the basic body of knowledge of the discipline.

In spite of this division, medical sociology became a well-established academic and professional specialty in academic and non-academic, medical and non-medical settings in the United States. The Section on Medical Sociology of the American Sociological Association was established in 1959 and over the years became one of the largest and most active sections of the national association. A considerable number of textbooks and readings were published and the *Journal of Health and Social Behavior* became the official journal of the section in 1966.

After this early period of rapid growth and diversification of activities, which can be considered the "golden age" of medical sociology in the United States (Bloom 2000: 26), the social landscape changed dramatically from the 1980s onwards, affecting the subdiscipline significantly. Large-scale political and cultural changes impacted both federal policy and the health care system. Relatively progressive policies were replaced with neo-conservative ones, leading to a steady reduction of federal support and resources and greater interest in more individualistic psychological,

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managerial, and market economic knowledge. The health care system was also profoundly restructured in an industrially oriented direction by the "managed care revolution" (Wholey and Burns 2000), which emphasized cost-containment and cost-effectiveness of health services, significantly challenging the relevance of medical sociological knowledge.

An era of uncertainty, turbulence, and continuing dynamics characterizes the new millennium, calling for a re-examination of well-established medical sociological theories (Bird et al. 2000: 7–8). The growth of the specialty has brought about a meaningful diversity of approaches, concepts, and methods, making the subdiscipline a really pluralistic field; but, at the same time, it has spread these theories and tools to other disciplines, resulting in the migration of sociological expertise to them. This has also produced the emergence of new disciplines, such as health services research, an interdisciplinary field specifically concerned with the organization, delivery, and evaluation of health care, which in the last three decades has absorbed many medical sociologists, who have thus lost their original disciplinary identity. In other fields, such as the moral implications of medical care, medical sociologists have missed the opportunity to influence medical decision-making, leaving the ground free to the incursions of the emerging field of bioethics, which has often reduced the social to the individual by decontextualizing medical issues (Fox and Swazey 1984). Finally, most of the research traditionally carried out by medical sociologists on social classes and health inequalities is nowadays done by social epidemiologist or public health researchers, who often adopt a purely empiricist and positivistic approach, lacking "the sociological framework that contextualizes social variables and recognizes the interactions among them" (Bird et al. 2000: 8). However, this can also be read from a more positive angle as a further institutionalization of the subdiscipline and of cross-fertilization with both old and new disciplines within which medical sociologists can now work in interdisciplinary teams.

The Counter-Narrative: An Eclectic and Global Subdiscipline

The above canonic version of the American origin of medical sociology has been questioned by a counter-narrative considering it just a foundational myth aimed at creating a canon and establishing disciplinary boundaries. Particularly, the idea that the sociological founders prior to Parsons were uninterested in health and medicine began to be challenged by some medical sociologists who found evidence of an exploration of topics related to medical sociology in under-examined pieces of otherwise well-known classical works of Saint-Simon, Stuart Mill, Marx, Engels, Weber, and Durkheim (Collyer 2010: 89–95). Moreover, the eclectic European origins of the subdiscipline can be traced back to the work of some eminent precursors in the field of social medicine, like the German pathologist Rudolf Virchow – who considered medicine as a social science; the British public health reformer Edwin Chadwick – who deemed the social aspects of health and disease as relevant as the biological and ecological ones; and Friedrich Engels's classic socio-epidemiological treatise *On the Condition of the Working Class in England*, published in 1845.

The political settings and the health care systems that provided the context for the origins of the subdiscipline in Europe and American differed markedly. Particularly, the central role of the state and the mainly public or non-profit character of the health care system in Europe differentiates the health care systems there from that in the United States. Claus (1983: 1592–1593) lists six "enabling factors" and five "disabling factors" which significantly influenced the development of medical sociology in Europe. Among the enabling factors, she includes the role played by governments in funding medical sociological

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research, the growth of the universities and of social sciences, the development of sociology partly modeled after American sociology, the student revolt movement of 1968 with its demand for critical social knowledge, the new recommendations and/or regulations concerning medical education emphasizing the role of social sciences in better adapting teaching to the practice of medicine, and the emerging professionalization and institutionalization of medical sociological research and teaching activities. On the other hand, the disabling factors included a number of countervailing forces which, at least at the beginning, partially impeded the development of medical sociology in Europe. These included the rigidity of university structure and professional careers and the weak non-autonomous position of sociology in academic departments; physicians' negative perception of medical sociology as a discipline often associated with Marxist criticism of health care and the medical profession; the power of well-established rival disciplines such as social medicine, social hygiene, public health, medical geography, and demography; the lack of support from the mother discipline, which made the establishment of medical sociology often easier in medical school than in social sciences departments; and, consequently, the lack of proper training opportunities for aspiring medical sociologists.

These factors worked differently in various European countries, allowing the emergence of medical sociology at different time frames in each – in the 1950s in Great Britain, Netherlands, and West Germany; during the 1960s in Poland, Belgium, and France; and from the 1970s onwards in Scandinavia, in Italy, and in the other Euro-Mediterranean countries. Therefore, we can understand the reason why Claus, after her survey throughout Europe, concluded that "the term *European medical sociology* might in itself be a misnomer … Hence, it might be more appropriate to speak about the discipline in terms of *European medical sociologies*" (Claus 1983: 1591).

In spite of this meaningful diversification, Claus (1983) was able to identify three common denominators in the origins and development of medical sociology in Europe, reflecting the specific styles of work, professionalization, and institutionalization of the field. First, the boundaries of the subdiscipline appear ill-defined and often blurred, given its broad scope as a result of the eclectic backgrounds of European medical sociologists. These blurred boundaries are also reflected in the labels used to define the subdiscipline, "sociology of health and illness" in the UK and "health and medical sociology" in the rest of Europe. Second, the primarily applied character of the subdiscipline means it often subordinates its knowledge to those in the more applied fields of public health and social epidemiology. Third, and consequently, the subdiscipline has a policy-making orientation, with an emphasis on providing descriptive and evaluative research data as tools for decision-makers in health care, especially where national health services are present. Clearly, all three of these features reflect the European political tradition of social welfare and the central governments' role in the funding of medical sociological research.

The trend toward Europeanization of national medical sociologies – the strongest of which is the Medical Sociology Group of the British Sociological Association (Hughes 2012), but formal organizations also exist in Germany, Italy, Switzerland, Austria, Poland, and the Scandinavian countries (Giarelli and Vignera 2012) – fostered the establishment of the European Society for Health and Medical Sociology (ESHMS) in 1983, an interdisciplinary scientific society that also includes epidemiologists and public health doctors working both in and out of universities. A more academic Research Network 16 – Sociology of Health and Illness has been recently established within the European Sociological Association (ESA). Five specialized journals exist. Three are in the UK – *Sociology of Health and Illness*, published since 1978 and closely associated with the Medical Sociology Group of the BSA; *Health*, an interdisciplinary journal started in 1999; and *Social Theory and Health*, started in 2003 and

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officially affiliated with the ESHMS. One in France, *Sciences Sociales et Santé*, published since 1983 with the support of the Institut des Sciences Humaines et Sociales of CNRS (National Council on Social Research), and one in Italy, *Salute e Società*, published in Italian and English since 2002.

In the rest of the world, medical sociology has begun to emerge or develop, albeit in different shapes according to various contexts. In Australia, the *sociology of health and medicine* is a well-established specialty in the universities (Collyer 2011). In Latin America, medical sociology has been part of a process of institutionalization of social sciences within the medical setting and connected to the field of public health, via postgraduate courses and research projects (Nunes 2006). In Africa, the only country where medical sociology is well established is South Africa, where it started in the 1970s as a teaching discipline in the health sciences. In Japan, an interdisciplinary Society for the Study of Health and Medical Sociology was established in 1974. It became the academically accredited Japanese Society of Health and Medical Sociology in 1989, when it was recognized by the Japan Sociological Society (Anesaki and Yamazaki 2012). Finally, an International Sociological Association (ISA) Research Committee on Medical Sociology (RC15), established in 1966 (renamed "Sociology of Health" in 1986), is now among the most populated committees in the ISA. Therefore, there are consistent signs that medical sociology has expanded well beyond its official American origins half a century ago and become a truly global subdiscipline.

Theoretical Perspectives on Core and Emerging Topics

Until a few decades ago, it was a common lament and an accusation, especially by sociologists *of* medicine against their colleagues *in* medicine, that medical sociology remained largely detached from mainstream sociological and social theory (Stacey and Homand 1978). Then, two edited books appeared (Scambler 1987 and 2012) with the aim of showing that the subdiscipline was capable of theoretical reflection by engaging itself with some of the most prominent social theorists, both classic and contemporary. This was certainly positive, since it strengthened ties between this specialty and the parent discipline against the dangers of specialty isolation – self-reference, loss of identity, and vulnerability to being taken over by competing disciplines (Light 1992). However, one can wonder whether we shall see in the near future an analogous collection about the theoretical contributions of medical sociology to general sociology and social theory. This raises the question of whether medical sociology has a corpus of proper theories and methods of its own (Johnson 1975), a cognitive identity.

To answer this question, we first need to historicize the issue under discussion. In fact, as Collier (2010) has shown, historically the professionalization of the parent discipline of sociology was a consequence of the rising dominance of biomedicine during the first half of the twentieth century. The hegemony of the new biomedical model reducing health and illness to biological states, excluding social dimensions, shaped even the cognitive identity of the new discipline. Sociologists, to side-step any potential conflict, accepted "the separation of theories of health, disease and mortality from the mainstream of sociology, and the emergence of distinct origin myths for each subfield" (Collier 2010: 102). Therefore, the recognition of the exclusive biomedical jurisdiction on matters of health and illness implied for sociology on one side the acceptance of the notion of disease as a purely biological phenomenon, and on the other side the creation of medical sociology as a new specialty of applied, peripheral knowledge exclusively devoted to the analysis of the social aspects of disease. Actually, the first approach adopted by the subdiscipline, the structural-functionalist, took the biomedical definition of health and illness for granted, arguing only on its social consequences. This does not mean that it did not

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produce valid knowledge, but simply that it was not an alternative to or independent from the biomedical paradigm.

In fact, according to Parsons (1951), the leading scholar of structural-functionalism and the first who "established a theoretical foundation for medical sociology that brought the subdiscipline the intellectual recognition that it needed" (Cockerham 2007: 292), sickness represents a form of social deviance because it makes individuals unable to fulfill their normal social roles. The role of doctors is to treat the patients and to legitimize their withdrawal from social obligations by conferring on them the "sick role." Because health is a functional pre-requisite for the social system, people, when feeling unhealthy, are obliged to consult a doctor to assume this special role, and they should follow the doctor's treatment regime and return to normal social functioning as soon as possible.

The conflict perspective is well represented in medical sociology by the Marxist variant, inspired by Marx's theory and Engels's classical study, which examined how the pursuit of profit by the capitalist system produces disease and health inequalities (Navarro 1976 and 2002). Focusing on the political and class context of health inequalities by adopting a political economy perspective, this approach does not contest the objectivity of the biomedical paradigm but rather the interests actually served by the medical institution. In helping to maintain a healthy and productive labor force, the medical profession and health care organizations play a significant role in the interest not of the society as a whole but of the capitalist and ruling classes only. Being shaped by the dominant profit ideology of capitalism, the medical institution is part of the commodity production process and of a commodity-fetishist culture of health care which eventually represents a direct threat to the clinical freedom and occupational autonomy enjoyed by the medical profession (Waitzkin 2000).

Marxist researchers also contribute to understanding the power of the pharmaceutical industry, health care systems and their reforms, how income inequalities affect population health and other global health issues (Navarro and Muntaner 2004). Therefore, we can conclude with Deborah Lupton that "this approach remains an important perspective on the social aspects of health and illness, especially in its focus on highlighting the political and economic dimension of health states. Without this perspective, the social structural reasons for disparities in patterns of ill-health across populations would not be identified and challenged" (Lupton 2012: 8). Some feminist scholars have adopted this perspective to analyze the political economy of gendered health (Doyal 1995) and mechanisms by which Western male medical practice has shaped pregnancy and childbirth (Oakley 1984), extending medical dominance and control over women's bodies by their medicalization (Ballard and Elston 2005).

However, like structural-functionalism, Marxist approaches remain inherently concerned with the structural issues which shape and condition health/illness, having little to say about how the individual doctor or patient may negotiate his or her role, or indeed subvert it. The relatively deterministic character of both approaches does not allow them to see how individuals experience the medical encounter. Structural approaches like these cannot answer issues of agency and choice related to the social processes of the medical encounter. This is instead the focus of the interpretive perspectives which emerged since the 1960s, exploring the micro-level study of the routine medical activities of individual social actors engaged in face-to-face social interactions. The most influential approach adopting this perspective is symbolic interactionism, which has had a major impact on medical sociology during the last half-century.

Symbolic interactionism is an agency-centered perspective focusing on the processes which take place through social interaction in everyday life. With regard to the health field, it looks particularly at the processes of meaning-making out of somatic experiences and of becoming ill in

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different social contexts. Differently from structural approaches, it challenges the biomedical paradigm on its own terrain, by distinguishing the concept of *disease* – as referring to the biomedical categorization of body pathologies – from *illness*, considered as the cultural meaning attached to the social relationship and experience of being ill by the patient (Twaddle and Nordfelt 1994). In doing so, it legitimates an alternative point of view on *sickness* from biomedicine, allowing us to understand *illness behavior* as a consequently coherent form of action according to cultural meaning attached by social actors to their illness experience.

The symbolic interactionist approach has given rise to two different models, the crisis and negotiation models (Gerhardt 1989: 89). The crisis model is associated with labeling theory, which sees medicine as a dominant profession ascribing a stigmatized status on mentally or physically ill people. The deviant label is not an intrinsic characteristic of the person, but rather the consequence of its definition by a dominant group. Classic studies adopting this framework were Thomas Scheff's (1966) work on psychiatric patients and Erving Goffman's landmark publications, *Asylums* and *Stigma* (1961 and 1963). The negotiation model of symbolic interactionism considers instead the medical encounter and the interaction it implies as open to the process of meaning-making. It is well exemplified by Freidson's two outstanding works – *Profession of Medicine*, wherein he significantly developed the Parsonsian concept of sick role (1970a), and *Professional Dominance* (1970b), which analyzes medical doctors as a powerful professional force shaping and controlling the system of health care professions as a whole.

The 1980s began the period that saw the meteoric rise and fall of postmodern theories followed by the more lasting dominance of social constructionism. Postmodernism involved a congeries of disciplines and scholars adopting various theoretical approaches concerned with deconstructing and delegitimizing previous forms of thought and concepts of truth and knowledge. In medical sociology, apart from a monograph (Fox 1993) and just a few papers (Glassner 1989; Cockerham et al. 1997; Pescosolido and Rubin 2000; McQuaide 2005; Varga 2005), very little was produced and soon almost disappeared. This fate of postmodern theories in medical sociology, according to Cockerham (2007), is a paradigmatic case teaching us the basic requirements for success in medical sociology, i.e., "the theory must (1) relate to health matters and (2) be applicable to the empirical world" (Cockerham 2007: 291).

The only postmodern theory which has had significant and enduring influence on the subdiscipline is post-structuralism, especially Michel Foucault's seminal works on madness and civilization, the birth of the clinic and of the prison, and the history of sexuality (1967; 1975; 1977; 1979). Social constructionism represents the most pervasive legacy of post-structuralism in medical sociology, even though some other theoretical influences can be traced in it, such as the phenomenology of Husserl and Merleau-Ponty and the hermeneutics of Gadamer. Foucault's archaeology of knowledge has provided social constructionists two powerful tools to autonomize the subdiscipline from the biomedical paradigm. First is an understanding that any disciplinary knowledge, usually taken for granted as neutral, is socially constructed and the result of the particular power relations in the context of a specific regime of authority. This understanding of social constructionism has become the basis for a powerful critique of the medicalization of society and of the specific connection between power and knowledge in medical institutions (Turner 1992; 1995; 1996; Lupton 1997; Petersen and Bunton 1997). Second, "Foucault's analysis of institutional discipline over individual behaviour through medical systems of surveillance, placed medical sociology as less marginal to the concern of a broader sociological project" (Bradby 2012: 35). Beyond the "anatomo-politics of the human body," which defines the human body as an object of medical study and intervention, the "bio-politics of the populations" involves

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the role of public health as the new authoritative discipline and institution of surveillance, promotion, and regulation of the population's health (Amstrong 1983; 2002; Lupton 1995; Petersen and Lupton 1997). The social constructionist perspective has also been adopted by feminist scholars to deconstruct the idea of "biology as destiny," i.e., the way medical and scientific knowledge has been used to elaborate a binary social construction of a gendered human body (Annandale and Clarke 1996).

While the social constructionist approach is still rather fashionable in the subdiscipline, especially in the Western world, it has been criticized "for making broad generalizations and avoiding a detailed examination of the micro-context in which discursive processes take place (such as the everyday experiences of people); for its insistence that discourses have general social effects regardless of social class, gender or ethnicity; and for not recognizing human agency and the opportunity for resistance" (Lupton 2012: 10). Undoubtedly, most of these criticisms are true, at least for those radical constructionist views which in their exclusive concentration on the discursive construction of health, illness, body, and medicine end up denying the significance of the material reality of embodiment or even the existence of a biological base (Bury 1986; Williams 2006). In doing so, this view becomes "ethnocentric in the sense that is only tenable in a wealthy, democratic Western setting where poverty and disease do not (mostly) structure daily life" (Bradby 2012: 37). Conversely, the "weaker" version of social constructionism inspired by philosophical and sociological critical realism (Bhaskar 1989; Archer 1995; Danemark et al. 1997) admits that an external material reality exists independent from human interpretations, even though our understanding of it is inevitably shaped by cultural and social processes, which renders them amenable to change, negotiation, and resistance. Although "critical realism has yet to make much impact within medical sociology" (Bradby 2012: 38), some attempts to use it in this realm already exist, especially in the field of mental health, chronic illness, and disabilities studies (Williams 1999; 2003; Bhaskar and Danemark 2006; Pilgrim 2014), which show its potential for further future research.

In summary, medical sociology "evolved from being categorized as a field largely devoid of theory in the 1970s to a robust area of theoretical discourse some thirty years later" (Cockerham 2007: 286). Furthermore, we can identify (Bird et al. 2000: 2–4) a series of five "core topics" on which the subdiscipline has built up its unique contributions by adopting the different perspectives highlighted: (1) the study of the medical profession – which has formed a basis for the general sociological study of the professions – and of the deprofesssionalization of health care professions, particularly from the structural-functionalist, symbolic interactionist, and conflict perspectives; (2) the study of the sick role, illness behavior, and patterns of health care utilization, which expanded into a broader study of illness experience by moving from structural-functionalism though symbolic interactionism to social constructionism; (3) the social construction of illness and medical knowledge, including the problem of medicalization, from a post-structuralist and social constructionist perspective; (4) a sociological epidemiology with specific concern for health inequalities related to social class, gender, and ethnicity from a Marxian conflict perspective; and (5) a sociological study of health care services as complex organizations, by adopting almost all the perspectives described.

In addition to these core topics, we can identify some emergent new areas of research challenging the subdiscipline to show its relevance in the health field. They range from the influence of social networks and social capital to the impact of the Internet on ill people, from illness narratives to the sociology of death and dying, from the shifts in the organization of health care delivery according to managed care to strategies to reform health care systems, from evidence-based medicine and quality and safety of care to new

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health social movements, from genetics and biotechnologies to how social factors and biomarkers can interact in influencing health/illness, from bioterrorism to the influence of religion and spirituality on health, from the interaction between culture, organization, and technology in shaping health/illness to bioethics, and from medicalization and contested illnesses to complementary and alternative medicines.

Therefore, it can be concluded that medical sociology can no longer be accused of "theoryless empiricism." In fact, it views many of the issues it faces today through a plurality of theoretical approaches. In doing so, it offers an alternative to the biomedical perspective and important contributions to its mother discipline and the overall society. Today, medical sociology is an integral part of the overall sociological perspective and plays an important societal role in a time when health and disease – and suffering and death – increasingly represent fundamental sociological issues impacting the social cohesion of society.

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