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MEDICAL SOCIOLOGY

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With a formal institutional history that dates back more than 50 years, the academic discipline of medical/health sociology is both rich and varied. As one of the largest subfields in sociology, it has explored a long list of health care issues, including the physician-patient relationship, illness behavior, stress and coping, the social distribution of health, medical professionalism, health care policy, and public health. It also has drawn on and made excellent use of a wide range of sociological theories, including structural functionalism, symbolic interactionism, feminism, and postmodernism. Finally, it has intersected with a variety of other social sciences, including medical anthropology, health psychology, and epidemiology, to produce an important literature that has helped to improve the practice of medicine and the health and well-being of people worldwide.

In light of this richness and diversity, we seek first to identify resources that will enable readers to have a deeper appreciation for the field of medical/health sociology. Second, we highlight ways of thinking about medicine and health care from a sociological perspective, which, in turn, may enhance our understanding and possibly assist in managing what has become society's most complex social institution.

This chapter is organized into three sections. First, we briefly explore medical sociology's historical roots. Second, we address the issue of what makes medical sociology sociological. That is, we assess how sociology contributes to our understanding of health and illness and how medical sociology contributes to the general sociological discourse. Third, we examine medical sociology in terms of the major sociological theories it draws upon to study health care issues.

Throughout this chapter (and per above), we will use the terms "medical sociology," "health sociology," and "sociology of health and illness" interchangeably or in some combination (e.g., medical/health sociology). Over the years, there has been considerable debate about what to label academic sociology's foray into the world of medicine, health, and illness. Herein, it is important only to note the debate.

HISTORICAL ROOTS

Medical sociology can trace its intellectual lineage to the late 1800s. In the waning decades of the nineteenth century, two nascent disciplines, sociology and allopathic medicine, began to cross paths in small but significant ways. For allopathic medicine, this time period witnessed the beginnings of medicine's ongoing attempts to consolidate its professional powers and social legitimacy. Meanwhile, *sociology* (the term being first coined by Auguste Comte in 1838) was beginning to emerge as a distinct discipline. In the United States, for example, Herbert Spencer's *The Principles of Sociology* (three volumes, 1876–1896) was a seminal

publication, along with the establishment of the first American sociology course ("Elements of Sociology" at the University of Kansas, Lawrence, in 1890), and the founding of the first department of sociology (at the University of Chicago in 1892 by Albion Small—who three years later also would launch the first sociology journal, *American Journal of Sociology* [*AJS*], in 1895).

Examples of work from this time period that formally link "medicine" and "sociology" include two articles by Charles McIntire (1915, 1991) ("The Importance of the Study of Medical Sociology"—first published in 1894 and reprinted in *Sociological Practice*—and "The Expanse of Sociologic Medicine") along with two key books, the first by Elizabeth Blackwell (1902) (*Essays in Medical Sociology*) and the second by James P. Warbasse (1909) (*Medical Sociology: A Series of Observations Touching Upon the Sociology of Health and the Relations of Medicine*). The second McIntire article is of particular interest because of where it appeared—in the *Journal of Sociologic Medicine,* which was published not by a sociology association but by the *American Academy of Medicine.* This journal, with its distinctive sociological title and medical "residence," existed for a scant four years (1915–1919) before both the parent and the journal disappeared from view. The American Public Health Association hosted a similar sociologic offspring—its "Section of Sociology"—for a slightly longer period of time (1909–1921), but with a similar demise (Bloom 2002). It would take another quarter century before the next medical sociology journal (*Journal of Health and Human Behavior*—see below) appeared.

The initial timing and brief duration of these links between medicine and sociology reflected a much broader transformation taking place within allopathic medicine and between medicine and society, as both rushed to affirm the "scientific side" of medicine (Starr 1982; Stevens 1971). As medicine grew in clinical effectiveness and organizational complexity, however, the social-psychological and behavioral sides of medicine began to atrophy—with instruction, research, and principles relegated to "second-order" medical fields such as psychiatry and public health. While scattered "sociology of medicine" articles would continue to appear (albeit infrequently) in medical journals between 1920 and 1950 (Lawrence J. Henderson's [1935] "Physician and patient as a social system" being a notable example), the few that did surface would have a far greater impact on sociology than on medicine (one famous "benefactor" of the Henderson article, for example, was Talcott Parsons). In 1960, E. Gartly Jaco published what would become the first substantive disciplinary journal in medical sociology, the *Journal of Health & Human Behavior* (*JHHB*). In the spring of 1967, the American Sociological Association (ASA) took *JHHB* under its organizational wing where it was renamed the *Journal of Health and Social Behavior* (*JHSB*). Eliot Freidson was the first editor. This same year also marked the first issue of *Social Science & Medicine* (*SS&M*), with its distinctively international and multidisciplinary social science focus. By the early 1970s, the medical sociology section of the *British Sociological Association* had established its own organizational footprint, and in 1979 published its own "medical sociology" journal (*Sociology of Health & Illness*). Like *SS&M,* it too would have an international and multidisciplinary focus (Jobling 1979).

During the 1950s and 1960s, the field of medical sociology underwent an explosive period of growth—before peaking in the early 1970s (Bloom 2002; Day 1981). During these two decades, the field enjoyed considerable academic excitement and success, including what today might be considered a lavish amount of grant support, both from private foundations and the federal government. At its peak in the early 1970s, for example, the National Institute of Mental Health subcommittee for social science training was awarding 1,500 graduate student stipends per year—80 percent of which went to sociology departments. The number of stipends was well in excess of what was needed to support medical sociology graduate students—and thus the entire field of sociology benefited from this philanthropic and federal largess (Bloom 2002). Even the founding of the medical sociology section itself and the ASA's decision to adopt the *JHSB* were underwritten by outside funding.

Membership in the new ASA section (established in 1959) was mercurial. In less than a year, the medical sociology section grew to 561 members. By 1964, membership had soared to nearly 900 (which, not incidentally, is close to the section's membership today). In less than a half dozen years, the field went from publishing introductions to the field (Anderson 1952; Hall 1951) to summative reviews (one notable example is Eliot Freidson's [1961] "The Sociology of Medicine: A Trend Report and Bibliography," published as a special issue in *Current Sociology*).

By the mid-1970s, however, there were signs of trouble (Bloom 2002; Day 1981). Established funding streams had dried up and were not replaced by alternative resources. Section membership had plateaued and coverage of medical/health issues in flagship sociology journals, such as the *AJS* and the *American Sociological Review,* became more infrequent. Meanwhile, colleges and universities were undergoing their own upheavals. Faced with considerable financial pressures, schools looked to trim programs, and sociology was high on a number of lists. As one small but indicative example, Yale University's Department of Sociology, which housed the first medical sociology program in the United States, decided in the 1990s to eliminate that program.

The 1980s and 1990s were a difficult time for allopathic medicine as well. The rise of managed care, the commodification of medical services, and the discovery of medicine by Wall Street and corporate America during the "go-go" years between 1985 and 1997 had earth-shattering implications for the future of medicine as an autonomous profession.

The 1970s through early 1990s also were a time of vigorous debates within academic sociology about the fate and future of allopathic medicine as a profession (Hafferty and Light 1995; Hafferty and Wolinsky 1991). Beginning with Eliot Freidson's (1970a, 1970b) transformative *Profession of Medicine* and *Professional Dominance,* a number of distinguished medical sociologists in the United States (Mark Field, David Frankford, Marie Haug, Eliot Krause, Donald Light, John McKinlay, Fredric Wolinsky) and elsewhere (David Coburn, Julio Frenk, Rudolf Klein, Magali Larson, Gerald Larkin, Elianne Riska, Evan Willis) began to debate the changing fortunes of organized medicine's status as a profession (Hafferty and McKinlay 1993). Once again medicine and sociology crossed paths. It is worth noting, however, that by the time organized medicine began to mount a campaign to reestablish its professional status and stature, sociologists had moved on to other debates (Castellani and Hafferty 2006).

Issues of Identity and Identification

From its very conception as an academic entity, medical sociology has been plagued by issues of identity (self) and of identification (others). On the one hand, the study of medical and health issues offered sociology great challenges and opportunities (Fox 1985). On the other hand, these same opportunities had the potential to strip sociology of its unique perspective (Bloom 1986). One hallmark of this tension is the now 50-year-old debate about whether the *ASA*'s section should be named "medical sociology" or whether it should sport some other marquee such as "health sociology" or the "sociology of health and illness." Many of these tensions are reflected in Robert Straus's (1957) famous distinction between a *sociology of* and a *sociology in* medicine. The problem is one of placement and perspective. The former (*of*) reflects situations where sociologists maintain their disciplinary base (an academic sociology department for example) and train their sociological lens on fields of inquiry (such as medicine) for the purpose of answering sociological questions. The latter (*in*) connotes a state of affairs where sociologists work, for example, in a medical setting and employ sociological concepts and perspectives to solve problems that are defined as such by medicine. *Sociology of* medicine thus became considered (by academically based sociologists) as more in keeping with the sociological tradition, with the presumption being that those operating from a *sociology in* medicine ran the risk of being co-opted or at least corrupted by the medical perspective. More recently, there have been efforts to "retire" this distinction by insisting that sociology has passed through its *of/in* phase and has graduated into a *sociology with* medicine (Levine 1987). This is wishful thinking. Organized medicine remains one of the most powerful social institutions in modern times—forces of deprofessionalization notwithstanding. Furthermore, medicine has little incentive (then or now) to welcome sociology to its table unless it feels that sociology can help solve issues or problems—*as defined by medicine* (and not sociology). Under such circumstances (and expectations), any working relationship between sociology and medicine involves considerable potential for sociology to undergo disciplinary co-option. Sociologists who work in medical settings must be particularly sensitive to these issues. Often they function betwixt and between, receiving little respect from physicians or from their academically based peers who consider their "wayward" colleges to be too "applied." Whatever the particulars, organized medicine retains considerable institutional power and social legitimacy within today's society. Medicine has been able to establish its knowledge, skills, and culture as the everyday, taken-for-granted order of things, and this is what makes the medical perspective so potentially corrupting.

Medical Sociology and Medical Education

The move to introduce medical sociology into the medical school and nursing curriculum played an important role in the discipline's evolution as an institutional entity. The first beachhead came in 1959, when Robert Straus founded the first Department of Behavioral Science at the University of Kentucky. Straus also helped to found, in 1970, the discipline's first professional association (Association for the Behavioral Sciences and Medical Education). For Straus, "behavioral science" (note the singular form) reflected the intersection of medical sociology, medical anthropology, and medical psychology—and therefore represented a unique and transcending social science discipline. The field quickly established a presence within a number (but not all) of medical schools during the 1960s and 1970s, particularly in those 40+ community medical schools that were being founded during the 1970s and 1980s. Nonetheless, the field's fundamental identity within the basic science and clinical arms of the medical school was—and would remain—marginal and suspect.

As departments and programs of behavioral science(s) began to grow in number and size, once supportive allies such as psychiatry and community medicine began to mount counteroffensives to reestablish control over domains of medical knowledge and instruction that once had been their exclusive jurisdiction. Today, there are only three formally labeled "Departments of Behavioral Science(s)" in the United States: the University of Kentucky College of Medicine, the University of Minnesota Medical School–Duluth Campus, and Northeastern Ohio Universities College of Medicine (NEOUCOM).

Another indicator that points to the rather persistent marginal status for the behavioral sciences (including medical sociology) within medicine and medical education is reflected across the numerous national committees, commissions, and reports (dating back to the 1920s) that have emphasized the necessary role of the social sciences in medical education (Christakis 1995)—yet with little change over these decades in actual institutional and

instructional practices by medical schools. Bloom (1986) famously likened this ongoing state of affairs to "reform without change." Straus's sociology *of* and *in* medicine also raises the question of whether there are two (or more) medical sociologies. One way to answer this question is to ask whether the medical sociology taught/presented to medical and/or other health science students, for example, is the same medical sociology presented to undergraduate and graduate medical sociology majors. Although we do not pretend to answer the question here, there is a sufficiently large body of relevant material to at least raise the question and suggest that there are, indeed, differences. Books by Thomas (2003) and Taylor and Field (2003), along with articles written for medical journals depicting sociology (Bilkey 1996; Chard, Lilford, and Gardiner 1999; Chard, Lilford, and Court 1997; Chaska 1977; Petersdorf and Feinstein 1981; Ruderman 1981) are a good place to begin any such inquiry.

Finally, we note that for some sociologists and sociology programs, the label *applied* is something to be courted, not condemned. There is a vigorous movement within organized medical sociology (and sociology in general) to make sociology training more explicitly "applied" and or "clinical" in focus—with the goal to make students more "job ready" or employable postgraduation (Dolch 1990; Gabelko and McBride 1991; Haney, Zahn, and Howard 1983; Hoppe and Barr 1990; Sengstock 2001).

Medical Sociology as Sociology: Or, What Makes Medical Sociology Sociological?

Any new or emergent subfield must draw on its parent discipline for theoretical, conceptual, and methodological sustenance. Thus, when Talcott Parsons (1951) began to craft his now famous Chapter 10 of *The Social System* ("Social Structure and Dynamic Process: The Case of Modern Medical Practice"), he drew on core aspects of sociological theory (e.g., the sociology of deviance, role theory, etc.) to reframe issues of health and sickness from a functionalist perspective. Similarly, Eliot Freidson (1970a, 1970b) drew on the sociology of knowledge and the framing of social order as the product of ongoing human production (Berger and Luckman, 1966) to help shape his analytical approach to medical work, language, and knowledge. As a final example, two of the most famous early studies of medical education, Robert Merton, Leo Reeder, and Patricia Kendall's (1957) *The Student Physician* and Howard Becker et al.'s (1961) *Boys in White* were less studies of medical education per se than they were efforts to test competing theories of social action, including adult socialization. The Merton camp advocated a structural functionalist perspective and the Becker camp a symbolic interactionist perspective. In short, the core issue was sociological theory, not occupational training, and therefore both studies were a *sociology of* rather than a *sociology in.* Medical education was "simply" the backdrop or battlefield (Hafferty 2000).

It seems reasonably self-evident that "medical sociology" must involve the application of sociological knowledge and concepts to issues of health and illness. It is distinct in its approach because it considers the import that social and structural factors have on the disease and illness processes as well as on the organization and delivery of health care. This includes factors such as culture (e.g., values, beliefs, normative expectations), organizational processes (e.g., the bureaucracy of hospitals), politics (e.g., health care policy, political ideology), economics (e.g., capitalism, the stock market, the costs of health care), and microlevel processes such as socialization, identity formation, and group process.

All of this conceptual blocking notwithstanding, what we have remains too limiting a definition. It is not enough that someone labeled a "sociologist" employs sociological concepts to answer questions if the questions themselves are defined/framed in a nonsociological manner. Asking sociologists to help solve the "problem of patient compliance" proposes that the sociologist take on a medical definition of the situation (where any deviation from "doctor's orders" is considered the responsibility and fault of the patient). Lost in the shuffle of who gets to define the topics and terms is the fact that physicians and patients interact within a highly complex system involving medicine and society, along with broader social issues such as the role of experts in society or the social management of risk.

There is another question here as well. Where and how does medical sociology contribute to the greater sociological enterprise? More specifically, where do we find evidence that medical sociologists/sociology directly contributes to the advancement of sociological theory or methods? The question is not rhetorical. Much of Anselm Strauss's early work on grounded theory (Glaser and Strauss 1967) came via research on the topics of death and dying (Glaser and Strauss 1965, 1968; Strauss and Glaser 1970). On the other hand, while it is clear that Erving Goffman's (1986) work on stigma has been widely employed within medical/health sociology, and while it is equally clear that the concept has great applicability to the sociology of chronic illness and the sociology of disability/disability studies, it is less clear how studies in these areas have contributed to the conceptual development of stigma as a sociological concept and therefore as a tool that can be applied by social scientists studying issues other than medicine.

Finally, we have a third question related to the multiple medical sociology question raised above. It is not always self-evident how the work of medical sociology differs from that of medical anthropology, medical economics, health policy, medical epidemiology, and public health. As such, is medical sociology itself a unique and singular perspective? Asked in a more sociological manner, Can we disentangle "medical sociology" from the broader social context in which it functions? To answer this question, we will briefly explore differences between U.S. and British medical sociology.

THE CASE OF BRITISH MEDICAL SOCIOLOGY

In addition to the possibility that medical (nursing, health science, etc.) students receive a different medical sociology than what is taught to sociology graduate students, there appears to be considerable (and important) differences between British and American medical sociology. We begin by noting that the parent disciplines (British and American sociology) themselves harbor key differences (Abbott 2000). British sociology is more theoretically inclined, more accepting of qualitative research strategies, and more critical of "abstract empiricism" (not only with respect to data analysis but also with respect to the very definition of data itself). There also are differences in theoretical constructs. British sociology, for example, has a strong tradition focusing on the "sociology of the body" (e.g., "constructing the body" or "gender, sexuality, and the body") (Shilling 2004; Turner 1992, 1996)—something much less visible in U.S. sociology. There also are differences in the use of analytic concepts—the British use of social class and the American use of socioeconomic status being one example (Halsey 2004; Reid 1979; Stacey and Homans 1978). Finally, we can point to significant differences between the U.S. and British health care systems. The American system is more capitalistic and "market oriented," while the British have a national health system organized and controlled by the state. Indeed, there are those who believe that while the British have a coherent and organized health care "system," the American arrangement of competing capital interest is, at best, a "nonsystem system."

All these differences are reflected in the focus and tone of British versus American medical/health sociology. Comparisons between White (2002) and U.S. textbooks such as Conrad (2005) and/or Weitz (2003) show differences in content and context. Chapter titles in White (e.g., "Foucault and the Sociology of Medical Knowledge," "Postmodernity, Epidemiology and Neo-Liberalism," and "Materialist Approaches to the Sociology of Health") have no parallel in Conrad or Weitz.

We continue to see these same differences in the medical/health sociology taught to British medical versus American medical students. One major difference is the use of medical/health sociology textbooks. Not only is there a market for such textbooks within British medical (and/or other health science) education, but the volumes themselves are formally identified as health and/or medical sociology text (Scambler 2003; Taylor and Field 2003; Thomas 2003). There are no such textbooks in the United States. Furthermore, in the rare instance when textbooks are used in the United States, the operative label used is "behavioral science" (Sahler and Carr 2003). Even here, most "behavioral science" textbooks sold in the United States are "board review" (Fadem 2001) or biostatistics (Gravetter and Wallnau 2003) books.

Similar differences can be found with other types of medical curriculum materials (Cook 2004; Iphofen and Poland 1997; Kitto 2004; Turner 1990). The article by Cook (2004), for example, describes course materials for health professional students built around "the concepts of differentiation, commodification, and rationalization (associated with the work of Émile Durkheim, Karl Marx, and Max Weber, respectively)," with these materials providing "a useful conceptual 'launching pad' for understanding key changes to medicine and doctor-patient relationships since pre-modern times" (p. 87). Similarly, the article by Kitto (2004) describes a new "health, knowledge, and society" curriculum for medicine, nursing, and health sciences students built around "aspects of C. Wright Mills' sociological imagination to teach 1st year medical students the importance of analysing the social aspects of health and illness in medical practice" (p. 74). Course materials with titles or rationales such as these simply do not exist within U.S. medical education. In the United States, behavioral sciences faculty are urged by students (via course evaluations) and administration (also driven by student evaluations) to be "relevant," "applied," "practical," "case based," and/or "patient centered"—all antonyms for the dreaded terms "theory" or "theoretical" (which are interpreted by U.S. medical students as having little to no applicability to issues of patient care). Moreover, even if we were to sweep away the stigmatizing presence of theoretical materials, the fact remains that medical students (along with many basic science faculty) consider the entire field of behavioral/social science to be "soft" and "subjective" when compared with the remaining basic sciences (pathology, pharmacology, molecular and cell biology, etc.) and clinical coursework. Within U.S. medical education circles, data demonstrating that U.S. medical students learn better when course materials are "patient oriented" rather than "theoretically oriented" (Leigh and Reiser 1986) have great face validity.

Theoretical Passages through Medical Sociology

As William Cockerham (2001) explains in his essay "Medical Sociology and Sociological Theory," because medical sociology is an applied field of study, there is a tendency to think that it lacks a theoretical rationale for the various topics it studies. Such conclusions are false. As we explained above, the general aim of medical sociology (whether the sociologist be Talcott Parsons or a newly hired junior faculty person or research associate) is to apply sociological theory and concepts to the topics of health and health care. This is true of both the sociology *of* and *in* medicine (Bloom 2002; Gerhardt 1989).

Obviously, an important part of what medical sociologists "know"—independent of what they study—is sociological theory. As each cohort of medical sociologists is trained, they learn not only the older canon of sociological theory—what has gone on before them—but also the latest

theoretical advances. One hallmark of any academic discipline is how each new cohort of scientists goes about applying this "new-found" theoretical knowledge to what they seek to examine and understand. This, in turn, advances the field. A survey of the medical sociology literature suggests just this process to be the case (Gerhardt 1989).

While such an unfolding of the field certainly represents *advancement,* this progression, for medical sociology, has not been linear, nor has it been entirely cumulative. There also is much debate within medical sociology about the validity of applying various sociological theories to the fields of medicine and health care—one such example being the case of postmodernism (Cockerham 2001). Moreover, there are a variety of rifts in the field over the epistemological assumptions behind many of these theories. These rifts concern, for example, the validity of deductive reasoning and the linear model of statistics, the reliability of qualitative methodology and scientific representation, the appropriateness of various sociological units of analysis—micro, meso, macro—and the authority of medical and sociological knowledge (Annandale 1998; Levine 1995; Link 2003; Williams 2001). Finally, it appears that while different theories are useful in some areas, are less appropriate in others. Postmodernism, for example, is a useful way to critique the power of medical knowledge. It is, however, not much help in studying social stress or the social distribution of health and illness.

Despite the complexity and nuances of these differences—yet in many ways because of them—medical sociology is a theoretically rich and diverse field of study. Our purpose in this section is to provide a quick overview of this richness by surveying some of the more important sociological theories that have been employed by medical sociologists over the past 50 years. While no strict chronology is implied in our review, it is historically accurate to label the first four theoretical orientations as "classical" sociological theory, while the remaining three are more recent in both origin and application within the field.

The first major theoretical passage through medical sociology is structural functionalism. Grounded in the work of Talcott Parsons (1951), this theory takes a systems view of health and illness, focusing on the functional role that social institutions such as medicine play in maintaining the well-being of society. Despite the controversy that ensued during the 1960s and 1970s regarding the legitimacy of this perspective, it retains considerable influence and relevance (Williams 2005). Not only did the presence of Parsons (as probably the most famous sociologist of his time) and the utility of structural functionalism help to establish the study of health and illness as a worthy sociological endeavor, this lineague and apparent applicability also helped to develop several of the field's most important areas of research: the patient-physician relationship, the sick role (which later became known as illness behavior), the medicalization of deviance, and medical professionalism

The second major theoretical passage is symbolic interactionism. Unlike strucutural functionalism, this perspective focuses more on the "microlevel" social processes of health and health care and the important role that patients and health care providers play in the creation, development, and transformation of the larger health care systems of which they are a part. Through the work of Anselm Strauss, Erving Goffman, Howard Becker, Norman Denzin, and Kathy Charmaz (to name a few), this perspective has examined such important topics as how medical schools socialize physicians, how patients learn the role of being chronically or mentally ill, how physicians and nurses use the tools of medicine and the medical model to impose on patients the normative expectations of society, how patients and their families manage the emotional labor of "illness," and how patients and health care providers negotiate the "politics" of daily medical encounters (Charmaz and Paterniti 1999; Gerhardt 1989). Like structural functionalism, symbolic interaction theory predates the origins of modern-day medical sociology. For example, and as noted above, the two most famous studies of medical student socialization, the Merton and Becker studies, built their respective investigations around this theoretical divide.

The third major theoretical passage is conflict theory. Building on the work of Karl Marx and Max Weber and represented by more contemporary conflict theorists such as Randall Collins (Collins and Makowsky 2004), this perspective demonstrates how a society's health and health care system is the result of a complex network of conflicting and competing aims and interests based on differences in income, gender, ethnicity, occupation, education, political affiliation, and so on (Navarro 2002). Conflict theory has been an important addition to the field of medical sociology because it has provided a much-needed theoretical framework for the *sociology of medicine,* which has enabled medical sociologists to study such important topics as the social distribution of health and illness, inequalities in the health care delivery system, the politics of health care policy, the economics of health insurance, and the failures of medicine to meet the health care needs of society (Gerhardt 1989; Henderson et al. 1997; Navarro 2002).

The fourth major theoretical perspective is feminism (Annandale 2003; Bury 1995; Clarke and Olesen 1999; Harkess 2000). Drawing on a variety of theories within sociology, including symbolic interaction and conflict theory, this perspective is concerned with the role that patriarchy, sexism, and gender play in the health and well-being of women. This perspective has examined important issues such as the medicalization of the female body, the quality of health care women receive, and the role that patriarchy has played in the construction of medical knowledge.

The fifth major theoretical framework is poststructuralism. Based on the work of the French philosopher and historian Michel Foucault, this perspective examines how people use the discourses of medicine, psychiatry, and science to care for and control themselves and others (Petersen and Bunton 1997). Like Parsons before him, Foucault (1980, 1987, 1988) examined many of the key topics in medical sociology, such as the history of madness, the medicalization of deviance, the birth of the modern medical clinic, and the various ways in which health care providers and everyday people use medical knowledge—think of, for example, the self-help literature, medical diets, and plastic surgery—to master and control the body.

The sixth major theoretical passage is postmodernism. Building on the work of Lyotard, Baudrillard, and Derrida (Best and Kellner 1991, 2001; Fox 1994), this perspective makes two radical assertions. First, it asserts that medicine and biomedical science are nothing more than discourses; powerful textual strategies that use a variety of binaries to control such important issues as (a) who is a medical expert (physicians versus traditional healers), (b) what constitutes valid medical knowledge (biology versus sociology), and (c) what sits outside "normal" ideas about health and health care (allopathic medicine versus alternative medicine). Second, it asserts that the dominating discourses of medicine and biomedical science need to be deconstructed and re-created to form new ways of thinking about health and health care, ways that are better able to address the postindustrial, globally interdependent, culturally fragmented, and nonlinear world in which we now live.

While postmodernism has provided an effective critique of modern medicine, critics point out that its wholesale dismissal of medicine and science as little more than normative ways of thinking oftentimes appears to "throw the baby out with the bathwater." While modern medicine and biomedical science are hierarchically ordered and still decidedly patriarchal, it hardly seems reasonable to issue a blanket dismissal of biomedicine as little more than dominating textual strategies, given its role in improving the health of populations throughout the world. It is for this reason that postmodernism has had a limited presence, impact, and utility in medical sociology.

The seventh major theoretical passage is multiculturalism (Lupton 2003; White 2002). Drawing on the theoretical perspectives of symbolic interactionism, conflict, feminism, poststructuralism, and postmodernism, this perspective has three major foci. The first is to examine the negative impact that racism, sexism, homophobia, ethnocentrism, and cultural intolerance have on the health and well-being of people. The second is to examine the ways in which culture affects the practice of medicine and biomedical science. The third examines the ways in which culture affects the health behaviors of different populations and, in turn, their use of contemporary Western health care (Lupton 2003; White 2002).

TWO SUBSTANTIVE THEORIES

Two important substantive theories have played a major role in medical sociology: (1) stress and coping (Cockerham 2004; Mirowsky and Ross 2003) and (2) professionalism (Hafferty and Light 1995; Hafferty and McKinlay 1993). Stress and coping is situated at the intersection of sociological traditions such as symbolic interactionism, conflict theory, and the sociology of work. The sociological study on stress and coping itself has two foci: (1) the role that certain social factors (e.g., chronic poverty, lifestyle, health behaviors, occupation, gender, etc.) play in the creation and exacerbation of stress and conversely, (2) the role that other social factors (e.g., marital status, strength of kinship networks, financial stability) play in assuaging stress.

The sociological study of professions has a longer and more storied history. While the sociological study of professions and occupations date back to the turn of the century (Carr-Saunders and Wilson 1928), modern-day discussions of medical professionalism are linked to Parsons and his conception of medical dominance and autonomy as necessary/functional for the well-being of both patients and society. Since Parsons, medical sociology has been engaged in an extended (and critical) examination of American medicine's claim to be a profession and the extent to which medicine has been able to maintain and live up to this claim. More specifically, medical sociology has examined the impact that medicine's professional status has on the lives of physicians and patients, as well as also on the entire issue of how work is organized relative to free market and bureaucratic organizational forms (Freidson 2001). According to the sociological analysis of medicine as a profession, medicine has gone through four major transformations: professional reform and rise (1890s–1930s), professional dominance (1940s–1960s), deprofessionalization (1970s–1990s), and organized medicine's efforts to reclaim and redefine its professional status (1990s–present) (Castellani and Hafferty 2006). As an aside, both traditional and modern-day medical sociology have strong disciplinary ties to the sociological study of profession. For example, the germination of medical sociology at Columbia, including *The Student Physician* study, arose out of a seminar organized by Robert Merton and William J. Goode on professions ("University Seminar on the Professions in Modern Society").

EMERGING THEMES

We see two emergent lines of sociological investigation as we move to examine the future of medical sociology—each related to the other. The first is globalization. It is clear that the world in which we live is going through major transformation. This is particularly true of health and health care. We now live in a world where the spread of disease is global and where the poor health of one country affects the

well-being of others. Global financial markets and economic competition are challenging the ability of business and governments to provide affordable health care. As such, we can expect that as globalization increases, so will its importance as a major theme in medical sociology (Bury 2005). There are an increasing number of studies examining issues of health and illness in countries other than the United States or Britain—far more than can be listed here. Resources such as Mechanic and Rochefort's (1996) "Comparative Medical Systems" and Cockerham's (2004) *The Blackwell Companion to Medical Sociology* (with its 17 chapters on the United States, Canada, Mexico, Brazil, the United Kingdom, France, Germany, Sweden, Russia, Poland, the Czech Republic, South Africa, the Arab world, Israel, Australia, Japan, and the People's Republic of China) provide an excellent beginning.

The second and related theme is "complexity science." As argued by a growing list of scholars, and due to key factors such as the information revolution and globalization, anj emerging theme within twentieth-first-century science is complexity (Capra 1996, 2002). One example is the study of complex health networks (Freeman 2004; Scott 2000). While this perspective has been an important part of medical sociology since the 1970s, primarily in terms of explaining the role that social support and kinship networks play in promoting health and well-being, the latest advances in the study of complex networks (e.g., small worlds, scale-free networks) are providing new insights into the processes by which diseases spread and the ways that health care providers can improve the health and well-being of large populations (Watts 2004).

As these two new themes suggest, the theoretical framework of medical sociology continues to change to meet the new and contextually grounded needs of health care providers and patients. Medical sociology is—and remains—a theoretically rich area of study.

CONCLUSION

Medical sociology is a rich and diverse field that has, in its short history, gone through an appreciable amount of institutional and intellectual development. Some of these changes have been good, as in the case of the continuing application of sociological theory to the field. Others, such as the continued institutional difficulties medical sociology has had in finding a home in both sociology and medical education, continue to plague the field, both in terms of its legitimacy and the impact of its ideas. Despite these struggles, medical sociology remains an important part of the sociological family and the field of health care. This is particularly evident given the increasing relevance that health and health care issues have—along with a "sociological understanding" of these issues—to the global world in which we now live. Following a tradition that emphasizes theoretical relevance, the current generation of medical sociologists are once again embracing the latest theoretical advancements in sociology (e.g., network analysis, complexity science, globalization) and advancing them to help us better understand (as a global society) the evolving patterns of social relationship we call health and health care.