Part I
Substantive Topics

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Medical Sociology and Sociological Theory

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The link between medical sociology and sociological theory is crucial to the subdiscipline. Theory binds medical sociology to the larger discipline of sociology more extensively than any other aspect of the sociological enterprise. Theory is also what usually distinguishes research in medical sociology from socially-oriented studies in allied fields, like public health and health services research. Whereas seminal sociological contributions in quantitative and qualitative data collection and analysis, along with many fundamental concepts on social behavior, have been subsumed by multidisciplinary approaches in several fields, sociological theory allows medical sociology to remain unique among the health-related social and behavioral sciences.

This could be considered as a somewhat surprising statement because medical sociology has often been described in the past as atheoretical. It is true that much of the work in the field historically has been applied, intended to help solve a clinical problem or policy issue, rather than develop theory or utilize it as a tool to further understanding. Medical sociology was not established until after World War II when the American government provided extensive funding through the National Institutes of Health for joint sociological and medical research projects. The same situation prevailed in western Europe, where, unlike in the United States, few medical sociologists were affiliated with university sociology faculties and connections to the general discipline of sociology were especially weak (Claus 1982; Cockerham 1983). It was primarily through the stimulus of the availability of government funding that sociologists and health professionals embraced medical sociology as a new subdiscipline. Funding agencies were not interested in theoretical work, but sponsored research that had some practical utility in postwar society as western governments had come to realize that social factors were important for health.

By the end of the twentieth century, however, this situation had changed significantly. Most research in medical sociology remains oriented toward practical problem solving, but the use of sociological theory in this endeavor is now widespread. There has been a general evolution of work in medical sociology that combines both applied and theoretical perspectives, with the utilization of theory becoming increasingly common as a framework for explaining or predicting health-related social behavior. At the same time, medical sociology moved away from a state of dependence upon medicine for defining and guiding research agendas to a position of relative independence. Although the relationship between medical sociology and medicine has been important, it has not always been harmonious (Gerhardt 1989). Medical sociology tended to side with patients and call attention to instances of poor treatment, while some physicians have been contemptuous of medical sociologists in clinical settings. Yet medicine nurtured, funded, and sponsored medical sociology early in its development and continues to do so today. In fact, one could arguably state that medicine has supported medical sociology with funding and job positions to a much greater extent than sociology. It can also be claimed that the increased use of theory in medical sociology represents more of an effort on the part of medical sociologists to establish and reinforce links to the parent discipline, than vice versa. In many ways, medicine has been a better ally of medical sociology than sociology.

While medical sociology is moving closer to sociology, it has generally removed itself from a subordinate position to medicine. There are four reasons for this development. First, the shift from acute to chronic diseases as the primary causes of death in contemporary societies has made medical sociology increasingly important to medicine. This is because of the key roles of social behavior and living conditions in the prevention, onset, and course of chronic disorders. Medical sociologists bring more expertise to the analysis of health-related social conditions than physicians who typically receive little or no training in this area. Second, medical sociology has moved into a greater partnership with medicine as it has matured and fostered a significant body of research literature, much of it relevant to clinical medicine and health policy. Third, success in research has promoted the professional status of medical sociologists, both in relation to medicine and sociology. And fourth, medical sociology has generally set its own research agenda, which includes medical practice and policy as an *object* of study. In the case of malpractice, failure to police incompetent practitioners, limited access to quality care for the poor, and placing professional interest ahead of the public's interest, medical sociologists have been significant critics of medicine. In doing so, they have established themselves as objective professionals.

The movement of medical sociology toward greater connections with general sociology reflects the desire of a mature subdiscipline to expand its analytic capabilities and reinforce its potential. Changing social conditions associated with the transition in society from the postindustrial to the current late modern or postmodern period requires all of sociology to account for altered circumstances and formulate new concepts. This situation suggests that not only is medical sociology connecting with general sociology, but that sociology is mov-

ing toward a closer affiliation with it – given the considerations of health increasingly evident in the everyday social lives of people and medical sociology's capacity for explaining it. Under the current conditions of social change, medical sociologists are making greater use of sociological theory because theory promotes the explanatory power of their empirical findings. This development has led some to suggest that medical sociology may indeed prove to be the "leading edge" in some areas of the development of contemporary theory (Turner 1992). Whether or not this assertion will be fully realized is not yet certain, but it is clear that medical sociology has a strong theoretical orientation that is continuing to evolve. The remainder of this chapter will therefore provide a general review of the theoretical work in medical sociology that has taken place to date.

Parsons, Durkheim, and Structural-Functionalism

From 1946 to 1951, the new field of medical sociology was almost completely an applied area of research. Medical sociologists worked with psychiatrists and other physicians on government-funded projects to largely address medical problems; few were employed in university departments of sociology in the United States and they were generally absent from sociology faculties in Europe and Asia. However, a pivotal event occurred in 1951 that oriented medical sociology toward theoretical concerns and initiated the establishment of its academic credentials. This was the publication of Talcott Parsons' long anticipated book, *The Social System*, which established the author at the time as the dominant figure in American sociology (Ritzer 2000). Anything Parsons published attracted great attention because he was thought to be charting a course for all of sociology. This book, providing a structural-functionalist model of society, contained Parsons' concept of the sick role and was the first time a major sociological theorist included an analysis of the function of medicine in his view of society. Parsons (1951: 428–9) was interested in the differing roles of professionals in capitalistic and socialist societies and decided to include physicians and their relationship to their clients in his analysis because this topic was an area of long-standing interest and one in which he felt he had familiarity. Parsons himself had undergone training in psychoanalysis in the 1950s at the Boston Psychoanalytic Institute when he was on the faculty at Harvard University (Smelser 1998).

This experience had grounded him in the theories of Sigmund Freud which became an important influence on his own work, along with the ideas of the classic sociological theorists Emile Durkheim and Max Weber. Parsons had completed his doctoral studies at Heidelberg University in Germany in the mid-1920s where he participated in the "Weber Circle" that continued to meet regularly to discuss sociology after Weber's death at the home of his widow, Marianne Weber. Parsons subsequently translated Weber's book on the *Protestant Ethic and the Spirit of Capitalism* (1958) into English, and reintroduced the work of both Weber and Durkheim to European sociologists after the disruption of their work during World War II. Freud's concepts of transference and countertransference helped Parsons draw analogies between the roles of parent–child

and physician–patient important in his notion of the sick role. Freud's structure of the personality and theory of the unconscious also assisted Parsons in developing his ideas on the motivation of sick persons to either recover or desire the "secondary gain" of privileges and exemption from normal social roles that accompany sick-role legitimation (Gerhardt 1989). Parsons also incorporates Durkheim's ideas on moral authority and Weber's analysis of religion into his discussion of the normative requirement to visit physicians when sick and the dominant position of the physician in the doctor–patient role relationship.

Parsons' concept of the sick role is a clear and straightforward statement of four basic propositions outlining the normative pattern of physician utilization by the sick and their respective social roles. Parsons not only constructed the first theoretical concept directly applicable to medical sociology, but by utilizing the work of Durkheim and Weber, he did so within the parameters of classical sociological theory. His formulation was recognized as "a penetrating and apt analysis of sickness from a distinctly sociological point of view" (Freidson 1970a: 228), which indeed it was. Parsons also influenced the study of professions by using the medical profession as the model for professions based on expertise and a service orientation. Although extensive criticism was to subsequently lessen the acceptance of the Parsonian approach to theory, this outcome does not negate the significant influence Parsons initially had on promoting debate and research in medical sociology. Parsons, more so than any other sociologist of his time, made medical sociology academically respectable by providing it with its inaugural theoretical orientation (Cockerham and Ritchey 1997).

However, structural-functionalism, with its emphasis on value consensus, social order, stability, and functional processes at the macro-level of society, had a short-lived period as the leading theoretical paradigm in medical sociology. Robert Merton and his colleagues extended the structural-functionalist mode of analysis to the socialization of medical students in their book, *The Student Physician* (1957), but other major works in medical sociology were not forthcoming. Structural-functionalism itself was under assault by critics in the 1960s and early 1970s and lost considerable influence.

Durkheim (1950), who was generally responsible for the theory in sociology, emphasized the importance of macro-level social processes, structures, norms, and values external to individuals that integrated them into the larger society and shaped their behavior. People were depicted as constrained in exercising free will by the social order. Durkheim's (1951) only work that had a direct application to medical sociology was his theory of suicide in which the act of taking one's life was determined by the individual's ties to his or her community or society. This is seen in his typology of three major types of suicide: (1) egoistic (social detachment), (2) anomic (state of normlessness), and (3) altruistic (a normative demand for suicide). The merit of his concept is that it shows the capability of the larger society to create stressful situations where people are forced to respond to conditions not of their own choosing. Thus, Durkheim helps us to not only understand the social facets of suicide, but to recognize that macro-level social events (like economic recessions) can affect health in a variety of ways through stress and that the effects of stress can be mitigated through

social support (Thoits 1995; Cockerham 1998). Indirectly, Durkheim (1964) also influenced the study of health professions in noting the transition from mechanical to organic social solidarity, with its emphasis upon specialization, in the modern division of labor.

However, symbolic interactionists objected to the relegation of individuals to relatively passive roles in large social systems, while conflict theorists found structural-functionalism inadequate in explaining the process of social change and the social functions of conflict. The theory's emphasis on equilibrium and consensus also seemed to favor maintenance of the status quo and support for dominant elites (Ritzer 2000), at a time (the 1960s) of widespread social protest against authority in the West. Structural-functionalism in general and Parsons in particular suffered a serious fall in popularity, although Parsons' work enjoyed a mild resurgence in the 1990s (Robertson and Turner 1991; Callinicos 1999). Parsons' concept of the sick role, however, has remained a central theoretical proposition in medical sociology, despite challenges. It is still utilized as a basic ("ideal-type") explanation for physician–patient encounters in which the model of interaction is primarily that of guidance on the part of the physician and cooperation by the patient in clinics or patient care office settings.

Symbolic Interaction

The first major theoretical perspective to challenge Parsons and structural-functionalist theory in medical sociology was symbolic interaction, based largely on the work of George Herbert Mead (1934) and Herbert Blumer (1969). Symbolic interaction maintained that social reality is constructed on a micro-level by individuals interacting with one another on the basis of shared symbolic meanings. Human beings were seen to possess the capacity to think, define situations, and construct their behavior on the basis of their definitions and interpretations. "It is the position of symbolic interaction," states Blumer (1969: 55), "that the social action of the actor is *constructed* by him [or her]; it is not a mere release of activity brought about by the play of initiating factors on his [or her] organization." Social life was therefore produced by interacting agents choosing their own behavior and acting accordingly, not by large-scale social processes and structures channeling behavior down option-less pathways. Symbolic interaction not only had its particular (micro-level) orientation toward theory construction, but also its own qualitative research methodologies of participant observation that focused on small group interaction and natural social settings. A related approach was ethnomethodology which featured description of taken-for-granted meanings in natural settings, rather than analysis.

The major figures in early medical sociology working in the symbolic interactionist tradition were Anselm Strauss and Erving Goffman. Strauss joined with Howard Becker and others in their now classic study of medical school socialization, *Boys in White* (Becker et al. 1961). Strauss made his own contributions to theory and methods in a number of areas, including seminal work on the social process of death and dying (Glaser and Strauss 1965, 1968); observation

of the "negotiated order" of hospital routine featuring a minimum of "hard and fast" regulations and a maximum of "innovation and improvisation" in patient care, especially in emergency treatment (Strauss et al. 1963); and formulation of grounded theory methodology featuring the development of hypotheses from data *after* its collection, rather than before (Glaser and Strauss 1967).

Goffman, who became a major theorist in sociology generally, began his research career in medical sociology by using participant observation to study the life of mental hospital patients. His classic work in this area, *Asylums* (1961), presented the concept of "total institutions" that emerged as an important sociological statement on the social situation of people confined by institutions. His observations also led to the development of his notions of impression management and the dramaturgical perspective in sociology that views "life as a theatre" and "people as actors on a stage," as well as his concept of stigma (Goffman 1959, 1967).

With the introduction of symbolic interactionist research into an area previously dominated by structural-functionalism, medical sociology became an arena of debate between two of sociology's major theoretical schools. By the mid-1960s, symbolic interaction came to dominate a significant portion of the literature in the field. One feature of this domination was the numerous studies conducted in reference to labeling theory, a variant of symbolic interaction, and the controversy it provoked. Labeling theory held that deviant behavior is not a quality of the act a person commits but rather is a consequence of the definition applied to that act by others (Becker 1973). That is, whether or not an act is considered deviant depends upon how other people react to it. Although labeling theory pertained to deviance generally, the primary center of argument was focused on the mental patient experience, with Thomas Scheff (1999) the principal proponent of the labeling approach. Labeling theory was also employed in studies of the medical profession as seen in Eliot Freidson's (1970b) alternative concept of the sick role.

By the 1980s, however, symbolic interaction entered a period of decline in medical sociology. Many of its adherents had been "rebels" intentionally subverting the dominant paradigm of structural-functionalism and giving voices to women and marginal social groups like mental patients, the physically-handicapped, and the aged and their caretakers by entering their social world and observing it. Yet, as Norman Denzin (1991) points out, between 1981 and 1990, the canonical texts in the field had shifted from Mead to Blumer and Blumer himself was under attack on several methodological and substantive issues – but most importantly for not advancing the field to meet his own early criticisms; moreover, practitioners of the perspective were getting older ("the graying of interactionism"), the number of students espousing interactionism was decreasing, and the old enemy (structural-functionalism) had been largely vanquished. Unfortunately, symbolic interaction had taken on the image of a "fixed doctrine" and, except for Mead's (1934) concept of the "generalized other," was unable to satisfactorily link small group processes with social phenomena reflecting the behavioral influences of the larger society. It was particularly unable to account for interaction between institutions or societal-level processes that affect each other, not just individuals. In addition, labeling theory,

despite its merits in accounting for the powerful behavioral effects of "labels" placed on people, had not been able to explain the causes of deviance (other than the reaction of the social audience), nor whether deviants themselves share common characteristics like poverty, stress, or family background.

But it would be a mistake to relegate symbolic interaction to history, as participant observation remains the primary form of qualitative research in medical sociology. Participant observation and ethnomethodology are still the best methods for recording social behavior from the personal standpoint of those being studied and the settings within which they lead their usual lives. Annandale (1998) reports that interactionism has been the dominant theoretical perspective in medical sociology in Great Britain as seen in the majority of published studies. The observed patterns of behavior and first-person accounts of social situations bring a sense of "real life" to studies that quantitative research is unable to capture. While symbolic-interaction theory has not moved far beyond the original concepts of Mead and Blumer, it persists as an important theoretical approach to the study and explanation of social behavior among small groups of people interacting in ways that are relevant for health.

A relatively new area of research in medical sociology helping to revive symbolic interaction is the sociology of emotions, a topic that had been neglected in the past. Research in this field seeks to understand the link between social factors and emotions, since emotions are expressed either in response to social relationships or situations or both. Symbolic interactionism fills in the analytic gap between organic or biological approaches to the study of emotions and approaches like social constructionism that ignores biological processes and focuses more or less exclusively on the social and cultural components of emotions (Williams and Bendelow 1996). Interaction between people plays perhaps the major role in the activation and expression of emotions (Freund 1990). Thus, emotions are biological responses to social situations and the interaction between people involved in those situations. According to Simon Williams (1998), emotions, as existentially embodied states, also connect "personal troubles" to social structure in ways that affect health and shape patterns of disease. Williams finds, for example, that feelings of stress, helplessness, depression, sense of coherence, insecurity, and lack of control have been shown to be associated with increased levels of mortality and morbidity.

Conflict Theory

Conflict theory, with its roots in the work of Karl Marx and Max Weber, joined symbolic interaction in significantly reducing the influence of structural-functionalism, but has failed to date to establish a major foothold in medical sociology. Conflict theory is based on the assumption that society is composed of various groups struggling for advantage, that inequality is a basic feature of social life, and conflict is the major cause of social change. Marx's perspective in conflict theory is seen in the rejection of the view expressed by structural-functionalism that society is held together by shared norms and values. Conflict theory claims that true consensus does not exist; rather, society's norms and

values are those of the dominant elite and imposed by them on the less privileged to maintain their advantaged position. Weber adds, however, that social inequality is not based on just money, property, and relationships to the means of production, but also on status and political influence. Since all social systems contain such inequality, conflict inevitably results and conflict, in turn, is responsible for social change.

Whereas the Marxian-oriented features of conflict theory have emphasized class struggle, other theorists have moved toward emphasizing conflicts that occur between interest groups and the unequal distribution of political power (Dahrendorf 1959). According to Bryan Turner (1988), modern societies are best understood as having a conflict between the principles of democratic politics (emphasizing equality and universal rights) and the organization of their economic systems (involving the production, exchange, and consumption of goods and services, about which there is considerable inequality). Therefore, while people have political equality, they lack social equality. This unresolved contradiction is relatively permanent and a major source of conflict. Ideologies of fairness are constantly challenged by the realities of inequalities, and they influence governments to try to resolve the situation through politics and welfare benefits.

This situation represents one of conflict theory's most important assets for medical sociology; namely, the capacity to explain the politics associated with health reform. Conflict theory allows us to chart the maneuvers of various entities, like the medical profession, insurance companies, drug companies, the business community, and the public, as they struggle to acquire, protect, or expand their interests against existing government regulations and programs and those under consideration. Other conflict approaches are connected more directly to classical Marxism by relying on class struggle to explain health policy outcomes (Navarro 1994) and the disadvantages of the lower and working classes in capitalist medical systems where the emphasis is on profit (McKinley 1984; Waitzkin 1983). While a major focus of conflict theory in medical sociology is on the role of competing interests in health care delivery and policy, other interests concern the sources of illness and disability in work environments, working-class health, differences in health lifestyles, and capitalist ideologies supportive of physician–patient interaction (Waitzkin 1983, 1989, 1991; McKinlay 1984; Navarro 1986; Blane 1987).

However, there are inherent limitations in the use of conflict theory in medical sociology. While some health situations are affected by conflict-related conditions, others are not. People may maintain their health or become sick and these outcomes can have little or nothing to do with conflict, politics, interest-group competition, class struggles, and the like. Moreover, Marxism began losing influence from the late 1970s onward. As Alex Callinicos (1999) points out, political events sank Marxist theory in the universities. First, French scholars turned their back on Marxism as a "theory of domination" in response to Soviet labor camps, the cold war, and the crackdown on Solidarity in Poland in 1981, followed by similar reactions elsewhere in Europe and Latin America. "The process of retreat was slower in the English-speaking world," states Callinicos (1999: 261), "but by the beginning of the 1990s, under the impact of

postmodernism and the collapse of 'existing socialism' in Eastern Europe and the Soviet Union, Marx was a dead dog for most intellectuals there as well."

As a political doctrine, Marxist–Leninism also failed to construct healthy social conditions and an adequate health care delivery system in the former Soviet Union and eastern Europe. This region experienced a 30-year rise (1965–95) in adult male mortality, which is unprecedented for a group of industrialized societies under stable administrations in peacetime (Field 1995; Cockerham 1997, 1999). The epicenter of the downturn in life expectancy was in Russia where male longevity fell nearly six years during this period. The greatest potential of conflict theory for medical sociology thus lies in its non-Marxist aspects, as interest-group competition in welfare states proves more relevant for health concerns than class struggle.

Max Weber

None of the classical theorists – Comte, Spencer, Simmel, Marx, Durkheim, and Weber – concerned themselves with medical sociology. Weber, however, has had the greatest direct influence on the field. His most important contributions are associated with his concepts of formal rationality and lifestyles. Weber (1978) distinguished between two major types of rationality: formal and substantive. Formal rationality is the purposeful calculation of the most efficient means and procedures to realize goals, while substantive rationality is the realization of values and ideals based on tradition, custom, piety, or personal devotion. Weber described how, in western society, formal rationality became dominant over its substantive counterpart as people sought to achieve specific ends by employing the most efficient means and, in the process, tended to disregard substantive rationality because it was often cumbersome, time-consuming, inefficient, and stifled progress. This form of rationality led to the rise of the West and the spread of capitalism. It is also linked to the development of scientific medicine and modern social structure through bureaucratic forms of authority and social organization that includes hospitals (Hillier 1987). The rational goal-oriented action that takes place in hospitals tends to be a flexible form of social order based on the requirements of patient care, rather than the rigid organization portrayed in Weber's concept of bureaucracy (Strauss et al. 1963). But his perspective on bureaucracy nevertheless captures the manner in which authority and control are exercised hierarchically and the importance of organizational goals in hospital work (Hillier 1987).

Weber's notion of formal rationality has likewise been applied to the "deprofessionalization" of physicians. Deprofessionalization means a decline in power resulting in a decline in the degree which a profession maintains its professional characteristics. Eliot Freidson's (1970a, 1970b) seminal work on the medical profession in the 1970s had captured American medicine's professional dominance in its relations with patients and external organizations. Medicine was *the* model of professionalism, with physicians having absolute authority over their work and ranked at or near the top of society in status. However, George Ritzer and David Walczak (1988) noted the loss of absolute authority by physicians as

their treatment decisions came under increasing scrutiny in the late twentieth century by patients, health care organizations, insurance companies, and government agencies.

Ritzer and Walczak found that government policies emphasizing greater control over health care costs and the rise of the profit motive in medicine identified a trend in medical practice away from substantive rationality (stressing ideals like serving the patient) to formal rationality (stressing rules, regulations, and efficiency). Government and insurance company oversight in reviewing and approving patient care decisions, and the rise of private health care business corporations, decreased the autonomy of medical doctors by hiring them as employees and controlling their work – joined with greater consumerism on the part of patients – to significantly reduce the professional power and status of physicians. Thus, the "golden age" of medical power and prestige ended, as medicine's efforts to avoid regulation left open an unregulated medical market that invited corporate control and public demands for government control to contain costs. Frederic Hafferty and Donald Light (1995: 138) predict that "the basic overall thrust of professionalism is toward a loss and not a continuation or strengthening of medicine's control over its work."

Weber's work also provides the theoretical background for the study of health lifestyles. Weber (1978) identified life conduct (*Lebensführung*) and life chances (*Lebenschancen*) as the two central components of lifestyles (*Lebensstil*). Life conduct refers to choice or self-direction in behavior. Weber was ambiguous about what he meant by life chances, but Ralf Dahrendorf (1979:73) analyzed Weber's writings and found that the most comprehensive concept of life chances in his terminology is that of "class position" and that he associated the term with a person's probability of finding satisfaction for interests, wants, and needs. He did not consider life chances to be a matter of pure chance; rather, they are the chances that people have in life because of their social situation.

Weber's most important contribution to conceptualizing lifestyles is to identify the dialectical interplay between choices and chances as each works off the other to shape lifestyle outcomes (Abel and Cockerham 1993; Cockerham, Abel, and Lüschen 1993). That is, people choose their lifestyle and the activities that characterize it, but their choices are constrained by their social situation. Through his concept of *Verstehen* or interpretive understanding, Weber seems to favor the role of choice as a proxy for agency over chance as representative of structure in lifestyle selection, although both are important. Weber also made the observation that lifestyles are based not so much on what people produce, but what they consume. By connecting lifestyles to status, Weber suggests that the means of consumption not only *expresses* differences in social and cultural practices between groups, but *establishes* them as social boundaries (Bourdieu 1984).

Health lifestyles are collective patterns of health-related behavior based on choices from options available to people according to their life chances (Cockerham and Ritchey 1997; Cockerham, Rütten, and Abel 1997). These life chances include class, age, gender, ethnicity, and other relevant structural variables that shape lifestyle choices. The choices typically involve decisions about smoking, alcohol use, diet, exercise, and the like. The behaviors resulting from the interplay of choices and chances can have either positive or negative consequences for

health, but nevertheless form a pattern of health practices that constitute a lifestyle. Although positive health lifestyles are intended to produce good health, the ultimate aim of such lifestyles is to be healthy in order to use (consume) it for something, such as the capability to work, feel and look good, participate in sports and leisure activities, and enjoy life (d'Houtaud and Field 1984). Health lifestyles originated in the upper middle-class, yet have the potential to spread across class boundaries in varying degrees of quality (Cockerham et al. 1988). While Weber did not consider the health aspects of lifestyles, his concepts allow us to view them as (1) associated with status groups and principally a collective, rather than individual, phenomenon; (2) patterns of consumption, not production; and (3) formed by the dialectical interplay between choices and chances.

Theory in the Twenty-first Century

The twentieth century ended with massive social changes causing both sociology and medical sociology to adjust to new realities and forge new theoretical orientations, as well as adapt older ones to account for the changes. As Bernice Pescosolido and Jennie Kronenfeld (1995: 9) explain:

> We stand at a transition between social forms. The society that created the opportunity for the rise of a dominant profession of medicine, for a new discipline of sociology, and for a spinoff of the subfield of medical sociology, is undergoing major change. As the larger social system unravels in the face of rapid social change, established problems, solutions, and understandings are challenged because they do not as successfully confront current realities.

It is clear that the breakup of the industrial age is occurring and, as Ulrich Beck (1992) explains, a "new modernity" is emerging. "Just as modernization dissolved the structure of feudal society in the nineteenth century and produced the industrial society," states Beck (1992: 10), "modernization today is dissolving industrial society and another modernity is coming into being." With the twenty-first century at hand, we have already witnessed the collapse of communism in the former Soviet Union and eastern Europe, the multiculturalization of Europe and North America, the rise of cultural and sexual politics, changing patterns of social stratification, the increasing importance of information as an economic commodity, and the dominance of the service sector in the global economy. Changing social circumstances have resulted in new theoretical approaches in medical sociology which will be reviewed in this section: poststructuralism, postmodernism, the work of Pierre Bourdieu, and critical realism.

Poststructuralism: Foucault, the Sociology of the Body, and Feminist Theory

Poststructualism emerged out of a short-lived structuralist perspective that was popular in France in the 1960s. Structuralism has its roots in linguistics, most

notably the semiotic (sign systems) theory of Ferdinand de Saussure, and is largely based on the work of the anthropologist Claude Lévi-Strauss. Both structuralism and poststructuralism developed theories which analyzed culture in terms of signs, symbolic codes, and language, and took the position that the individual was not autonomous but constrained in social action by discourse (Best and Kellner 1991). Structuralism, however, depicted social meaning as a product of signification, a process maintained by traditional and universal structures forming a stable and self-contained system. Poststructuralists rejected the notion that there were universal rules organizing social phenomena into compact systems, as well as structuralism's failure to account for the motivations of users of language and its ahistorical approach to analysis. One approach to poststructuralism is the work of Jacques Derrida that helped lay a foundation for the emergence of postmodern theory. Derrida's (1978) analysis (deconstruction) of texts suggested that written language was not socially constraining, nor were its meanings stable and orderly. Depending upon the context in which they were used, meanings could be unstable and disorderly.

The leading representative of poststructuralism is Michel Foucault who focused on the relationship between knowledge and power. Foucault provided social histories of the manner in which knowledge produced expertise that was used by professions and institutions, including medicine, to shape social behavior. Knowledge and power were depicted as being so closely connected that an extension of one meant a simultaneous expansion of the other. In fact, Foucault often used the term "knowledge/power" to express this unity (Turner 1995). The knowledge/power link is not only repressive, but also productive and enabling, as it is a decisive basis upon which people are allocated to positions in society. A major contribution of Foucault to medical sociology is his analysis of the social functions of the medical profession, including the use of medical knowledge as a means of social control and regulation, as he studied madness, clinics, and sexuality. Foucault (1973) found two distinct trends emerging in the history of medical practice; "medicine of the species" (the classification, diagnosis, and treatment of disease) and "medicine of social spaces" (the prevention of disease). The former defined the human body as an object of study subject to medical intervention and control, while the latter made the public's health subject to medical and civil regulation. The surveillance of human sexuality by the state, church, and medicine subjected the most intimate bodily activities to institutional discourse and monitoring. Thus, bodies themselves came under the jurisdiction of experts on behalf of society (Armstrong 1987; Turner 1992; Peterson and Bunton 1997).

Foucault's analysis of the body also led to the development of a new specialty, the sociology of the body, with Turner's book *The Body and Society* (1996, originally published in 1984), the seminal work in this area. Theoretical developments concerning the sociological understanding of the control, use, and the phenomenological experience of the body, including emotions, have been most pronounced in Great Britain where this subject has become a major topic in medical sociology. One area of inquiry is the dialectical relationship between the physical body and human subjectivity or the "lived" or phenomenological experience of having and being in a body. As Deborah Lupton (1998: 85)

explains: "The body-image shapes the ways in which individuals understand and experience physical sensations and locate themselves in social space, how they conceptualize themselves as separated from other physical phenomena, how they carry themselves, how they distinguish outside from inside and invest themselves as subject or object."

Another area of investigation is the social construction of bodies, illness, and emotions. In medical sociology, the social constructionist approach is closely tied to Foucault and analyzes the body as a product of power and knowledge (Bury 1986; Nettleton 1995; Annandale 1998). It focuses on examining the manner in which people shape, decorate, present, manage, and socially evaluate the body. Chris Shilling (1993), for example, points out that social class has a profound influence on how people develop their bodies and apply symbolic values to particular body forms. Schilling (1993: 140) finds that bodies are forms of physical capital with their value determined by "the ability of dominant groups to define their bodies and lifestyles as superior, worthy of reward, and as, metaphorically and literally, the embodiment of class."

Judith Lorber (1997) and others (Radley 1993) argue that illness is also socially constructed in that the expression of symptoms is shaped by cultural and moral values, experienced through interaction with other people, and influenced by particular beliefs about health and illness. The result, claims Lorber, is a transformation of physiological symptoms into a diagnosis, socially appropriate illness behavior, and a modified status. When it comes to emotions, social constructionism emphasizes the social, rather than biological nature of emotional states (James and Gabe 1996). It takes the position that emotions vary cross-culturally and socially in their meaning and expression; consequently, they are first and foremost social and cultural constructions (Williams and Bendelow 1996).

Feminist theory in medical sociology also has poststructural roots, especially in regard to social constructionist accounts of the female body and its regulation by a male-dominated society. Social and cultural assumptions are held to influence our perceptions of the body, including the use of the male body as the standard for medical training, the assignment of less socially desirable physical and emotional traits to women, and the ways in which women's illnesses are socially constructed (Martin 1987; Lupton 1994; Annandale and Clark 1996; Lorber 1997; Clarke and Olesen 1999). Other feminist theory is grounded in conflict theory or symbolic interaction, and deals with the sexist treatment of women patients by male doctors and the less than equal status of female physicians in professional settings and hierarchies (Fisher 1984; West 1984; Riska and Wegar 1993). There is, however, no unified perspective among feminist theorists other than a "woman-centered" perspective that examines the various facets of women's health and seeks an end to sexist orientations in health and illness and society at large (Nettleton 1995; Annandale and Clark 1996; Annandale 1998; Clarke and Olesen 1999; Lengermann and Niebrugge-Brantley 2000).

Regardless of its widespread influence on many facets of contemporary theory in medical sociology, poststructuralism has its critics. Some argue that

poststructuralism has been overtaken and surpassed by postmodern theory or, at best, cannot be easily distinguished from postmodernism (Ritzer 2000). Others suggest that the perspective does not take limits on power into account, nor explain relations between macro-level power structures other than dwell on their mechanisms for reproduction; moreover, there is a disregard of agency in poststructural concepts, especially those of Foucault (Giddens 1987; Münch 1993). Anthony Giddens, for example, notes Foucault's history tends to have no active subjects at all and concludes: "It is history with the agency removed." Yet Foucault's knowledge/power equation, applied to social behavior and poststructuralism in general, is important for a number of topics in medical sociology (Petersen and Bunton 1997).

POSTMODERNISM

There is considerable disagreement about the nature and definition of postmodernity, but a common theme is the breakup of modernity and its postindustrial social system that is bringing new social conditions. Postmodernism was generally ignored by sociologists until the mid-1980s when primarily British social scientists decided it was worthy of serious attention (Bertens 1995). Postmodernism emerged out of poststructuralism as a more inclusive critique of modern sociological theory and grand narratives; it rejected notions of continuity and order and called for new concepts explaining the disruptions of late modern social change (Best and Kellner 1991). Rather, it argued that there was no single coherent rationality and the framework for social life had become fragmented, diversified, and decentralized (Turner 1990). Its sociological relevance rested in its depiction of the destabilization of society and the requirement to adjust theory to new social realities. However, there have been few works to date in medical sociology explicitly adopting postmodern themes. Exceptions include highly abstract and poststructuralist-oriented discourses on health and the definition of the body (Fox 1993), along with works concerning the fragmentation of modern society and medical authority leaving individuals with greater self-control over their bodies (Glassner 1989) and increased personal responsibility for their health (Cockerham et al. 1997).

Postmodern theory has been criticized for a number of reasons, including its failure to explain social conditions after the rupture with modernity is complete, lacking an adequate theory of agency, being too abstract, not providing clear conceptualizations, and not having empirical confirmation (Best and Kellner 1991; Ritzer 2000). While its demise has been announced in Britain (Williams 1999), it is still popular in France and has gained adherents in the United States (Ritzer 2000). The advantage of postmodern theory is that modern society is indeed shifting into a new form with social conditions different from the recent past (the 1960s and 1970s) and the perspective provides a theoretical framework, despite its diffuse literature, for explaining many of the changes. Its ultimate fate is therefore unknown.

Pierre Bourdieu

Identified as the leading intellectual in contemporary France, Bourdieu's work focuses on how the routine practices of individuals are influenced by the external structure of their social world and how these practices, in turn, reproduce that structure (Jenkins 1992). Through his key concept of habitus, Bourdieu connects social practices to culture, structure, and power (Swartz 1997). Bourdieu (1990) describes the habitus as a mental scheme or organized framework of perceptions (a structured structure operating as a structuring structure) that predisposes the individual to follow a particular line of behavior as opposed to others that might be chosen. These perceptions are developed, shaped, and maintained in memory and the habitus through socialization, experience, and the reality of class circumstances. While the behavior selected may be contrary to normative expectations and usual ways of acting, behavioral choices are typically compatible with the dispositions and norms of a particular group, class, or the larger society; therefore, people tend to act in predictable and habitual ways even though they have the capability to choose differently. Through selective perception, the habitus adjusts aspirations and expectations to "categories of the probable" that impose boundaries on the potential for action and its likely form.

Of all Bourdieu's works, the one most relevant for medical sociologists remains his book *Distinction* (1984) in which he systematically accounts for the patterns of cultural consumption and competition over definitions of taste of the French social classes. It includes an analysis of food habits and sports that describes how a class-oriented habitus shaped these particular aspects of health lifestyles. Cockerham (1997, 1999) follows Bourdieu's theoretical framework in identifying negative health lifestyles as the primary social determinant of the late twentieth-century downturn in life expectancy in Russia and eastern Europe. The group most responsible for reduced longevity were middle-age, working-class males. The living conditions of these men and their relatively low and powerless position in the social structure produced a habitus fostering unhealthy practices (heavy drinking and smoking, disregard for diet, and rejection of exercise) that resulted in a lifestyle promoting heart disease, accidents, and other health problems leading to a shortened life span. These behaviors were norms established through group interaction, shaped by the opportunities available to them, and internalized by the habitus. The structure of everyday life both limited and molded health-related choices to the extent that lifestyles led to premature deaths.

According to Williams (1995), the merit of Bourdieu's analysis for understanding the relationship between class and health lifestyles lies in his depiction of the relative durability of various forms of health-related behavior within particular social classes and the relatively seamless fashion in which he links agency and structure. "In particular," states Williams (1995: 601), "the manner in which his arguments are wedded to an analysis of the inter-relationship between class, capital, taste, and the body in the construction of lifestyles . . . is both compelling and convincing." Although Bourdieu has been criticized for overemphasizing structure at the expense of agency and presenting an overly

deterministic model of human behavior (Münch 1993), he nevertheless provides a framework for medical sociologists to conceptualize health lifestyles and for sociologists generally to address the agency-structure interface.

CRITICAL REALISM

Critical realism is a new theoretical perspective that has recently emerged in Great Britain and is based on the work of philosopher Roy Bhaskar (1994, 1998) and sociologist Margaret Archer (1995; Archer et al. 1998). Critical realist theory argues that social constructionism does not account for agency and provides an "oversocialized" view of individuals overemphasizing the effects of structure, while other theorists, like Bourdieu and Giddens, opt for a "seamless" approach to agency and structure, but the operations of the two in reality are not synchronized. Consequently, critical realism, in opposition to poststructuralism, treats agency and structure as fundamentally distinct but interdependent dimensions that need to be studied separately in order to understand their respective contributions to social practice. The "analytical decoupling of structure and agency" is necessary, states Williams (1999: 809), "not in order to abandon their articulation, but, on the contrary, so as to examine their *mutual interplay across time*; something which can result both in *stable reproduction* or *change* through the *emergence* of new properties and powers."

Critical realism takes the position that social systems are open to process and change and that people as agents and actors have the critical capacity, reflexivity, and creativity to shape structure, yet, in turn, are shaped by structure. But the key factor for the critical realist is the capacity of the individual to transform structure and produce variable outcomes (Archer 1995). Structure, for its part, is relatively enduring, although it can be modified, and deep structures have generative mechanisms going beyond the observable that influence behavior. A goal of critical realism is to connect agency and structure in a way that the distinctive properties of both can be realistically accounted for without being reduced to a single entity. Space limitations preclude a more extensive discussion of critical realism and its recent emergence has not yet evoked major criticisms, nor has the perspective achieved widespread prominence to date. Among the few studies in medical sociology employing critical realism is an examination of the body from the standpoint of chronic illness and disability, which focuses on the interrelationship of biological and social factors in shaping outcomes (Williams 1999).

CONCLUSION

The notion that medical sociology is atheoretical is wrong, although there have been past problems in this regard. This chapter has provided a brief account of the history and variety of viewpoints in sociological theory that have been utilized within the field and provided influential statements on the relationship between society and health. Beginning with Parsons and

structural-functionalism, medical sociology in reality has a rich theoretical tradition spanning more than 50 years and incorporating the work of both classical and contemporary theorists. Debates in general sociology, such as those involving the opposition of symbolic interactionists and conflict theorists to structural-functionalism and the current agency versus structure issue, became points of theoretical contention in medical sociology as well. The trend in twenty-first century sociological theory that seems to be aligning more with structural concerns, as seen in poststructuralism, is reflected in medical sociology, along with the counter perspective of critical realism. Although the ultimate direction of theory in medical sociology this century is uncertain, the theoretical basis for work in the field is extensive and its potential explanatory power is exciting. Medical sociology has become a theoretical subdiscipline.

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