Part I

Introduction
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 of social behavior, have been adopted 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 to practical problems rather than theoretical questions. That is, it was intended to help solve a clinical problem or policy issue, rather than develop theory or utilize it as a tool to enhance 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. 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, in relation to both 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 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 moving 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). The extent to which this assertion will be fully realized is not yet certain, but it is clear that a considerable amount of theoretical work is taking
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 2008). Anything Parsons published attracted great attention because he was thought to be charting a course for all of sociology. This book, providing a structural-functional 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 capitalist 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 counter-transference can be seen in the way Parsons drew 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 are also apparent in 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. Parsons likewise 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.

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 not only to understand the social facets of suicide, but also 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 (Cockerham 2010). 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 2008), 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 (Callinicos 2007). 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 had not only its particular (micro-level) orientation toward theory construction, but also its own qualitative research methodologies of participant observation that focused on small group interaction in 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 their 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. Elsewhere, in Great Britain, where interactionism had been the dominant theoretical perspective in medical sociology as seen in the majority of published studies (Annandale 1998), a related theoretical perspective – social constructionism – is now the leading theory (Nettleton 2006; Seale 2008).

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 or groups. 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, family, or class 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. Moreover, 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.

One area of research in medical sociology helping to revive symbolic interaction is the sociology of emotions, a topic 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 sociological 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 and analyzing interpersonal relations is a strength of symbolic interaction. Emotions, as Simon Williams (1998) points out, are existentially embodied states that also connect “personal troubles” to social structures 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 consistently 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 yet 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 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 (McKinlay 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 in the physician–patient relationship (Blane 1987; McKinlay 1984; Navarro 1986; Waitzkin 1983, 1989, 1991). 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 (2007) 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 (2007: 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, Marxism–Leninism also failed to construct healthy social conditions and an adequate health care delivery system in the former Soviet Union and the East European socialist countries that experimented with it (Cockerham 1997, 1999, 2000, 2007b). Most of these countries experienced a 30-year decline (1965–95) in male life expectancy and for some – Belarus, Kazakhstan, Russia, and Ukraine – the health crisis is still continuing (Cockerham 2007b; Cockerham et al. 2006a, 2006b). The epicenter of the downturn in life expectancy was in Russia where male longevity fell 5.2 years between 1965 and 2005 and female life expectancy rose only 0.3 years. The theoretical and practical failure of Marxism to produce healthy societies substantially undermines the utility of Marxist-based theories in medical sociology (Cockerham 2007a). 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 Marxist notions of class struggle.
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. 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, Ritzer and 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. This, joined with greater consumerism on the part of patients, significantly reduced 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. Hafferty and Light (1995: 138) accurately
predicted 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 Dahrendorf (1979: 73) analyzed Weber’s writ-
ings and found that the most comprehensive concept of life chances in his terminol-
ogy 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 con-
side 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 activi-
ties 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
2005, 2007a; 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
choices can have either positive or negative consequences for health, but neverthe-
less 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 life-
styles is to be healthy in order to use (consume) it for something, such as the capa-
bility 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, Kunz, and Lüschen 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. His conceptualization of
lifestyles provides the foundation for current theorizing on health-related lifestyles
Critical Theory and Jürgen Habermas

The term critical theory has a long history but in sociology has come to be associated with a group of philosophers and social theorists pre-eminent in “culture critique” in Frankfurt in the interwar years and later, with the advent of Nazism, in California. Under the inspiration of Horkheimer and Adorno, and in the 1960s in the USA with Marcuse, the classical contributions of Marx and Weber were reworked and framed in response to fascism, Stalinism, and managerial capitalism (Outhwaite 1996). The name of Adorno, in particular, came to be linked with a profound and remorseless cultural pessimism: the logic of the twentieth century, even of modernity, was seen as one of ineluctable decline. The influential Dialectic of Enlightenment, written with Horkheimer during World War II and published in 1947, epitomizes this inexorable sense of decay. One of Adorno’s assistants, Jürgen Habermas, did not share the gloom of his mentor and it is his contribution that came to dominate critical theory during the last decades of the twentieth century. Some medical sociologists turned to his work for theoretical inspiration. It was Habermas’ concept of rationality that differentiated his theories from those of predecessors like Marx, Weber, Adorno, and Horkheimer. He rejected any suggestion that rationality be subsumed by Weber’s Zweckrationalität, or instrumental rationality. In other words, rationality is more than that which governs the choice of means to given, usually material, ends. He developed the notion of what he came to call “communicative rationality,” which refers to the activity of reflecting on our taken-for-granted assumptions about the world, bringing basic norms to the fore to be interrogated and negotiated. Not only does instrumental rationality bypass these norms, but it is on its own insufficient to capture the nature of either “cultural evolution” or even the economy and state, which are too complex to be seen merely as its product.

Basic to his early work is a distinction between work and interaction. Marx, Weber, and his Frankfurt predecessors had, he felt, fixated on the former and neglected the latter. In the case of Marxian theory, what Habermas understands as the reduction of interaction, or “communicative action,” to work, instrumental or “strategic action,” dramatically limited its scope both to account for modernity and to ground a project of human emancipation. The two-volume Theory of Communicative Action, published in Germany in 1981, took this analysis to a new level of subtlety and comprehensiveness (Habermas 1984, 1987). Locating his theories within the orbit of a “reconstructed” Enlightenment project, Habermas sought to bring together two long-standing, “rival” approaches to social theory. The first analyzes society as a meaningful whole for its participants (Verstehen theory); and the second analyzes society as a system that is stabilized behind the backs of the participants (system theory) (Sitton 1996). This goal gave rise to the celebrated distinction between the lifeworld, based on social integration, and the system, based on system integration.

The lifeworld is characterized by communicative action and has two aspects or sub-systems: the private sphere comprises the rapidly changing unit of the household, while the public sphere represents the domain of popular communication,
discussion, and debate. The system operates through strategic action and it too has its sub-systems, the economy and the state. These four sub-systems are interdependent: each is specialized in terms of what it produces but is dependent on the others for what it does not produce. The private sphere of the lifeworld produces “commitment” and the public sphere “influence”; the economy produces “money” and the state “power.” These products or “media” are traded between sub-systems. Thus the economy relies on the state to set up appropriate legal institutions such as private property and contract, on the public sphere of the lifeworld to influence consumption patterns, and on the private sphere to provide a committed labor force, and itself sends money into each other sub-system. Habermas argued that in the modern era, system and lifeworld have become “decoupled.” Moreover, the system has come increasingly to dominate or “colonize” the lifeworld. Thus decision-making across many areas owes more to money and power than to rational debate and consensus.

This notion of system penetration and colonization of the lifeworld has been taken up in medical sociology (Scambler 2001). It has been suggested that “expert systems” like medicine have become more answerable to system imperatives than to the lifeworlds of patients. Using Mishler’s (1984) terms, the “voice of medicine” has grown in authority over the “voice of the lifeworld.” Independently of the motivations and aspirations, and sometimes the reflexivity, of individual physicians, they have become less responsive to patient-defined needs, notwithstanding ubiquitous rhetorics to the contrary. Habermas’ framework of system and lifeworld, strategic and communicative action, continues to be used in the twenty-first century to analyze and explain macro-level changes to health care organization and delivery and micro-level changes to physician–patient interaction and communication. Scambler (2002), for example, draws on it to account for (1) Clinton’s failure to partially decommodify health care in the US in the early 1990s, and (2) the partial recommodification of the British National Health Service from the 1980s onwards. He deploys it also to address the diminution of patient trust in individual encounters with physicians, a theme of growing importance in health care.

**THEORY IN THE TWENTY-FIRST CENTURY**

The twentieth century ended with new social realities causing both sociology and medical sociology to adjust and consider new theoretical orientations, as well as adapt older ones to account for the changes. As Pescosolido and 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.
With the twenty-first century at hand, we have witnessed the aftermath of 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, the dominance of the service sector in the global economy, the rise of China as the world’s center for manufacturing consumer goods, a global economic recession, and the election of the first black president of the United States. Changing circumstances have resulted in new orientations toward living for many individuals. Crawford (2000), for example, sees a contradiction at the heart of the new “consumer society.” He argues that capitalism only functions if people are simultaneously producers and consumers, but that the personalities and ethics of the two are in opposition. To be a producer in the workplace requires self-denial, self-control, rationality, self-discipline, and willpower, while irrationality, release, indulgence, and pleasure-seeking characterize consumption. Such “co-presence” is evident in relation to health lifestyle practices like smoking, eating various foods, exercise, drinking alcohol, and so on. These practices have a binary character in that they can be either good or bad, depending on how they affect a person’s health. Whereas people may have more or less taken their health for granted in past historical eras, this is no longer the case as health is considered an achievement and everyone is expected to work at being healthy or risk chronic illness and premature death if they do not (Clarke et al. 2003). Changing health-related social conditions signify an adjustment in theoretical approaches for medical sociology or the emergence of new ones so these changes can be taken into account.

**Poststructuralism: Michel Foucault**

Many current theories are grounded in poststructuralism, which emerged out of a short-lived structuralist perspective 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 by discourse (Best and Kellner 1991). Structuralism depicted social meanings as fixed, not free, and maintained by traditional and universal structures (deep structures) that formed a stable and self-contained system. Poststructuralists, however, rejected the notion that there were universal rules organizing social phenomena into compact systems, along with structuralism’s failure to account for the motivations of users of language and its ahistorical approach to analysis. One major approach to poststructuralism is the work of Jacques Derrida, which 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 the French theorist 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 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 (Petersen and Bunton 1997; Turner 1992, 1996).

Foucault’s approach to the study of the body also influenced the development of a new specialty, the sociology of the body, with Bryan 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 both having and being in a body. As 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.”

Regardless of its influence on many facets of contemporary theory in medical sociology, poststructuralism and the work of Foucault has its critics. Some 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). Giddens (1987: 98), for example, notes Foucault’s history tends to have no active subjects at all and concludes: “It is history with the agency removed.” And he (Giddens 1987: 98) goes on to say that the “individuals who appear in Foucault’s analyses seem impotent to determine their own destinies.” Yet Foucault’s knowledge/power equation, applied to social behavior, remains important for a number of topics in medical sociology (Petersen and Bunton 1997). While both structuralism and poststructuralism are now considered dead traditions of social thought, some of the themes associated with them nevertheless remain influential (Giddens 1987) and reappear in social constructionism, feminist theory, especially postmodern theory, and the work of Bourdieu.
Social constructionism

One theoretical area of investigation with links to poststructuralism is social constructionism, which is based on the premise that phenomena are not discovered but socially produced (Turner 2004). That is, things are what they are defined as, even illness. For example, Lorber (1997) and others (Radley 1993) maintain that illness is 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 what constitutes health and illness. The result, claims Lorber, is a transformation of physiological symptoms into a diagnosis which produces socially appropriate illness behavior and a modified social 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).

In medical sociology, one branch of the social constructionist approach is closely tied to Foucault and analyzes the body as a product of power and knowledge (Annandale 1998; Bury 1986; Nettleton 2006). It focuses on examining the manner in which people shape, decorate, present, manage, and socially evaluate the body. 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. Shilling (1993: 140) finds that bodies represent 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.” Nettleton (2006) summarizes the Foucauldian wing of social constructionism in medical sociology by emphasizing its three major characteristics. First, it denies the existence of truth and the possibility of arriving at a single valid account of disease and the body. Second, it opposes traditional histories of medicine which suggest steady and continuous progress toward an increasingly valid knowledge of disease. Instead, social constructionism favors a more eclectic approach, focusing on specific and discontinuous arguments. And third, since all types of knowledge, whether based on science or experience, have equal validity, a rethinking of the relationship between medical “experts” and lay persons is required. The notion that all knowledge is socially constructed removes any claim that medical knowledge is always superior to lay knowledge.

The other branch of social constructionism is based on the seminal work of Peter Berger and Thomas Luckmann in their book *The Social Construction of Reality* (1967), which is grounded in symbolic interaction and its emphasis on agency. This approach is also influenced by Eliot Freidson’s (1970a, 1970b) analysis of medical professionalization. Freidson examined how the medical profession monopolized power and authority in health matters to advance its own interests. Given the significant differences between Berger and Luckmann in comparison to Foucault, it is obvious that social constructionism lacks a single, unified doctrine. According to Turner (2004: 43), “These different types of constructionism present very different accounts of human agency and thus have different implications for an understanding of the relationship between patients, doctors, and disease entities.” The more social
constructionist work is influenced by Berger and Luckmann, the more agency oriented it is; the closer to Foucault, the less agency has a role.

**Feminist theory**

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 (Annandale and Clark 1996; Clarke and Olesen 1999; Lorber 1997; Lupton 1994). 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; Hinze 2004). 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 (Annandale 1998; Annandale and Clark 1996; Clarke and Olesen 1999; Lengermann and Niebrugge-Brantley 2000; Nettleton 2006).

**Postmodern theory**

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 making sweeping generalizations about society as a whole; 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), increased personal responsibility for their health (Cockerham et al. 1997), and enhanced use of alternative forms of health care (McQuaide 2005). Pescosolido and Rubin (2000) linked postmodern conditions to the deinstitutionalization of the mentally ill in the United States.

The theory reached its highest level of popularity in sociology during the early 1990s and momentarily seemed poised to have an important future in medical
sociology. But this did not occur. Use of the theory abruptly declined in the late 1990s and a strong foothold in medical sociology was never achieved (Cockerham 2007c). Why? Postmodern theory turned out to have a number of shortfalls, including its failure to explain social conditions after the rupture with modernity is complete, the lack of an adequate theory of agency, being too abstract and ambiguous, not providing clear conceptualizations, an inability to account for social causation, not having empirical confirmation, and invariably featuring an obtuse jargon that only its dedicated adherents found meaningful and others came to regard as nonsense (Best and Kellner 1991; Cockerham 2007c; Pescosolido and Rubin 2000; Ritzer 2008). While its demise for medical sociology has been announced (Cockerham 2007c; Williams 1999), it is still popular in some circles although its influence has waned considerably in recent years and become less important. The advantage of postmodern theory is that modern society is undergoing a transition, with social conditions different from the recent past (the latter part of the twentieth century), and the perspective provides a theoretical framework, despite its diffuse literature, for examining some of these changes.

**Pierre Bourdieu**

Once ranked as the leading intellectual in France, Bourdieu (1984) focused 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. 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, 2000, 2005, 2007b) follows Bourdieu’s theoretical framework in his theory of health lifestyles and in identifying negative health lifestyles as the primary social determinant of ongoing downturn in life expectancy in Russia. The group most responsible for reduced longevity are 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 (Cockerham 2005).

Critical realism

Critical realism is a relatively new theoretical perspective that emerged in Great Britain and is based on the work of philosopher Roy Bhaskar (1994, 1998) and sociologist Margaret Archer (1995, 2000, 2003; 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. Among the few studies in medical sociology employing critical realism to date are examinations of the body from the standpoint of chronic illness and disability, which focus on the interrelationship of biological and social factors in shaping outcomes
CONCLUSION

The notion that medical sociology is atheoretical is wrong. 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 almost 60 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 dispute, became points of theoretical contention in medical sociology as well. During the latter part of the twentieth century, structural theories like structural functionalism were largely abandoned in favor of agency-oriented theories like symbolic interaction, labeling theory, and the agency side of social constructionism. However, improved statistical techniques to measure the effects of structure – such as hierarchical linear modeling – forecast a paradigm shift back to greater considerations of structure and structural approaches to theory (Cockerham 2007a). Although it is too early to determine the ultimate direction of theory in medical sociology this century with exact precision, these improved statistical procedures should provide a more comprehensive approach to research with theory guiding and adjusting to this capability. Already the theoretical basis for work in the field is extensive and its potential explanatory power is likely to increase. Medical sociology has become a theoretical subdiscipline.

References


