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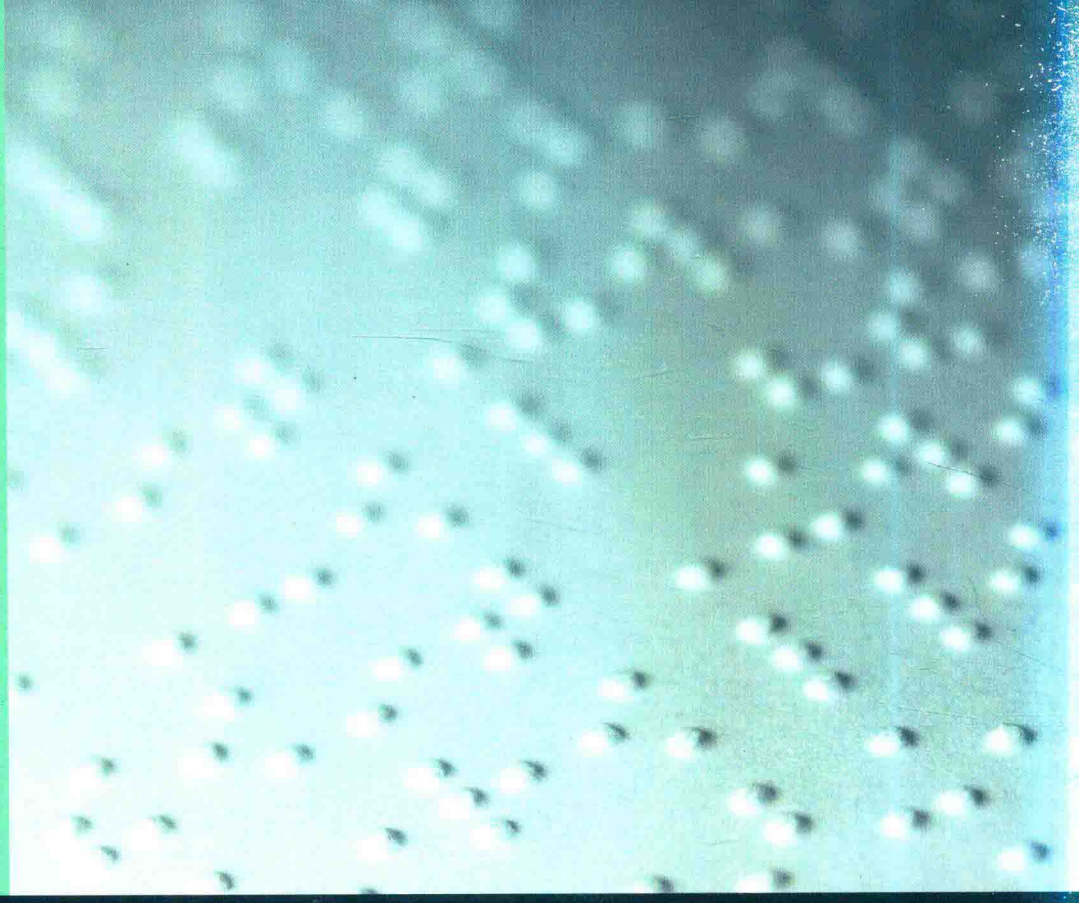

SECOND EDITION

Key Concepts in Medical Sociology

JONATHAN GABE AND LEE F. MONAGHAN

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Edited by

JONATHAN GABE AND LEE F. MONAGHAN

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introduction[1]

The first edition of *Key Concepts in Medical Sociology*, published in 2004, was a huge success. The text proved popular among students of sociology and cognate subjects, as well as those undertaking professional training in health-related disciplines. For instance, students of medicine and nursing are increasingly being exposed to sociological insights into the relationships between social structures and health inequalities, stigma, the social aspects of bodies or embodiment, death and chronic illness. Hence, as with our own teaching of under- and postgraduate students in the social sciences and future clinicians, we have found it useful to include the first edition of this text as a key reference on our class reading lists.

Nine years have passed since that first edition was published, and, as might be anticipated amidst broader social transformations, the domains of health and illness continue to represent rapidly moving objects for and subjects of sociological analysis. Health issues demand ongoing consideration amidst increasing complexity and controversy, or at least people's growing awareness that health, illness and care cannot be taken for granted. McDonnell et al. (2009), for example, flag such concerns in relation to the internet and heightened sensitivity to medical risk (iatrogenesis), citing controversies surrounding the putative safety of vaccinations for children. We could, of course, add to this, drawing from health inequalities literature which elucidates the impact of neoliberal globalization as Western capitalism lurches from one crisis to the next. At the current historical juncture, we certainly remain mindful of the pressing salience of sociology in understanding class divisions (in interaction with gender and ethnicity, for instance) and their relation to (growing) health inequalities in the UK and beyond. When considering people's private troubles, especially in health contexts, attention cannot veer too far from larger social structures and what C. Wright Mills (1959) termed public issues.

Other popular medical sociology texts, which this book seeks to complement, are similarly revised and updated under rapidly changing social conditions (e.g. Nettleton, 2006). Such updates are welcomed insofar as sociology is a living and breathing discipline, dealing with the stuff of our everyday shared existence and ultimate demise. In short, the sociological community must continually revisit its knowledge base. This book aims to satisfy that mandate, adding to the learning resources available to students via a collection of short, highly focused essays on particular topics. As will be seen, contributors have elaborated on, debated and critiqued ideas within what continues to be a lively, thriving, and at times controversial area of study. The ongoing theorization of concepts such as 'embodiment', 'risk' and 'social class' clearly demonstrates that medical sociology is in good health, so to speak, and as relevant as ever in the new millennium. New concepts are also included in this edition, such as 'eHealth', as contributors explore phenomena that

[1]This is a revised and updated version of the introduction from the first edition of *Key Concepts in Medical Sociology*, edited by Jonathan Gabe, Mike Bury and Mary Ann Elston.

have hitherto escaped sustained sociological scrutiny. As environments, technologies, debates and other social concerns emerge, evolve and morph, sociologists' interests also develop while remaining connected with, and indebted to, an established canon of key concepts, research and theory.

The aim behind the 'key concepts' approach is to provide readers with systematic, easily accessible information about the building blocks of medical sociology. Our priority has been to present those key concepts (loosely defined here to include substantive issues) that have preoccupied medical sociologists and shaped the field as it exists today. For each one of these concepts, contributors have presented an entry that covers its origin or the background to the issue, an account of its subsequent development and, where relevant, an assessment of its significance to the field. In order to orientate readers, each entry is preceded by a working definition. These were not always easy to write because some of the concepts remain contested within the literature. Each entry then elaborates on the definition, identifying controversies, variations in use and, if relevant, more recent developments in the literature. The entries thus go beyond the inevitable oversimplification of a dictionary, or the passing references that many concepts receive in textbooks. By following cross-references, a picture of the relationship between different concepts can be built up. The short list of references given at the end of each entry provides suggestions for further reading. Our hope is that this book helps guide readers through some of the complexities of the field, encouraging further study and equipping them with the knowledge to understand health and illness, whether as a sociology student, a health care professional in training, or an already experienced practitioner.

Before we describe the contents of the book in more detail, we present a short account of the recent development of medical sociology, highlighting its dual orientation towards sociology and health care. We hope that this will help the reader to understand the context in which the field and its key concepts have been shaped.

MEDICAL SOCIOLOGY AND ITS DEVELOPMENT

When thinking sociologically it is possible to relate to health and illness in at least two different ways (Bury, 1997). On the one hand, a sociological perspective can be applied to the experience and social distribution of health (disorders) and to the institutions through which care and cures are provided. In this sense, medical sociology can have an applied orientation to understanding and improving health, and can also be seen as one among many disciplines that might appropriately be studied by health care providers. On the other hand, the sociological study of health, illness and institutions of health care can stand alongside analysis of other significant social experiences and institutions, as a means of understanding the society under study. Thus, medical sociology is also a theoretically orientated field, committed to explaining large-scale social transformations and their implications, as well as interactions in everyday settings that bear upon health. These two aspects of medical sociology have, in a well-worn phrase, been characterized as sociology *in* medicine and sociology *of* medicine (Straus, 1957). This double-edged

character is, in our view, one of the reasons why medical sociology is such an exciting, challenging and rewarding field to work in.

The attractions and challenges of medical sociology have a history. In the mid-twentieth century, medical sociology was a scarcely known subfield of the then controversial but expanding discipline of sociology. Those calling themselves medical sociologists were few and far between. Moreover, they were usually working on applied projects related to public health and social aspects of medicine, often located in medical schools. These sociologists were continuing a long, diverse tradition of research into the relationship between social factors and health in Europe and North America (Bloom, 2000). However, as academic departments of sociology grew in the 1960s, and developed a strongly theoretical orientation, the study of health and illness was sometimes regarded with disdain as being 'an applied activity ... lacking in theoretical substance' (Bird et al., 2000: 1). Yet today, medical sociology is the largest specialist professional study group within both British and North American sociology, and thrives in many other parts of the world, notably Australia, New Zealand and the Nordic countries. Sometimes it will be found under alternative designations, such as the 'sociology of health and illness', with the term 'medical' being regarded by some as evoking too strong an association with one particular health care profession and with pathology rather than health. But whatever the terminology (and in this volume we have chosen to retain the older title), courses which examine sociological aspects of health, disease and health care are now almost ubiquitous offerings within undergraduate sociology programmes, as marked by the number of textbooks (e.g. Barry and Yuill, 2008; Bradby, 2009) and readers (e.g. Albrecht et al., 2003; Bird et al., 2010) that are available.

As a result medical sociology can no longer be regarded as an isolated and applied specialism within its parent discipline. In recent years there has been an increasing rapprochement between long-standing analytical concerns of medical sociology and new issues in sociological theory, most notably in the growing theoretical interest in embodiment (e.g. Turner, 2008), emotions (e.g. Bendelow, 2009) and risk (e.g. Gabe, 1995; Monaghan, 2001). Indeed, we are reminded of Turner's (1992) contention that medical sociology, with its attention to corporeal matters, has the potential to become the 'leading edge of contemporary sociological theory' (p. 163). And it is this concern with sociological theory, or formal conceptual matters, which serves as a central defining characteristic of medical sociology. Cockerham (2007: 291) writes: 'what makes medical sociology most distinct in relation to other disciplines – like public health and health services research – is its use of sociological theory'. At the same time, medical sociologists have been increasingly working across the boundaries with other sociological or interdisciplinary fields, for example, criminology (Timmermans and Gabe, 2003) and social studies of science and technology (Faulkner, 2009).

Another growing area of medical sociology research, which travels across disciplinary borderlands, is the study of health care organization and health policy. The accessibility and quality of health care are significant issues for citizens of any country and, at least in relatively affluent nations, health care (public and/or

private) is a major component of the domestic economy and one of the largest employers. Moreover, almost all economically developed and many less developed countries have experienced major reforms to their health care systems since the 1970s. Sociological analysis of these changes and their significance has brought new vigour to the academic study of health policy (Gabe and Calnan, 2009).

Medical sociology has thus now established a secure and prominent place in the social science academe, but not at the expense of its applied institutional roots. In the 1960s and early 1970s, although medical sociologists were mainly to be found in medical schools, their position there was generally a marginal one. In this new millennium, the place of social science is far more central in radically revised medical curricula. Sociology textbooks for medical students and other health professionals are now well established and regularly updated (e.g. Scambler, 2008). And, with the increasing incorporation of professional education for nurses and professions allied to medicine within universities, there has been a burgeoning of medical sociology courses for a wider range of health care students. The same holds for qualified professionals, for example through the distance learning programmes of institutions such as the Open University in the UK (similarly, for the USA, see Bloom, 2000).

Today, then, medical sociology is studied by a wide range of students, with some intent on pursuing a career in one of the health professions, and others, at the opposite end of the spectrum, with strong theoretical interests in the constitution of society. One of the impetuses behind this book was our concern that all such students should have the opportunity to learn about the building blocks of their chosen subject.

EDITORIAL DECISIONS

When editing this text we decided to keep its original structure, as described further below, while either seeking updates or deleting previous entries. We also commissioned and (co-)authored new material. This edition contains new entries on, for instance, 'health professional migration', 'bioethics', 'eHealth', 'emotions', 'awareness contexts' and 'trust in medicine'. To inform our editorial decisions we not only drew on our pre-existing knowledge of medical sociology, we also surveyed leading journals (for example, *Sociology of Health & Illness* and *Social Science & Medicine*) and sought the views of colleagues who are established experts in this field. We asked each contributor to the first edition whether they thought an update of their original entry was needed and, if so, whether they were in a position to undertake that task. Sometimes entries were written afresh by new contributors. If necessary, we updated entries ourselves, either in collaboration with or with the prior agreement of their original authors. For instance, we revised concepts such as 'the sick role', 'stigma' and 'illness narratives' in light of more recent literature. Throughout, each contributor was asked where possible to attend to an international and increasingly global context.

When deciding to retain and update concepts, a key criterion was the continuing discussion about each concept within the broader community of medical sociologists.

Often, concepts were retained if there was also scope for their further development and application. For example, while 'medicalization' was well defined and explained in the first edition, we have retained and updated it here given, among other things, writings on biomedicalization. The latter concept has been defined as 'the increasingly complex, multisited, multidirectional processes of medicalization, both extended and reconstituted through the new social forms of highly technoscientific biomedicine' (Clarke et al., 2003: 161). 'Illness behaviour' has also been retained from the first edition, though it has now been combined with a discussion on 'health-related behaviour' as part of a critical reflection on these concepts within and beyond medical sociology.

As noted above, we also excised some entries. In part, this was a pragmatic decision given the exigencies of space and our wish to include some new material. Excisions were nonetheless informed by several considerations, including the need to make the text more internationally relevant. Some new entries have effectively replaced old ones and have been included in order to capture particular issues and processes in a politicized global context. Thus, we decided the previous entry on 'health and development' should be replaced by an entry on 'neoliberal globalization and health inequalities'. And, while some entries have been deleted, relevant discussion is often subsumed under particular concepts that are becoming increasingly visible in health debates and policy; for example, 'social support' has been replaced with a critical entry on 'social capital'. Some entries from the first edition have also been combined and condensed, with this text featuring entries on 'ageing and the lifecourse' and 'medical autonomy, dominance and decline' (thereby effectively replacing four entries with two).

Selecting our key concepts has involved some difficult decisions about what to omit. Other medical sociologists' final list might have looked different, but, we believe, only a little. Most of our colleagues would agree, we think, that the topics we have chosen are ones that have significantly shaped the discipline and/or are of obvious contemporary importance, even if we have not been able to include all possible candidates for this accolade. In line with our commitment to giving the reader a sense of how medical sociology has developed, we have emphasized classic concepts rather than opt only for those of obvious current (and possibly ephemeral) interest. Talking only in terms of 'concepts' is less than ideal, but in selecting topics we have recognized that, in addition to the key concepts that have been regularly used in medical sociological analysis, there are recurrent substantive issues or particular approaches which cannot easily be captured by single concepts.

STRUCTURE AND CONTENTS OF THE BOOK

Entries are organized under five pre-defined themes: (1) the social patterning of health; (2) the experience of health and illness; (3) health, knowledge and practice; (4) health work and the division of labour; and (5) health care organization and policy. These themes cover a substantial proportion of medical sociological

research and scholarship. There is, of course, some overlap between them, as reflected in the cross-references made between entries. We will outline each of these themes below.

Part 1 focuses on the social patterning of health and includes entries on health inequalities and the social causation of (ill) health. Entries set out the ways in which social divisions, such as 'social class', are associated with various measures of health status, and discuss the ways in which such concepts have been operationalized. The study of inequalities in relation to occupational 'social class' has been particularly prominent in the UK, for instance. However, as the other entries in this section show, the distribution of life chances and health within and between nations are also structured by 'age', 'gender', 'ethnicity', 'place of residence' and 'neoliberal globalization'. Furthermore, these entries illustrate how research deploying these concepts has developed through collaborating with other disciplines, such as epidemiology. At the same time, understanding how this social patterning of health comes about requires moving beyond statistical correlations. Hence, entries in Part 1 include conceptual approaches that have been used to study the causes of health inequalities. One of the striking aspects of this section is how clearly the different approaches can be related to classic sociological debates. The relative role in health causation of ideas and values compared to material factors in shaping social change and individual behaviour, and the significance of social integration for health, are concerns that would be recognizable to sociology's founding European triumvirate: namely Karl Marx, Max Weber and Emile Durkheim.

The themes taken up in Part 2 derive more directly from North American traditions of sociology, in the form of functionalism and symbolic interactionism, with the conception of illness as a form of deviance linking the two. Sociological studies of the experience and meanings of illness and people's interactions with health professionals have, indubitably, generated concepts that have had a profound impact on both sociology as a discipline and the delivery of care. Arguably, the concepts of 'stigma', 'chronic illness' and 'quality of life' have become so taken-for-granted in discussions of health care that their origins in particular concerns and the ways in which their use may have changed can be overlooked. Few sociology students go back, for example, to Parsons' (1951) original formulation of 'the sick role' and, as a result, often fail to appreciate fully either the context in which Parsons wrote or that this concept was a depiction of normative expectations and not actual behaviours. Other contributions to this section cover concepts that have risen to prominence more recently, such as 'illness narratives', 'embodiment', 'risk' and 'emotions'. In developing and using these concepts, medical sociology has sought to move beyond one-dimensional accounts of illness as deviance to link up with more general concerns with self-identity and cultural meaning that characterize late modern societies. The experience of illness can therefore be seen to reflect and contribute to the shaping of contemporary cultures. The emphasis on personal narratives has expressed this central motif, both for sociology and the wider society.

Part 3 focuses on knowledge of and practice about health. Here the entries begin by discussing what has, at times, been regarded as not so much a useful analytical concept, but more an object to be attacked: 'the medical model'. Underpinning this model is scientific knowledge about the working of the human body and the next two entries examine recurrent concerns within medical sociology: the social shaping of this scientific knowledge and its relationship with lay people's knowledge and understanding of health and illness. In health care, scientific knowledge and technologies are combined to create forms of practice in which professionals and lay people interact. In recent years, there has been growing sociological interest in how this interaction is shaped, particularly in relation to innovative technologies such as those increasingly involved in the management of 'reproduction' and in genetic medicine or 'geneticization'. New entries on 'eHealth' and 'bioethics' are also included here. Finally, reflecting the influence of the French social thinker, Michel Foucault, on medical sociology, another growing area of practice is examined – that which is concerned with monitoring and promoting population health. Discussion in this area focuses on the tension between promoting the welfare of patients and the role of health care – especially health promotion – in effecting surveillance and disciplinary power over lay people's behaviour. At the same time, modern health care is a highly developed set of social processes, involving many different forms of activity, and is provided by many actors, from highly trained professionals to self-care. This complex division of labour is, therefore, the focus of Part 4.

Until relatively recently, medical sociology was preoccupied with doctors, as members of an archetypal, autonomous profession of a particular occupational form and as the dominant occupational group in health care provision. The first two entries in Part 4 cover such issues. However, in recent decades, sociological research on health care providers has developed beyond the study of doctors. This has evolved in three main ways. First, there has been a certain, albeit limited, increase in research on other health care occupations such as nursing and midwifery. Second, particularly since the mid-1980s, sociologists' interest in the rise of medical power and authority has been superseded by a consideration of their putative decline. One possible indication of this is the apparent growth in resorting to non-orthodox medicine, which has revived sociological interest in the concept of 'medical pluralism' (subsumed in this text under an entry on 'complementary and alternative medicine'). Third, there has been a shift in emphasis away from specific occupations towards the division of labour itself and the character of health care work, wherever it is undertaken. Alongside micro-sociological studies of inter-professional interactions and boundary work, feminism has had an important influence on medical sociology research in this area since the 1970s. On the one hand, it has led to recognition of the value of 'emotional labour' as a relevant concept when studying health care as a form of people-processing. On the other hand, it has resulted in a wider conception of the location of health and the division of labour, including 'informal care' which takes place in the home. We would add, as with the entry on 'health professional migration', that such labour needs to be examined with a close eye on global power relations. Hence, sociological attention should focus not only

on relations between health workers and their recipients of care but also on relations between higher and lower income nations, with care delivered in the former often leaving deficits in the latter.

The final section, Part 5, considers some of the key concepts and issues that have shaped medical sociological research on health care organization and policy. As might be inferred from the above discussion, such studies can be focused on different levels: the macro, societal level; the meso level of the formal organizational structure; and the micro interactional level. A concern with these different yet interconnected levels is reflected in our choice of topics, ranging from the hospital and what unfolds therein to the political economy of medicine and the legal systems surrounding health care. The key concepts and issues reviewed here fall into three main, albeit overlapping, categories. First are the theoretical concepts used to analyse the major shifts that are currently occurring in health care across much of the relatively affluent world, such as 'privatization', 'managerialism', 'consumerism', and the reconfiguration of 'citizenship' in relation to health care entitlement. Second, there are sociological concepts that have been deployed in the analysis of how some issues become health policy concerns, as exemplified in relation to 'social movements'. Finally, there are concepts relating to institutional processes and organizations that are increasingly prominent in contemporary health care, such as 'medicines regulation', 'evaluation' and 'malpractice'. These latter concepts feed back into the discussion of the possible decline of an autonomous and all-powerful medical profession.

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