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The Changing Face of Medical Sociology

David Wainwright

- Modern medicine has brought dramatic improvements in life expectancy and the treatment of disease.
- Despite these achievements medicine is increasingly viewed with suspicion and ambivalence.
- Medical sociology not only provides an analysis of medical discourse; its promotion of social models of health and illness have influenced the development of policy and practice.
- Three social models of health and illness are introduced and critiqued, concluding with an account of critical realism.

Medicine is an enormous achievement, but what it will achieve practically for humanity, and what those who hold the power will allow it to do, remain open questions. Roy Porter, *The Greatest Benefit to Mankind* 1997

The new discourse of health

The last century brought dramatic improvements in virtually all major objective indicators of health status, at least in the developed world. Many infectious diseases have been controlled, infant mortality has fallen dramatically and life expectancy continues to increase. The so called scourges of modernity, coronary heart disease and cancer, are slowly retreating in the face of high-technology medicine. Science has ameliorated many of the more troublesome problems and constraints of the human body; reproductive technologies have radically extended control over fertility; transplant surgery has enabled damaged organs to be replaced; joint replacements have made the elderly mobile again; even the outward appearance of the body can be surgically manipulated and enhanced.

Yet despite these achievements there is a widespread belief that 'bio-medicine' is a double-edged sword. Rather than celebrating the benefits of modern medicine, many fear its potency, preferring 'natural' or 'complementary' remedies.¹ Rather

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than focusing on how rapidly medical science can be progressed and implemented, public debate is often concerned with subordinating technological innovation to legal and ethical regulation.² Scandals have erupted over the retention of human organs for research, and anti-vivisectionists have succeeded in placing the interests of animals ahead of those of humans.³ New developments from stem cell technology, to gene therapy, to therapeutic cloning are presented as potential threats to be reined in and governed by the *precautionary principle*, which insists that safety must be proven before implementation – a demand which is arguably impossible to meet.⁴

Ambivalence about bio-medical science has been matched by a diminution of trust in health care providers, policy makers and other ‘vested interests’.⁵ The authority of the medical profession has been undermined by high-profile cases of professional incompetence or criminality. Clinical expertise and professional self-regulation are constantly eroded by a pluralistic approach to medical knowledge and the imposition of a managerial structure of control. Corporate interests, such as private healthcare providers and particularly the pharmaceutical companies are viewed with unalloyed suspicion. Neither the free market nor social planning are seen as legitimate means of advancing healthcare policy.⁶

The retreat from medical science has been matched by the promotion of a putative social model of health and illness, based on two key observations: first that health status is shaped by social factors, for example, morbidity and mortality are patterned by social class, gender and ethnic group, and second, that health has a subjective as well as an objective dimension, that is, it is about how we feel and choose to act as well as the presence of physical pathology. Both of these observations are valid, but their translation into health policy and medical practice has brought adverse consequences.

Most notably, the emergence of the social model has radically expanded the domain of therapeutic intervention. Expenditure on health care may still be dominated by hospital services, but the thrust of health policy is much more towards the regulation of behaviour and the management of subjectivity. The New Public Health movement has shifted the clinical gaze from treatment of the sick to regulation of the well. What we eat, drink and smoke, who we sleep with, how we relate to family members and friends, and the demands of working life, have all become subjects of professional advice in the pursuit of that elusive endpoint: ‘wellbeing’.

The regulation of healthy bodies has been matched by a rapid expansion of psychotherapeutic intervention. Most of the Victorian asylums have been closed and their inmates decarcerated, but the reintegration of the mentally ill has been accompanied by a blurring of the boundary between sanity and madness. New psychiatric and psychological categories have emerged, such as Attention Deficit Hyperactivity Disorder, Seasonal Affective Disorder, Post-traumatic Stress Disorder, and a host of new addictions, to pathologise what were previously thought of as aspects of everyday emotional life. The severely mentally ill may have to wait to access scarce psychiatric resources, but a burgeoning army of arguably under-qualified and loosely regulated psychotherapists is available to minister to the anxious and the glum.⁷

Taken together the New Public Health and the rise of psychotherapy have led to a significant transformation of the relationship between the individual and the state. Aspects of everyday life which were previously sacrosanct have been opened up to therapeutic scrutiny and regulation. This colonisation of the lifeworld has given momentum to a new sense of personhood which emphasises vulnerability and dependence. Health scares which emphasise the physical or emotional threat

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posed by mundane aspects of everyday life, such as, sunbathing, using a mobile phone, work stress, vaccination, and so on are commonly reported in the media. Paradoxically, as health has improved, stoicism and resilience have declined. Physical and mental health are increasingly viewed as fragile states which need to be defended against a growing list of social and environmental threats.

The above trends and changes constitute a fundamental shift in our experiences of health and illness and constitute the emergence of a *new discourse of health*. The history of medical sociology parallels this transformation.⁸ From the high water mark of clinical science in the post-war period, to the psycho-social model that informs much health policy today, medical sociologists have not been passive observers, simply documenting changes as they unfold, but have played a significant role in interpreting, and in some instances precipitating, change. Broader social, cultural and political forces have driven these changes, but medical sociology has often provided the crucible in which these changes are made sense of; formulating the language and analytical framework through which policy makers, professional elites and pressure groups have articulated them. Thus, many of the themes to be found in contemporary public debates about health have their origins in earlier sociological discourse; the social model of health now shared by many medical practitioners and policy makers has its origins in sociological accounts of the social causation of illness, and the critique of medical power to be found in many official reports damning clinical autonomy and calling for greater regulation of the medical profession can be traced back to the medicalisation thesis of the 1970s.^{9,10,11,12}

The aim of this book is to explore these transformations by examining a series of key issues in the contemporary experience of health and illness from a sociological perspective. Our approach is not to see medical sociology as detached from its subject matter, but to pick up on an earlier debate within the sub-discipline,^{13,14,15} which recognises that medical sociology has played an active role in shaping that which it also reflects upon. A sociology of time would not begin by taking the back off a clock, but by observing the movements of the hands around the clock face and studying the social consequences of time-keeping. Likewise we begin our account of medical sociology not by 'taking the back off' to reveal its conceptual and methodological components, but by observing the changing face of medical sociology and its consequences for how society collectively makes sense of the experiences of health and illness.

The emergence of medical sociology

Writing the intellectual history of medical sociology presents several problems. The sub-discipline has drawn on perspectives and theories from mainstream sociology, including functionalism, symbolic interactionism, Marxism, feminism and post-modernism. Different paradigms have had more or less prominence at different points in time, for instance, Parsonian functionalism in the 1950s, interactionism in the 1960s, Marxism and feminism in the 1970s and post-modernism in the 1980s. However, although this crude chronology grasps something of the changes that have occurred in medical sociology, it needs to be treated with circumspection.

First, the rise and fall of the different paradigms does not reflect a linear process of scientific progress from error and ignorance to truth and knowledge, for instance,

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the apparent decline in the study of the political economy of health from the late 1970s and the growing interest in the epistemology of medical knowledge from the early 1980s, cannot be explained exclusively in terms of the inadequacies of the former or the veracity of the latter. Second, mapping paradigms onto specific periods of time implies a degree of homogeneity and consensus which is hard to find in reality. Not all medical sociologists writing in the 1950s were doctrinaire Parsonian functionalists; likewise the concepts and theories of feminism have influenced medical sociology across its history, not just in the 1970s. The influence of different perspectives varies not just across time, but also between countries, sociology departments and individual writers. Third, the researchers who have contributed to medical sociology are increasingly difficult to pigeon-hole in terms of the perspective that informs their work. Not only are they often drawn from disciplines outside sociology, but few define themselves exclusively as Marxists, feminists, interactionists or post-modernists. The influence of different intellectual traditions can still be observed, but they are often invoked and synthesised pragmatically according to the research question that is being addressed. This 'mix-and-match' approach is particularly apparent in empirical research, for example, proponents of 'mixed methods' often combine qualitative and quantitative methods of data collection, despite the difficulty of reconciling the epistemological assumptions of naturalistic and positivist methodologies.¹⁶

Finally, while medical sociology is a product of intellectual currents and methodologies drawn from mainstream sociology and applied empirically to the study of health and illness, their significance is only apparent behind the walls of the academy, in seminar rooms and lecture theatres, publications and conference proceedings. The face that medical sociology presents to the world and, more importantly, the influence that it has had on the way in which society makes sense of and comes to understand experiences of health and illness, is not mediated through the categories and constructions of different strands of social theory, but through engagement with a much broader discourse of health, specifically through the articulation of social models of health and illness.

Social models of health and illness

The bio-medical model of disease with its emphasis on physical pathology and biological reductionism has been criticised for neglecting the social influences on health and illness. While bio-medicine has advanced over the last century, a range of other disciplines including sociology, psychology, epidemiology and economics has explored these social influences on health, providing not just a critique of the limits of bio-medicine, but a different way of understanding and addressing health and illness. This *social model of health* is often presented as a single unified theory; however, the range of assumptions and perspectives included under this broad umbrella is so diverse that it is more accurate to refer to several social models. No taxonomy is likely to capture all of these differences, here we have aggregated them into three broad groupings which can be identified in the literature and which have had a significant impact on the broader discourse of health: the social determinants of health; unhealthy lifestyles; and the social construction of health and illness. It should be noted that there is inconsistency and disagreement within these groupings as well as between them.

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The social determinants of health

This perspective has been adopted by epidemiologists and others working in the field of social medicine. Of the social models this is closest to the bio-medical model in that it is traditionally concerned with physical pathology, but seeks to extend notions of aetiology or disease causation, beyond the identification of a pathogenic agent, such as a virus, to include social and economic factors, such as poverty, homelessness and air pollution. This approach has a long history, charting the influences of urbanisation and industrialisation on the nation's health from the beginning of the industrial revolution.¹⁷ Central to the approach is the claim that material deprivation plays a fundamental role in the causation of disease, as the poor are denied many of the goods and services required for health and are more likely to be exposed to environmental hazards, such as damp housing or occupational injuries.

The social determinants of health model is supported by a substantial body of empirical evidence which reveals a strong social gradient for most diseases, with the poorer classes experiencing higher rates of disease than their more affluent peers.¹⁸ From this perspective social development, particularly reducing poverty, poor housing and environmental pollution, play a more important role in improving the nation's health than that played by curative medicine.¹⁹ This claim has not gone uncontested.²⁰

If evidence is required for the claim that an adequate supply of food and clean water, shelter from the elements, clean air and protection from hazardous substances and machinery in the workplace, make a significant contribution to health, then the contemporary experience of many people living in the third world will provide it. But what about societies in the developed world which have succeeded in providing these basic requirements for health; has rising affluence and the welfare state succeeded in overcoming the social determinants of disease? Evidence suggests that above a certain level of social development an *epidemiological transition* occurs in which the traditional diseases of poverty, particularly infectious diseases and malnutrition, are replaced by the diseases of affluence, such as cancers and heart disease.²¹ Despite these changes, social variations in health status persist, so where does this leave the social determinants of health model?

The epidemiological transition has prompted a conceptual shift in the social determinants of health literature. While some continue to pursue the materialist approach of linking health inequalities to the direct effects of deprivation or exposure to hazards, this perspective has been largely supplanted by a second strand which argues that the psychological consequences of social inequality now play a more important role than material deprivation in the causation of disease. The Whitehall studies^{22,23} explored the health status of different grades of British civil servants over time and found that the junior grades experienced significantly greater ill health, especially heart disease, than their more senior colleagues. Although the grades varied in seniority, none suffered the material deprivation experienced by the poor, the implication being that the variations in health must be caused by the different psychological characteristics of the work done by different grades of staff. The second Whitehall study explored this possibility and found that junior staff reported higher job demands, lower job control and less social support at work than their senior colleagues.²⁴ Controversially, it was argued that exposure to these job characteristics caused psychological stress, which in turn triggered physiological changes which led to higher rates of disease. New disciplines, such as psychoneuroimmunology

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and ecocardiology have emerged to study the link between psychological stressors and disease, and more significantly, using international comparative data, Wilkinson has argued that beyond a certain level of economic development rich countries with wide economic inequalities have poorer average health than more equitable societies that have less wealth, because of the adverse health effects of psychological distress caused by social inequality.²⁵

The claim that psychological distress can cause physiological changes in the body which in turn cause diseases such as heart disease, reduced immune function, or even some cancers, marks a fundamental shift in the social determinants of health model, which as we shall see in Chapter 4, has influenced the broader discourse of health. Introducing psycho-social stressors into the pathway between social conditions and physical pathology has revitalised the social determinants model and broadened its explanatory range in developed societies. However, its claims have not gone uncontested. The fundamental problem is that the social determinants model overlooks the subjective nature of psychological distress. While polluted water supplies or insufficient nutrition have an objective effect on the body irrespective of what the individual makes of their circumstances, this is not the case with psycho-social stressors which must be subjectively recognised and appraised as a threat in order to have an effect on the body.²⁶

The problem becomes apparent in the social determinants of health literature on work-related stress. There are two dominant theoretical models in this approach to work stress or job strain: Karasek and Theorell's Demands-Control-Support model,²⁷ and Siegrist's Effort-Reward Imbalance Model.²⁸ Both models assume that work stress and the illness behaviour produced by it are an unmediated response to objective conditions in the workplace. For Karasek and Theorell the key factors are high job demands, low job control, and lack of support from other employees, and for Siegrist a disparity between the amount of effort invested in work and the rewards that are received is the trigger for the stress response. Missing from both models is any attempt to explain how people's attitudes and beliefs about what constitutes a heavy workload, or what is a reasonable reward for work, shape their response to their working conditions, or, how these attitudes and beliefs are shaped by personal experiences and changing cultural norms. This deficiency in the social determinants model leaves its proponents struggling to explain variations in the response to objectively similar working conditions between individuals and over time. Why do some people thrive in jobs which others find unbearably stressful, and why was work stress unheard of before the 1960s despite the physically and psychologically harsh working conditions that prevailed in the nineteenth and early twentieth centuries?

Unhealthy lifestyles perspective

Where the social determinants model underplays personal volition in the genesis of illness behaviour the unhealthy lifestyles perspective focuses on individual choices. Social variations in morbidity and mortality are recognised, but they are explained in terms of 'lifestyle choices', for example, the higher prevalence of smoking, alcohol consumption, dietary fat, and lack of exercise among manual working class is seen as the primary cause of their higher rates of cancers and heart disease.²⁹

The claim that lifestyle choices could have an impact on health and illness received much of its impetus from the groundbreaking research into the association

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between tobacco smoking and lung cancer by Austin Bradford Hill and his colleagues in the early 1950s.³⁰ The link between smoking and cancer was only confirmed after years of meticulous and highly rigorous research, yet the profound consequences of this research for the prevention of disease provoked the scientific equivalent of a goldrush as epidemiologists raced to find other Pathogenic LIFESTYLE Factors, often with far less caution and rigour than that employed in the search for a link between smoking and cancer.

A key moment came in 1981 with the publication of Richard Doll's *The Causes of Cancer*.³¹ Doll had worked with Bradford Hill in the 1950s and, with his colleague Peto, added much to our understanding of the link between tobacco and cancer. As an internationally renowned cancer epidemiologist, Doll's claim that (excluding those caused by smoking) 70 per cent of cancers are caused by diet, carried considerable weight with policy makers, particularly as costly high-technology cancer treatments were making little headway against the disease. The notion that the pain, suffering and medical costs caused by cancer could be largely avoided simply by changing what we eat was compelling, but not without its critics.

Doll's argument in *The Causes of Cancer* is supported by a wealth of references and statistical evidence, but as Le Fanu³² has pointed out, the basic methodology is a simple one. Essentially, his argument is based on comparison of specific cancer rates obtained from the Connecticut Cancer Registry, with the lowest recorded rates for those cancers elsewhere in the world, for example, Doll found 60 cases of pancreatic cancer per million head of population in Connecticut, compared with a mere 21 per million in India; a difference which Doll ascribes to the western diet which is heavy in high fat meat and dairy produce. Le Fanu points out that while diet may explain these variations, the evidence supporting this hypothesis is not nearly as compelling as that for the link between tobacco and lung cancer; there are conceptual difficulties, including the strong evidence that cancers are caused by ageing, and examples which contradict the dietary hypothesis:

The Mormons and Seventh-Day Adventists are identical in virtually every way: they lead sober lives, don't smoke or drink and go to church on Sundays. The only difference is that the Mormons eat meat and the Seventh-Day Adventists on the whole are vegetarians. If the 'high fat diet' explanation for cancer was valid, the meat eating Mormons must *by definition* have a higher incidence of these cancers than the Seventh-Day Adventists. But they do not.³³

Others have also pointed to the lack of scientific rigour in much of the epidemiological research on the relationship between lifestyle factors and disease, for instance, Skrabanek and McCormick³⁴ have argued that statistical associations between putative risk factors and health outcomes are frequently presented as cause-and-effect relationships even though these apparent associations could be caused by the effects of other factors which have not been controlled (confounding variables), or could even be produced by chance (Type 1 error). This and other criticisms made by Skrabanek and others are explored in greater depth in Chapter 2.

Despite a well-developed critique of the 'junk science' behind many of the claims made for the role of environmental and 'lifestyle factors' in the causation of disease, the epidemiological 'goldrush' continued to gain momentum, generating an ever increasing tide of 'health scares' about the potential threat to health and wellbeing posed by agents or substances encountered in everyday life, including: coffee rinking, hair dye, the use of phthalates in plastics, pesticide residues in fruit and

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vegetables, sunbathing, the MMR vaccine, formula baby food, mobile phones, oral contraceptive pills – the list continues to grow.³⁵ Such ‘discoveries’ make good news copy and are frequently reported in the media in highly sensationalised terms with scant regard paid to the scientific rigour of the research.

The unhealthy lifestyles perspective has also been criticised for *victim blaming*, because it implies that unhealthy lifestyle choices stem from irresponsibility or moral fecklessness and overlooks the extent to which choices are constrained by structural and cultural factors.³⁶ Not surprisingly, many in the social determinants of health camp have set out to debunk the unhealthy lifestyles perspective, by demonstrating the ways in which the choices of people living in poverty are constrained, for instance it has been argued that social security benefits are insufficient to support healthy eating.³⁷

Another strand of the victim-blaming critique looks at cultural and psychological factors, for example suggesting that tobacco smoking and alcohol consumption are deeply embedded in working-class culture and that their use may be determined by peer-group pressure and the behavioural norms of the sub-culture.³⁸ Gender has also been presented as a determinant of lifestyle choices. The life expectancy of men is shorter than that of women, and it has been argued that men’s higher mortality results from a culture of masculinity that values risky behaviour, including tobacco smoking and heavy drinking, and which discourages the uptake of health services and other health maintenance strategies.³⁹

At the heart of this debate is an old tension between notions of free will and determinism. The unhealthy lifestyles perspective may (in early iterations) have overlooked socio-cultural influences, but it did at least credit the individual with a high degree of free will or agency, rather than viewing him as a pawn whose choices are pre-destined. The criticism that the unhealthy lifestyles approach is victim blaming is often founded on a far less optimistic assessment of human subjectivity. People’s capacity to appraise the health risks of activities like smoking, weigh the likely costs and benefits, and *freely* choose how to live their lives, is often down-played in favour of a diminished sense of subjectivity in which individuals can never resist the influence of social determinants like peer-group pressure or stress. The assumption is that the individual cannot transcend his milieu and consciously choose a course of action which contradicts the script dictated by his social position.

The criticism that the unhealthy lifestyles perspective was victim blaming, emphasised the extent to which the approach initially overlooked structural and cultural influences on behaviour in favour of moral exhortation and stigma; however, the influence of this criticism has not been to shift attention away from the individual and towards tackling the social determinants of lifestyle choices, rather it has resulted in an approach which remains essentially individualistic but which emphasises the individual’s diminished capacity to resist the external influences on behaviour. Where earlier strands of the unhealthy lifestyles approach assigned a significant role to personal choice and the individual’s ability to assimilate evidence about the risks posed by unhealthy lifestyle choices, more recent approaches to the promotion of healthy lifestyles assume a diminished role for subjectivity, for example, the reluctance of some social groups to heed the evidence relating to the health risks of tobacco smoking, is increasingly explained in terms of the potency of the addiction and the individual’s inability to resist social and cultural incentives to continue smoking.⁴⁰ As we shall see later, this has led to the development of a therapeutic approach to the promotion of healthy lifestyles which goes beyond the provision of health warnings to offer interventions which aim to bolster the individual’s capacity to make

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the 'right' choice, for instance through the provision of nicotine patches to reduce the potency of physical addiction, or psychotherapeutic interventions to boost self-esteem or self-advocacy.

The unhealthy lifestyles perspective has also been applied to work-related stress. When work stress first began to emerge as an issue it was often applied to senior white-collar workers who, it was argued, were suffering from 'Executive Stress'. The assumption was that in vigorously pursuing career advancement by working long hours at the office and taking on a heavy workload and onerous responsibilities, such individuals were making themselves vulnerable to stress, burn-out and health problems such as ulcers and heart attacks. Popular culture in the 1970s contained several examples of former executives who had turned their backs on the 'rat race' in order to lead the 'good life'.

The implication is that choosing to work hard can be just as unhealthy a lifestyle choice as smoking or eating a high-fat diet. This theme is still apparent in debates about work/life balance which suggest that individuals need to adopt a healthy distribution of time and effort between the home and the workplace. This argument is often directed towards women who pursue a career but also want to have children or, in the language of popular culture, 'women who want it all'. It is often implied that such women are not only risking their own health and wellbeing, but also that of their children who are placed in nursery schools and childcare.

As with other examples from the unhealthy lifestyles perspective the claim that work stress is a consequence of personal choice is open to the accusation of victim blaming. Not everyone has the luxury of choosing how to divide their time between home and work, nor the freedom to determine their own workload. Again, the response of the unhealthy lifestyles perspective to such criticism has been to adopt a therapeutic approach to the stressed individual, for example through the provision of stress avoidance or relaxation techniques. Again, this stems from a diminished view of subjectivity; the belief that people lack the capacity to manage their own mental life without the support of professional intervention.

The unhealthy lifestyles approach represents an advance on the social determinants of health perspective because it recognises the role of subjectivity and individual choice in mediating the relationship between structural and cultural factors and illness behaviour. However, the way in which this process of mediation is conceptualised is simplistic and implies that unhealthy lifestyle choices either stem from lack of information about the risks associated with a particular activity or behaviour, or from a personal cognitive deficiency, which stops the individual from choosing a healthy lifestyle even when they recognise it as such. While the unhealthy lifestyles approach recognises that how we behave in the world is shaped by how we understand it and the choices we make that stem from this understanding, what it fails to grasp is the extent to which this understanding is not purely an individual affair but a product of social interaction and negotiation. This becomes apparent when we consider the third and final social model of health and illness.

The social construction of health and illness

Social constructionism is a way of conceptualising the way in which knowledge or *discourse* is produced and the effects that knowledge has on behaviour. The approach is based on the assumption that there is a gap between objective reality, how the world 'really is', and the ways in which that reality is represented in

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human consciousness. We are able to observe the real world through our senses, but the ways in which we label, understand and explain what we see are not simply a mirror image of reality but also the products of human interpretation, imagination and creativity.

Soldiers returning from war, for instance, may exhibit symptoms and behaviours which today might be labelled as 'Post-traumatic Stress Disorder' and, having received this psychiatric diagnosis, they might be provided with a range of therapeutic services, excused from combat and perhaps given financial compensation. However, this way of labelling, understanding and responding to the emotional and behavioural problems of soldiers is not a unique or unmediated representation of objective reality, but a historically and culturally specific way of understanding and making sense of the phenomenon. In their account of military psychiatry in the twentieth century, Jones and Wessely⁴¹ explore the different ways in which the same symptoms have been labelled and understood. During the Boer War soldiers whose emotional state rendered them unable to fight were diagnosed with 'Disordered Action of the Heart', a generation later in the First World War the same symptoms were labelled as 'Shell Shock'. During the Second World War, air crew who had lost the will to fight were diagnosed as suffering from 'Lack of Moral Fibre', not surprisingly many were reluctant to have their exhaustion and fatigue stigmatised in this way, although the phrase is perhaps preferable to the earlier 'Lack of Intestinal Fortitude'.

The shifting lexicon of military psychiatry represents much more than the application of new names to old problems. It is not just the label that changes, but the understanding and explanation of the symptoms, for example the labels discussed earlier variously locate the origins of mental distress in the heart, the gut or the psyche. These different ways of understanding the phenomenon have implications for the self-identity of the individual so labelled and for the ways in which others respond to them. A modern soldier suffering from Post-traumatic Stress Disorder will feel differently about himself and be treated differently to a World War II airman suffering from a Lack of Moral Fibre, yet both might be exhibiting the same symptoms and behaviour. Indeed, during the First World War many soldiers were executed because their mental distress was defined as cowardice.

The ways in which we make sense of phenomena, the words we use to label them, and the theories we develop to understand them, have fundamental consequences for the self-identity of the individual who experiences the phenomenon and also for the ways in which others respond. This approach was taken up in the 1960s by labelling theorists who explored the way in which 'normality' and 'deviance' were defined and enforced through the imposition of socially constructed labels. The key insight of labelling theory is that deviance is not seen as inherent in the behaviour of an individual, but dependent upon the imposition of a label by powerful others; as Howard Becker famously put it, 'deviant behaviour is behaviour that people so label'.⁴² The value of this insight for medical sociology is immediately apparent; it raises the possibility that the diagnostic categories and labels applied by the medical profession to their patients may be largely independent of physical pathology. Robin Scott in *The Making of Blind Men* explored the way in which visually impaired, but partially sighted, people were encouraged to relinquish their efforts to use their remaining vision and take on the role and self-identity of complete blindness, through the process of diagnosis and labelling. He notes that 'the overwhelming majority of people who are classified as blind according to this definition [i.e. the Snellen measure] can in fact see'.⁴³

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Labelling theory raises the political question of which social groups have the power to impose a label and make it stick. In a classic social experiment Rosenhan⁴⁴ sent a group of volunteers to seek entry to 12 mental institutions in the United States. All of the volunteers reported a single symptom consistent with a diagnosis of schizophrenia: claiming to have heard voices in their head saying 'thud' or 'empty'. All of the volunteers were diagnosed as schizophrenic and admitted to hospital. Despite the fact that none of the volunteers were mentally ill and did not exhibit further symptoms, they were kept in hospital for up to 52 days. While many of their fellow patients detected their sanity, the psychiatric staff did not change their initial diagnosis and interpreted the volunteers' behaviour, for example the writing of field notes, as further evidence of mental pathology.

Rosenhan's study reveals the way in which expert knowledge, in this case psychiatry, is implicated in the labelling process, by providing an interpretation and a set of expectations which can be imposed on the individual, often against their best interests. For social constructionists, this insight applies beyond psychiatry, to a much broader discourse of medical knowledge, for example, in the early 1970s Ann Oakley⁴⁵ challenged the way in which childbirth was increasingly constructed as a medical procedure, dominated by high technology wielded by doctors, and in which the expectant mother played a largely subordinate if not passive role. Interestingly, Oakley's work gave impetus to the natural childbirth movement, whose promotion of home births, minimal pain relief, and breast feeding, is arguably just as disempowering as the medicalised model it seeks to challenge.

Social constructionists share a common belief in the gap between objective reality and the phenomenal forms or discourses through which reality is represented in human consciousness. Where they differ is in the extent to which they believe that this gap can be bridged by the scientific method. Among sociologists who apply social constructionism to the study of health and illness there is a divide between those who retain a *realist* orientation, which starts from the assumption that there is an objective reality which can be known by humanity even if this knowledge is vulnerable to distortion by social and cultural influences, and those who embrace *relativism*, in which science-based knowledge cannot be viewed as any truer than that derived from other belief systems, such as, Catholicism or homeopathy.

In the late twentieth century, epistemological relativism had a profound influence on British medical sociology, from those who were keen to elevate the lay perspective on health and illness

medical theories and lay theories are, from a sociological point of view, of equal interest and status. Magic, religion, politics, science, sociology, can all be seen as folk systems for understanding the world. They can all be taken equally seriously.⁴⁶

to those intent on diminishing the status of bio-medical science:

A body analysed for humours contains humours; a body analysed for organs and tissues is constituted by organs and tissues; a body analysed for psychosocial functioning is a psychosocial object.⁴⁷

The notion that no belief system or discourse could claim to offer a truer account of reality than any other has practical implications, according to those who advocate *medical pluralism*. If bio-medical science has no epistemological primacy then why should its practitioners have a privileged position in the diagnosis and treatment of

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illness; why should the oncologist be preferred to the acupuncturist; why should the general practitioner's diagnosis be accepted more readily than the patient's account?

From this perspective, the production of medical knowledge or discourse is simply a means of justifying the exercise of power and the truth or falsity of that knowledge becomes an irrelevant issue. The claim that scientific knowledge is essentially concerned with the exercise of power rather than the pursuit of truth is central to the work of Michel Foucault:

the problem does not consist in drawing the line between that in a discourse which falls under the category of scientificity or truth, and that which comes under some other category, but in seeing historically how effects of truth are produced within discourses which in themselves are neither true nor false.⁴⁸

For Foucault, discourse is much more than a body of knowledge, it also includes institutions, practices and technologies, thus the discourse of psychiatry not only includes a set of beliefs and ideas about the functioning of the mind, but also the therapeutic regimes and other apparatus used in the governance of the mentally ill. Foucault's project was a historical one, to reveal how different discursive formations emerged over time, and their implication in the exercise of power; an approach which he applied to criminality, madness, sexuality and, in *The Birth of the Clinic*,⁴⁹ to medicine. Central to Foucault's argument is the claim that the 'clinical gaze', as it emerged in the hospitals of nineteenth-century France, did not simply *reveal* an objective physiological reality which had previously lain undiscovered, but that it simply *created* a new way of making sense of the body based on the techniques of surveillance and observation, but also bound up in the exercise of power. Of course, many others before and after Foucault have explored how social knowledge is used to serve the interests of the powerful. Marx's account of ideology claims that in any historical period the dominant ideas will be those of the ruling class.⁵⁰ However, there are key differences between the approach adopted by Foucault and his followers and others who have adopted a critical perspective on social knowledge.

First, where others see ideology as a distortion of objective knowledge, which can be penetrated to reveal an authentic and essential truth, for Foucault there can be no escape from discourse. Replacing one set of beliefs with another does not represent progress in the journey towards an objective account of reality and, to the extent that emancipation can be achieved, it lies in rejecting the authority of truth claims rather than in revealing their falsehood, for example while the discourse of psychiatry may be implicated in the social control of deviance, liberation lies not in replacing existing psychiatry with a discourse which more adequately grasps the reality of madness but in questioning the distinction between madness and reason and psychiatry's right to police the putative boundary between the two.

A second difference lies in Foucault's emphasis on the micro-relations of power. Rather than seeing power residing in institutions, such as the state, or in a dominant class, race or gender, Foucault sees power as something which cannot be accumulated but only exercised in specific situations, such as the doctor-patient relationship. Moreover, power is not exercised as repression but as a productive force, for example in *The History of Sexuality*⁵¹ Foucault overturns the traditional view that the Victorian period was characterised by sexual repression, by pointing to an explosion of discourse on sexuality, producing new subjects, such as the masturbating child

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and the hysterical woman. It is this process by which discourse is internalised by the individual as a means of making sense of his own subjectivity, that Foucault aims to reveal, particularly in his later writings. It is not just the case that discourse legitimates the coercive actions which others exercise over the individual, but the extent to which discourse provides *technologies of the self*,⁵² ways of reflecting on and understanding our sense of selfhood. Thus, for Foucault there is no pre-social self existing outside of discourse. While we may subjectively experience a sense of scepticism about different knowledge claims and critique or challenge them, the apparatus we use for this critique, be it rationalism, Marxism or psychoanalysis is itself socially constructed – while we have the illusion of being an independent critical thinker, we have only used one form of discourse to overturn another.

Not surprisingly, Foucault's bleak conclusions and those of other strong constructionists, have been challenged by critics in the realist camp. In the field of medical sociology Bury's⁵³ critique of strong social constructionism has been highly influential and has provoked considerable debate within the sub-discipline.⁵⁴ Bury's critique contains three key components. First, that social constructionism does not give sufficient weight to the lived reality of the body as it is experienced in everyday life; pain suffering and death are only too *real* for those touched by them. Second, Bury argues that strong social constructionists underestimate the demonstrable effectiveness of bio-medical interventions in preventing and curing disease. While mistakes have occasionally been made, and some of the improvements in health status that have occurred over the last century may be attributable to social development rather than clinical interventions, there remains a compelling body of evidence to show that the eradication of many infectious diseases, the amelioration of physical trauma, and many other improvements in mortality and morbidity RATES are directly attributable to the practice of modern medicine. In response constructionists have argued that this body of evidence relating to the effectiveness of bio-medicine is itself a social construction which is specific to the time and culture in which it was produced.

This leads to Bury's, third criticism, that the relativism adopted by strong social constructionists is self-refuting: if one belief system cannot be judged more valid than any other, then why should the claims of social constructionists be accepted as truthful. Nicolson and McLaughlin have responded by suggesting that social constructionists do not deny an individual's right to judge the truth or falsity of knowledge, only the claim that one belief system is truer than another. This defence has its flaws, however. When social constructionists state that their analysis debunks science's claim to grasp objective reality more adequately than other belief systems, they are surely saying that social constructionism is a more valid belief system than science. Also, just how are individuals supposed to judge the truth or falsity of knowledge if the evidence presented to support or contradict it must always be dismissed?

The relativist strand of social constructionism reached its high point in the post-modernism of the closing years of the twentieth century. More recently, a new strand of social constructionism has emerged in medical sociology, influenced by the *critical realism* of Roy Bhaskar and his followers.⁵⁵ The ability of the scientific method to produce knowledge which grasps objective reality more accurately than other belief systems is accepted, but it is also recognised that other social and cultural factors are bound up in the transition from rigorous scientific enquiry to the production of a scientific discourse.

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There is of course, room for scientific debate and contradictory interpretations of data within the parameters of scientific enquiry. Moreover, scientific evidence can be strong or weak depending on methodological rigour and the number of times that an experiment or observation has been replicated. Thus scientific knowledge is never fixed or irrefutable; there is always the possibility that new observations or better data will lead to the revision or rejection of a scientific theory. Social and cultural factors can also intervene to bias or invalidate scientific research. More broadly, the decision to apply the scientific method to one area of study rather than another is also shaped by social, economic, political and cultural factors. Most importantly, the decision of how to respond to scientific evidence is shaped by the same non-scientific factors, for example the link between tobacco smoking and lung cancer is well supported by scientific evidence, but if and how to respond to this finding, whether to ban smoking, produce information leaflets for smokers, develop nicotine patches, or develop better treatments for lung cancer, or not to respond at all, depends upon far more than scientific evidence of the likely outcome of such responses.

Critical realism, therefore, entails an engagement with the scientific content of a discourse, but also a sociological critique of the political, economic and cultural factors that determine the form taken by a particular discourse at a specific point in time. Burgess's analysis of the health scare surrounding the use of mobile phones,⁵⁶ for example, comprises a thorough evaluation of the scientific evidence concerning the health risks associated with mobile phones. Having established that the scientific evidence of a health risk is very weak, Burgess goes on to explore the sociological factors that have given rise to the ongoing discourse of risk management and precautionary measures. The value of the analysis stems not from an outright dismissal of scientific evidence, but from the attempt to disentangle that in a discourse which is rigorously scientific and that which is socially constructed.

As with Foucauldian social constructionism, critical realism is also concerned with the ways in which discourse creates subjects and gives rise to particular forms of subjectivity. Wainwright and Calnan's⁵⁷ analysis of the work-stress epidemic, for example, critically engages the scientific evidence relating to the effects of paid employment on mental health and provides a sociological critique of the social and cultural forces that have shaped the work-stress discourse, but it also examines the consequences of medicalising problems at work rather than constructing them as political or economic problems. While the discourse of work stress is presented as an objective scientific account of the psychological consequences of conditions in the workplace, the analysis reveals that the emergence of the passive work-stress victim is contingent on broader social and cultural factors, which give rise to this form of subjectivity.

Critical realism, therefore, neither takes scientific discourse at face value, nor does it dismiss its claim to grasp reality more adequately than other belief systems. Rather than overturning the scientific project, critical realism aims to complement and extend scientific rigour by revealing the social and cultural aspects of scientific discourse. The goal of this approach is to aid the development of *critical consciousness*, which synthesises the insights of scientific enquiry, with an awareness of the different ways in which scientific knowledge can be interpreted and applied to the resolution of problems and the fulfilment of human potential. Scientific discourse can never be reduced to a core of objective knowledge which is absolute and incontestable; there can be no *purely* scientific solutions to human problems and advancement, but critical realism can bring into consciousness the conjuncture between science, social and cultural distortions, and political will.

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Conclusion

This chapter began by identifying some of the paradoxes, tensions and uncertainties that characterise the contemporary experience of health and illness in western societies which, taken together, represent the emergence of a distinctly new discourse of health. Objectively, our health is improving, but subjectively we have a heightened sense of vulnerability, risk and anxiety. While rates of objectively measurable physical pathology are in decline subjective symptoms and associated forms of illness behaviour continue to rise. Many of the improvements in rates of objective health indicators stem from the application of modern scientific medicine, yet the trustworthiness of the professions, institutions and organisations responsible for developing and delivering effective healthcare is increasingly being challenged. Medical sociology exists to understand and explain these changes, but is itself embroiled in them.

Medical sociology is in a constant state of flux. There is not a linear process of development characterised by a cumulative accretion of knowledge, but a continual cycle of contestation in which different standpoints are adopted, challenged and tested against the reality of lived experience and the problems of everyday life. In this chapter we have considered three of the main strands of the social model of health and illness. While each strand has contributed substantially to our understanding of health and illness there are fundamental problems with each. They explain part of the human experience of health and illness, but leave unanswered questions relating to free will and determinism, the mind-body problem, science and discourse, individualism and collectivism, realism and interpretivism. There are no easy answers to any of these questions, and it seems unlikely that a grand unified theory lies in wait around the next conceptual corner. Even so, there is some evidence of a growing recognition of the limitations of earlier approaches and a willingness to develop new ways of thinking about health and illness that transcend these limitations. Critical realism is one such attempt, but it is important to recognise that this is not a fully extemporised theory in which all of these tensions are resolved; it remains very much a work in progress.

Discussion topics

- Why has the relationship between medical sociology and medical science often been an antagonistic one? Is this antagonism inevitable?
- Are the three social models of health compatible, complementary or antagonistic?
- What are the differences between strong social constructionism and critical realism?

Further reading

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