PROLOGUE: SOCIOLOGY, MEDICINE AND MEDICAL SOCIOLOGY

INTRODUCTION

Do all disciplines fret over the state of their own intellectual and policy-relevant health? Is it a symptom of our hyper-reflexive and confessional times that collective anxiety has to be rehearsed over the track record, and present and projected perform-ance of a group of scholars? Medical sociology's lengthy reflections on the state of its own practice are recognizable as part of a more general trend, whereby the certainties of bodies of knowledge and the limits of disciplinary boundaries have been undermined in the light of post-structuralist thought. As sociology examines the social construction of various forms of knowledge, in particular socio-cultural contexts, how could its practitioners avoid turning the analysis on itself? Sociology's particular interest in the social nature of human endeavour and the ideological bent and constructed nature of progress and achievement renders the discussion of disciplinary origins, limits and prospects particularly hard to grasp. But that's not a reason for not trying.

Medical sociology is a reflexive area of academic endeavour which has devoted a large number of words to considering its own origins, legitimacy, progress and potential. Since the contested moment of its inception, medical sociology has struggled for legitimacy on account of its ambiguous outsider status with regard to both sociology and medicine (Bloom, 2002: 25). In the process of establishing itself as a distinct area of theoretical and empirical research, medical sociology has fretted over its relationships with both medicine and sociology, regarding neither as taking its own claims to expertise sufficiently seriously. Horrobin likened medical sociology's situation between two unsympathetic existing disciplines to

sitting at the 'interstices between the citadel of medicine and the suburb of sociology' (1985: 95). Horrobin caricatures medical sociology as in the throes of an identity crisis, beset by self-doubt and failing to emulate the imperialist tendencies of sociology's territorial expansionism. The citadel and the suburb are simultaneously medical sociology's competitors, and its parents, although the precise nature of medical sociology's conception (or misconception) is disputed as part of the discussion of its place in academic and practitioner worlds. One outcome of the identity crisis was a shift away from a sociology focused on medicine and towards a broader sociology of health, illness, healing and medicine, which describes the wider remit of current work.

MEDICAL SOCIOLOGY AND ITS RELATIONSHIP WITH SOCIOLOGY

If Horrobin was correct and medical sociology has (or had) an identity crisis, perhaps it is simply following the example of its parent discipline, sociology. Writing in the late 1950s, when sociology was an even younger discipline than it is today, C. Wright Mills diagnosed a widespread uneasiness – intellectual and moral – about its direction of development (Mills, 2000 [1959]: 19). Such uneasiness was still in evidence two decades later, with Philip Abrams (1981) asking whether British sociology was in total collapse and John Urry (1981) suggesting that sociology was an essentially parasitic discipline. In seeking to characterize the discipline, Abrams pointed to an argumentative mixture of self-doubt and self-importance, while John Urry saw all innovation as originating beyond sociology's boundaries, from philosophy and cultural studies. A certain critical discontent is an inadequate disciplinary demarcation of sociology, and certainly not one that permits an assessment of medical sociology's role therein. It has been claimed that there is no essence of sociological discourse beyond a commitment to the idea of the interdependence of individuals and social groups (Urry, 1981). Horrobin states that to speak of 'sociology' is 'nonsensical reification' and the practitioners of sociology do not represent a unified view, being as they are 'riven by dissension' (1985: 96) as to what sociology might be for. The disunity or diversity of the sociological approach has been seen as a cause of its disciplinary decline, despite its 'distinguished lineage and tradition', due to its lack of relevance to policy-making (Horowitz, 1994: 3). Sociology's lack of disciplinary coherence (Collins, 1990) is interpreted by others as a virtuous willingness to get involved with the conceptual messiness that more fastidious and prestigious disciplines disown (Beck, 1999: 123).

Sociology's lack of theoretical unity applies also to medical sociology, with its equally 'eclectic character' (Riska, 2003). Again, there is little disagreement on the diversity (or disarray), only on what, if anything, should be done about it. Elianne

Riska (2003) sees sociological research into health and medical sociology as similar to any other social activity in its culturally embedded nature, and therefore the eclectic nature of the discipline is predictable as a result of sociology's development in a variety of cultural settings. Sociology is an argumentative discipline in which no single theoretical framework holds sway, instead new ones arrive to overlap with the existing array (Abrams, 1981), giving rise to a lack of unity of analytic perspective that characterizes both sociology and medical sociology (Gerhardt, 1989: xxii).

Despite sociology's characteristic diversity of approach, it is possible to outline limited features that qualify as typically sociological. C. Wright Mills described sociology as offering insight into the historical and social connections between personal troubles and larger issues in the social structure (Mills, 2000 [1959]). The systematic study of social institutions, their constituent social roles and norms and their effect on individual behaviour and practice describes sociology as a research practice. The classical statements of sociology from the founding fathers (Marx, Weber, Durkheim, Tocqueville, Comte, Simmel) describe religion, the law and labour relations as the structures which shape people's experience of society.

This commitment to refer back to the classical statements of the founding fathers and to engage with a progressive politics, which imagines a more egalitarian, more humane society is characteristic of sociology. The overt political agenda of sociological enquiry requires, to a greater or lesser extent, that the practitioner adopt a campaigning, advocacy role in combination with the position of detached, analytic scholar. As Burawoy puts it, there is a sense of the 'passion for social justice … that drew so many of us to sociology' (2005: 26). This dual thrust towards progressive reform and the development of knowledge, brings about a tension between objectivity and advocacy (Bloom, 2002: 24) that is a central part of sociology's legacy to medical sociology.

When the foundations of sociology were being laid in the nineteenth century, medicine and healthcare were not institutionalized and not yet a statutory responsibility. In considering the experience of the 'common man' in a society undergoing rapid urbanization and industrialization, the founding fathers did not recognize the well-being of individuals as a matter of academic interest. Furthermore, they did not identify how crucial a player medicine was to become, both in conveying the benefits of the scientific revolution to the populace and in developing the commercial possibilities of medical technology. Health and healthcare were not considered to be key aspects of social integration and cohesion during the time that sociology was defining its own disciplinary territory. Health and illness were not headline issues in the developing sociological purview and, furthermore, they were considered profane in comparison with the sacred matters worthy of academic study: the law, labour and religion (Gerhardt, 1989: xiii).

This lack of reference to health and medicine from the founding fathers has led medical sociology to question whether its problematic is sufficiently connected with the classical questions of sociology. Rather than berating sociology's founders for failing to foresee how the expansion of medicine's influence would develop into a statutory and commercial–scientific powerbase, medical sociologists have sought to recover the seeds of an interest in the work of Marx, Weber and Durkheim.

Turner reminds us that sociology developed in opposition to the dominance of social Darwinism, with Marx and Engels seeking to reject the survival of the fittest as an ideological distortion and bring into focus the meaning and interpretation of the social actor (Turner, 1995 [1987]: 7). The aim of asserting the active, strategic nature of members of society did not engender an interest in the sick and disabled, with their compromised ability to act, and their (perceived or enacted) passivity. For Marx and Engels, morbidity and mortality were indicators of capitalism's effects on the class as a whole rather than a way of understanding the experience of individual bodies (Gerhardt, 1989: xv). Durkheim's work on suicide is sometimes upheld as evidence of an early interest in matters of health, but of course he was primarily interested in a demonstration that sociological forms of explanation were powerful enough to explain social facts autonomously without supplementary recourse to psychology or philosophy (Turner, 1995 [1987]: 7). Suicide was taken as an example of a social fact, indicating social cohesion or its failure, rather than being an index of mental health.

The absence of medicine from the classical legacy has hampered medical sociology's sense of legitimacy with regard to the wider field of sociology. Early theoreticians' lack of interest in medicine as an institution shaping the nature and structure of society, gives medical sociology 'an aberrant character' when compared with sociology's core fields (Cockerham, 1983: 1514; see also Ruderman, 1981). The long-standing sense of medical sociology's illegitimacy within the sociological project is refuted by Uta Gerhardt's assertion that medical sociology is actually a 'legitimate offspring, if not a vital part, of … general sociology' (1989: xxix). Similarly, Bryan Turner insists that a coherent, integrated and relevant approach to medical sociology exists which 'draws on the classical legacy of sociology' (2004: ix), despite the lack of statements from the founding fathers.

The neglect of medicine in the nineteenth century means that the birth of medical sociology is usually said to have taken place in the 1950s, when the study of social expectations that defined the sick role was conceptualized and the doctor–patient relationship studied as a social system in which colliding worlds required regulation (Parsons, 1951). Parsons' work made medical sociology academically respectable, conferring 'intellectual recognition' and 'academic credence' (Cockerham, 1995: 10) because of the links that could be made back to the thinking of Durkheim and Weber. Parsons' approach has been hugely influential in defining a theoretical

medical sociology in ways that can be interpreted as negative as well as positive. Since Parsons' main interest was in deviance, his focus was on the social aspects of medical consultations, their management and performance, which, arguably, led to a subsequent neglect of the experience of being ill and the content of medical knowledge (Ruderman, 1981; Cockerham, 1983).

While Parsons' 1951 statement of the functionalist understanding of doctors and patients provoked enormous discussion within sociology and the establishment of medical sociology in the USA, subsequent contributions to the sub-discipline from structural functionalists have been rare (Scambler, 1987: 2). In the absence of their further development, Parsons' structural functionalism and systems theories gave way to labelling theory, phenomenology and ethnomethodology, which characterized the 1960s. Goffman's work, in particular, promoted interplay between sociology and medical sociology, with his 1961 analysis of total institutions in *Asylums* developing theoretical insights for those interested in institutions in general and hospitals in particular. Interactionism was criticized by the conflict theorists of the 1970s but since then, according to Cockerham (1983: 1518), no new theories have emerged to rival Parsons, Becker, Friedson and Goffman (an assessment which depends on regarding post-structural research as offering a new method rather than a new theory). Gerhardt, for instance, suggests that Foucault's ideas do not even constitute a new approach, but should rather be viewed as a form of cultural relativism which amounts to a modified version of conflict theory (Gerhardt, 1989: xxvi). Those who are more persuaded by the analytic novelty and acuity of Foucault's archaeology of knowledge in demonstrating the shifts in regimes of power, argue that sociology itself has its origins in early medical surveys. Rather than medical sociology being an applied sub-discipline of sociology, medicine is, in this view, applied sociology (Turner, 1995 [1987]: 7).

Nineteenth-century writers such as Engels and Marx did not see themselves as (only) sociologists and were, crucially, part of the reform movement that campaigned to ameliorate the conditions of the urban poor. The measurement and mapping of inequality in terms of rates of morbidity and mortality by social class, gave rise to the legacy of sociology as well as that of public health and social medicine, demography and epidemiology. This empirical work demonstrating the links between poverty, deprivation and low life expectancy that underpinned the reform movements can be claimed as medical sociology's intellectual genesis, thereby conferring an intellectual pedigree that pre-dates Parsons' work (Turner, 2004: xvi). Yet such empirical work has not always been claimed as the rightful ancestor of medical sociology: Illsley refers to 'isolated sociological contributions' to the study of health and medicine, relating them to the debate on the socio-economic condition of the working class, wherein mortality and fertility are simply indices of inequality (Illsley, 1975: 64). The rejection of the study of inequality as an

insufficiently sociological task indicates complexity as a key sociological character-istic, an issue to which we return below. A lack of research sophistication in the study of inequality may also have been relevant to medicine's failure to develop a systematic understanding of how social factors relate to morbidity and mortality from the basis of the pioneering nineteenth-century work. The rapid growth of medical bacteriology and germ theory distracted medical attention from the social environment as a causative factor in disease (Bloom, 2002: 19). Furthermore, the establishment of the NHS and the welfare state in the mid-twentieth century represented what was thought to be a lasting solution to the health problems associated with poverty that social reformers had highlighted, and may have reduced research interest in inequalities for a time.

According to one version of medical sociology's development, it is an unclaimed offspring: too theoretically impoverished for sociology and lacking in scientific or technological glamour for medicine. This version has been challenged as a 'founda-tional myth' whose primary effects are to create a canon and strategically maintain disciplinary boundaries. For Fran Collyer, the notion that, prior to Parsons, sociology was 'largely devoid of human reflection on the experience of life, death, healing, or bodily health', is an 'origin myth' aimed at securing disciplinary legitimation and enhancing the processes of professionalization (Collyer, 2010: 87). Through 'a brief reanalysis of some of the texts' of early sociologists, Collyer demonstrates that throughout the nineteenth century, while biomedicine was in the process of emerging as a dominant institution, 'sociology offered a continuous critique of the narrow and reductionist conceptions of human well-being' (2010: 92). That these interventions from the likes of Weber and Durkheim are not reflected in what Collyer calls con-ventional histories of medical sociology is attributed to 'the institutional power of medicine, and prevailing discourses of health, disease and mortality' (2010: 88–9). Collyer states that the founding fathers' interests in health and medicine have come to be widely underestimated in the recounting of sociology's early formation. This 'mis-reading of history' was due, not only to the rising dominance of biomedicine during the first half of the twentieth century, but also to 'the newly professionalizing discipline of sociology' seeking to establish its own distinct canon (Collyer, 2010: 95). So, although the 'classical founders' of sociology were actively interested in debating matters of health, disease and mortality and offered useful theoretical frameworks, Collyer suggests that:

> these early theories of health, disease and mortality were discounted and overlooked in the reframing of the sociological project after the 1920s when sociologists ceded ground to the authority of the new experimental sciences and biomedicine. This occurred as a consequence neither of a sociological consensus, nor of a political or professional conspiracy. Instead the new conceptual frameworks of biomedicine

became the lens through which sociologists, writing in the new genre of the student text, came to select appropriate 'founders' and 'classic works' for the discipline, define the 'essence' of sociology and its landscape, and offer an interpretation of the past. (Collyer, 2010: 102)

The rival myth of medical sociology's origins traces descent from social medicine, public health, epidemiology and sociology. While medical sociology is a largely post-Second World War phenomenon in the USA, its origins in France, Germany and Britain can be traced back to the late eighteenth-century study of social aspects of disease under the auspices of social medicine and public health (Scambler, 1987: 1). The extent to which the institutions of biomedicine and the experimental sciences have shaped sociology and medical sociology have, according to Collyer (2010), been underestimated. Her reading suggests that sociologists involved in establishing the discipline in the mid-twentieth century were:

forced to accept the newly reformulated conceptions of health and disease, and reorder their knowledge base to avoid conflict and inter-disciplinary rivalry. One of the previously unacknowledged consequences of efforts to side-step this potential conflict was the separation of theories of health, disease and mortality from the mainstream of sociology, and the emergence of distinct origin myths for each subfield. (Collyer, 2010: 102)

Whatever the combination of historical and developmental factors that account for its divergence from sociology, some commentators see medical sociology as increasingly accepted by sociology (Turner, 1995 [1987]: 8), to the extent of having established itself as an independent specialism. In this view, medical sociology has developed from being something of a pariah in orthodox sociology to having achieved a separate, distinct status, cemented by contributing substantially to the development of mainstream sociological theory and methodology (Illsley, 1975: 67). However, the fact that such assertions have been repeated periodically for the last several decades, indicates an uncertainty in their veracity.

In 1978, the state of medical sociology as a sub-discipline was described as 'one of great activity, but little theoretical or methodological unity' (Stacey and Homans, 1978: 281). Yet for Cockerham, echoing Illsley, it has been medical sociology's increasing tendency to use sociological theory to promote the explanatory power of empirical findings that has amplified its connections with general sociology (2001: 4–5). This claim is taken further by Turner's confident assertion that medical sociology is at the leading edge in contemporary social theory (Turner, 1992). Perhaps a more common view is that sociology continues to treat medical sociology with some suspicion due to its close collaboration with the institution of medicine

as sponsor and gatekeeper. This suspicion has been articulated in accusations of medical sociology being atheoretical and 'merely' applied.

THEORY AND APPLICATION

The accusation of the 'theoryless empiricism' stems from the assumption that much medical sociological research comments on public policy which has been formulated by the same agency that sponsors the research (Cockerham, 1983: 1514). The theoretical inadequacy of medical sociology, as judged by social theorists, potentially indicates that its collaboration with medicine has been insufficiently critically independent. Medical sociology has been described as failing to contribute to general sociological theory in any significant manner (Johnson, 1975) and British medical sociologists' attempts to theorize the discipline have been deemed at least partially motivated by a desire to 'enhance the faltering theoretical reputation of the applied subfield among mainstream sociologists' (Wegar, 1992: 964). There are echoes here of British sociology's perceived failure to contribute adequately to the nineteenth- and twentieth-century development of the discipline as compared with American, German and French thinkers, and related debates about British sociology's intellectual adequacy (Renwick, 2012).

A comparative analysis of the main sociology and medical sociology journals has shown that the theoretical interests of published medical sociologists are more limited than their sociologist peers, and that this is more marked in British than American journals (Seale, 2008: 692). The best-known medical sociology theorists have been largely American-based, including Parsons, Goffman and Straus. The precipitate post-war establishment of the NHS perhaps meant that UK social scientists became quickly involved with research into the practicalities of a national organization that moved from laudable aspiration to policy to actuality. The enormous popular support that the NHS has from the British populace has perhaps also constrained the range of theoretical questions about models of healthcare delivery that can be asked or that can be researched.

The question of whether medical sociology is sufficiently theoretical is not a dispute that can be resolved, since the answer depends on the relative evaluation of theoretical and empirical work. For some, the (alleged) applied, empirical character of medical sociology is no bad thing. Cockerham (1983) states that medical sociology is primarily an applied subject, dependent on medicine, and that cooperation with medicine is desirable, as long as the sociological perspective and objectivity is unimpaired, since sociology's contributions have to have some basis in the reality of medical practice if they are to be accurate and relevant. This, of course, assumes that medical sociology's prime objective is to comment on and improve health services,

rather than to develop theoretical models of medical aspects of the social world. Bloom (2002) hopes to retain a dual thrust at the heart of medical sociology, towards both progressive reform and the development of knowledge, thereby keeping 'a tension between objectivity and advocacy' (2002: 24). The dual thrust is evident in Straus' much cited division between a sociology in medicine, which researches problems on medicine's terms, and a sociology of medicine that interrogates medicine as a sociological problem (Straus, 1957). Freidson (1970) sees medical care as a key focus for medical sociology with the study of the coming together of knowledge, staff and patients in 'concrete settings' as crucial to evaluating medicine's social worth. For Freidson, the 'special position of the medical man is … justified by his effective performance of practical ameliorative tasks rather than by his contribution to abstract knowledge', and therefore the study of the practical work undertaken in hospital settings is a crucial task for medical sociologists to evaluate the prospects for future improvements (1970: 32–3).

SOCIOLOGY AND MEDICINE

How close is the relationship between medicine and the sociological study of medicine and how close should this relationship be? Is medical sociology's relationship with medicine sufficiently critical?

A sociology of medicine clearly has to have a close relationship with medicine and no medical sociologist, however critical, wishes to see an absolute divorce from medicine, but the recommended nature of collaboration varies. Freidson (1983: 219) suggests that we should be standing right outside medicine looking in, to give a critical, dispassionate analysis, whereas Straus (1957) recommends a chameleon-like insertion into medical settings. The problem with the chameleon-sociologist is that she or he might take on medical values which should, more properly, be under critical scrutiny. The presumption that all medical work is good since it relieves human suffering is one that sociologists have been accused of accepting uncritically, leading them to avoid critical analyses that might undermine the assumption that medicine works in the best interests of humanity (Cockerham, 1983). Furthermore, medical sociologists may bask in reflected glory, identifying strongly with the medical mission and justifying sociological work in the same terms. Gill and Twaddle suggest that this danger is exacerbated by the number of assumptions that sociology shares with medicine, such as a positivist approach that looks for technological solutions, an exclusive focus on the European experience, and a conviction that medicine is beneficial and to some degree 'sacred', the most noble of professions (1977: 382). Particularly in the US context, medicine has used some of its power to sponsor and develop medical

sociology (Cockerham, 2001: 4), which fuels suspicion of a lack of critical distance. Perhaps the blinding of sociologists to the more problematic aspects of medicine was hard to avoid during the golden age of medical advance through the 1940s and 1950s, but now that biomedicine is wrestling with the complexity of multiple causation (Turner, 2004: xxvi), the long-term social costs of medical work should stand in stark contrast to the benefits.

Medical sociology is accused of suspending its critical judgement due to the need to gain access to data and the desire to be accepted as a relevant health-related discipline (Gill and Twaddle, 1977: 382). Suspending a commitment to a sociological perspective results in sociologists treating 'medical categories as unproblematic, rather than as historico-social constructions meriting analysis in their own right' (Scambler, 1987: 3). Critical suspension can be exacerbated by a tendency to be employed by the very institutions that have commissioned the research (Cockerham, 1983: 1514). A sociologist of medicine working in close collaboration with medics, potentially experiences 'role strain' and, with a worsening fiscal context for the health services, medical sociology's tendency to apply sociological insight to medically defined questions becomes more pronounced (Morgan et al., 1985) as funds for more theoretical work evaporate. Scambler (1987) sees the close collaboration of sociology with medicine as damaging, not only in terms of the questions that sociology can ask, but also in the development of sociology's analytic purchase. He points to the dominant epistemological approach of science, termed 'systematic empiricism', as hindering the development of sociological insight into relationships between social structure, processes and health (Scambler, 1987: 4). Others have described how the biomedical establishment has symbolically expropriated medical sociology, not for its specific research findings, but 'for the concepts and generalizations which help them define and express their agenda' (Wegar, 1992: 964). This tendency to incorporate sociological perspectives into the medical project has sometimes enhanced biomedicine's public image without necessarily enhancing medicine's social responsibility in the long term (Wegar, 1992).

Medical sociology, particularly in the UK, has perhaps paid a price for enjoying the close patronage of medicine in terms of a degradation of the quality of research that the discipline pursues. While medical sociology's post-war expansion to become the largest sub-discipline of sociology owes much to its close relationship with medicine, excoriating critiques of medical imperialism have, nonetheless, developed at the same time (Scambler, 1987: 2). Cockerham states that, compared with the situation in the 1970s, sociology no longer depends on physicians for its practice, having 'evolved into a mature, objective and independent field of study and work' (1995: xi) and that it has 'removed itself from a subordinate position to medicine' (Cockerham, 2001: 4). By the 1970s, Illsley (1975: 66) was announcing that sociologists have access to medical settings and can formulate their own

research problems without pressure to service the interests of medicine. The shift away from a medical focus was reflected in the disciplinary nomenclature which took hold from the 1980s, referring to a sociology of (some combination of) health, illness, disease, healing and medicine, rather than simply medical sociology.

US medical sociology has been seen as better insulated from and therefore more independent of medicine, compared with Britain, because US sociology became established as an independent academic field earlier (Cockerham, 1983: 1520; Bloom, 2002: 42). In this view, medical sociology starts out being in the service of medicine, but then evolves an increasingly autonomous practice allowing a more equal collaboration. This evolutionary process is portrayed as more highly developed in the USA than in the UK, to the extent that American medical sociology has achieved a state of independence allowing it to investigate applied health situations on socio-logical terms (Cockerham, 1983: 1519). But British sociologists have nonetheless claimed a maturity of their discipline with research 'no longer dependent on the goodwill of a few innovative physicians' (Illsley, 1975: 67). Concluding a survey of influential papers published in a key journal, sociological independence from medicine is confirmed by David Armstrong:

> Despite its affinity with (and often subservience to) the dominant medical empire, the sociology of health and illness has succeeded in establishing its own roots with its own agenda that is amply demonstrated by a quarter century of publications in *Sociology of Health and Illness*. (Armstrong, 2003: 72–3)

While the sociological study of health and medicine is well established in terms of academic publications and taught courses, a testy relationship between medicine and sociology, characterized as a 'struggle for legitimacy' (Bloom, 2002: 25), persists. While Bloom considers this struggle to derive from the overlap between medicine and sociology, particularly around public health, preventative medicine and psychiatry, others see the similar concerns of sociology and medicine as offering grounds for a rapproche-ment (Nettleton, 1995). Socio-demographic shifts in the disease burden from acute to chronic and increasing life expectancy, with a concomitant change in emphasis from curing to caring and towards preventative medicine with a focus on lifestyle factors, increasingly delivered in community settings, have made routine medical practice more sociological, according to Nettleton (1995: 11). Shifts in the style, content and location of the practice of medicine are, in part, due to medicine's response to sociological critiques and challenges such that, for instance, patients' views and their socio-economic context are increasingly being considered in the process of healthcare provision (Nettleton, 1995: 12). Medicine needs a sociological approach to ensure the ongoing relevance of its practice in an evolving social world. Given the enormous preoccupa-tion with empirical results which characterizes the medical approach to illness, the

distinctive sociological attention to identity and 'the inter-relationship between the individual and the broader society – their interactions, their mutual constitutiveness', together with a 'conceptual invention and creativity', is salutary (Armstrong, 2003: 72). A sociological medical practice is one which Turner considers would be holistic, progressive and humanistic (1995 [1987]: 10), thereby, presumably, avoiding the problems that his criticism identifies elsewhere. Sociology is in a position to recognize the important contribution medicine makes to our lives while remaining alert to the negatives in the political and the moral domain (Turner, 2004: xv).

The differences between sociology and medicine are, of course, as important as the common interests in defining the relationship between the two. Gerhardt reminds us of the distinct nature of medicine and sociology as practices with different virtues and vices: 'Clinical work is practice and therefore case-bound and situationally specific, whereas sociology is an analytic science and a reflection on societal matters of which medicine may make use' (Gerhardt, 1989: 351). While some aspects of medicine are indeed clinically based and conceptualize disease as a matter of individual bodies invaded by germs and disorder, sociology's view of disease as a social fact has allowed it to ask questions about social action and the character of social order (Turner, 1995 [1987]: 17). But approaches that see disease as a social fact are not confined to sociology, being shared by public health, general practice and a plethora of other disciplines. The multiplicity of disciplines investigating social and cultural aspects of health, illness and medicine raises further questions about sociology's role.

INTERDISCIPLINARITY AND MULTIDISCIPLINARITY

Sociology is not alone in considering the social and cultural dimensions of health and illness, indeed the field is becoming positively overcrowded. The large number of disciplines, sub-disciplines and inter-disciplines, including cultural studies, sociology, the sociology of health and illness, medical anthropology, the history of medicine, and discourse analysis, have, according to Deborah Lupton merged 'in the wake of the poststructuralist and postmodernist movements' (2003: 3). Since sociologies, anthropologies, histories and cultural studies of medicine, health and illness share both 'intellectual tradition and trajectory' based on similar 'trends and developments in social theory', there is very little to distinguish them from one another, according to Lupton (2003: 6). This view could be character-ized as typical of a cultural studies approach, missing, as it does, the distinctive and systematic approach to power, the relations between individual and state, between biography and history, which sociologists feel to be their distinctive contribution. Moreover, since the history of academia could be characterized by the arbitrary

setting of boundaries 'separating each discipline from the others' (Kaplan, 2007: 99), the post-structuralist claim that disciplinary boundaries no longer exist is no more than a post-modernist inversion of this long-standing disciplinary policing, whereby a group of scholars claims territorial rights to comment, in this case on the lack of territorial boundaries. The balkanization of disciplinary politics has drawn comment from sociologists of health and illness, usually as part of an appeal for a more interdisciplinary approach to study.

Support for the emergence of an interdisciplinary model that gets beyond the balkanized boundaries in sociological studies of health and illness has been linked with the desire to avoid 'disciplinary dogmatism' (Macintyre, 1996: 901). Calls to translate research findings across disciplinary boundaries, thereby facilitating administrative and professional action in response to research (Clair et al., 2007), are related to an aspiration to methodological diversity and international reach. Such developments are often presented as having the potential to reinforce the existence of a coherent sub-discipline, an approach that is 'truly sociological' (Blaxter, 2000: 1140), although Macintyre's plea to avoid disciplinary dogmatism may acknowledge that greater interdisciplinary could imply the disappearance of sociology. Within the crowded field of health sciences, sociological approaches are presented as offering a breadth of method and approach that other disciplines need (Clair et al., 2007: 250).

> Sociology can be at the center of an integrative network of a broad range of practitioners rather than somewhere toward the bottom of a scientific hierarchical structure, where our ideas are seen as intellectually lacking in real, relevant and relational ways. (Clair et al., 2007: 257)

The rationale for sociology becoming the lynchpin discipline within studies of health and illness is unclear from Clair and colleagues' account. For a sense of the centrality of sociology as a distinct discipline within the broader social sciences, we could refer to Michael Buroway's assertion that the 'social sciences are not a melting pot of disciplines' (2005: 24). He nominates civil society, and hence the sociology which depends upon it, as 'the best possible terrain for the defense of humanity – a defense that would be aided by the cultivation of a critically disposed public sociology' (Burawoy, 2005: 25).

Thus, for Burawoy, sociology amounts to an active defence of humanitarian values, the absence of which lead to 'Stalin's Soviet Union, Hitler's Germany, Pinochet's Chile' (Burawoy, 2005: 24). Sociology is defined by its study of a variety of topics 'from the standpoint of civil society' (Burawoy, 2005: 24) that draws on 'a century of extensive research, elaborate theories, practical interventions, and critical thinking, multiple understandings, reaching across common boundaries, not least but not only across national boundaries, and in so doing shedding insularities of old' (Burawoy,

2005: 25). Burawoy offers sociology as a disciplinary site where humanitarian values are established and hence defended but suggests that, in doing this, we need to cut across national boundaries and become less insular. Insularity is perhaps an inevitable outcome of defending a boundary and Clive Seale sees it as attendant upon British sociologists' focus on the production and refinement of social theory leading to a 'somewhat introverted sociology' (Seale, 2008: 692). Medical sociology has a certain parochialism in its relative lack of interest in the social relations of health beyond the Anglophone world.

Burawoy's call to public sociology seeks to galvanize sociologists around a progressive social project and asserts sociology's distinctive and particular character. In the more applied field of the sociology of health and illness, the diversity encompassed by sociological approaches can be seen as an advantage, since interesting advances often play out on the interdisciplinary boundaries.

> Indeed, much of the exciting work in recent decades in relation to health is that which is at the interface of sociology and/or social geography, health economics, health psychology, social epidemiology, health policy and, of course, anthropology. The boundaries between the disciplines are blurred but nevertheless the interactive effect of disciplinary engagement can give rise to novel ways of producing, 'seeing' and interpreting data. (Nettleton, 2007: 2411–12)

Sociology's close association with medicine has perhaps led to its borrowing medicine's mission statement and a sense of the righteousness of the medical endeavour for sociological research. And the righteousness of that mission perhaps chimes in with Burowoy's sense that sociology constitutes a defence of humanitarian values in the face of medicine's untamed excesses. Medical sociology, as a close observer of medicine's own dispersal and the balkanization of its subsidiary parts, knows that a lack of unity in practice, theory or method has not impeded medicine's disciplinary professional progress.

The contested nature of health sociology's interdisciplinarity pertains to how medical sociology, sociology and medicine relate to one another and to the broader project of a sociology of health, medicine and society. Excessive attention to our own boundaries potentially reinforces an introverted academic insularity, but can also be seen as part of the critical project of our research. The challenge of avoiding disciplinary and geographic introversion, to make our research internationally relevant offers progressive possibilities, but also perhaps the end of a sociology of health and illness as a recognizable organizational entity in universities and research programmes. Perhaps it goes without saying that the possibilities of progressive social change that the sociology of health and medicine offers in examining systems of power and subjectivity in a globalized world are more important than the disciplinary allegiances of the researchers.

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