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SOCIAL THEORY AND THE SOCIOLOGY OF HEALTH AND MEDICINE

INTRODUCTION

Given the broad and eclectic nature of the sociology of health and medicine, any account needs to attend to the substantive research topics as well as the theoretical frameworks that have underpinned or justified the approach to research. As noted in the Prologue, theoretical frameworks derived from sociology (an inherently fragmented discipline [Johnson et al., 1984]) predominate in the sociology of health and medicine. Furthermore, the problem-solving orientation and hybrid disciplinary nature of much research relevant to medical sociology, with its strong empirical tradition, means that a theoretical position is not always explicitly described in published research. Researchers have often taken a very pragmatic approach to theory, picking elements that serve specific purposes. Despite its sometimes implicit and frequently fragmentary nature, social theory is nonetheless a key attribute of the sociology of health and medicine, and seen as distinguishing it from other social science approaches. This chapter sketches out the theoretical developments of the discipline from functionalism to realism, via interactionism, while subsequent chapters concentrate on substantive findings around particular research problems as outlined in Chapter 1.

PARSONS AND FUNCTIONALISM

The obvious place to start a survey of medical sociology is, of course, the beginning. And yet, as indicated in the Prologue, the beginnings of medical sociology are contested and there is dispute as to who were the key figures. Do we start with the mid-nineteenth-century reformers who recognized the statistical link between social position and rates of morbidity and mortality? Do we follow Foucault's suggestion and tie the origins of sociology to those of modern medicine and the emergence of anatomical, sociological and demographic bodies as objects of interest? Whether or not he is regarded as the founding father, there's no denying the significance of Talcott Parsons' work for the subsequent development of medical sociology as a body of research recognized by other disciplines. Parsons offered medical sociology an 'academic respectability by providing its inaugural theoretical orientation' in the shape of structural functionalism, calling attention to its potential as an area of sociological inquiry (Cockerham, 2007: 293). Parsons recognized the doctor–patient relationship as a social system built upon Emile Durkheim's interest in the societal norms, structures and processes which were beyond individuals and whose effect is social cohesion. Durkheim (1858–1917) viewed the fundamental social problem to be the limitlessness of human desires in the face of finite resources. He envisaged the resolution of this problem through the imposition of a framework of expectation that permits only attainable aspirations. When the framework fails to limit people's desires in line with the means to respond to them, Durkheim (1952 [1897]) termed the resultant discontented normlessness 'anomie'.

Talcott Parsons (1902–1979), influenced by Emile Durkheim, Max Weber and others, was interested in the maintenance of value consensus and its translation into a stable social order. Like Durkheim, the role of people's internalized self-control in maintaining a functional social order, was of particular interest. Parsons was committed to grand theory to unify a social scientific understanding of society's working under a single framework, which has come to be known as structural functionalism. Parsons' interests were wide ranging, taking in education, race relations and psychoanalysis, and his high-profile academic career as a faculty member of Harvard University, meant that his work attracted critical comment in his own lifetime, some of which he responded to.

Like Durkheim's explanations of suicide in terms of social facts, Parsons sought to analyse individual behaviour in the context of large-scale social systems and the link between the two was 'pattern variables' which structure any system of inter-action. His interest in ill health was in terms of its influence on the wider functioning of society: high levels of illness and low levels of health being dysfunctional for society, preventing people from fulfilling their social roles (Parsons, 1951: 430). A certain level of good health in the population was, in Parsons' view, a key social

resource for the efficient functioning of society, with medicine working to maintain this favourable level of health. The onset of illness was of interest to Parsons because it prevented the fulfilment of social roles, such as paid employment and parental duties, and he also conceptualized disease as motivated in some measure. The motivation to withdraw from social roles and to be cared for as a sick person is, in this model, countered by the medical practitioner. Where a person's ill health requires a relinquishing of normal social roles, he or she is expected to visit a doctor and this encounter involves a reciprocal set of obligations and privileges. The incapacitated person is offered a niche, termed 'the sick role', where usual expectations are lifted and he or she is permitted time off to recover. The sick role offers the privilege of bed rest and the suspension of domestic and employment duties, on condition that professional help is sought out and full cooperation is ceded to the physician. In return, the physician is reciprocally obliged to act in the patient's best interests and to offer technically competent care in an objective fashion. Writing in the USA, Parsons underlined that the patient's welfare, rather than personal or commercial gains through the profit motive, must inform the physician's actions towards the patient (Parsons, 1951: 435). Where doctors achieve the required affect, neutrality and technical competence in the skilful application of medical knowledge to their patients' problems, they are granted the freedom to behave as autonomous professionals, and have privileged access to patients' bodies in ways that would be taboo under other circumstances.

Parsons described an ideal type, delineating institutionalized roles of doctor and patient that were reciprocal, consensual and functioned to reduce the social costs of deviant illness behaviour, such as hypochondria and malingering. The doctor's official sanctioning of a state of illness discourages illegitimate claims to the privileges of the sick role and means that doctors and the medical diagnoses they make regulate access to sickness benefit, sick leave and treatment. Parsons saw the reciprocal obligation on the patient to make an effort to recover as the means whereby people were returned to the performance of their normal social roles as rapidly as possible, thereby reducing the harm done to the social consensus by illness. Blaxter (2004: 94) describes Parsons' theoretical proposition as: 'if the function of institutions is to maintain social stability, then these are the rules which are necessarily followed in the case of medicine'.

Parsons' interest in deviance was part of a wider preoccupation in the sociology of the time. Gerhardt sees the widespread nature of the interest in deviance as a legacy of the Second World War, during which boundaries of 'normal' and 'deviant' became blurred in civilian, as well as military populations. In the aftermath of the war, it became clear that the roots of Nazi thought which justified the extermination of various 'deviant' groups, were far more widespread than had been thought (Gerhardt, 1989: xvii). Gerhardt emphasizes the dual nature of Parsons' sick role,

which encompassed not only the deviancy model focusing on the 'positive-achievement' motivated aspects, but also the incapacity model capturing the 'negative-achievement' aspects of illness (1989: 15).

CRITICISM OF PARSONS' IDEALIZED TYPE

As already noted, Parsons is credited with offering a theorized sociological approach to understanding the medical treatment of illness as a social encounter. The sick role has provoked theoretical and empirical further investigation and, as a result, has been much subject to criticism. The idealized typing of doctor and patient roles has attracted criticism for being too simplified to be a useful model of real healthcare encounters. Far from the consensual negotiated doctor–patient encounter of the ideal type, a patient's entry into the sick role can be a process that is both complex and fraught, and that is mediated by specific features of the illness and of the patient. The severity, the familiarity and the likelihood of recovery from the illness may influence how easily the patient is admitted to the sick role. Parsons' model envisages the sick role as a temporary one, and whether it is primarily seen as a state of deviancy or of incapacity, there is a presumption that occupancy of the role will be resolved by recovery from illness and a resumption of normal social duties. Of course, this timely relinquishing of the sick role may not happen when the illness is chronic rather than acute. There is an assumption in the model that the nature of the illness brought to the doctor is irrelevant since the professional's affect neutrality ensures the same treatment for all conditions. However, some conditions are highly stigmatized, to the extent that at certain times doctors have been unwilling to treat, for instance, people with HIV or those who have overdosed with illegal drugs. Thus, features of the patient's illness or incapacity are relevant to the ease of their entry to the sick role, as too are char-acteristics of the patient. Stereotyped ideas mean that some types of people find it harder to get their symptoms taken seriously than others. For example, Black people with sickle cell disease have found it difficult to obtain good palliative care when the condition's crises occur, in the face of twin racist assumptions, namely Black people's supposed poor tolerance of pain and exaggerated risk of opiate addiction. Whether stigma applies to the individual because of their gender or racialized group, or to the condition, because of its (assumed) method of transmission or self-infliction, there is enormous variation in how people and their symptoms are treated when they encounter physicians.

Another important criticism of Parsons' idealized sick role is the presumption of its universality. Parsons was not interested in illness as a bodily state, but focused rather on the regulation of the social roles involved, and there is an implicit assumption that

with the onset of symptoms, people will adopt a passive, compliant role as a patient. A minority of people who experience symptoms seek a consultation with a doctor, with the majority self-medicating, consulting with others (family members, pharmacists, internet sites) or taking no action at all beyond waiting for the problem to resolve itself.

Parsons' model is asymmetric in terms of rights and obligations and it is conceived as working consensually, with patients complying willingly with their physicians' orders and submitting to their regimes of care. Conflict theorists saw this as an inappropriate characterization, since rather than being consensual, the tenor of the doctor–patient relationship can be highly conflictual. The inequality of power and the lack of common interest between doctor and patient means that patients' efforts to get professional help with illness is more akin to a struggle than a consensual playing out of mutually agreed roles.

Beyond the workings of the idealized sick role, Scambler notes two additional, general problems with Parsons' structural functionalism. First, he suggests Parsonian structural functionalism is described at such a level of generality that it defies testing or revision (Scambler, 2002: 15). Second, he points out that 'agency goes missing' in that individuals are conceptualized as 'over-socialized' (2002: 16). Some of these criticisms are explicable in terms of what Camic (1989) sees as a key goal of Parson's work – that is to defend sociology as an intellectual enterprise at a time when its future was in doubt. With a sociological analysis of the logic of 'The Structure of Social Action' (Parsons, 1937) in the social and intellectual context of the 1930s, Camic shows that Parsons was writing an extended manifesto to defend sociology's disciplinary expertise. In making this defence, Camic sees the strength of Parsons' book as a charter laying claim to the science of the socio-cultural realm for sociology, but this is also the root of some of the problems when extracting his conceptions of social action, social structure and social order to apply elsewhere (Camic, 1989: 94–5).

Why, despite these criticisms, does Parsons' idea of the sick role continue to attract the attention of medical sociologists seeking to re-evaluate his legacy for the sub-discipline (for example, Williams, 2005)? Parsons' insight is more than simply a starting point for others' criticism and investigation, since he manages to combine a rare range of approaches to illness within his model. Gerhardt (1979) underlines how Parsons' insights range from psychodynamic features of illness and healthcare, to inequalities in power and the regulation of deviance, thereby offering a structural view of the incapacitated person in the wider apparatus of society, without losing sight of the individual sick body interacting with a professional. Furthermore, while Parsons does not anticipate the intense interest in patients' life-worlds that characterizes much later research, his grasp of the system of healthcare was acute (Scambler, 2002: 16).

As important as the strengths of Parsons' ideal type have been, it is its weaknesses that have effectively provoked further research, thereby shaping the developing character of medical sociology. A number of the criticisms of the sick role described above can be grouped together under the general problem of Parsons' model being insufficiently critical of medicine (see Prologue). Parsons problematizes the patient's behaviour during illness and considers the physician's role in regulating that behaviour. The good conduct of the professionals and the utility of their work for both individual patients and for society remains under-interrogated, while the presumption of consensus in the relationship leaves the power inequality between doctor and patient equally uninvestigated.

Structural functionalism was swept away as the leading theoretical paradigm in the 1960s and 1970s. Functionalism emphasizes equilibrium and consensus, and although Parsons saw this consensus as fragile, functionalist explanations favour the ongoing dominance of the most powerful interests in society, and relegate individuals, especially marginalized ones, to a passive role. Structural functionalism left little place for theorizing individuals and was unable to explain how social change might occur. Symbolic interactionism, developing in reaction to structural functionalism, sought to explain social life as arising from the interaction of agents making independent interpretations of a situation, thereby giving individual perception and agency a more important role. Approaches that were more explicitly critical of medical power also gained prominence – theories which emphasized conflict and political economy, and that set about emancipating analyses of health and medicine from a biomedical model to lay bare the workings of power in routine medical settings. These theories of conflict and political economy are discussed in the next section, before returning to interactionism and phenomenology.

THEORIES OF CONFLICT AND POLITICAL ECONOMY

While Talcott Parsons' (1951) work on the sick role gave medical sociology a place in mainstream sociology, it was the work of Eliot Freidson (1952–2005) that gave medical sociology its critical dimension. *Profession of Medicine* published in 1970 defined the boundaries of medical sociology, suggesting how sociological perspectives on the practice and profession of medicine as well as on health and illness could be examined. By introducing a conflict perspective to the study of medicine and taking patients' perspectives seriously, the claims of the then powerful medical profession were interrogated. Freidson advocated a distinctive kind of medical sociology that applied structural perspectives to medical institutions and yet remained 'detached from medicine's own viewpoints and assumptions' (Conrad, 2007: 142).

Whereas structural functionalism views social hierarchy as a necessary, functional feature of a complex society wherein a universal value consensus ensures stability and social order, conflict theorists view competition between groups for scarce resources as the characteristic nature of social relationships. Social structures mean that access to resources is inherently unequal and those who benefit from the inequality will seek to maintain the hierarchy, and so conflict theorists anticipate that social change will occur through revolution rather than evolution. Blaxter (2004: 95) points out that conflict theory focuses attention on sources of ill health in the economic environment and on the competition of rival interests in the healthcare sector, and hence are preoccupied with the relationship between medicine and society. She suggests that this preoccupation has distracted research interest from the broader issue of the relationship between health and society. Political economy approaches to health have the class struggle for resources at the centre of analysis, and the influence of the approach has informed understandings of other social divisions as similarly conflict-driven. Conflict theory has shaped feminist medical sociological analyses of the sexist treatment of women by physicians and the disadvantaged position of women within the medical profession. Analysis of the medical division of labour and iniquitous patients' outcomes in racialized groups interrogates another system of privilege and power. While analyses that include class, gender and racism in a single analytic framework are an ideal, the tendency to collapse all systems of inequality back to a class-based understanding of power and inequality derives from the influence of the political economy approach to health.

A political economy approach emphasizes that under capitalism a person's relationship to the means of production is central to understanding not only their position in the hierarchy, but also their prospects of wealth and health. Research by Fredrich Engels (1820–1895) showed that the aetiology and distribution of the main diseases (communicable and incommunicable) are directly associated with the means of production (Engels, 1971 [1845]). This early social class mapping of disease incidence, pointed up the centrality of socio–economic structures to understanding people's living conditions, including their experience of illness, and indicated that individual medical intervention could not, of itself, hope to eradicate disease. The central insight of the political economy approach is to understand disease as socially produced and not, as the medical model would suggest, a result of the random occurrence of infection and environmental and congenital misfortune to luckless individuals.

Political economists of health describe how capitalism's relentless pursuit of profit is regularly in direct contradiction to workers' health and how medicine is entangled in the capitalist system through its statutory roles and its relationships with a range of industries. Under highly developed (or late) capitalism, where all dimensions of life are dominated by the unregulated market, the welfare state and national health

service is left with the unenviable and, by definition, impossible job of solving the health problems created by the pursuit of profit. In view of the failure of state socialism in the former Soviet Union and its modification towards capitalist forms of trade in China, there seems to be no serious alternative economic system to rival capitalism (Waitzkin, 2000). Thus, any system of healthcare apparently serves to maintain the workforce for ongoing employment in a capitalist system. Physicians have been criticized on grounds of the professional dominance (for which they have campaigned) within the division of healthcare and the statutory responsibility that they hold to keep the workforce healthy for the smooth-running of the economy. However, the political economy view suggests it is unfair to hold the medical profession responsible for medicine's complicity in the capitalist oppression of workers. Physicians are merely the lackeys of capitalism, rather than the main authors of disaster. In this view, health is simply another arena in which capital can operate in pursuit of profit and the multiplicity of ways in which this can be done is breath-taking; from the big business of servicing clinical settings with personnel and equipment for cleaning and catering to pharmacogenetic products at the fore-front of big science.

Marxist ideas developed as a critical commentary on the expansion of industrial capitalism's project to transform raw materials into commodities with stable use-value that was changing the face of Northern European cities in the nineteenth century. Manchester, the city to which Engels moved to work in his father's company factory, like other British industrial centres, was being transformed with a sudden explosion of its population and little in the way of sanitary infrastructure. Hence the squalid conditions of the working classes, which stood in dramatic con-trast to the burgeoning wealth of industrialists. Marx referred to Engels' work to demonstrate the way in which capitalism ruined workers' health in its pursuit of profit. The damage done by industrial hazards and the risks which the owners of capital ran with their human and financial assets is understood to be an inherent part of the destructive nature of capitalist accumulation rather than an avoidable side-effect. Marx divided the population according to its position with regard to the ownership or otherwise of the means of production. Under this scheme, the great majority of the population of an industrializing nation were viewed as 'working class', and, like natural resources such as iron ore, they were exploited by the small minority who did not have to sell their labour because they owned and controlled society's productive assets, that is the factory, farmland or foundry. Those who cham-pioned public health reform, such as Engels, and Chadwick (1800–1890), who sur-veyed living conditions and marked their association with rates of mortality and morbidity, had benefited from family fortunes accumulated through the industrial revolution. In this respect, they were not disinterested parties in the development of capitalism, and argued in favour of reform in terms of the interests of the middle and

upper classes being served by improving the health of the poorest: preventing malnutrition and disease among the working classes to ensure a more productive workforce. While Marx referred to the exploited alienated worker who 'mortifies his flesh and ruins his mind' (Marx, 1975: 326), his analysis was aimed at explaining the motor of world history and predicting changes in the stratified order of society, rather than the definition or solution of public health problems.

INEQUALITIES AND SOCIAL STRATIFICATION

That a person's position within the social hierarchy, as defined by labour market position and property relations, affects their life chances has been a central socio-logical insight, with theories of social stratification seeking to delineate the dimensions of this relationship and refine ways of modelling it. The observation that one's experience of illness and chances of premature death are related to one's position in the socio-economic hierarchy is central to the study of health inequalities (and explored further in Chapter 3). Marx saw a social class as a group of individuals who shared similar conditions and circumstances which might have an environmental impact on health, but also as a collectivity that shared a similar history and identified its common interests to some extent. An identification of group interests facilitates a class-consciousness which may lead to collective negotiation and hence action to ameliorate class interests.

The Marxist classification of people into workers and owners, while highlighting important historical changes arising from the industrial revolution, is too crude to be useful for the ongoing study of health inequalities. A materialist emphasis persists in the ongoing interest in class-based health inequalities, but it has been modified by a Weberian insistence that forms of status other than economic superiority should be considered in the measurement of social status. The main index of social stratification used by the UK's national statistics office is the 'National Statistics – Socioeconomic Classification' (NS-SEC) which considers the characteristics of a person's employment as well as their position in the labour market. This index seeks to capture whether or not the job is routine, skilled or professional and the extent to which it involves power over other employees, and in these respects is an improvement on its predecessor, the 'Registrar General Social Class classification', which relied on individual referees' rankings given to particular occupations of their 'general standing'. Despite the somewhat subjective nature of the Registrar General classification, throughout the twentieth century it nonetheless consistently demonstrated the inverse relationship between high social class and low rates of morbidity and premature mortality that Engels and Chadwick had identified in the nineteenth century. Alternative indices of socio-economic class, such as the Erikson–Goldthorpe

scheme and the Cambridge scale of occupations, rely on different weightings for aspects of social, occupational and economic life. The ongoing research into the relationship between socio-economic differentials and health outcomes has not settled the issue of the extent to which aspects of income or of lifestyle associated with absolute or with relative poverty are responsible (see Chapter 3).

Recent controversies have centred on how relative poverty, that is, having basic requirements for food, clothing and shelter met but living near the bottom rung of a wealthy society characterized by inequality, potentially damages health through psycho-social influences on the immune system. The persistence of inequalities in mortality and morbidity, even as life expectancy in wealthy nations has consistently risen, suggests that competition for scarce resources is a better model of human society than the value-consensus cooperation imagined by structural functionalism. In a competitive environment, a key resource is the possibility of an extended and disease-free life. Measurement of inequality in mortality rates has been shown to be sensitive to the degree to which equality of opportunity characterizes a society: social democracies with redistributive central taxation and high quality provision of social services have smaller disparities in mortality rates between rich and poor compared with countries without policies of reallocating social resources through education, health and social care services. The importance of equality of opportunity and social cohesion for the well-being of individuals seems to go beyond an individual's interest in the functioning of social institutions such as hospitals and schools and has been described in terms of social capital.

Turner (2004: 13) defines social capital as the social investments of individuals in society in terms of membership in groups, networks and institutions, which serves to measure the extent of reciprocity in a society and the degree of trust. A high level of income inequality reduces social trust between citizens and thereby degrades the social environment and, hence, individuals' health. The mechanisms that cause high social capital to be translated into good measures of individual health are controversial, with various models of the appropriate role of state and citizen in contention. A materialist view suggests that high levels of income inequality relate to poor health outcomes because of consistent under-investment in infrastructure (including schools, libraries, hospitals, parks, housing) that sustains the population's well-being. An individualist psycho-social interpretation contends that the trust and cohesion that typifies an equitable society provokes a good psychological response from individuals which translates into good health (Kawachi and Kennedy, 1997).

Marxist theories have been subject to ongoing and exhaustive criticism with regard to their ability to analyse high modernity and its accompanying form of disorganized capitalism. The failure of state socialist models of the redistribution of wealth and the provision of healthcare in the former USSR has been seen as undermining the validity of a political economy analysis. However, the legacy of Marxist thinking can be

seen in novel philosophical developments, such as critical realism (see Scambler's [2002] comments regarding Bhaskar's work). With regard to understanding health inequalities, political economy perspectives continue to be influential. Capitalist economic development has obviously changed dramatically from Marx's day, to become a global and highly fragmented system extracting surplus value from the production of knowledge and information and through the service industry, producing no tangible product. It seems indisputable that social class alone is no longer an adequate measure to understand the social divisions in a globalized world of unregulated capitalism. Income inequality and occupational category have to be understood in the context of integration and social cohesion, which can be seen as representing a combination of Weber's insights with those of Marx (Turner, 2004: 28).

However, it can be argued that capitalism has restructured to such an extent that the validity of any Marxist analysis is called into question. The centrality of commodity production to Marx's analysis of capitalism requires that the theory be considerably modified to analyse the production of services and products without obvious use-value but which are nonetheless traded. The neo-conservative economic revolutions of the 1970s altered the groupings of political solidarity such that people are increasingly difficult to define according to their class, occupation, family or geographic origins. Unregulated capitalism has created demand for goods such as mobile phones and designer sunglasses, whose value is defined not by their use function, but by their novelty, their designer tag as a mark of their provenance and the apparent authenticity of that tag. Consumer choice has taken on a huge importance, as people increasingly become defined by how they spend their money. This tendency has been accompanied by an individualization and reflexivity whereby the body and the self have become central projects to which money and time is devoted (see Chapter 6). This has important implications for health and illness as a fit, healthy and aesthetically attractive body has itself become commodified, both as something to be attained with the appropriate expenditure on personal trainers, clothes, plastic surgery, beauty therapy, etc., and simultaneously as something that has been marketed, exploited and sold as a commodity in itself. The emergence of the reflexive individual as a central social actor, in parallel with great upheavals in manufacturing, employment, class structure and the marketplace, has been accompanied by the reconfiguration of the relationship between the individual and society, to which we return at the end of this chapter.

INTERACTIONISM

As with the rise of political economy approaches, interactionism developed as a means of interrogating vested interests. Gerhardt relates the development of interactionist approaches to sociology as part of the political scene of the 1960s, whereby

old orthodoxies were abandoned in the search for 'a more humane sociology' (1989: 75). While interactionism is recognizable as a widespread practice in sociology, it is not a coherent theoretical position in the same sense as the structural functionalism against which early interactionists were reacting. Developed from the work of George Herbert Mead (1865–1931), the central proposition of interactionism is that the self is a social product, dependent on interactions with and responses from other people. As creative and thinking beings, people can choose their own behaviour to a great extent. The interactionist production of the self is highly dependent on language as a means of gauging the reactions of others and reflecting upon the meaning of this interaction. Charles Cooley (1864–1929) devised a theory of the 'Looking Glass Self' (1964) that said people see themselves as they believe they are viewed by others. The socially constructed self is limited by the responses of others and the reflexive nature of the self means that people can manage their interactions so as to select preferred responses and manage the meanings of social encounters. Annandale (1998: 22) pinpoints the contradiction inherent in any interactionist encounter: how the individual both modifies and is modified by the social relations of health and illness in which she or he participates. This theoretical paradox is central to any interactionist encounter where that encounter constitutes both the location where human agency occurs but also the main impediment to its growth. While the tension of apprehending human agency within a structural context is not confined to interactionism, a focus on constraints on patient agency in medical encounters in interactionist research has shown how little power patients often wield. Much qualitative medical sociological research has promoted the patient's point of view in the patient–carer interaction, with a particular interest in exploring the turn-taking, negotiation and blocking that occurs during the course of medical work, and the means whereby professionals' priorities are asserted.

Gerhardt distinguishes two forms of interactionist model in medical sociology: crisis and negotiation models (1989: 89). The crisis model is associated with labelling theory as exemplified by the anti-psychiatry movement which sees medicine as a dominant profession in the process of ascribing and validating a status such as 'mentally ill' (Scambler, 2002: 17). Gerhardt's negotiation model sees the interaction between healthcare professional and patient as more open in the process of creating meaning: while professionals may dominate in defining the meaning of an interaction, the possibility of a consensual negotiated definition is at least mooted (1989: 90).

Goffman (1922–1982) offered a dramaturgical analysis of rule-governed encounters between healthcare professionals and patients, and the ways that these performances played out in a constrained but not entirely scripted fashion (Scambler, 2002: 18). While Goffman's work cannot easily be subsumed under a single theoretical perspective, influential aspects are close to Gerhardt's view of a negotiated version of

interactionism. Interactionism is commonly criticized for having little to say with regard to social structures and as better able to analyse agency than structure: there is more capacity to analyse the life-world than the covert constraints of the structural features of systems.

PHENOMENOLOGY

Phenomenology offers another means of apprehending the social world, and therefore the world of illness, by interrogating how social reality is maintained. Harold Garfinkel (1917–2011) developed theories about how we constitute the everyday knowledge on which we rely into the practice of ethnomethodology, which concentrates on how we create and share social order but does not seek to validate these methods of production against an external benchmark. Garfinkel paid particular attention to what happens when the everyday routines of life which constitute reality are disrupted, noting that people's strong attachment to the rules that govern daily routine lead to a designation of rule-breakers as deviants. The analysis of talk between health professional and patient to ascertain how meaning is negotiated, resisted and achieved through interaction and speech has been an important contribution to medical sociology. Maurice Merleau-Ponty (1908–1961) has been a key phenomenologist for medical sociology because of his attempt to conceptualize soul and body as irreducibly fused, which has been taken up by those seeking to theorize our 'being-in-the-world' through the body's habitual relationship with the wider world.

Gerhardt (1989: 196) points out that the phenomenological view only conceptualizes illness as trouble, which, arguably, elicits one of two possible responses. First, the ill person can neutralize their environment and reduce their participation to avoid 'deviant' encounters with others or, second, the trouble can be diagnosed and dealt with by an expert. This view allows for consideration of how the clinical encounter is achieved, but does not offer space for consideration of how medical dominance happens, nor how it might be resisted. More generally, and in common with interactionism, phenomenology stands accused of paying insufficient attention to power, to hierarchy and, crucially, to diagnosing how current social structures might be overthrown or otherwise transformed.

MODERNITY AND POST-MODERNITY

The theoretical frameworks outlined so far can all be associated with enlightenment thinking, a philosophical movement which emphasized the systematic application of reason as a means of understanding the world. The age of enlightenment has been

defined in contradiction to the tradition, superstition and tyranny characterizing the preceding dark ages. Progress through the rational application of reason and the rise of the self-determining individual have been central motifs, crucial in the transformation from pre-industrial to industrial society and from the pre-modern to the modern era. The structural functionalists, political economists, interactionists and phenomenologists were all seeking to understand modernity and the changed relationship between individual and society that the rise of industrial capitalism wrought. Modernity can be recognized by an idea of the world as open to transformation by human intervention, an industrial mode of production and a market economy encompassed by a nation-state together with an ethos of mass democracy (Giddens and Pierson, 1998: 94).

A question that has exercised sociologists is whether recent shifts in these features mark a break with modernity or a continuous development of its character, in other words 'late modernity or post-modernity?' The globalizing of commodity and money markets, of human migration streams, the end of the cold war and the emergence of new forms of community and status group have prompted some to suggest that we are in a post-modern age, while others have preferred the terms hyper-, high-, late- or super-modernity. While modernity has been characterized by its search for and trust in big truths, assumed to be of universal relevance, post-modernity is recognizable by its insistence on the deconstruction and querying of truth and an assumption that any socially accepted truth has been constructed in order to serve an interest group of some description. Enlightenment approaches to understanding the world assumed that appropriate levels of knowledge and understanding would be progressive in facilitating material well-being as well as a confidence in the nature of the world. By contrast, late or post-modernity is characterized by an intensification of reflexivity through which the individual and institutions examine and reform their own practice which, in the absence of fixed certainties, intensifies uncertainty.

Taking post-modernity as a label for what follows, modernity indicates that the critical deconstructive approach is a reaction to the failures of modernity. The mass killings associated with the Second World War and perpetrated by both sides (in particular at Auschwitz and at Nagasaki) were key moments in which modern values of progress and self-determination were seen to justify genocide. Theorizing the form and prospects for the development of modernity (or its disjunct) has been the territory of critical and literary theorists as well as sociologists. The theorist most closely associated with a post-modern approach in medical sociology, Michel Foucault (1926–1984), described himself as an archaeologist of knowledge and rejected the term post-modernist. Despite disagreement over whether we are currently in a new form of capitalism or a development of the old form, there is consensus that classical notions of a single framework of truth, reason, identity and

objectivity have given way to a complex, unstable, contingent, multiplicity of interpretations of what constitutes truth, identity and history, in which very little is taken for granted and nothing can be assumed to be universal.

SOCIAL CONSTRUCTIONISM

Social constructionism is arguably the most pervasive and influential legacy of post-modern theory. A constructionist view holds that knowledge or practice that is normal and taken for granted can be understood as a result of the particular power relations pertaining in that historical and social context. Understanding disciplinary knowledge as socially constructed in the context of a particular regime of authority has been the basis of a powerful critique of medicine, as exemplified by the work of Foucault. Foucault provided a means of analysing the medicalization of society by seeing the exercise of medical power as operating via diffuse and diverse local factors, rather than through a central or unified power structure. Foucault's work shows that power and knowledge ('savoir') are key to understanding medical institutions and how the moral character of disease categories operates in quotidian settings. Foucault's interest in medicalization was part of a wider survey of 'the institutions of normative coercion' including the law and religion as well as medicine (Turner, 1992). Foucault's analysis of institutional discipline over individual behaviour through medical systems of surveillance, placed medical sociology as less marginal to the concerns of a broader sociological project.

   Of course, the work of sociology itself can also be understood as a construction, or interpretation of signs and symbols, against which there is no external measure of intrinsic, fixed validity. The deconstruction of the truths of sociology has been taken up enthusiastically by feminist scholars analysing binary divisions between male–female and masculine–feminine as a powerful construction that defines a class of women apart from men. The binary social construction of gender creates an expectation of false opposition, such that men are assumed to have more in common with other men than with women, and features that are associated with masculinity cannot then be associated with women and the feminine. Feminism has built on this insight across all areas of sociology, including medical sociology, such that gender has become an almost routine dimension of sociological enquiry (see Chapter 4). Taken-for-granted norms around sexuality, race, disability and age have been successfully and convincingly exploded by taking a social constructionist approach to understanding marginalized groups as constructed through highly partial value judgements being promoted as neutral, often with the support of medical authority.

POST-STRUCTURALISM AND STRUCTURALISM

This deconstructionist effort, sometimes called post-structuralism, constitutes a reaction to the widespread influence of twentieth-century structuralist thought, as initiated by the work of Ferdinand de Saussure (1857–1913) in linguistics and developed in the analysis of cultural systems by anthropologist Claude Lévi-Strauss (1908–2009). Saussure's work envisaged a linguistic system as a series of different sounds combined with a series of different ideas in which it was held that an independent signifier was superior to that which it signified. Lévi-Strauss saw universal laws as governing the symbolic elements of culture such that diverse practices, from food preparation to myth-making, could be related to the same cultural structures. Structuralism views social meaning as a product of signification, a universal process which makes up a stable, self-contained system that constrains discourse and hence the individual's potential for social action. A structuralist approach emphasizes the distinction between biological signs and their meaning within a medical system, giving rise to research into the process of diagnosis whereby people come to be defined as ill and take on the patient role. Deconstructionism developed by those now referred to as post-structuralists (Michel Foucault, Louis Althusser, Jacques Lacan, Julia Kristeva) was a response to the problems of structuralist thought as having an essentialist ahistorical view. Thus, the realities of, for instance, truth and beauty are assumed in structuralist terms to be apprehended through stable, signifying systems that correspond with systems of human thought. Post-structuralism overturns a structuralist view of humans as sacred, metaphysical beings wherein lie meaning and value, to replace it with culturally and symbolically constructed subjects in which meaning is constructed by difference and the signifier and signified are not united in a single meaning system and so need to be studied separately. Post-structuralists rejected the idea that universal rules organize social phenomena and introduced the possibility that users of language were motivated in particular directions.

Social constructionism has a powerful ability to undo assumptions which has had a liberating effect on specific interest groups, for instance by showing the situatedness of racist or sexist ideology and demonstrating the racialized or gendered interest groups that such ideas serve. The work of Foucault, and those who have developed his ideas, has sought to explicate the social construction of bodies (Turner, 1992; Shilling, 1993) and emotions (James and Gabe, 1996) with an approach that emphasizes the role of power and knowledge in shaping the body's evaluation. Scientific medicine, like any other knowledge system, is seen as an ideologically inflected product of the society in which it arises and, as such, in a radical version of constructionism, has no inherent merit over and above any other knowledge system. Foucault identified two trends in his investigation of medical practice: medicine of the species which classifies, diagnoses and treats states of disease; and the medicine of social

spaces which seeks to prevent disease. The medicine of the species defined the human body as an object of study and intervention, while the medicine of social spaces defined public health as subject to surveillance and regulation by civil and medical authorities. Feminist theoretical approaches in medical sociology have drawn on post-structuralism to critique the medical regulation of women's bodies, emotions and diseases and to show how this has systematically served male interests.

CRITICISM OF CONSTRUCTIONISM

The political and ethical nature of social constructionism has been heavily criticized, to the extent that one authority has declared the failure of post-modern theory, at least within medical sociology (Cockerham, 2007). If all forms of knowledge are equally plausible interpretations of the signs and symbols around us, how can we discriminate between oppressive forms of knowledge and progressive, egalitarian and humane understandings of the human condition? The intrinsic value of the knowledge itself for explicating our daily realities and its potential for creating a better, more just world are both, apparently, impossible to evaluate in a social constructionist view. A radical constructionist view would hold that the only reality with which we can work is that which is legible because of our cultural interpretations, thereby denying the significance or even the existence of a biological base. This view draws on evidence from areas where diagnoses are contested and pathologies ambiguous, such as depression or Repetitive Stress Injury (RSI), and so risks underestimating the real advances of modern scientific medicine and ignoring the global burden of contagious disease, which is most likely to be alleviated with biomedical methods. A radical constructionist view is ethnocentric in the sense that it is only tenable in a wealthy, democratic Western setting where poverty and disease do not (mostly) structure daily life.

Like structural functionalism, constructivism can hold an over-socialized view of the individual, leaving no scope for agency and the modification of context by actors. A more defensible view is a presumption that an external reality exists, but that our interpretation of, for instance, illness is powerfully affected by the cultural values we hold and therefore the meanings that we read into that illness for our own identities and the wider social order. This 'weaker' social constructionism might be justified by the philosophical position of critical realists such as Bhaskar (1979) who distinguish between the real world and the descriptions that we make of it. Critical realists argue that social constructionism fails to account for agency and structure and offers an over-socialized view of individuals, overplaying the constraints of structure. Critical realists conceptualize agency and structure as fundamentally distinct but interdependent factors that need to be studied to ascertain their distinct contribution to

social practice. A key point for critical realists is to defend the idea that social systems are open to process and change and that people have the critical capacity to affect them (Archer, 1995). As a new theoretical formulation, critical realism has yet to make much impact within medical sociology. Nonetheless, the prefix 'realism', implying a perspective that claims objects, events and beings exist in the world externally to us and independent of our experience and conception, has become routine.

The huge interest in the sociology of the body and of narrative is perhaps a reaction to some of the extremes of social constructionism. Sociology of the body seeks to understand health and illness as an embodied, lived process that is embedded in the world, without denying the importance of the social and cultural aspects of the experience. The study of narrative in the sociology of illness has sought to connect the interpretation of bodily suffering to a human lifespan. Both narrative and the body can be seen as trying to re-humanize the study of illness, which, in seeking to deconstruct the humanist assumptions of the centrality of persons to meaning, has, perhaps, lost sight of humanity altogether. In a world that is constantly subject to deconstruction, the re-telling and reconstructing of personal and familial narratives and the assertion of this as an inalienably human activity is perhaps a restorative or even redemptive reaction.

CONCLUSION

Ultimately, the interest of the theoretical positions outlined in this chapter lies in their ability to offer critical perspectives on the relationship between people's experience of illness, seeking healthcare and their place in wider social structures. The biggest factors in seeking to understand these social processes hitherto have been the inequalities in social position and the institution of medicine. Despite enormous changes since medical sociology emerged as a distinct area of sociology, in terms of the configuration of social and economic hierarchies and the statutory and commercial roles played by medicine, in many ways its core interests remain unchanged. Ever since Parsons' time, sociologists have sought to understand the regulation of health and illness in terms of the individual and the wider social order.

Questions of balance between developing theoretical frameworks and pursuing empirical enquiry (raised in the Prologue) crystallized in the accusation that medical sociology is atheoretical and empiricist. Such a challenge, issued from a comparative perspective, should not, perhaps, provoke an absolute response. Strident assertions that 'Medical sociology has become a theoretical discipline' (Cockerham, 2001: 19) and 'The notion that medical sociology is atheoretical is wrong' (Cockerham and Scambler, 2010: 21) suggest an over-sensitivity about medical sociology's image in

the academic world. While medical sociology indubitably debates and tests theoretical ideas, compared with some branches of sociology, it retains, by definition, an interest in questions that relate to policy, practice and lived experience. The interest in practice and policy has kept medical sociology abreast of the world of science and technology and of government, in terms of imagining possible futures and the ways in which they might alter our humanity with both social and individual terms of reference. Medical sociology's merit should lie in understanding the excitement of scientific and technological innovation without being dazzled by its salutary potential and keeping sight of its implications in terms of social justice.

REFERENCES

Annandale, E. (1998) *The Sociology of Health and Medicine: A Critical Introduction*. Cambridge: Polity.

Archer, M. (1995) *Realist Social Theory: The Morphogenetic Approach*. Cambridge: Cambridge University Press.

Bhaskar, R. (1979) *The Possibility of Naturalism.* London: Routledge.

Blaxter, M. (2004) *Health*. Cambridge: Polity.

Camic, C. (1989) 'Structure after 50 years: the anatomy of a charter', *American Journal of Sociology*, 95(1): 38–107.

Cockerham, W.C. (2001) 'Medical sociology and sociological theory', in W.C. Cockerham (ed.), *The Blackwell Companion to Medical Sociology*. Malden, MA: Blackwell Publishing. pp. 3–22.

Cockerham, W.C. (2007) 'A note on the fate of postmodern theory and its failure to meet the basic requirements for success', *Medical Sociology, Social Theory and Health*, 5: 285–96.

Cockerham, W.C. and Scambler, G. (2010) 'Medical sociology and sociological theory', in W.C. Cockerham (ed.), *The New Blackwell Companion to Medical Sociology*. Malden, MA: Blackwell Publishing. pp. 3–26.

Conrad, P. (2007) 'Eliot Freidson's revolution in medical sociology', *Health*, 11: 141–4.

Cooley, C. (1964) *Human Nature and the Social Order*. New York: Schocken.

Durkheim, E. (1952 [1897]) *Suicide: A Study in Sociology* (trans. J.A. Spaulding and G. Simpson). London: Routledge and Kegan Paul.

Engels, F. (1971 [1845]) *The Condition of the Working Class in England* (trans. W.O. Henderson and W.H. Chaloner). Oxford: Blackwell Publishing.

Freidson, E. (1970) *Profession of Medicine*. Chicago: University of Chicago Press.

Gerhardt, U. (1979) 'The Parsonian paradigm and the identity of medical sociology', *The Sociological Review*, 27(2): 229–51.

Gerhardt, U. (1989) *Ideas about Illness: An Intellectual and Political History of Medical Sociology*. Basingstoke: Macmillan.

Giddens, A. and Pierson, C. (1998) *Conversations with Anthony Giddens: Making Sense of Modernity*. Stanford, CA: Stanford University Press.

James, V. and Gabe, J. (eds) (1996) *Health and the Sociology of Emotions*. Oxford: Blackwell Publishing.

Johnson, T., Dandeker, C. and Ashworth, C. (1984) *The Structure of Social Theory*. Basingstoke: Macmillan.

Kawachi, I. and Kennedy, B.P. (1997) 'Health and social cohesion: why care about income inequality?', *British Medical Journal*, 314(7086): 1037–40.

Marx, K. (1975) *Karl Marx: Early Writings*. London: Penguin.

Parsons, T. (1937) *The Structure of Social Action*. New York: The Free Press.

Parsons, T. (1951) *The Social System*. New York: The Free Press.

Scambler, G. (2002) *Health and Social Change: A Critical Theory*. Buckingham: Open University Press.

Shilling, C. (1993) *The Body and Social Theory*. London: Sage.

Turner, B. (1992) *Regulating Bodies*. London: Routledge.

Turner, B. (2004) *The New Medical Sociology*. New York: Norton.

Waitzkin, H. (2000) *The Second Sickness: Contradictions of Capitalist Health Care*. Lanham, MD: Rowman and Littlefield.

Williams, S.J. (2005) 'Parsons revisited: from the sick role to ...?', *Health*, 9(2): 123–44.