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## 1

# Introduction

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Health is traditionally understood as a personal trouble, and rightfully so, since it is individuals who experience illness. It is individuals who suffer asthma attacks, or undergo kidney dialysis, and it is individuals who die prematurely from coronary heart disease. Sociological research seeks to describe, analyze, and ultimately understand the lived experience of these situations. It also aims to examine what it means to be ill, and how illness affects the lives of individuals and their families. Such research may be applied in nature and seek to develop ways of improving social policies or medical interventions – by documenting how user fees may deter a person living in poverty from using hospital services, for example, or by closely examining the “illness narrative” of a person undergoing treatment with the goal of developing more effective treatment regimes. Alternatively, medical sociological research may hold a more abstract focus; in such cases, illness experiences are analyzed in order to develop our understanding of core sociological concepts, such as gender, normative roles, identity, and power. And the social patterning of diseases may be examined to better understand class divisions or socio-economic inequalities.

An important overarching theme of this book is the notion that whilst we need to appreciate the personal troubles associated with any illness, we also need to acknowledge that illness and disease – be it asthma, diabetes, heart disease, tuberculosis, HIV/AIDS, or any other condition – is socially patterned. This implies an underlying public issue, or the effects of structural forces, rather than a focus on biography alone. Indeed, to the extent that social conditions influence patterns of morbidity (illness) and mortality throughout the lifecourse, and that because the organization of health care systems reflect decisions about the way to provide support for those in need of medical treatment, health ought to be considered a public issue. Seen in this light, a population’s health is a reflection of complex and interactive social, political, historical, cultural, and economic forces. In other words, there is a political economy to disease; the structure of health care systems reflects political struggles, and social conditions are inextricably

intertwined with biomedical outcomes (Farmer, 1999; Wilkinson, 2000). Even the way we think about disease reflects complex social and political forces.

In many ways, understanding health and illness requires what the American sociologist C. Wright Mills (1959) called the “sociological imagination”, a kind of thinking that involves understanding and drawing connections between personal troubles and public issues. Mills conceptualized sociology as a discipline interested in the inter-connections in our biographies, history, and society. For Mills,

the individual can understand his own experience and gauge his own fate only by locating himself within his period...he can know his own chances in life only by becoming aware of those of all individuals in his circumstances. In many ways it is a terrible lesson; in many ways a magnificent one.

(1959: 5)

Mills’ sociological imagination requires us to link personal circumstances with structural economics and politics; it requires us “to be aware of the idea of social structure and to use it with sensibility” (1959: 10–11). This influential approach to social research enables us to see ill health – surely one of the most personal of all personal troubles – as explicitly social. Applied in medical sociology, the distinction between personal troubles and public issues leads us to a diverse array of empirical and theoretical possibilities. The works examined in this book utilize a wide range of methodological approaches covering the entire quantitative–qualitative spectrum, reflect myriad ontological and epistemological positions, and engage with sometimes contradictory theoretical traditions. On some levels these works will seem to have little in common with each other, as they reflect drastically different approaches to research. Yet they are all part of the grand tradition of health-related social research; their differences and, at times, commonalities will offer important lessons on the nature of social research in general, and enhance our understanding of health issues in particular.

Also central to this book is the notion that health is inherently a sociological concept. This is because at the most basic of levels, determining if we are healthy or not involves social comparisons. We judge our health in comparison to the standard of living of our peers (Kaplan and Baron-Epel, 2003; Sen, 2002). The very definition of what is “health” and what is “illness” is socially constructed, and varies by culture in time and place (Samson, 1999). For example, recent empirical work in Canada highlights significant cultural variation in the reporting of pain and mental health problems (Kopec et al., 2001). And my own research on health inequities in Argentina shows that people who live in some of the least healthy parts of the country (as evidenced by rates of life expectancy and infant

mortality significantly worse than the national average and by the presence of infectious diseases not found elsewhere in the country) may nevertheless report being in good health (De Maio, 2007a). Amartya Sen (2002) has documented similarly incongruent findings from studies of life expectancy and self-reported health in India. All this reflects the notion that health is socially constructed; social forces, including culture, shape how we respond to pain and suffering, how we conceptualize our bodies, and how we define health and illness. Examples in this book will use a wide range of conceptualizations of health, including epidemiological indicators of life expectancy (with low life expectancy being an indicator of an increased likelihood of premature death), as well as individual-driven accounts of pain and suffering as markers of illness.

The sociological foundation of health as a concept can also be seen at the societal level, considering that “health” involves decisions regarding how to structure health care systems: is health a private good, to be purchased under market mechanisms? Or is it a public good, guaranteed by human rights or citizenship? Health also reflects societal power relations: what conditions are considered illnesses? What conditions are considered to be outside of the medical sphere?

And lastly, health is a sociological concept in the sense that social conditions ultimately determine levels of population health (Marmot and Wilkinson, 2006). As sociologists and epidemiologists have firmly documented, social position – our place in society’s hierarchy – is strongly related to our risk of developing illness and partly determines how long we may expect to live. This notion has been a central theme in sociological research on health, from the origins of our discipline in Engels’ *The Condition of the Working Class in England* (1987 [1845]) to more contemporary medical sociological and social epidemiological research on health inequities.

Sociology offers a unique perspective on the study of health and illness, for it allows us to understand the nature of health “problems” in a more holistic way than is usually afforded by the more clinical, biomedical perspective that usually dominates discussion of these issues. In other words, it changes the “frame” within which we seek to understand health and illness. Consider Peter Berger’s definition of a sociological problem, as developed in his classic book *Invitation to Sociology*:

...not so much why some things “go wrong” from the viewpoint of the authorities and the management of the social scene, but how the whole system works in the first place, what are its presuppositions and by what means it is held together. The fundamental sociological problem is not crime but the law, not divorce but marriage, not racial discrimination but racially defined stratification, not revolution but government.

(1963: 37)

This influential definition of a “problem” encourages us to see health research as something that should not only focus on wait times for specific surgeries, or on the relative efficacy of a particular pharmacological treatment over another (the kind of health “problems” that typically make the daily newspapers), but also on wider issues such as the social determinants of health, health inequities, the structure of health care systems, the medicalization of everyday life, and the social interaction embedded in the medical encounter itself.

This perspective encourages a comprehensive frame of analysis; of course we remain interested in when things go wrong, like an outbreak of a new infectious disease, such as SARS in 2002/2003 and swine flu in 2009, or the increasing burden of mental health problems in industrialized countries. The key is to go beyond that to also incorporate a systemic and structural focus. This encourages an historical and truly contextual analysis, one that integrates analysis of personal agency and social structure and can acknowledge their complex interconnections. Social theory plays a central role in this endeavour.

## **Empirical and Theoretical Levels of Research**

A key feature of this book, and the series of books to which it belongs, is its emphasis on the dynamic connection that exists between empirical and theoretical levels of research. The relationship between these at-times disparate strands of scholarship has been perhaps best discussed by Robert K. Merton, who argued that empirical research does not merely play the passive role of testing hypotheses and concluded that it was not “enough to say that research and theory must be married if sociology is to bear legitimate fruit. They must not only exchange solemn vows – they must know how to carry on from there” (1968: 117). Arguably, sociological research has not been able to accomplish such a union, leading to a situation where empirical and theoretical research often seem to have little to do with one another, or are at best superficially connected.

Medical sociology offers a particularly interesting example of how this “marriage” unfolds in practice. To examine the connection between empirical and theoretical strands of research in medical sociology, I want to raise three inter-related questions: To what extent has empirical research in medical sociology been informed or inspired by theoretical ideas? To what extent has empirical research been constrained by theoretical or epistemological assumptions? And has empirical research in medical sociology fed back to the larger discipline and led to the development or refinement of theoretical concepts? These questions enable a critical analysis of the interplay between empirical and theoretical research, including the ways theory shapes the kind of empirical evidence that is valued, and how

that empirical evidence is interpreted. At the crux of these questions is a basic but important point: theory both drives and constrains empirical research. Theory implicitly and explicitly shapes what we consider to be “knowledge”.

Appreciating the complex relationship between the empirical and theoretical is fundamental to understanding the development of medical sociology. This requires us to revisit Mills’ warnings against both grand theory and abstracted empiricism – the former is characterized by highly abstract theorizing that cannot readily be connected to historical and structural contexts, and the latter describes research that, through its intense focus on method, loses touch with underlying problems of structure and politics. Mills saw both tendencies as “withdrawals from the tasks of the social sciences” (1959: 50) and warned against “the blindness of empirical data without theory and the emptiness of theory without data” (1959: 66). Recognizing the prevalence of these characteristics in sociology, Mills urged us to instead centre our research gaze on the intersection of biography, history, and society. He described this as the “promise” of social science and argued that “any systematic attempt to understand involves some kind of alternation between (empirical) intake and (theoretical) assimilation . . . concepts and ideas ought to guide factual investigation, and . . . detailed investigations ought to be used to check up on and re-shape ideas” (1959: 74). Appreciating these complex connections in medical sociology will enable us to develop a more holistic understanding of some of the most pressing health issues of our time:

- The global HIV/AIDS pandemic.
- The seemingly ever increasing rates of mental health problems, including depression and anxiety, throughout the world.
- The rapidly increasing rates of obesity in both developed and developing countries.
- The fact that social inequities in health exist in all countries in the world, regardless of the quality and nature of their health care systems.
- Life expectancy data that indicate that whilst people in the richest nations may expect to live about 80 years, people born in the poorest nations in the world can expect half that amount – about 40–45 years, with life expectancies in some sub-Saharan countries now dipping below 40.
- The emergence (and sometimes re-emergence) of preventable infectious diseases and the development of new, drug-resistant strains of diseases such as tuberculosis that severely threaten the lives of billions of people (particularly poor people) around the globe.
- The pressures to reform health care systems throughout the world in order to achieve adequate levels of care and access and balance the goals of equity and efficiency, whilst at the same time, enable access to expensive new treatments.

Indeed, whether or not we perceive these issues as “problems” partly depends on both data and theory. Importantly, all of these issues can be examined using myriad sociological perspectives. For example, what might conflict theory contribute to an analysis of the global HIV/AIDS epidemic? Does it help us to better interpret the prevalence of HIV/AIDS, which by the best current estimates afflicts over 33 million people worldwide (UNAIDS, 2007)? Does theory help us to understand why only 30 per cent of people estimated to be in need of anti-retroviral treatment in low- and middle-income countries actually receive it (WHO, 2008b)? Social research examines the structural factors shaping infection and treatment and brings attention to the political economy of the disease in all areas of the globe. Or, does it help us to conceptualize more adequately the root causes of infection? More generally, can empirical data or theoretical frameworks help us to decide how, as a society, we address this growing problem and provide timely treatment for those infected with the AIDS virus? As we will see in this book, medical sociology and related disciplines such as medical anthropology, particularly through the work of Paul Farmer (2003), have made substantial contributions on these issues.

Looking even further, other questions arise: what might a Foucauldian analysis of mental health pharmacological treatments look like? Can social theory be used to examine the very meaning of mental illness and how psychiatric categories of disease are constructed and change over time (Busfield, 1996; Horowitz, 2002)? Do Durkheimian notions of social integration and social cohesion contribute to analyses seeking to explain patterns of health inequities? Do feminist conceptions of patriarchy help to frame the “problem” of depression in a particularly useful way? Do conceptualizations of profit and competition – with connections to conflict theory and the tradition of political economy – help us to better understand the power of the pharmaceutical industry? Can the sociological traditions of symbolic interactionism and structural functionalism help us to understand issues related to medical care? All of these theoretical traditions indeed have much to offer empirical researchers, and in turn, empirical research of these health issues can enable us to refine theoretical constructs.

But whilst we might assert that theory can play an important part in understanding contemporary health problems, the explicit role of sociological theory in medical sociology is and has been quite controversial. Currently, widely different assessments can be found in the literature. For example, William Cockerham, in the *Blackwell Companion to Medical Sociology*, asserts that: “the link between medical sociology and sociological theory is crucial to the subdiscipline. Theory binds medical sociology to the larger discipline of sociology more extensively than any other aspect of the sociological enterprise” (2001: 3). In contrast, Graham Scambler’s influential book *Sociological Theory and Medical Sociology* begins by positing: “when sociologists have been invited or felt the need

to comment on the current state of medical sociology . . . they have almost invariably included a lament on its theoretical impoverishment. This has generally been attributed to its detachment from mainstream social theory” (1987: 1). Scambler’s assessment echoes a 1975 review published in *Social Science & Medicine*, where Malcolm Johnson argued that medical sociology was “theoretically impoverished, not only through its failure to contribute significantly to sociology’s conceptual stock, but also through its shyness in utilizing theoretical constructs in its research” (1975: 227). What is at the root of these contradictory assessments? What is the basis of Scambler’s and Johnson’s concerns that medical sociology has been theoretically impoverished? Has so much changed in medical sociology in the past three decades that these assessments may all be accurate?<sup>1</sup>

Scambler’s concern stems from the (largely unacknowledged) limitations that exist in much of medical sociology due to the enduring dominance of positivist approaches to research. The notion of epistemology (the branch of philosophy concerned with the nature of knowledge and truth) is central to this book and will be examined in the subsequent chapters.<sup>2</sup> Epistemology is key to coming to an understanding of the dynamic connections between empirical and theoretical work. As Trigg thoughtfully points out: “The philosophy of the social sciences cannot be an optional activity for those reluctant to get on with the ‘real’ empirical work. It is the indispensable starting-point for all social science” (1985: 205). Epistemological positions underlie many of the debates explored in this book.

## Outline of Chapters

The present chapter introduces the main themes of the book and, in the following pages, lays out its structure. Chapter 2 examines the earliest manifestations of what we now define to be medical sociology in the works of Friedrich Engels and Rudolph Virchow. It also identifies the intellectual space of medical sociology in comparison to the discipline of epidemiology. This comparison helps us to understand the problems medical sociologists have traditionally been concerned with and also helps us to develop a richer understanding of the evolution of the field.

Chapter 3 traces medical sociology’s theoretical contours and explores landmark conceptual advances – among them, Talcott Parsons’ development of the *sick role*, Erving Goffman’s work on *stigma*, Irving Zola’s writing on *medicalization*, Eliot Freidson’s work on the *profession of medicine*, and contemporary research by Richard Wilkinson on the *social determinants of health*. Tracing these developments illuminates the main theoretical approaches associated with medical sociology, and enables an assessment of their contributions to the field over the past 60 years.

In many ways, the theoretical approaches dominant at any given point in time in medical sociology reflect their overall popularity within the field of sociology. Whilst structural functionalism was very important in the early development of medical sociology as a subdiscipline in the 1950s (primarily because of Parsons), it gave way to the symbolic interactionist-inspired medical sociology of Howard Becker and Anselm Strauss in the 1960s. The 1970s and 1980s witnessed a growing engagement with symbolic interactionism, political economy and conflict theory, and the work of Michel Foucault. The 1990s saw post-modernism quickly rise in prominence in both medical sociology and the general discipline – only to experience a recent downturn in popularity (Cockerham, 2007).

Interestingly, all of these theoretical perspectives can be seen at play in contemporary medical sociology. It is perhaps this richness of theoretically informed work that led to the establishment of the journal *Social Theory & Health* in 2003. Theoretically centred or theoretically informed articles can also be regularly found in the main scholarly journals publishing medical sociological research, including the *Journal of Health & Social Behavior*, *Social Science & Medicine*, *Sociology of Health & Illness*, as well as the *American Journal of Public Health*. It is also not uncommon to see theoretically informed work published in the major biomedical journals, including the *British Medical Journal*, the *Journal of the American Medical Association*, and the *Lancet*. In tracing the history of medical sociology and the debates which have received particular attention, we will not only analyze the changing theoretical contours of the discipline but also gain insight into the future directions of health research.

Chapters 4–7 examine the interplay between empirical and theoretical work in different areas of current debate in medical sociology. Health inequities are the primary focus of Chapter 4. In many ways, they are the fundamental medical sociological issue, linking health and illness to society like no other. More specifically, Chapter 4 examines how health issues reflect larger patterns of social divisions, arguing that population health levels are sensitive indicators of the quality of a country's social fabric (Kawachi and Kennedy, 2002; Sen, 1999). We will examine the large (and rapidly growing) literature on *within-* and *between-*country inequities. These studies – mostly quantitative, but epistemologically connected to both positivism and to critical realism – will provide us with important lessons on the connections between empirical data, theory, and epistemology in medical sociology.

Many of these studies are centred on the notion that *social forces* are ultimately the most important determinants of health, arguing that our health depends more on social conditions like housing and income than on magnetic resonance imaging (MRI) machines or hospital-based technologies. From this perspective, health is a product of the society in which we live. Indeed, a tradition in this branch of medical sociology engages with

the philosophy of John Rawls (1972) and argues that health is a product of social justice (Daniels et al., 2000).

An important recent development in this literature has been Wilkinson's income inequality hypothesis, a conceptual model proclaimed to be one of the "big ideas" of our time in a 1996 editorial in the *British Medical Journal*. Chapter 4 closely examines the income inequality hypothesis, its empirical underpinnings, and theoretical relevance. It has been the subject of a great deal of debate; a rare situation which has brought into the open important epistemological issues and unresolved theoretical debates building from the works of Durkheim, Marx, Veblen, Bourdieu, and others. Much of the debate has integrated advanced empirical analysis and nuanced theorizing, a discussion that has traversed the distance between the *Journal of Critical Realism* and the *Journal of the Royal Statistical Society*. This body of research has also attempted to integrate biomedical research on stress mechanisms and neurohormonal connections to macro-level analysis of social structure and meso-level work on social interaction – an issue discussed in Chapter 4 under the Foucauldian concept of *embodiment* (Freund, 2006; Krieger, 2005; Krieger and Davey Smith, 2004).

In addition, Chapter 4 touches upon ethnographic research revealing the lived experiences of health inequalities, such as Laurie Abraham's (1993) *Mama Might Be Better Off Dead* as well as the medical anthropology of Paul Farmer in *Aids & Accusation* (1992), *Infections and Inequalities: The Modern Plagues* (1999), and *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (2003). The work of these authors – characterized by interpretivist and critical realist epistemologies – enable us to more fully grasp the suffering that lies behind quantitative analyses of health inequities. At the same time, these ethnographies are informed by concepts such as *structural violence* and *institutionalized racism* and reveal the wide-ranging theoretical foundations of empirical research on health inequities.

Chapter 5 closely examines health care systems, an area of study with contemporary political relevance. It is not an overstatement to suggest that health care reform is one of the most ubiquitous political issues in both developed and developing countries, with both experiencing rapidly rising costs of health care. Costs associated with health care are widely seen as one of the most substantial pressures on state and household budgets; in the United States, for example, medical expenses are the leading cause of personal bankruptcy (Angel et al., 2006).

Within Chapter 5, I examine the literature on the comparative study of health care systems and how theoretically informed empirical research has approached the study of a health care system's myriad goals, including effectiveness, efficiency, and equity (Blendon et al., 2002; Caplan et al., 1999). Drawing from a Marxist political economy, work in this area has

examined how global capitalism has shaped the structure of health care systems (Navarro, 2002b). For example, researchers have critiqued the exportation of private US-style managed care systems to developing countries in Latin America (Iriart et al., 2001; Waitzkin and Iriart, 2001). These studies are intertwined with debates on capitalism, globalization, the retrenchment of the welfare state, and political economy (Navarro, 1999) – issues of particular relevance to sociology.

The discussion of health care systems in Chapter 5 also engages with medical sociological research on the power of health professionals, and the ways in which different health care systems deal with that power. Freidson's landmark *The Profession of Medicine* (1970a) – one of medical sociology's canonical books – is explored in depth; it is an excellent example of how theoretical positions develop through debate and further research. In particular, Freidson's critique of the Parsonian model of the professions leads us to a new understanding of the role of medical doctors. As we will see, the symbolic interactionism of Freidson refined Parson's original work, and brought our attention not only to the traits and characteristics of the medical profession, but also its ideology – the very ideas that underlie its claims to autonomy. Examples from Canada and Venezuela are then presented to examine the controversial roles that the profession of medicine can play in struggles for health care reform.

Chapter 6 investigates the medicalization of everyday life, one of the most important concepts in the canon of medical sociology. It was initially developed by Irving Zola (1972), who argued that medicine itself was becoming an institution of social control, a “new repository of truth” as more and more of social life began to be seen through the lens of medicine. As we will see in Chapter 6, Zola's analysis is built upon the 1950s and 1960s structural functionalism of Parsons, as well as Eliot Freidson's social constructionist refinements of Parsons' work.

The concept of medicalization was also central to the radical critique of medicine offered by Ivan Illich, who famously noted that “medicine is but a device to convince those who are sick and tired of society that it is they who are ill, impotent, and in need of technical repair” (1976: 9). The discussion of medicalization offered in Chapter 6 will examine how disease constructs are created, following the example of alcoholism's shift from *sin* to *crime* to *illness*, before examining the tremendous power held by the pharmaceutical industry in defining what is health and what is sickness. The pharmaceutical industry – whilst a relatively new area of interest for sociologists (Busfield, 2003, 2006b; Hollander, 2006) – today holds unprecedented power in shaping discourse surrounding health and illness. Recognition of the economic issues underlying the power of the pharmaceutical industry brings to light significant conflict, which Conrad has recently summarized: “[i]t may well be to the shareholders' advantage for pharmaceutical companies to promote medications for an ever-increasing

array of human problems, but this in no way insures that these constitute improvements in health and medical care” (2005: 11). Chapter 6 investigates the ways in which current debates regarding the power of the pharmaceutical industry reflect the warnings developed by Illich (1976) in *Limits to Medicine*, and at the same time, the chapter examines how our understanding of medicalization has changed as a result of social research published in the last few decades. Due to both empirical and theoretical advances, the concept of medicalization is now understood to be a complex and multi-faceted term (Ballard and Elston, 2005).

Chapter 7 examines research on the *medical encounter*, an area of significant research productivity in medical sociology. Like other topics in the book, the literature on the medical encounter has incorporated a wide range of empirical approaches, including in-depth interviewing (Lupton, 1997a; Werner and Malterud, 2003), questionnaires (Waitzkin, 1991), conversation analysis (Campion and Langdon, 2004), and even secondary analysis (May et al., 2004). Work in this area has included positivist (Waitzkin, 1991), interpretivist (Werner and Malterud, 2003), and critical realist (Porter, 1993) epistemologies. The integration of these different methodological and epistemological approaches offers many lessons; above all, a comparison of these works reminds us of the different ways in which researchers have approached the generation of knowledge and will encourage us to develop a reflexive attitude towards our own positions on research strategies.

Research on the medical encounter has primarily focused on its structure, how doctors and patients negotiate power in the consultation, the type of “turn-taking” incorporated into their conversations, and how knowledge and preferences are transferred from one to the other. Work in this area has contrasted different “ideal types” of physicians and patients, including physicians as “perfect agents” and patients as “informed patients” (Gafni et al., 1998). The former describes a knowledgeable physician who assumes authority over the patient to make decisions, and justifies this imbalance by the asymmetry of information experienced by the two parties (physicians in this case holding professional expertise on which they can base treatment decisions). Gafni et al. describe this ideal type: “the doctor possesses the knowledge needed for making a treatment decision regarding the patient’s illness and for assessing the expected effectiveness of health care interventions in improving the patient’s health status” (1998: 347). The position is described as that of a perfect agent because it assumes that the doctor’s decision-making process is informed by knowledge of the patient’s preferences. The latter ideal type, that of the “informed patient”, describes a situation where authority to make treatment decisions rests with the patient; the physician in this case is responsible for transferring knowledge needed to make the decision to the patient.

These Weberian “ideal types,” whilst not reflective of all empirical circumstances, offer us models on the spectrum of the different kinds of interaction and communication that are possible in the medical setting. Work in this area has also closely investigated breakdowns in the medical encounter: what happens when a patient presents symptoms that are not recognized by the medical authority? What happens when a patient seeks treatment that a doctor cannot or will not provide?

Cases where the experience of the patient clashes with the medical training of the physician offer important clues to the underlying structure of the medical encounter. Studies in this area have explored the notion of “medically unexplained symptoms” from the perspective of both physicians (Reid et al., 2001; Wileman et al., 2002) and patients (Johansson et al., 1996; Ware, 1992; Werner and Malterud, 2003), offering unique viewpoints on what can be frustrating, tension-filled encounters characterized by credibility claims (patients wanting to be “believed”) and knowledge claims (physicians seeking to maintain authority in situations where they may not be able to alleviate painful symptoms or provide effective curative treatment). Ultimately, research on “contested” medical encounters reveals the negotiation that ultimately leads to the creation of new disease constructs. It also has the potential to feedback to the substantial sociological literature on small groups and interaction which has emerged from the ground-breaking work of Erving Goffman.

Research on the medical encounter displays a sophisticated use of social theory. For example, Lupton (1997a) uses the medical encounter as a means to explore notions of consumerism, risk, and Anthony Giddens’ *reflexive project of the self*. Werner and Malterud (2003) use the medical encounter as a means to examine the notion of “doing gender”. And much of this research builds from Goffman’s work on *interaction order*, a foundational concept of micro-sociology. Perhaps the most important contribution of this work to sociology, however, lies in the linkages between the micro-politics of the medical encounter and the macro-politics of health inequities. Analysis of these links raises the question of how interactions between doctors and patients reproduce what Waitzkin calls “macro-level structural patterns of domination and oppression” (1983: 119). Research on the medical encounter is therefore particularly well-suited to integrating much of what concerns medical sociologists, and clearly benefits from concepts we can trace to a range of theorists, from Marx to Parsons to Foucault.

Chapter 8 offers a re-evaluation of the role of social theory in medical sociology. Drawing from the work of Merton, the chapter assesses sociology’s contribution to our understanding of health, and highlights the interplay between theoretical and empirical work in medical sociology. The chapter also discusses some ideas regarding the future direction of health-related social research.

Whilst this book is primarily concerned with social theory, methodology is also central to all of the chapters. As we will see, medical sociology has a rich tradition of both qualitative and quantitative research. And like sociology in general, it has experienced problems in integrating findings from these seemingly disparate approaches to empirical data. At times it seems like sociology is firmly shaped around the so-called quantitative–qualitative divide, with each tradition advancing more or less on its own. David Mechanic’s insight on this issue, published almost 20 years ago, is still useful today:

As quantitative multivariate methodologies have come to dominate research work in medical sociology, investigators have split into two cultures separating quantitative and qualitative studies. These cultures share little communication, publish in different journals, and, for the most part, ignore and sometimes belittle each other’s research contributions.

(1989: 187)

This is a most unfortunate situation, and one that hardly lives up to the promise of social science as envisioned by Mills. Instead of a sociology that seeks to understand the connections between biography, history, and society, we currently have a sociology deeply divided along methodological grounds.<sup>3</sup>

This book, focused as it is on the interplay between theoretical and empirical realms of research, draws from both quantitative and qualitative aspects of empirical medical sociology. In this way, *theory* may bridge the quantitative–qualitative divide by reminding us of the overarching questions that have interested medical sociologists for decades. Theory brings our attention back to what is at stake: unnecessary sickness and preventable death, inequalities that are avoidable, unnecessary, and unfair, and unequal access to health care – essentially, suffering that people endure and the social forces that underlie it.

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