Chapter 1

Medical Sociology and
Sociological Theory

The purpose of this book is to describe, discuss, and provide examples of the major theories commonly used in medical sociology or what is sometimes called health sociology or the sociology of health.¹ The focus is on contemporary theory because it applies to contemporary conditions; however, since theory in sociology is often grounded in historical precedents and classical foundations, this material is likewise included here as it relates to present-day medical sociology. Sociological theory has an especially important role in the practice of medical sociology because its theories distinguish the subdiscipline from virtually all other scientific fields engaged in the study of health and illness. It is not that these other fields are theoryless; rather, it is a sociological perspective, as exemplified by its theoretical viewpoints, which gives medical sociology its unique outlook in investigating and explaining health and illness. Consequently, a mastery of theory is a critical skill for its practitioners.

At the outset, it should be noted that “theory is in the eye of the beholder.” What is meant by this is that theory is unsettled in sociology as various sociologists have their favorite theorists and theoretical perspectives and can be passionate advocates of their position, yet other sociologists and sociological theorists may disagree in part or in whole with that viewpoint. This is not necessarily a bad thing because debate can lead to the demise of out-of-date or weak theories, improvements in others, and the appearance of new ones more applicable to current conditions. It is up to the reader to look at the various theories to be discussed and decide for him or herself about the quality, validity, and utility of a particular theory.

A sociological perspective is the awareness or recognition that society and its various components have a reality above and beyond that of the individual that affects a person’s behavior and way of life. This reality is not real in a material sense, but it nonetheless is a reality that exists in the mind as society’s imprint on us and others. So while people usually choose their behavior,
there are social structures in their lives that influence, shape, and give meaning to what they do. Even though such structures are “imagined,” they have an “empirical” or real world existence in the way they affect social behavior. This is seen in the fact that families, groups, organizations, communities, social classes, nation-states, societies, and other social entities, along with various institutions such as religion, medicine, and the law—all have standards or norms of behavior, values, and customs that people who are associated with these entities are socialized to model their behavior after and accept as their own. Some people may deviate from what is considered socially acceptable behavior, but the reality of the existence of social entities beyond the individual and their influence still remains. Sociology’s “gaze,” however, looks not only at the impact of that reality upon individual and group behavior, but also at the social structures and conditions caused by an awareness of it. Sociology therefore helps us to understand the social forces at work in particular situations and the patterns of behavior that emerge from it.

When it comes to health and longevity, the social context of a person’s life is particularly important because it determines the risk of exposure, susceptibility, and often the course and outcome of a health abnormality, regardless of whether it is infectious, metabolic, genetic, malignant, degenerative (Holtz et al. 2006), or mental (Cockerham 2017). A person’s social circumstances, however, can also affect an individual’s physical and/or mental health in positive, not just negative ways. Consequently, the “social” can be determining factors in the quality of a person’s health and how long that individual lives. Such factors can determine not only whether or not a person becomes sick or stays healthy, but also how illness is experienced and the pattern of a population’s level of health. Thus it is not surprising that social factors have become recognized as fundamental causes of health and mortality (Link and Phelan 1995; Phelan and Link 2013), and a sociological perspective is an important analytic tool in recognizing this.

As the late British historian Roy Porter (1997) pointed out many years ago, medicine can no longer be preoccupied with focusing on biological abnormalities and be indifferent as to how they got there. Medicine has to consider, among other things, wider questions of living conditions, lifestyle, diet, work situations, education, and family structure in meeting the challenges in treating the health problems of the “whole” person existing outside of a doctor’s office in the real world. “Disease,” according to Porter (1997:634), “became conceptualized after 1900 as a social no less than a biological phenomenon, to be understood statistically, sociologically, and psychologically—even politically.”

Recognition of the connection between social conditions and health led to the development of medical sociology as a major subdiscipline within general sociology. Medical sociology focuses on the social causes
and consequences of health and illness. It brings sociological perspectives, theories, and methods to the study of the social facets of health and illness behavior and the social determinants of health. Areas of investigation also include the social causes of health disparities, the social function of health care providers, the social organization and delivery of health care services, and the social aspects of health policy and its politics. The role of theory in this enterprise is particularly important, as will be seen.

**Epidemiologic Transition Theory**

It should be noted before continuing that medical sociology has become increasingly important in the study of health and disease, which is significant for the status of theory in the subdiscipline. The value of medical sociology for medicine, public health, and other health sciences becomes obvious when the epidemiological transition of diseases over the course of human history is considered. Epidemiologic transition theory, a theory in epidemiology (the science of epidemics), provides a framework for illustrating this outcome. Epidemiologic transition theory was originally formulated in 1971 by Abdel Omran who observed that some diseases were more prevalent in particular historical periods than others, a fact that led him to organize the major causes of mortality into three distinct stages:

1. The “Age of Pestilence and Famine” in which infectious and parasitic diseases are the major causes of death from the earliest times until the 1800s.
2. The “Age of Receding Epidemics,” a transitional stage during which infectious and parasitic diseases are brought under control by improved hygiene, sanitation, nutrition, public health measures, higher standards of living, and medical advances featuring mass immunizations, antibiotics, and other innovations from the early 1800s to about 1960.
3. The “Age of Degenerative and Man-Made Diseases” in which non-communicable or chronic diseases, such as cardiovascular disease and cancer, emerge as the dominant causes of mortality beginning around 1960.

Omran further notes that not all of the world undergoes a transition in diseases at the same time. Changes occur first in the most advanced countries, while developing countries slowly catch up as they experience varying degrees of modernization over the years. This theory seemed a reasonable summary of epidemiological trends until the 1970s and 1980s. But then there was a surprisingly rapid decline in deaths from cardiovascular disease (Bongaarts 2014), followed shortly thereafter by the arrival of new infectious
diseases such as West Nile disease, SARS, and Ebola in the late 1990s and early 2000s (Armelagos and Harper 2016), along with the coronavirus (COVID-19) in 2019–2020. This development led some to propose further changes in the theory. These changes include adding newly emerging infectious diseases to the third stage as these diseases had made an unexpected and deadly appearance, or alternatively creating a new fourth stage:

4. The “Age of Delayed Degenerative Diseases” in which chronic diseases like heart disease and cancer do not result in death until increasingly older ages due to further advances in medicine (Olshansky and Ault 1986), or the “Hybristic [or Mixed] Age” in which individual behaviors and lifestyles are added to heart disease and cancer as another major cause of mortality significantly affecting the other causes (Rodgers and Hackenberg 1987), or the “Age of the Cardiovascular Revolution” during which improvements in medicine pertaining to heart disease continue to reduce mortality and improve life expectancy (Meslé and Vallin 2006).

The title and contents of a new fourth stage are yet to be fully determined or agreed upon. The devastating effects of COVID-19 on the world brings back the first stage of the “Age of Pestilence,” which turns epidemiologic transition theory back on its head and needs to be accounted for in devising a fourth stage. The addition of newly emerging infectious diseases in which a primary means of halting infections is “social distancing” and “stay-at-home” policies again points toward the relevance of the “social” in relation to disease. When the transition of diseases is viewed over time from the past to the present it is apparent that social behavior and conditions have gained in importance as causal factors in disease transmission. Stage 1 features infectious and parasitic diseases related to human migration, the transition from hunting and gathering societies to agricultural settlement, and the rise of trade and urban living. Stage 2 reflects the lessened prevalence of epidemics associated not just with medical advances but with better living conditions and improved normative behavior with respect to hygiene, sanitation, diet, and the like. In Stage 3, the connections between health lifestyles, stress, and other social factors with health become particularly obvious with respect to heart disease (Cockerham, Hamby, and Oates 2017) and cancer (Hiatt and Breen 2008).

And in a yet to be formulated Stage 4, social factors are especially relevant regardless of whether it is a case of (1) “delayed degenerative diseases” in which the biological effects of aging or the physical “weathering” of the body caused by social stress and the consequences of unhealthy lifestyle practices—are postponed as life expectancy increases, or (2) the
“cardiovascular revolution” where health lifestyles are again paramount in mortality outcomes because of their close association with heart disease, or, what seems the best choice, (3) “hybristic (mixed) causes” in which risky behaviors (i.e., lifestyles) are recognized as a major cause of death for both chronic and infectious diseases, including the relevance of “social distance” as a causal factor in epidemics and pandemics. In this new fourth stage, smoking, obesity, and unhealthy behavior, along with the addition of climate change and newly emerging diseases, will be essential. What is obvious is that this current stage of epidemiological transition takes cognizance of the fact that health improvement requires behavioral changes. However, throughout each and every stage, social-class position has universally demarcated the rich from the poor in terms of who is the most healthy and who is least healthy in a consistent trend over centuries.

What is Theory?

Turning now to sociological theory, an initial step is to define it. There are varying definitions of theory, but one definition consistent with the way in which sociologists and other scientists generally understand and use the term is as follows: “a theory is a set of explicit, abstract, general, logically related statements formulated to explain phenomena in the natural world” (Webster and Markovsky 2007:4987). Sociological theories are similar to theories in other fields, including the physical sciences upon which scientific theories are often modeled, in that they likewise consist of a set of interrelated propositions that describe causal processes. That is, they are statements or propositions claiming that one class or type of phenomenon is connected in some way to another class of phenomenon invariably producing or causing a certain condition, behavior, or outcome.

Theories thus organize and categorize variables, explain past and present outcomes, predict future outcomes, and provide understanding about what causes those outcomes (Reynolds 2007). A major difference, however, between theories in the physical sciences and sociological theories is that physical science theories deal with events occurring in nature and the cosmos, whereas sociological theories explain human social behavior that is motivated. As Neil Smelser (1994:21) once explained about sociological theory:

Every item of empirical research in the field, however narrowly defined and circumscribed, is rooted in general propositions about human beings and society and contains the seeds of abstract reasoning and normative evaluation. These elements are implicit but never absent. For this reason, theory should be regarded as an integral aspect of sociological inquiry rather than something separate from it. In another sense,
however, theory is distinguishable. It is legitimate to consider the rela-
tions among the general elements in their own right; in doing so, we
enter the realm of sociological theory.

Theory is critically important to every scientific discipline because it pro-
vides a conceptualization about how sets of phenomena or a particular
phenomenon operate in the empirical world. As Austrian–British philoso-
pher Karl Popper pointed out long ago in *The Logic of Scientific Discovery*
([1934] 1992:59), theories are “nets” that allow us to catch what we call
the world in order to understand and explain it, and we endeavor to make
the net’s mesh ever finer and finer. Theories in sociology provide defi-
itions and sets of propositions explaining some facet or facets of social reality.
Usually these propositions are testable, so the validity of the theory can
be either confirmed, modified, or rejected (falsified). Therefore, as German
medical sociologist Johannes Siegrist (2014:1637) observes, every theory
needs to be tested and therefore it is essential that theoretical hypotheses and
propositions are expressed in ways that allow for their rejection if found to
be unsubstantiated or false. Over time, theories may be discarded as social
conditions change or more informative theories emerge; consequently, the-
etorical work is continually ongoing and evolving.

**Theoretical Levels**

Theories in sociology explain social phenomena at three distinct levels:
(1) micro, (2) meso/middle range, and (3) macro/grand. *Micro-level* theories
explain patterns of face-to-face social interaction that regularly takes place
between individuals and within small groups. Typically such theories are de-

erived from relatively small samples of people (possibly 30 or less) whose social
behavior can be directly observed and subjectively analyzed by a researcher
using one or more qualitative methods, such as participant observation, in-
depth interviews, focus groups, unobtrusive measures (i.e., analyzing public
and private records, biographies and life histories, perhaps simple observa-
tions of what people are wearing or where they are standing in a room,
physical trace analyses of activities like souvenirs purchased or even garbage
left behind), ethnographies, and situational analysis consisting of mapping
the positions, situations, and social worlds of those being studied (Clarke,
Friese, and Washburn 2018; Denzin 2017; Denzin and Lincoln 2018; Guest,
Tolley, and Wong 2014). Some qualitative researchers use *mixed methods*—
such as conducting both observations and interviews in the same study—to
ensure the reliability of their findings if each method confirms the findings
of the other method. Or a small sample can be examined qualitatively within
a much larger sample in a quantitative study for the same reason.
Qualitative (non-numerical) methods are generally used in micro-level studies because the small number of participants is usually too few for meaningful quantitative (numerical/statistical) analyses. Although qualitative findings cannot be proven or disproven mathematically, they can be systematically evaluated for their (1) **credibility** (substantiated by data), (2) **dependability** (by using established research techniques), (3) **confirmability** (confirmed by other researchers), and (4) **transferability** (conceptually representative of similar study populations) in order to negate subjective bias or misinterpretation (Guest, Tolley, and Wong 2014). Qualitative studies also may utilize **analytic induction**, which is a method of discovery and verification that requires a researcher to search for negative cases that provide contradictory evidence and, if found, formulate a new hypothesis that is fully corroborated by the data (Denzin 2017).

Qualitative research and the micro-level theories that result from it can provide insightful data on face-to-face social interaction and small-group relationships and circumstances. This is because this type of research takes one directly into the social world of the people being studied and obtains their view of that world in their own words, perspectives, and actions. As I have stated elsewhere: “It puts a human face on what would otherwise be only a narrative of numbers” (Cockerham 2013a:26). However, qualitative approaches that concentrate on what individuals say or do are nevertheless constrained by their small scale. That is, there are limits to what can be achieved by micro-level methods in that such methods are not equipped theoretically or methodologically to explain or measure the dynamics of higher-level (meso and macro) social phenomena or interaction between such larger-scale phenomena (Sibeon 2004).

**Meso-level/middle-range** theories lie between the micro and macro levels. Meso-level theories focus on explaining the behavior and social conditions generated by social structures just above individuals and small groups, such as large groups, communities, formal organizations, institutions, social movements, political parties, and the like. Such collectivities have their own norms, values, and behavioral settings that influence the behavior of the people that are part of them. Medical personnel can interact routinely with their particular set of colleagues and have a shared small-group perspective at a micro level, but their views can also be shaped by the normative atmosphere of the larger health care delivery system within which they all participate, which can be studied at a meso level.

Also at a level above the micro, are theories of the **middle-range** that address specific topics or areas of investigation such as medicalization, health lifestyles, or health disparities. The concept of theories of the middle range was advanced by Robert Merton (1957) who rejected grandiose and abstract theorizing as a standard for sociology, as well as micro-level theories of
limited scope, in favor of what he called “substantive theories” of the middle range based on empirical research and data. These mid-level theoretical approaches typically utilize quantitative methods featuring various types of statistical analysis. Data supporting or rejecting meso-level and middle-range theories usually come from social surveys based on representative samples of large populations.

This approach is preferred when an overall or more general assessment of social phenomena beyond the micro level is needed and reliance on in-depth information obtained from a few individuals is insufficient. Sociologists had turned to the use of statistics between 1890 and 1915 in order to demonstrate that sociology followed established scientific procedures and at the same time develop their own modes of statistical analysis to differentiate their discipline from other, less quantitative sciences (Camic and Xie 1994). Large data sets more readily lent themselves to statistical analyses in which the scientific “truth” of theories can be proven or disproven. Not only can statistics analyze a large amount of information, but also depict how the world is organized and structured beyond individuals and small groups so that theories can be constructed to accurately account for the social processes representative of larger social entities (Babbie, Wagner, and Zaino 2019; Ritchey 2009; Wagner and Gillespie 2019).

Therefore, as British sociologist David Rose and his colleagues (Rose, Harrison, and Pevalin 2010:28, original emphasis) make clear: “most importantly, we have to think theoretically before we think statistically.” What this means is that a causal or explanatory narrative (a theory) is needed that can be formed into a testable hypothesis before a statistical test can be applied. That is, clear causal narratives theoretically explaining social relationships between variables need to be constructed prior to testing and statistical validation.

Finally, there are macro-level/grand theories at the societal level that model large-scale social processes within or between whole societies. Macro-level theories theorize about social processes involving national or even global systems of social stratification, culture, religion, politics, economies, and the like. These are theories about how entire societies and social systems operate. A problem, however, with many theories at the macro level is that they are difficult if not impossible to test because their scope covers such large phenomena. In one sense, they tell us everything, but at the same time they also tell us nothing that can be verified.

This category of theory also includes grand theories that attempt to explain the totality of social structures and social behavior in large, sweeping abstract generalizations about society (Sibeon 2004). While some of these theories still exist (e.g., classical Marxism), they are also typically quantitatively and qualitatively untestable and, as noted by British sociologist Roger Sibeon (2004:9), “bear little relation to concrete empirical happenings in particular
times and particular places.” They also tend to be inconclusive and, as Greek-British sociologist Nicos Mouzellis (2008) adds, even trivial if their universal scope does not consider the historical and cultural contexts in which all large-scale social phenomena are embedded. “On the other hand,” says Mouzellis (2008:218),

when universal theories manage to avoid such trivialities and tell us something interesting, i.e. something we did not know about the social world, they are wrong; their universal and countless scope does not allow specification of the conditions in which the statements put forward are valid and those in which they are not.

Consequently, in medical sociology, as well as in contemporary sociology generally, virtually all theoretical work is either micro or meso/middle range. They are typically evidence-based.

**Agency versus Structure**

Before examining the major theories in medical sociology in the chapters to come, it is relevant to discuss the agency–structure interface which will be on view in each theory discussed. One way to depict structure is as the skeleton of a body or the framework of a house, and agency as the processes taking place within that body or house (Stones 2018). Each can have an effect upon the other. This circumstance becomes a concern in constructing theory in sociology because some theories favor the constraining and enabling role of structure and others emphasize the choice and creativity of individual agency. According to British social theorist Margaret Archer (1995), the agency–structure issue has been the central sociological question since the beginning of sociology. As Archer (1995:1) puts it: “The vexatious task of understanding the linkage between ‘structure and agency’ will always retain this centrality because it derives from what society intrinsically is.”

Stated simply, people exercise choice (or agency) and therein become the “agent” of their behavior, but that behavior typically falls within the parameters or behavioral boundaries set by the social structures (i.e., families, groups, professions, social-class positions) in their lives that have the normative influence or power to shape decision-making. **Agency** is a sociological term referring to the ability of the individual to select his or her behavior, while social **structures** produce regularities in social interaction (by way of socially prescribed norms, roles, and institutions), systematic social relationships (such as kinship, group affiliations, social class, gender, and other forms of stratification), and the resources that are available. Social structures channel behavior in particular directions as opposed to others that might
be taken. While most theories recognize that agency and structure are both important in some way, debate centers over the extent to which one or the other is dominant in determining social behavior and identifying the social situations in which that dominance occurs.

Agency is formally defined as the process by which individuals, influenced by their past but also oriented toward the future (as a capacity to imagine alternative possibilities) and the present (as a capacity to consider both past habits and future situations within the contingencies of the moment), critically evaluate and choose their course of action (Emirbayer and Mische 1998:963).

Agency thus refers to an actor’s ability to (1) initiate self-chosen actions and (2) act independently of structural influences (Campbell 2009), especially in regard to achieving positive future outcomes (Hitlin and Johnson 2015). Advocates of agency-oriented theories in sociology invariably accentuate the ability of individuals to choose their behavior regardless of structural influences or constraints. However, agency theories that underemphasize the effects of structure on the individual run the danger of engaging in what Archer (1995:4) calls “upwards conflation” which is a term she assigns to theories whose behavioral models give so much causal power to individuals that it acts in a one-way, upward direction to create structure and does not seem capable of allowing structure to act back on individuals.

Alternately, proponents of structurally oriented theories emphasize the power of structures to contour individual dispositions and behaviors along socially prescribed lines. Structures, according to William Sewell (1992:19), are “sets of mutually sustaining schemas and resources that empower or constrain social action and tend to be reproduced by that social action.” Schemas are defined as rules or procedures applied to the enactment of social life, while resources are either human (i.e., physical strength, dexterity, knowledge) or nonhuman (naturally occurring or manufactured) that can be used to enhance or maintain power. Sewell equates resources with the power to influence action consistent with British sociologist Anthony Giddens’ (1984) concept of the duality of structure, which depicts structure as having the potential to either constrain or enable action. The enabling function suggests resources increase the range and style of options from which the actor can choose, but constraint means that resources invariably limit choices to what is possible. Although the enabling/constraining functions of social structures might seem contradictory, in fact, social reality is like this in the empirical world in that an individual’s resources may allow them to achieve their choices fully or partially, or be so inadequate that choices are impossible to realize.

In the case of theoretical models in which structure is overwhelmingly dominant, Archer (1995:3) says such theories reflect “downwards conflation” in that they overstate the causal power of structure to the extent that individuals
lack behavioral creativity and choice. Rather, individual choices in behavior are determined more or less exclusively by the social structures in a person’s life; for example, upper-class people usually act in an upper-class manner and lower-class individuals will invariably act in lower-class ways because of the norms and values inherent in their respective class positions. Agency theorists, however, maintain that agency will never be completely determined by structure, but conversely it is also clear that “there is no hypothetical moment in which agency actually gets ‘free’ of structure; it is not, in other words, some pure ... [form of] free will” (Emirbayer and Mische 1998:1004).

So while agency is important, structure is always there in the background. This is because, as Polish-British sociologist Zygmunt Bauman (1999) observes, individual choices in all circumstances are confined by two sets of constraints: (1) choosing from among what is available and (2) social rules or codes telling the individual the rank order and appropriateness of preferences. People do have the capability to act independently of the social structures in their lives, but the occasions on which they do so may be rare because of the constraining and enabling qualities of structures. Nevertheless, there may be situations in which agency is dominant and others in which structure is stronger, yet both are present in all social settings and the quality of a theory rests upon its capacity to distinguish the extent of their relative influence.

The Status of Theory in Early Medical Sociology

Medical sociology was initially a field whose work was largely applied or pragmatic, not theoretical (Cockerham 1983; Scambler 1987). In fact, medical sociology had been characterized in the 1970s and 1980s as “theoretically impoverished” (Johnson 1975; Scambler 1987). It had emerged in the late 1940s and 1950s as a promising new sociological subdiscipline because it had the potential to align itself with medicine in its efforts to provide comprehensive patient care (Simmons and Wolff 1954). Alvin Gouldner (1970:345), in his book, The Coming Crisis of Western Sociology, widely read by sociologists in the 1970s, had called attention to post-World War II efforts to finance the social sciences to help solve the problems of industrial societies and welfare states. What this meant for the fledgling science of medical sociology was a demand for applied and policy-oriented research, as the field appeared to be a prototypical social science along the lines exactly described by Gouldner.

While this was one way to use medical sociology, there was not much in medical sociology to use. The field barely existed. A few studies on the patient-physician relationship and the social ecology of mental illness, along with early essays and books written about medical sociology, had been published almost entirely by physicians. This body of work had not provided the critical mass needed to establish a sociological subdiscipline (Bloom 2002).
Nevertheless, public awareness and common sense that socially and economically disadvantaged people had shorter life spans and more health problems than the affluent, aroused interest in the subdiscipline as Western governments turned their attention from fighting a world war to rebuilding society. A field like medical sociology seemed to be a potentially promising ally for improving population health. Postwar government and private foundation funding thus provided the catalyst for the emergence of a new sociological specialty that could potentially inform medical practice and policy. It was primarily through the stimulus of this external funding that sociologists and health professionals adopted medical sociology as a career field (Claus 1982; Cockerham 1983). Some participants, especially in Europe, had no training whatsoever in medical sociology or had not even taken a class in sociology at a university, but were attracted to the field because of the availability of jobs and financial support for research in a new and potentially interesting health-oriented subdiscipline (Claus 1982; Illsley 1975).

In the United States, where medical sociology developed more extensively than anywhere else in the world, its emergence was stimulated by the expansion of the National Institutes of Health (NIH) in the late 1940s. Particularly important, according to August Hollingshead (1973), a medical sociologist who participated in some of the early research programs, was the establishment of the National Institute of Mental Health (NIMH) that was instrumental in both encouraging and funding joint sociological and medical projects. The NIMH accomplished this by bringing sociologists and medical people together to discover their common interests, then plan and engage in cooperative research. “It was through the impetus provided by this money,” noted British sociologist Malcolm Johnson (1975:89), “that sociologists and medical [personnel] changed their affiliations and embraced the field of medical sociology.” Samuel Bloom (2002:156) describes this situation in his authoritative book on the history of American medical sociology this way:

Although private sources of support remained important, medical sociology’s development at this stage was closely associated with the NIMH, then the newest federal institute.

In my opinion, NIMH, created in 1946, was the single institution that more than any other, was responsible for the emergence of medical sociology as we now know it. In the background there was, of course, the postwar increase of the government’s role in all of science in the United States, and medical sociology was part of that process.

Under the auspices of NIMH, medical sociology’s initial alliance with medicine was in psychiatry. A basis for cooperation existed because of earlier
research in Chicago in 1939 on urban mental health, conducted by Robert Faris (a sociologist) and H. Warren Dunham (a psychiatrist). A particularly significant cooperative effort that followed led to the publication in 1958 of *Social Class and Mental Illness: A Community Study* by Hollingshead (a sociologist) and Frederick Redlich (a psychiatrist). This landmark research, conducted in New Haven, Connecticut, produced important evidence that social factors could be correlated with different types of mental disorders and the way in which people received psychiatric care. Persons in the most socially and economically disadvantaged segments of society were found to have the highest rates of mental disorder in general and excessively high rates of schizophrenia—the most disabling mental illness—in particular. This study attracted international attention and is considered one of the most important studies ever of the relationship between mental disorder and social class. The study played a key role in the debate during the 1960s, leading to the establishment of community mental health centers in the United States, as did other significant joint projects involving sociologists and psychiatrists, such as the Midtown Manhattan study in New York City conducted by Leo Srole and his colleagues (1962).

Psychiatry began moving away from sociology and talking therapies like psychoanalysis in the 1960s toward a focus on the use of psychopharmaceuticals to control abnormal behavior (Cockerham 2017). However, funding from federal and private organizations also helped stimulate cooperation between sociologists and other physicians with regard to physical health. In 1949, the Russell Sage Foundation funded a program to improve the utilization of social science research in medical practice. One result was the publication of *Social Science in Medicine* in 1954 by Leo Simmons (a sociologist) and Harold Wolff (a neurologist) with a particular focus on the link between socially induced stresses and disease. Other work sponsored by the Sage Foundation came later, including Edward Suchman’s book on *Sociology and the Field of Public Health* (1963).

Since funding agencies were not interested in theoretical work on the part of medical sociologists, they sponsored and favored sociological research on health that had practical utility. Theory was absent in these early research efforts oriented toward helping solve clinical problems or address policy issues, rather than developing or testing theory and utilizing it as a tool to enhance understanding. Studies on patient attributes, attitudes, and behavior (Gold 1977), along with their utilization of medical services, were common. Gouldner (1970) pointed out that this situation always pressures theory to be practical as well. And the few theories that were developed during this period tended to be utilitarian, as seen, for example, in Suchman’s (1965) model describing the five probable stages of a sick person’s illness experience.²
As Gouldner (1970:82) stated:

Social theory “for its own sake” or “pure” theory, is always vulnerable and of challenging legitimacy in a utilitarian culture. Insofar as “theory” is regarded as the least practical aspect of social science—that is, as “mere” theory—the social science of a utilitarian culture always tends toward a theoryless empiricism, in which the conceptualization of problems is secondary and energies are instead given over to questions of measurement, research or experimental design, sampling or instrumentation. A conceptual vacuum is thus created, ready to be filled in by the common-sense concerns and practical interests of clients, sponsors, and research funders; in this way sociology is made useful to their interests.

In the case of medical sociology, the subdiscipline is useful to the interests of medicine, various other health-related professions, and policymakers seeking sociological insights about the relationship between social behaviors and conditions relevant to health. In this circumstance, applied research is essential, as medical sociology would not be important if it was not useful in helping people and societies to be healthy as a central contribution of its research orientation.

Nevertheless, by the twenty-first century medical sociology had evolved into more of an independent partnership with medicine in many institutional settings than simply serving as a subordinate area of research. Several factors were important in this development. First, physicians are not trained in medical sociology and therefore generally lack the background to conduct research requiring a sociological perspective and methodologies. They rely on medical sociologists for this expertise. Conversely, medical sociologists are not clinicians. So the grounds exist for a partnership, as each jointly brings his or her particular professional skills to the research enterprise. This is especially the case if the sociologist is a colleague with shared leadership responsibilities in the design and implementation of research rather than a subordinate employee. Second, medical sociologists began examining the field of medicine itself as a social institution. This was primarily seen in the United States, where the medical profession became an object of critical study, as medical sociologists focused objectively on its relationships with patients and other health care providers and on the organizational structure of health care delivery systems (Bloom 2002). The medical profession’s weak professional sanctions for medical mistakes and malpractice, the plight of the poor and medicine’s opposition to national health insurance, and a decline in professional autonomy were all researched critically in the latter part of the twentieth century (see, for example, Hafferty and McKinlay 1993; Light 1993; Ritzer and Walczak 1988; Starr 1982).
While such research could seem hostile to medicine, Brazilian medical sociologist Everado Nunes (2014) states that physicians and medical sociologists nevertheless work well together if a critical role is perceived as objective and constructive, rather than antagonistic. And third, medical sociologists started investigating questions of sociological interest in medical settings, not just those determined by physicians. They independently brought their own topics to the study of health, such as social stress, medicalization, women’s health issues, gender roles in medical practice, neighborhood health disadvantages, health lifestyles, social capital, health disparities, and other questions best answered by a sociological perspective.

As medical sociology was establishing a more solid professional footing, the use of theory became more common. Medical sociologists generally have the same or similar training in research methods and theory. Such training typically emphasizes that empirical research and theory are joint aspects of the same investigative activity (Denzin 2017). Consequently, the appearance of theory at some point should have been a predictable outcome. While some scholars may favor one endeavor as more important than the other, both are nonetheless central to the research enterprise. As German sociologist Richard Münch (1994:7) succinctly observed some years ago: “A scientific discipline does not make progress by accumulating large mountains of data if they have no relation to theoretical questions.”

Consequently, research in empirical settings is one of the two primary analytical pillars of medical sociology. The other is sociological theory. The interrelationship between empirical research and sociological theory is extremely close by necessity. Empirically grounded research is needed to verify or disprove theory, while theory is required to give a shape or form, as well as insight, to empirical findings. According to Aage Sorensen (2009:369):

The integration [of social theory and empirical research] comes about by two activities, theory development and gathering of evidence, inspiring and reinforcing each other: research improves theory and theory improves research. More precisely, evidence produced by research using appropriate methodology, … speaks to the validity and usefulness of theory, while theory inspires procedures and questions for the research enterprises.

Theoretical knowledge, as Münch (1994:4) reminds us, is explanatory in character; however, theory does not simply describe what happened in the past or happens in the present but explains why things happen the way they do or will happen when certain conditions exist. The conceptual framework provided by theory is the medium through which reality is explained and
understood. As symbolic interactionist theorist Herbert Blumer (1931:515) commented about theory in the 1930s, which remains relevant today: “To speak of a science without concepts suggests all sorts of analogies—a carver without tools, a railroad without tracks, a mammal without bones, a love story without love.”

The Status of Theory in Medical Sociology Today

As will be discussed in the forthcoming chapters, medical sociology has moved from being an atheoretical subdiscipline to a field in which theory has become a significant vehicle for expressing its findings and conclusions. While medical sociology had acquired a reputation for being atheoretical that persisted for decades, even after it was no longer true, considerable theoretical work in the field had nevertheless been taking place (Cockerham 2005, 2013a, 2013b, 2013c; Cockerham, Hamby, and Oates 2017; Cockerham and Scambler 2016; Collyer 2015; Conrad 2007, 2013; De Maio 2010; Link and Phelan 1995; McDonnell et al. 2009; Phelan and Link 2013; Scambler 2012, 2018). Much of it occurred in sociology departments in American universities, as medical sociology matured as a subdiscipline and became more closely aligned with general sociology through their commonalities—namely mutual theories and research methods. Contemporary medical sociology came to have a theoretically rich and abundant literature with its own theories specific to the subdiscipline, some of which are based on perspectives shared with sociology at large and others that are unique to its subject matter.

The result is that medical sociologists are making greater use of sociological theory than ever before to amplify the explanatory power of their empirical findings. Theory is typically required to be utilized in research papers submitted for publication in medical sociology’s scientific journals. A common question for the reviewers of such papers judging their quality pertains to whether or not the paper uses or contributes to theory. This situation clearly indicates that the use of theory is a general requirement for success in publishing research findings in medical sociology. It also suggests that through theory medical sociology is improving its connection to general sociology, as sociology increasingly recognizes that considerations of health are evident in the everyday social lives of people and medical sociology has the capacity for explaining it. Medical sociology has, in fact, taken the lead in developing its own theories rather than relying on general sociology to produce relevant theories. Evidence for this is found in the current upsurge of theoretical work in medical sociology, marking the field today as a highly theoretically engaged sociological subdiscipline, which is the subject matter of this book.
Summary

As noted in the beginning of this chapter, the purpose of this book is to describe, discuss, and provide examples of the major theories commonly used in medical sociology with a focus on contemporary theory. A central theme of the chapter has been to illustrate the important role that sociological theory has in the practice of medical sociology. This is because its theories distinguish the subdiscipline from virtually all other scientific fields engaged in the study of health and illness. Such theories provide a sociological perspective or gaze on medical care, disease, health disparities, and other facets of the “social” in relation to health. A mastery of theory is a critical skill for medical sociologists.

As for medical sociology, its importance becomes particularly obvious when epidemiologic transition theory, a theory based in epidemiology, depicts the manner in which the major causes of mortality have changed over time. The theory maintains that infectious and parasitic diseases were prevalent in causing mortality in Stage 1, receded in Stage 2, and were largely replaced by chronic diseases, namely heart disease and cancer, in Stage 3. However, this typology was subject to change again when deaths from cardiovascular diseases abruptly declined after 1960, leading to suggestions that newly emerging infectious diseases be added to Stage 3 or a new Stage 4 be created that recognized the cardiovascular revolution, or the degenerative diseases of aging or hybristic (a mixture) diseases that includes risky behavior and behavioral features of pandemics. Social causes gain in significance in each stage.

A theory is a set of statements or propositions claiming that one class or type of phenomenon is connected in some way to another class of phenomenon that produces a certain condition, behavior, or outcome. Theories explain and provide understanding about what causes something to invariably happen in the way that it does. In sociology, there are three levels of theoretical explanation: (1) the micro, (2) the meso/middle range, and (3) the macro/grand. Virtually all sociological theories today are in the micro or meso/middle range in order to be tested with empirical data so it can be determined whether their conclusions are valid or false. Macro and grand theories make sweeping generalizations about large-scale social phenomena that cannot be tested empirically. They tell us everything about something but nothing that can be verified with certainty since their propositions are too general to be validated with scientific accuracy.

There is also the agency–structure interface in which some theories emphasize agency, a term referring to the ability of individuals to act independently as their own agents in choosing their behavior. Other theories are instead oriented toward explaining the effects of social structures on
channeling individual behavior down particular pathways as opposed to others that might be taken. While most theories recognize that agency and structure are both important, there is debate over the extent to which one or the other is dominant in determining social behavior and the social situations in which that dominance occurs.

As for the status of sociological theory in medical sociology, the subdiscipline was one-sidedly atheoretical in its early development. Funding agencies, such as the NIMH, which were instrumental in sponsoring initial research in the field, were not interested in theoretical work on the part of medical sociologists. Rather, they favored research on health that had practical utility by way of helping to solve clinical problems or provide policy recommendations. This situation changed, however, as medical sociology evolved into a highly theoretically engaged specialty.

**Guide to Critical Thinking**

1. What is a sociological perspective and how would it apply to analyzing health problems?
2. How does epidemiologic transition theory illustrate the increasing importance of medical sociology in the study of health and disease?
3. Define theory and explain its use in research.
4. Describe the different levels of theory in sociology and their characteristics.
6. Why did the use of theory in medical sociology become commonplace?

**Notes**

1 Because of space limitations, not all of the many theories in medical sociology can be included in these pages but only those that are currently most prominent and for whom a sizeable body of literature exists.
2 According to Suchman (1965), the illness experience consists of (1) symptom experience (feels sick), (2) assumption of the sick role (acts sick), (3) medical care contact (sees a doctor), (4) dependent-patient role (becomes a patient), and (5) recovery and rehabilitation (gets well). Even though the illness experience may not involve all five of the stages and can be terminated at any stage, the model depicts the types of decisions and actions patients take over the course of an illness.
3 For example, medical sociologists partnered with physicians and other health scientists in a study of African American health funded by the National Institute of Minority Health and Health Disparities (NIMHD) in 2012–2017 as part of
the Mid-South Transdisciplinary Collaborative Center for Health Disparities Research in the Division of Preventive Medicine at the University of Alabama at Birmingham (UAB) School of Medicine (see the January 2017 special issue of the American Journal of Preventive Medicine, co-edited by Mona Fouad, William Cockerham, and Mario Sims).

Suggested Reading


Contains chapters providing an overview of medical sociology, including theory, by an international group of authors who are specialists in their fields.

References


