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# Health, Illness, and Healing in an Uncertain Era: Challenges From and For Medical Sociology\*

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*The current situation in health care organizations, among providers and for people, dramatically challenges the “business as usual” roles of medicine, government, insurance companies, the community, and the university. Health care reform marks the first attempt in a century to consider a reconstruction of the social contract between society and medicine. While sociology stands as one of the earliest social sciences to systematically study the health care arena and create a health-focused subfield, there is a perception, not without support, of a desertion of identity from within, an encroachment by other areas from without, and abandonment by the parent discipline. We argue that these situations in medical arenas and in research fields require serious rethinking. The key lies in understanding how these phenomena are related to each other and to larger social forces, and how they offer opportunities, rather than signal limitations, to medical sociologists. We turn to the theoretical tools of sociology to help unravel the complicated challenges that face both policymakers and researchers. After framing these issues in a sociology of knowledge perspective, we use the case of “utilization theory” to illustrate the connections between society and systems of care (as well as studies of them) and to create a future agenda. We end by raising three basic questions: (1) Why is a sociological perspective critical to the understanding of change and reform in health care? (2) Why is medical sociology critical to the survival of the general sociological enterprise? and (3) Why is general sociology critical to the research agenda in medical sociology?*

## INTRODUCTION

Medical sociology developed as one of the earliest of the social science subfields to target the study of health, illness, and disease as well as the nature, operation, and use of medical systems as important areas of scholarly inquiry and human social activity (Bloom 1986).<sup>1</sup> Much of early social science funding for medically-related topics provided through the National Institute of Mental Health (NIMH) (particularly the Laboratory for Social Environmental Studies) and the National Center for Health Services Research went to sociologists, premised on a belief in the centrality of a sociological understanding of health and

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health care and the complementary growth of relevant scholarly work located in sociology. There is a perception, not without support, that the importance, appreciation, and uniqueness of the sociological approach in health has diminished of late while other social sciences as well as multidisciplinary areas such as health services research and stress research have proliferated, prospered, and undermined the place of sociology.

Current discussions in health research often focus on “small” questions which downplay the contextual focus of sociology. Providers, trained in a narrow view of disease and constrained by the current medical system, seek the causes of disease in risky behaviors—psychologists try to understand what predisposes individuals to those behaviors, and economists identify their costs to the system. Medical sociologists, forgetting or ignoring the major integrating ideas that originally informed the sociological study of health and health care, have become less likely to ask “big” questions and, when they do, find themselves ignored by colleagues, the public, and policymakers. They, like the others around them, have become engaged in tinkering with solutions to immediate logistical and medical problems, offering mere technical skills and, indeed, behavioral scientific efforts that are indistinguishable from one another (Mechanic 1993).

Yet despite this assessment there is a renewed sense of optimism within a small quarter of the subfield about the role of medical sociology in current debates and events. The locus of this somewhat surprising optimism lies not at the core of the subfield but in the extraordinary changes occurring in society, in the medical system, and in the general discipline of sociology. This optimism finds voice in no particular organized group within sociology but among a growing number of individuals from all quarters, including ourselves. Regarding the medical scene, we see for the first time under the modern, scientific medical system a clear recognition of the importance of some social factors in the occurrence of health problems, as well as increased attention to environmental sources of disease, to alternative systems of healing, and to social “holes” in care. For the first time in nearly 30 years, a new federal administration recognized the failure of the medical system, insurance provision, and legal solutions, and placed the reform of the medical care system high on its agenda. For the first time in more than a dozen years, the federal administration does not disdain social research, nor blame it for the current state of society; in fact, it seems to appreciate and take seriously social science research for the policymaking process, even though the original Health Care Reform Panels seemed to be dominated by economists and short on sociologists. While major reform at the federal level has not been a success to date and now looks unlikely given the Republican takeover of both branches of Congress, the discussion during 1994 led to real change (e.g., declining rate of inflation in health care costs) based on reforms within the health delivery system which are likely to continue.

Regarding the field of sociology, there have been new discussions at national meetings and in the media (e.g., see *Newsweek's* Kantrowitz 1992) about the place and future of the discipline, inspired by: (1) the threat of department closings; (2) the projected decrease in the American Sociological Association's membership; (3) the proliferation and strength of sections within the Association; (4) a clear disaffection within the mainstream as well as its more applied areas; (5) a blurring of the boundaries among fields of knowledge, and (6) a painfully keen awareness of its limited advisory role to policymakers and the public (see also Lipset 1994).

This paradoxical pairing of pessimism and optimism about health and its sociological study forms the foundation for the issues we raise and the questions we ask. We begin by offering a basic perspective which argues for the crucial role of a sociological perspective in the current era. We turn backward to show how we arrived at this juncture by applying this perspective to periods of research addressing how, when, and why individuals use formal medical care. We draw specifically on the area of health care utilization or health services research, as it is increasingly being called, because while sociologists played key roles in the development of dominant explanatory models, health care utilization represents an area where sociological models are increasingly being displaced by psychology on the one side and economics on the other. We also chose health services research because of its prime importance to the architecture of health care reform and because we both have addressed utilization in our own research.

Finally, we turn forward and pose three sets of concerns that address the crucial and

reciprocal relationship of medical sociology to policy and to its parent discipline. We use Akers' (1992:4) distinction between a field of study or subfield which is problem-defined (e.g., medical sociology) and a discipline which is defined by a perspective (e.g., sociology). The first concern joins the study of health, illness, and healing to real-world concerns, discussing reasons why policymakers must take seriously the larger view that sociology traditionally offers. The second and third concerns tie the subfield and its parent discipline together as mutually dependent. We begin with the easy task for this audience, discussing why sociology places itself at risk by failing to strengthen its tie to the field of medical sociology. We follow with a trickier issue—why medical sociologists in turn proceed at risk by failing to maintain a tie to the theoretical center of sociology. We argue that the success of health care reform, the fate of sociology, and the strength of medical sociology are inextricably linked and depend on a fundamental reconfiguration of agendas.

## A PERSPECTIVE ON THE CHALLENGES OF MEDICAL SOCIOLOGY

A period which saw great prosperity in the United States also marked the beginning of disaffection with major social institutions and fields which studied them. Three phenomena are most relevant to our discussion here. By the late 1970s, we saw a decrease in public confidence in medicine and science, with medical sociologists including sections entitled "the end of the germ theory" in textbooks (e.g., Twaddle and Hessler 1977). By the middle 1980s, sociology was thought of as in the "doldrums" by many because research agendas seemed exhausted, because sociology had lost its impact on public policy and perhaps even its "impulse to public action," and because the quality of students reputedly declined (Collins 1986:1336). Likewise, medical sociology seemed to be at a "crossroads" because the major socio-medical conditions under which medical sociology grew up were changing radically, diminishing its centrality among the medical social sciences (Pescosolido 1987). In this section, we review the nature of these dissatisfactions and bring them together.

In essence, we analyze the current situation using a sociological perspective. We attempt to understand the shifts in medicine, in medical sociology, and in sociology by placing them in the context of their connections to other major social institutions. This is, after all, the daily and commonplace enterprise in which we engage. The argument here is a simple one: these dissatisfactions all represent symptoms of a larger social phenomena; that is, a transition to a new societal form where the original foundations of medicine, sociology, and medical sociology, all founded upon the birth and development of modern industrial society, no longer fit.

### *The "Crises"*

Perhaps the most overworked phrases in the popular and academic presses of the last two decades have to do with the reporting of this or that "crisis." The 1970s, even the 1960s according to some postmodernists, marked the beginnings of a profound change with which we are only now coming to grips. Richard Nixon announced the existence of the now familiar "health care crisis." Women demanded the right to give birth at home, with midwives as attendants and without legally-prescribed, standard medical regimes (e.g., silver nitrate eyedrops to prevent gonorrhea-induced blindness). Americans began to hear terms like "unnecessary surgery" and to demand input on life-and-death decisions. Around this time, enrollments in the College of Naturopathy in New York City quadrupled and individuals in growing numbers and from unexpected social classes turned to acupuncturists and other forms of "alternative" medicine. Much to the surprise of the American Medical Association, Congress approved the coverage of chiropractic under Medicare. The World Health Organization began an initiative to explore the potential of traditional medicine. In sum, it seemed that there was an erosion of the professional dominance of medicine (DeVries 1985; Haug and Lavin 1983b; Salmon 1984). At the same time, though they continued to hold their own personal physician in great esteem, Americans decried the growing number of uninsured

and the limited access to medical care. They demanded that the government devote large sums of money to traditional biomedical research for various diseases. In short, the honeymoon between Americans and the new form of scientific, modern medicine appeared to be over. Biomedicine's limits on a number of fronts (including chronic illness) were coming to the fore even as it continued to offer more sophisticated, technological solutions to diagnosis and treatment (Strauss and Corbin 1988).

Academic difficulties followed. Critiques of medical sociology came from within as well as without. Olesen (1975) and Gold (1977) have challenged assumptions of much work in medical sociology, as has the work of critical medical sociologists such as Elling, Waitzkin, and Navarro. Gold argued that medical sociologists tended to start their research with physicians' diagnoses—in today's terminology, already socially constructed phenomena. The perennial discussion within the Medical Sociology Section of whether to change the official name of the section to a more encompassing and less co-opted label (e.g., Sociology of Health, Illness, and Healing) was counterbalanced by the tendency of medical sociologists to take for themselves other labels, such as behavioral scientists, stress researchers, and health services researchers. Whatever the original contract between the Medical Sociology Section and the American Sociological Association, much discussion among medical sociologists, particularly in Council, centered around the perceived slights of the Association toward the Section. In general, ASA administration and the "elite" of the discipline continue to be perceived as hostile to all sections, with folk legends fueled by "the latest incident" and numerous informal tallies of the contents of the discipline's general journals that suggest underrepresentation.

Even more striking, there seemed to be a change in the larger societal support for medical sociology. As the medical care sector grew in size, scope, and importance following World War II, so did medical sociology, finding much support for training and research from the National Institute of Mental Health (Bloom 1986; Mechanic 1993). However, significant dislocations occurred. The National Center for Health Services Research, where sociologists once held major sway, became dominated by economists and by issues of cost containment, under its reincarnation as the Agency for Health Care Policy and Research, with few staff and even fewer resources targeted to central sociological concerns of access, differential treatment, and changing professional roles in health care delivery. The fate of the NIMH Laboratory for Social Environmental Studies, which has produced and continues to produce some of the best sociology, medical sociology, and sociology of mental health, is in jeopardy.<sup>2</sup> In general, many report their sense that medical sociology seems less recognized and understood than in previous eras.

Whether the parent discipline engaged in systematic discrimination against the subfield as many perceived or whether the neglect of medical sociology lay in the disciplines's own internal squabbles is not the main issue. The proliferation of subfields within sociology produced small, internal audiences who ignored, in the main, what sociologists investigating other topics were discussing. Research lines were not atheoretical; rather, they became topic-oriented rather than concept-oriented (Collins 1986). Sociologists, in larger proportions than ever before, turned away from current social problems and back to the past to examine socio-historical phenomena. Traditional battles, for example, over the superiority of qualitative versus quantitative approaches or social theory and applied sociology did not subside. Most importantly, a few departments of sociology were being targeted for closure as universities' resources were squeezed. The general discipline found itself increasingly unable to describe itself to the public, university administrators, to colleagues in other fields, and even to each other.

### *Bringing Problems Onto Common Ground*

Here we look sociologically for the commonalities and larger social causes of the disarray described above. We frame the question as a general one, one that places it squarely in the realm of the sociology of knowledge. Reflexivity applies not only to the subject matter we choose to study "out there" but to the enterprise in which we engage (Ennis 1992). The

sociological lens helps us gain an understanding of the growing wariness among members of the population about the disease-inducing properties of a man-made environment, among sociologists about their own agenda, and among medical sociologists about their own identity and loyalties.

We see modern medicine, sociology, and medical sociology each as intellectual structures, each in “crisis” and each tied to a larger social structure. We ask: Is there a general feature in society that helps us understand these particular situations? The answer we offer, in broad brush strokes, is relatively simple. *We stand at a transition between social forms. The society that created the opportunity for the rise of a dominant profession of medicine, for a new discipline of sociology, and for a spinoff of the subfield medical sociology, is undergoing major change. As the larger social system unravels in the face of rapid social change, established problems, solutions, and understandings are challenged because they do not as successfully confront current realities.*

Modern medicine, based on a social contract between physicians, the state, and the public, addressed the problems of an industrial form of society. As Brown (1979) and others have argued, the correspondence between the mechanistic imagery embedded within an industrial form of production, germ theory, and the general promise of science to cure social ills, allowed proponents in the growing professional middle class to argue for the preeminence of “scientific” medicine over other systems (Larson 1977; Starr 1982). As part of the current transition to some new societal form, social institutions like medicine falter in their ability to address population health and illness problems and do not provide a good fit with how providers expect the system to work and the way the public uses medical care.

Second, we often view sociology as a structure rather than a dynamic institution whose prominence and cultural capital rises and falls, sometimes in small ways (e.g., the student influx into sociology in the 1960s) while other times in large ways (e.g., its successful establishment). Sociology in the United States arose, like modern medicine, at the turn of the last century, to address the massive social dislocations, including large-scale population movements, resulting from the transition from agrarian, rural to urban, industrial society. The discipline was founded on classics which, like *The Protestant Ethic and the Spirit of Capitalism* (Weber 1958), asked how this transition was rooted in the cultural beliefs of newly formed religious groups and how it affected life chances, including mortality and morbidity. Durkheim (1951), in perhaps one of the first primarily socio-medical treatises, *Suicide*, looked to self-induced mortality as a seismometer for where dislocations took their greatest toll. Although more recent stress research has its bases in both psychology and public health (e.g., the work of Selye and Cassel), the sociological tradition began with the potential impact of Durkheim’s “social integration,” renamed social support (e.g., Myers, Lindenthal, and Pepper 1975; Thoits 1982). Sociology proved to hold a powerful lens with strong unifying concepts that permeated other social sciences. If, however, the basic structure and institutions are shifting, then the conceptualization on which research lines are based needs to be reexamined.

Third, medical sociology, addressing classic questions of social order and social conflict, came to offer general theories of the operation of medical systems and of the way individuals became practitioners and patients. There was never a single paradigm that informed medical sociology efforts but, as Mechanic (1993) argues, powerful conceptual frameworks like those described above stimulated early initiatives (see also Gerhardt 1989). They held wide sway across other disciplines, and within sociology were heralded as major theoretical contributions. For example, the sociology of the professions provided the linchpin in understanding the preeminence of “modern” medicine and its link to shifts in the class system and within educational institutions. This work became the reference point for studies of other professions. While Freidson’s (1970) concept of professional dominance captured medicine’s clinical and institutional “grasp” on society in the 1960s, later shifts from a provider-driven to a buyer-driven system, with growing concerns over costs and unnecessary procedures, found voice in theories of countervailing power and competing systems (Abbott 1987; Light 1993).

Because sociology, unlike many of its sister social sciences, aimed to look across such social institutions as politics, the economy, and the community in order to link them together to describe the social landscape of modern society, it enjoyed a great deal of public and academic attention. *That said, it may be that sociology holds its greatest appeal in times of disarray.*

*When society is in the process of building up or breaking down, a focus on larger contours overshadows the details.* In such times sociology may prosper. However, during periods of stability or largess, when we have come to a basic understanding of society, academic attention and social policy tend to focus on fine tuning (in which sociologists have a smaller role), tinkering with the system (which perhaps economists do better), and concentrating on how cognitive structures operate under these systems (which psychologists may well do better).

If we are in the midst of another great social transformation, then we can expect individuals, including sociologists in their work roles, to experience dislocation. However, if this analysis is correct, it offers an optimistic view and sets an agenda for sociology and medical sociology. While existing concepts and theories have general value, many of those on which sociologists and medical sociologists rely reference early or middle stages of industrial society. They may or may not be useful to understanding the foundations and operations of a new social form. Because of recent foci on small questions, we do not know much about how the large-scale contours of society have changed. And while “postmodernist” works punctuate this sense of change, they offer little guidance insofar as they embrace ambiguity as the most salient feature of future social life. Yet a number of consistent themes have emerged: the breakdown of long-term social contracts; the decreasing salience of place in the face of electronic interactions and the rise of the “global village”; the loss of faith in the supreme power of science (including biomedicine) to conquer nature; and the internationalization of capital, downward spirals in economic well-being, and increasing inequities (see, for example, Wolfe 1991; Seidman and Wagner 1992). These changes require a basic reorientation to large-scale issues. We turn now to an example to illustrate.

#### THE CASE OF “UTILIZATION” THEORY

We use utilization theory to trace the rise of sociological preeminence in the study of medical arenas, to mark how it has dissolved with multidisciplinary partnership, and to sketch out the relationship between recent social changes and sociological retooling. “Utilization” is a particularly useful case for a number of reasons. First, it is an area that some feel is “locked”—that is, we have solid approaches that incorporate the best of all disciplinary perspectives. Few in sociology now consider utilization to be an area of theory development. Second, from our experience, many sociologists involved in utilization research identify themselves not as medical sociologists but as health services researchers or behavioral scientists. Third, sociological dominance has been overtaken by psychology on the one side and economics on the other with sociologists replaced—in their own and the public’s mind—as primary practitioners. Finally, the case of utilization demonstrates that sociologists need to reconstruct their own agenda. If we continue to embrace current directions as unproblematic, we have little theoretical role, at best a “catch-up” role in analytic modeling, given the greater technical skills of economists (Davis 1994) and, with our training, no practitioner role. Under these conditions we cannot expect any serious attention from policymakers, the public, or our own discipline. But if we assume that major societal shifts question the utility of dominant theoretical models, the methods used to examine them, and the policy implications we draw from them, then sociologists again move to center stage in constructing a research agenda that links individuals to institutions.

Using a sociology of knowledge framework, we connect the sociological study of individuals’ health and illness behavior to two contextual issues, the larger socio-medical context and the character of the discipline of sociology with particular references to the nexus of sociological training.<sup>3</sup> Table 1 summarizes our conceptualization of four periods in the relationship between sociology and the understanding of how individuals use formal medical care services. This should not be confused with a periodization of the history of the medical profession or sociology. The dates, here as throughout, remain heuristic because we are interested in themes or trends in approaches. Dating the beginning of a new approach and marking the end of the dominance of another are tricky since work done in one tradition continues to appear after the landmark work signaling the next stage is published, producing multiple lines of inquiry.<sup>4</sup>

TABLE 1. Models of Health Care Utilization

	Stage I 1930–1955	Stage II 1955–1968	Stage III 1968–1980	Stage IV 1981–Present
Socio-cultural Context	Early era of professional dominance	Golden era of professional dominance	Challenge of professional dominance, “Health Care Crisis,” passage of Medicare and Medicaid	Waning of professional sovereignty, decreasing confidence in institutions, Changing socio-medical profile
Sociological Context	Large-scale description of social institutions and phenomena, community-based studies	Growth of federal funding in social sciences, Functionalism	Dominance of survey research, national-level studies, econometric Modeling, NIMH Training Program in major departments	Historical sociology, political economy, “Doldrums” critique
Model/Research Orientation	Use of “scientific” versus “quack” medical practitioners	Use of scientific physician or not	Volume of modern scientific use	Outcome, type of use
Predominant Explanations	Socio-cultural alignment of individuals’ beliefs with traditional or modern system	Ideo-typical set of role rights and obligations for physicians and patients	Systematic schemes for “contingencies” and “structures” influencing individual use	Need for services
Issues Examples	Acceptance E.L. Koos	Function Talcott Parsons August Hollingshead	Access Ronald Andersen Odin Anderson Marshall Becker	Cost Marie Haug David Mechanic

*Period 1: The Beginnings of the Sociological Study of Health Care Use—1930 to 1955*

Stage I encompasses the period before 1955, primarily from 1930, before medical sociology was an identifiable sociological subfield. The salient features of the socio-medical context during this early period lay not in what facilities looked like, how many there were, or how they were financed, but on the relative newness of the formal, scientific, modern system of medicine. Prior to the early 1900s, the forms of medical care practiced (e.g., bleeding and purgatives) did not call up images of “science-based” treatment. The Flexner Report of 1910, based on the progress and promise of “science” and the germ theory of disease, helped to seal a social bargain between the emerging modern, scientific form of medicine and the state. Rather than outlawing other forms of medicine, such as homeopathy which was favored by the upper classes, the content of medical licensing exams was changed. Individuals not trained in the new medical schools did not fare well (Brown 1979; Freidson 1970; Starr 1982). “Inferior” (i.e., nonscientific) medical schools were driven out of existence, and the economic status of the profession of medicine rose so that physicians’ incomes doubled from 1900 to 1928 (Light 1989). So, too, nursing moved toward the science model, changing dramatically from its historical roots (Davis 1969).

During this period, sociology in the United States was likewise in its early stages with positions and some departments established in the last quarter of the nineteenth century. Sociologists made large-scale descriptions of the new, modern society that surrounded them, developing concepts useful to the task and focusing on local places to anchor their studies. No theoretical approach or method held sway, and much work used both qualitative and basic quantitative analyses. Some work retained a more pragmatic focus and a goal of changing society, while other work focused on development of the discipline itself and its theoretical tradition. But there was little distinction among individuals who studied different substantive areas.

Researchers focused on a diverse array of broad-based topics, sometimes using health-related issues as one part of an overall profile (e.g., the Lynds’ [1929] Middletown studies; Ogburn’s [1922] use of medical care as his first case study of cultural lag) and sometimes making health-related issues the major focus (e.g., Koos’ *The Health of*



*Regionville*, 1954). Studies tended to be community-based, and in the University of Chicago tradition, turned their attention to illness and its treatment as major, contemporary social problems. Those who trained their sights on health, illness, and healing did so because they saw it as a crucial microcosm of social life (e.g., Wardwell's [1955] study of chiropractic as having a marginal social role). Most medical sociologists were educated in major sociology graduate programs as general sociologists. They drifted into interests linked to medicine and health. There were no specific training programs in medical sociology, and the subfield was rarely listed as an area of specialization. Finally, as Bloom (1986) points out, in this phase of the institutionalization of medical social science both academic and public policy concerns were central to sociologists (see also Twaddle 1982).

Medical care choices provided an indicator reflecting social change at a larger level, and the changing ideologies and behavior in this new society at a smaller level. Research questions in this period centered on who is likely to go to a doctor. The conceptualization, always made explicit by anthropologists and sometimes even by sociologists, turned on the use of modern versus traditional forms of medical care. Researchers asked who went to physicians and hospitals and who continued to use other forms of medicine. Early explanatory models cast lay decision-making in structural normative terms that echoed the larger historical reaction to microeconomics (Pescosolido 1992:1110). Although sociologists and anthropologists emphasized structure and culture, respectively, individuals were seen much as puppets in socio-cultural locations which pushed them to use one or another form of medicine. Education, social class, and rural/urban location reflected the strength of traditional, nonscientific belief systems that discouraged the use of modern medicine. There was little differentiation among sociological work and the work of anthropologists like Charles Erasmus (1952), W.H. Rivers (1927), H.A. Gould (1957), or Ozzie Simmons (1955), who grappled with changing beliefs about medical options and the impact of technology on those options.<sup>5</sup> Much more than anthropologists, however, sociologists were captivated by the promise of the new form of medicine to combat the infectious and parasitic diseases that ravaged existing populations in modern and premodern societies.

### *Period 2: The Emergence of a Sociological Perspective*

This period, spanning almost 20 years from the mid-1950s through the late 1960s, best represents the celebration of "modernism" in American society, the growth and prosperity of the American economy, and the expansion of American influence in world affairs. Both were captured by Henry Luce's remark that we had entered the "American century." This optimism was reflected in the institutions of medicine, higher education, and sociology, all central to the history of medical sociology (Lipset 1994). Following World War II, public faith in the promise of science to ensure progress and cure social ills was high. Medicine, as part of this, enjoyed its share of resources and grew. Sociologists, as part of an expanding university, prospered. Despite other agendas, much of the intellectual energy of sociologists focused on the development of functionalism, a theory which looked to the survival needs of a society to understand the structure of roles and institutions. Functionalist theory itself was a celebration of the "success" of modern society; things were the way they were because it was necessary to ensure the continuation of society (see also Merton 1949).

Yet this success was not unqualified for sociology. As part of the "social" sciences, sociology received mixed acceptance from the "scientific" community in the debates which drew the boundaries, for example, around the mission of the National Science Foundation. Compounded by the Cold War's confusion of "social" with "socialism," as well as the internal struggle over the appropriate place of "government influence" in social science, sociology came to emphasize its theoretical rather than applied interests even when federal funding sources recognized sociology, and particularly medical sociology, as "legitimate" (e.g., the establishment of the Laboratory for Social Environmental Studies at the National Institutes of Mental Health where John Clausen, Morris Rosenberg, Leonard Pearlin, Roberta Simmons, Erving Goffman, Melvin Kohn, and Carmi Schooler all conducted major work in medical sociology and mental health; Bloom 1986). In departments where sociologists were

undertaking these kinds of studies, students were now being trained (particularly by the end of this era) with some identification as medical sociologists (or an area of specialty in medical sociology). During this period, many of the strongest sociology departments were developing specializations in medical sociology within their PhD programs, often with NIMH support. This brought strength to the integration of medical sociology with broader sociological concerns.

After World War II, medical practitioners and the parent discipline began to invest in the coupling of the sociological imagination with an exploration of themes linked to medicine and health care. Two major types of research sealed this partnership. The first, represented by striking studies such as Hollingshead and Redlich's *Social Class and Mental Illness* (1958), succeeded in convincing practitioners as well as scholars that what happened beneath the canopy of modern medicine (e.g., diagnosis and treatment) was subject to *social*, not just biological, forces. The second, best represented by Parsons' *The Social System* (1951), demonstrated how social science perspectives shed light on how medical systems, practitioners, and the public respond to health problems and, conversely, how the medical arena was central to understanding the way societies work. Drawing both intra- and interdisciplinary attention to concepts such as the "sick role," Parsons simultaneously legitimated both the sociological approach in the medical arena and medically-related topics in the discipline of sociology (see also Cockerham 1983).

On utilization, Parsons did not deal with traditional, indigenous forms of medicine; he simply ignored them as meaningless to the survival and functioning of modern society. As men of science, physicians were thought to be "affectively neutral," not influenced by non-medical characteristics of their patients. As players in the modern world, prospective patients used "generalized objective criteria," also unaffected by social location, to make rational decisions in concert with those around them about when to enter the "sick role." Parsons is widely regarded now as having sketched an ideal type, a "fixed standard by which we can measure the variable deviation of reality" (Freidson 1961:381), a "yardstick" against which the real practice of medicine might be compared (Levine and Kozloff 1978; Siegler and Osmond 1973). That standard reflected the optimistic view of an optimistic time and an optimistic social science. The hundreds of studies which followed over almost two decades dominated by the Parsonsian scheme challenged the notion of entrance into the sick role and/or the patient role as "inherently universalistic" (Parsons 1951:438). To a point, they documented that social, cultural, and illness characteristics mattered. Some studies found that practitioners did not grant individuals with stigmatized diseases the rights of the sick role (Chalfant and Kurtz's [1971] study on alcoholics); others showed that ethnicity shaped patients' responses to pain (Zola 1963) along with a variety of other social, cultural, and social-psychological leanings toward the use of medical care (Kadushin 1966; Phillips 1965; Suchman 1964; see Kasl and Cobb [1966] for a review). By the early 1970s, sociologists documented how organizations and communities often structured access to the "sick role" by controlling, for example, the number of beds available and military deferments (Waitzkin 1971). These studies tended to focus on one concept or variable at a time, using percentages and cross-tabulations (with the most technically skilled of them much in the analytic framework that Lazarsfeld pioneered) often from small survey designs.

### *Period 3: Sociologists and Dominant Models of Health Care Use*

This period, beginning in the late 1960s and continuing through the late 1970s, signals the paradoxical coupling of challenges to medicine and the establishment of dominant models. While the "superiority" of modern medicine was no longer debated, questions about its relevance for chronic illness were being raised (Twaddle and Hessler 1977), and issues of access to care and equality in treatment became central in debates about Medicare and Medicaid (see Aday, Andersen, and Flemming [1980] for a review). Nursing practice changed and nurses questioned their subordinate place in the hierarchy of medicine (Ashley 1976; Reeder and Mauksch 1979). In sociology, the functionalist approach culminated in the appearance of the *American Occupational Structure* (Blau and Duncan 1967) which, according to Coleman

(1986:1311), represented a new brand of functional theory. Reflected in new utilization models, concern shifted from the community to the individual as a unit of analysis, from local studies to a focus on national samples, and from qualitative or multi-method research to quantitative survey research.

Medical sociologists educated in this period were still predominantly located in strong sociology departments, but students now entered the program with a clear goal of specializing in medical sociology. Partially linked with the growth of training programs in the NIMH and the National Center for Health Services Research (NCHSR), funding for medical sociologists became available within sociology departments, and a sense of “separate” programs within the context of sociology departments emerged. Medical sociologists were as likely to hold their first academic positions in health care settings such as in schools of public health or departments of behavioral sciences and preventive medicine in medical schools as they were to hold them in sociology departments.

In utilization research, these factors came together in formal theoretical frameworks and multivariate causal models. The period from the late 1960s to the early 1980s represented the development, testing, and refinement of these approaches. Focusing on how often and under what conditions individuals sought out care—and how much and what they used—researchers, implicitly or explicitly, saw individuals as active, rational decision makers.

Under this agenda, the late 1960s saw the stabilization of sociological preeminence, if not dominance, in utilization research. Two influential theoretical models, the Health Belief Model (HBM) (targeting health behavior or prevention; Rosenstock 1966) and the Socio-behavioral Model (SBM) (targeting more specifically illness behavior and overall use of medical and health care; Andersen 1968) organized the wide variety of contingencies laid out over the previous 20 years. These models emphasized differentially the same set of factors along one of the classic faultlines in sociology, social psychology, and social organization. The HBM was conceived originally within the psychology side of social psychology (Rosenstock 1966), but was developed further by and closely linked to the work of Marshall Becker (Becker 1974, 1976; Becker and Maiman 1983; Eraker, Kirscht, and Becker 1984). This model focuses on perceptions, beliefs, and other social psychological characteristics that influence whether individuals feel at risk for problems and position themselves to change health behaviors and to utilize health care services. The SBM, on the other hand, tended to lump social-psychological factors, socio-cultural characteristics, and basic socio-demographics together into a category of “predisposing” characteristics (Andersen 1968; Andersen and Newman 1973). The SBM emphasized two other factors: (1) the enabling factors of “access” to care such as income and presence of health insurance and (2) the actual “need” for care. A great deal of conceptual and methodological work was devoted to the attempt to rate illness problems on their severity and amenability to formal treatment. Studies expanded on particular parts of the model—arguing, for example, for more detail on enabling factors, including characteristics of providers (Kronenfeld 1978, 1980). As Andersen (1995) notes, the model has proceeded through three additional phases that have elaborated the health care system, health practices, outcomes, and complex causal relationships, each one reflecting new policy and academic concerns. The empirical examination of these models pushed the development of appropriate survey design, called for mounting a series of tailored national-level studies, and forced the adoption of increasingly sophisticated analytic techniques (Aday et al. 1980; Aday and Awe, forthcoming).

#### *Period 4: Questioning the Dominant Approach*

Earlier, when we introduced our perspective on the challenges to medical sociology, we laid out a set of conditions that have fostered a sense of disorganization in the subfield of medical sociology, the fields of sociology, medicine, and related health sciences, and the larger society. This period, beginning in the late 1970s and early 1980s, challenged some of the long-held assumptions of modern society. The American public became less sure that modern social institutions, based on scientific progress, could deliver on their promises. A skepticism about content and costs of medical care arose to accompany, if not replace, the concern for access. Four strains which may always have been present under modern medicine were exacerbated:

(1) ineffectiveness (inability to deliver comprehensive care); (2) unresponsiveness (a tendency to ignore the demands of rank and file professionals as well as clients); (3) insensitivity (disregard for the psychosocial needs of patients); and (4) inefficiency (failure to control costs [Lehman 1975]).

Anthropologists, who had turned their attention to medical markets and healing in urban areas of “modern” countries, documented that the resort to “unorthodox,” “alternative,” and “indigenous” forms of medicine had not disappeared as expected (Baer 1981; Berliner and Salmon 1980; Bhardwaj 1980; Cobb 1977). They conceptualized notions of “medical pluralism” and talked about the complementarity rather than competition among systems of medical knowledge and treatment (Good 1977; Kleinman 1978a, 1978b; Leslie 1980; Unschuld 1981). Medical journals devoted more space to this phenomenon both as a curiosity and warning against “quackery” (e.g., Annas 1978; Burkhalter 1977; Parker and Tupling 1977; Yesalis et al. 1980). Attention to these alternatives increased dramatically in the popular press (McQueen 1985; Pescosolido 1982). While ethnic and regional populations continued to use indigenous healers (e.g., Hispanics and botanicas; midwest working class and chiropractic), middle and upper classes turned to old, new, or exotic forms of alternative medical treatment, such as acupuncture. While they may not have done so in droves nor as their first resort to deal with their health problems, their behavior shattered the commonplace assumption that alternatives would fall by the wayside as the educational level of the population rose (Kronenfeld and Wasner 1982).

By this point in sociology as a discipline there was also major discontent. The end of the dominance of status attainment research and its accompanying highly individualistic, statistical, and survey-oriented approach scattered sociologists in a number of directions. Many who had worked in this area or had been trained in it turned their attention to the impact of political and economic structures (e.g., labor markets, industrial sectors) or to powerful historical forces which had been virtually ignored in the status attainment paradigm. Neo-marxist political economy and historical sociology replaced status attainment in the mainstream journals, in work authored largely by a younger generation (Fligstein 1981; Griffin, Devine, and Wallace 1983; Skocpol 1982; Wright 1981). Others who had not been captivated by the field’s concentration on status attainment or the subsequent reaction to it became increasingly oriented to topic or method rather than general theory. The dominance of status attainment research had hardened the disdain for quantitative research among those who used other methods and believed their research less likely to be received in mainstream journals.

Another important change in this period has been the decline of strong medical sociology graduate programs in some of the major sociology departments. The Universities of Wisconsin and North Carolina, and later the University of Chicago and Yale University gradually lost many major medical sociology faculty and, with this, the benefit of having medical sociology students in graduate school with students in other areas of sociology. Gradually, the number of medical sociology students in these prominent programs declined and no programs of their magnitude came to replace them. Some “medical sociologists” are now trained outside of traditional sociology departments, in schools of public health, departments of health administration, and departments of preventive medicine (e.g., the University of California, San Francisco’s medical sociology program in the School of Nursing).

These trends are reflected in the study of medical care use. The period from 1981 to the present represents a rethinking of dominant models at the same time that they have become the standard across socio-medical fields. The HBM and SBM are routinely used on different populations for different problems, and are refined continually in terms of more measures, better measures, and more appropriate techniques. While sociologists have continued to apply aspects of both models to studies of utilization of health care and health behavior, related studies have become more and more common in other disciplines (Coe, Wolinsky, and Miller 1985; Davis et al. 1984; Kronenfeld et al. 1988; Wolinsky, Arnold, and Nallapati 1988).

Interest in utilization has come also to be within the purview of two groups outside the field of medical sociology. “Health psychology” has grown as a theoretical, research, and clinical field, looking to utilization models as a basis for practical approaches and using the HBM and newer models such as the Theory of Reasoned Action and the Precaution Adoption Process to study both use of health care services and health behavior (Ajzen and Fishbein 1980; Champion

1994; Eisen, Zellman, and McAlister 1992; Hyman and Baker 1992; Walker et al. 1993; Weinstein 1993). Researchers in "Health Economics" found familiar the individualistic, rational, choice-oriented approach that undergirded dominant utilization models. Using even more sophisticated multivariate techniques, health economists asked whether individuals with problems are more likely to enter the formal system through the general sector, the specialty sector, or not at all (e.g., Frank and Kamlet 1983; Janssen 1992). They applied these models to policy, particularly where it dealt with the growing practical problems of rising health care costs and related concerns over excess and inappropriate utilization of the health care system (Anderson, Brook, and Williams 1991; Fries et al. 1993; McMenamin 1990).

Many sociologists became frustrated with these models. Little theoretical work and attention were placed here (Cockerham 1983), and some questioned whether refinements were actually getting the field anywhere (Wolinsky and Johnson 1991). Critics raised important questions about issues such as delay, continuity of care, appropriateness of care, and return to care, which dominant models had not addressed successfully. As utilization models became more fine-tuned in the study of formal services, medical sociologists called for redirection of studies toward broader health and illness concerns in the community (Murcott 1977). Outside of the narrow definition of formal services, they discussed the meaning of care, the duty of individuals to take care of their own health, and the invasion of medicine into areas where lay practitioners had been successful yet had been driven out (Zola 1982). Again medical sociologists raised the issue of whether they should ally themselves so strongly with the dominant medical establishment (Waitzkin 1983; see also Singer [1990] on medical anthropology). Nowhere was this dilemma made more clear than in the corpus of feminist health care research, which questioned the increasing medicalization of women's lives. Much of this work heralded the complaints of the period—asking whether the history of medicine was only a history of men and whether medical "advances" simply represented greater explicit or implicit social control by men (Addelson 1990; Bell 1986; Ehrenreich and English 1973; Olesen and Woods 1986; Reissman 1983; Ruzek 1978; Scully and Bart 1973).

In sum, as models become more sophisticated, social factors appeared to matter less in the presence of more or better measures of the nature and severity of health problems. The increasingly common finding that "need drives the system" seemed to echo the increasing dominance of economics and psychology and the marginalization of sociologists (Cleary 1989; Haug and Lavin 1983a; Mechanic 1990, 1989; Pescosolido 1991, 1992).

## NEW CONDITIONS, NEW QUESTIONS, AND THE ROOTS OF A NEW APPROACH

The current flux in society, the medical care system, and the social sciences present us with three possible agendas. The first, still predominant, clings to "business as usual" and builds health care reform on the way we understand, or better said, *understood* society to be. The second, presented by Postmodernists who have announced the "death of the state," "the end of history," and "the end of politics," describes the unraveling of old social forms, "deconstructing" systems of thought, embracing ambiguity, and eschewing grand theory as the fundamental mission of intellectual and political work (Pescosolido and Rubin 1994; Singer 1990). The third agenda—and the one we think best advised—realigns the original agendas of sociology, medical sociology, and policy to meet the challenges wrought by the end of modern industrial society and the failure of its social institutions to meet current individual and societal needs.

What are the contours of the new social form? Most relevant here, we are witnessing a renegotiation of the social contract of healing and of the professional dominance of medicine (both in the terms and content of medical work) as well as the reemergence of alternative modes of thought and practice about health and illness. Further, the university, including its professional schools of medicine and public health, is undergoing a transformation regarding its mission and role in society.

The present challenge to medical sociology arises from these shifts. Medical sociology offers a critical stance and a view for change which come, in part, from stepping outside accepted modes of thinking and organizing (Bloom 1986). Sociologists' frustration with dominant-use

models results, at least in part, from a recognition of a mismatch between the underlying assumptions of these models and the larger social context. These assumptions leave many questions unanswered, given contemporary socio-medical problems, and are unable to provide a solid base on which to build socio-political change. While dominant-use models feed some of the policy concerns in health care reform, they do not capture the shift in treatment locale from the hospital to the community or the view that decision-making for medical care is a social process and not a one-time “rational” decision. Nor do these models address the changing profile of medical problems in modern society from acute to chronic illness (Pescosolido 1992).<sup>6</sup> Dominant contingency models retain their utility but represent only one approach, perhaps best characterized as a systems or structural approach that lays out factors affecting care. These models can answer certain questions but not others. Dominant models are static. Even with feedback loops, they cannot fill the need for dynamic, process models.

Rather than closing sociologists out, the current context calls for sociologists to take the lead in reconstructing a theoretical and methodological agenda to address how, when, and why individuals use lay, folk, and formal healing systems. This agenda should trace whether individuals decide to follow advice or seek further care for the same or other medical problems and how the social institution of medicine shapes these pathways of choice. *What is required* is a dramatic shift in our “business as usual” attitude and the concerted effort of sociologists with different theoretical and methodological approaches to develop new conceptual frameworks, new and more complicated protocols, and suitable modes of analysis. In a context acknowledging the limits of biomedicine, concerns shift from cure—even complicated cures—to the quality of life (e.g., conceptualizing and measuring continuity of care, and outcomes such as functional health status).<sup>7</sup> In some pointed ways, our new task as medical sociologists harkens back to the agenda of the pre-Parsons period because we again need a basic descriptive understanding of what is going on “out there,” even if preliminary attempts describe the ideal-typical structure of new social institutions and individual cognitive frames. Here, recent work on how individuals construct medical problems and solutions provides a rich source for reconceptualizing use models (e.g., Furstenberg and Davis 1984).

Table 2 provides a profile of the present, describes basic structural conditions, and suggests a direction for research. To be “relevant,” models of medical care use in this new era must have four basic characteristics. First, they must be *community-based*. A good deal of health care reform, for example, hinges on decreasing reliance on tertiary care. The community becomes central, including how it interfaces with treatment systems to influence use, delay, continuity, and compliance with care. Second, utilization models must be *dynamic* and provide *meaningful brackets around sequences of use*. An orientation toward process is essential to understand both the management of chronic illness as well as how lay, folk, and professional resources assist in coping with a particular set of health problems over time. Knowledge of coping resources and styles, traditionally separated from the study of utilization, becomes a necessary component (see Thoits this issue) of a new approach. Issues such as continuity and compliance cannot be plucked out of an ongoing process and analyzed in a cross-sectional framework. Third, models must be *multimethod and multilevel* and escape the parochialism of current theory and methods. Addressing these complex issues

**TABLE 2. Models of Health Care Utilization**

Stage V	
Socio-cultural Context	Renegotiation of professional dominance; health care reform; reemergence of alternative medical systems
Sociological Context	Postmodern critique, Life Course Research, Macro-Micro, Dynamic Models and Methods
Model/Research Orientation	Patterns and sequences of use within and across episodes of illness
Predominant Explanations	Process; interface of community and treatment systems; social networks
Issues	Delay, continuity

will require transcending bifurcations in current levels of analysis, methodological approaches, and theoretical frames. For example, while contingency or correlation models have come to be dominant, studies providing process frames do exist in "illness career" approaches (e.g., Clausen and Yarrow 1955; Twaddle and Hessler 1977). A simple return to these dynamic frameworks will not provide an answer because, too often, they provide rich description but not explanation (Elder 1978). A synthesis of correlational (systems) and career (process) approaches is in order. In addition, as Coleman (1986) notes, sociodemographics has provided only a temporary escape for sociologists struggling with the conceptualization of social structure. The new agenda must link individuals in all their social psychological complexity to institutions and social context in all their structural complexity. Finally, new models must offer *different and viable* "engines of action," to use Coleman's (1990) term, outside of the economic psychology of rational action. After all, as Davis (1994:186) points out: "economic theory, when put to the test, doesn't work very well." Network theory, pioneered in the work of Freidson (1970) and Kadushin (1966) provides one possible alternative to economic theory that has received only occasional attention in the utilization literature (see Pescosolido [1991] for reviews). In network theory the underlying mechanisms are interaction and social influence processes. While dominant models have not ignored social relationships, as Andersen (1995) points out, they have not made them central. It is quite different conceptually to say, on the one hand, that social networks are a contingency of choice in a systems model and, on the other, the engine of action in a dynamic model of utilization. In sum, utilization research must develop models that can account for the fact that "the experience of illness is embedded in its social life and rhythms, that it is constrained by social structure, and that it is created in negotiation with others" (Pescosolido 1991:166; see also Furstenberg and Davis 1984; Mechanic 1990).

There has been a growing consensus among sociologists over the need for dynamic models, process-oriented approaches, a broadening of the idea of utilization and, though less so, a reconceptualization of how people make decisions.<sup>8</sup> Sociologists have begun to turn back to stage models (Goldsmith, Jackson, and Hough 1988; Mechanic and Angel 1983), to the notion of pathways (Rogler and Cortes 1993), and to life course, illness career, and social network approaches (Pescosolido 1991, 1992). All involve a specific attempt to infuse a dynamic component into our understanding of how individuals use medical care, often with the intent of remolding the dominant models of utilization to confront current limits. This seems a logical step because both the HBM and SBM suggest, in their most recent and complicated diagrammatic representations, that there is some sort of causal, time-ordered process with roots in the community.

Problems with current utilization models cannot be resolved merely by generating more "data" under standard protocols, whether qualitative or quantitative in nature. We do not have in our current methodological arsenal a way to think about systematically tapping "process" through typically static survey methods. We cannot simply ask more survey questions, cataloguing utilization of care over a year as unrelated to issues of timing and spacing. Health diaries tend to provide extremely low response rates (see the National Medical Expenditure Study II [NMES-II] as an exception), unrepresentative samples, and a greater probability of a Hawthorne-like effect which forces greater but uncharacteristic reflection on illness behavior. Small-scale observational studies cannot fill the gap alone because scope constraints limit the ability to uncover relevant social structural influences. Finally, we do not have analytic tools for these empirical analyses, be they qualitative or quantitative in nature. On the latter, social science methodologists have only begun to consider and develop suitable dynamic tools in the last decade (e.g., Abbott 1994; Griffin 1994; Tuma and Hannan 1981). And, like multiple regression at the time when Andersen began his early work, these are not easily available or understandable to the average sociological or even economic practitioner at this point. On the former, if we are serious about linking process and structures, we are only beginning to consider how one *stream* of processes influences another or to bring together the observations from one study to another. Like medical sociologists in earlier periods, we must push the limits of theory, methods, and analyses to fit challenges posed by problems in utilization research as well as the more general issues to which we now turn.

## MARKING SOCIAL TIME: THE STRENGTHS OF SOCIOLOGY IN THE CURRENT ERA

If sociologists come equipped with theoretical and methodological skills to address interesting and important questions, the historical record indicates that sociological contributions receive notice. The central question is whether we allow the current vision of what is interesting and important to set the agenda for medical sociology. For example, Mechanic (1993:99) notes that the focus on cost containment is likely both to be a mainstay of public policy and to leave American health care “in deep trouble.” This narrow perspective, he notes, is unresponsive to the consideration of significant structural change (and, we would add, the larger underlying problems facing medicine and the real processes by which patients and practitioners make their decisions).

We return to our original thesis. The major disruptions that we observe in the medical care sector come from the accumulation of adjustments of medical theory to medical practice formed under a set of societal conditions that no longer exist. The force of postmodern theory is its recognition of both the failure of modern institutions and of the current transition taking place in society; its basic weakness is that it mistakes contemporary societal conditions for a new form and foundation of society (Pescosolido and Rubin 1994). The current era bears a remarkable similarity (in form though not in content) to the upheaval before the turn of the last century when society shifted from agrarian and rural to industrial and urban. The central question of whether this is (1) late-stage capitalism (Waitzkin 1983); (2) entry into postmodern freedom and chaos (Seidman and Wagner 1992); (3) simply the consequence of modernity (Giddens 1990); or (4) a new social form cannot be ignored by medical sociologists. Understanding new bases of social life and, for medical sociologists, the way health, illness, and healing are treated within them becomes crucial.

Brint (1992) contends that sociologists stand in a better position to provide suggestions about the reform of institutions because of their attention to context and structure, which is absent in economics and political science. This position leads medical sociologists to uncommon and perhaps unpopular stances; for example, arguing against the economist’s and policymaker’s “truisms” which regard cost containment and privatization to be the linchpins of policy change in the medical system. We understand this stance to be a “construction” from important research like the RAND Health Insurance Experiment which also showed that co-payment reduced appropriate utilization (Mechanic 1993). According to Gray (1991), a survey of existing empirical research demonstrates that nonprofit hospitals provide good treatment for a wider range of the population for less cost, leading him to argue against purely economic solutions, which exclude ethical considerations (see also Gray and Phillips this issue).

In these times of social reconfiguration, the sociological imagination that sees the inevitable link between social history and personal biography is paramount. We need basic understanding of the new social and socio-medical landscape, including the stratification system, social institutions or their substitutes, and the nature of communities—understanding which sociology has traditionally provided. The key challenge *for* medical sociology is whether our generation comes to understand the larger task at hand or is doomed to a myopia that results in continual tinkering with outdated intellectual and social systems and that reifies stale and destructive debates about the “right” way to do sociology. The key challenge *from* medical sociology is aimed at policymakers and asks that they place their own concerns and shape their agendas for action in larger perspective. We now turn to questions of the relationship among medical sociology, sociology, and policymakers.

## WHY POLICYMAKERS PROCEED AT RISK WITHOUT THE LENS OF MEDICAL SOCIOLOGY: DILEMMAS IN THE REAL WORLD

Current images of health care reform really represent a reform of the formal system of medical services. The outcome of the November 1994 elections and decline in the inflation rate in health care spending make clear that reform is less likely to be structured by the federal government. Nevertheless, major restructuring is occurring in how services are organized and



delivered with the consolidation of hospitals and the growth of managed care. We continue to hear about how services might be paid for, how providers might organize their services, and how patients might be allowed to access them. A crucial gap from a sociological point of view is the omission from discussion of what leads people to seek care and what awaits them after care has been administered.<sup>9</sup>

We use three illustrations to make a simple point: *Reform, based primarily on economic considerations for the formal system, is jeopardized without (1) a deep consideration of how the larger social system is expected to take up the slack (of continuing care) and (2) how the human cost of change factors into the ultimate cost and success of the formal health care system.* The first illustration addresses how shrinking the formal system, while efficient and appropriate, depends explicitly or implicitly on an image of the “community” which may no longer exist. Second, any proposed financing of a health care system on a private, employment-based plan depends on an image of “work” that matches neither current situations nor likely trajectories. Third, the reshaping of the system depends, in part, on a medical care work force socialized under a theory of medicine and working under a reward structure which may prevent them from adapting to or supporting change. This hampers reform efforts unless they, as well as changes in facilities and payment systems, are considered essential targets of attention and resources.

### *The Community and Reform*

The keystone of modern medicine has been the hospital, and reform focuses on a decreased reliance on expensive specialty care. Hospitals do not stand as the logical integrators of managed care, given the emphasis on reduction of inpatient days (Shortell 1994). Discussions center on moving surgery to offices or overnight stay facilities and care for chronically ill patients home or to smaller secure dwellings. Despite all the rhetoric about new paradigms and community-centered providers, the general emphasis in reform plans and in contemporary medicine is still on the pharmacopoeia, the facilities, and system cost (Morrison 1994). But as hospitals take a more modest place in an umbrella health care system, the lack of understanding of the community is no longer a luxury. The community—its ability to pick up the burden of care created by shortened hospital stays and restricted inpatient days—and whether financial decision-makers will consider or fail to consider these issues in utilization review are crucial to the long-term success of reform and the health of the system. Breast cancer and mental illness provide two relevant cases.

Recent developments in anesthesia, pain relief (particularly through the drug Dipravin), and procedure (portable individual monitoring) following mastectomy now may allow women to opt to return home five to six hours after surgery. Three factors influence the suitability of this option in any particular case. First, whether the “candidate” is at risk for complications; second, whether there were complications during the procedure itself; third, *whether there is anyone at home to care for the woman following surgery.* The third is most interesting because reform must contend with the clash of a clear financial imperative and an ambiguous social one. How can the presence of an “appropriate” someone at home be determined, and how long will insurance companies accept this determination for approving longer stays and greater costs? Presently, this is determined only in a short-term manner, judged with poor data on outcomes. Who is available for post-operative care is not considered at the moment, for day surgeries, under utilization review guidelines.

Mental illness provides a second case in point. As individuals proceed through a mental illness career, they have fewer and fewer people that they can count on in the community (Estroff 1981). Yet dominant treatment approaches rely heavily (sometimes almost exclusively) on medication strategies and do not address the problem of social support. Combined with current proposals which rename deinstitutionalization as “downsizing” or “rightsizing,” these approaches have led to a continued relative neglect of the long-term implications of community outcomes for cost and care. Despite some sustained efforts by social researchers and policymakers, the success of mental health care reform hinges on hidden assumptions about what the “community” is expected to do for the day-to-day care of

individuals with mental health problems. As Good (1993) argues, the “Decade of the Brain,” with its exclusive focus on neuropsychiatry and genetics, does not eliminate the need for behavioral science. The benefits of biological research are constrained, however, by our inability to translate new clinical findings into the real world contexts of communities, neighborhoods, ethnic groups, families, and individual lives.

These cases represent only two of many. For example, sociologists have been and remain dominant contributors to research on stress, particularly the social risk factors for mental health and well-being (see Thoits this issue). Here, the development and evaluation of intervention efforts that do not take into account social structure and community context risk failure.

### *The Social Bases of Insurance Provision*

Discussions of health care reform in the United States have posited and probably will continue to posit a system based on the current private provision of insurance and on the work place, where consumers pick plans annually. This reflects an image of work and workers’ future that does not match fundamentally the current nature of work and will probably look even more divergent in the near future. The social institution of work is undergoing dramatic shifts with the locus of economic growth being in small business and in the service sector, which offer the lowest pay and fewest fringe benefits. In general, the work place is moving toward higher and higher levels of temporary and short-term employment (i.e., “soft” jobs), where benefits are either not included or severely restricted (Field and Shapiro 1993; Krecker and O’Rand 1991; Pfeffer and Baron 1988). While some labor economists hail the freedom inherent in the ability of professionals to contract their work independently, the downside of jobs bereft of benefits cannot be ignored. How can individuals be expected to depend on the work place as the primary site of health coverage, and how can they realistically have choice over the years under conditions which include continual readjustments to new work places, new health care plans, and restricted benefits?

This question pertains to the whole debate on health care “reform” in America. No major proposal, including the “single payer” proposal, departs from standard assumptions about the nature of insurance, of the medical profession, or of the structure of work. As a result, when the rhetoric is stripped away, the proposals look similar to those of bureaucrats in government agencies such as the Congressional Budget Office that are charged with “costing” them out. More generally, we can understand why health care is said to be in “crisis” in all advanced industrial democracies. As we enter the twenty-first century we need to ask whether debates on matters such as the value of “all-in insurance” which stirred such political passion in Britain and in much of Europe four generations ago continue to be the best terms for policy discourse.

### *The Medical Work Force and Changing Ideologies*

In this third illustration, we discuss a factor that has gone almost unnoticed in reform debates—the human factors necessary to change the system. The ability to successfully reshape the system depends on those who work in it daily. Of course, as the American experience with Medicare showed, medical care practitioners accommodate to changes in the system even when they are not predisposed to believe that they are good (Colombotos and Kirchner 1986). Yet implementation of large-scale changes that directly address the principles of medicine and medical care under which providers have worked will be difficult.

Little attention or research has yet addressed the radical change in values and orientation which current reforms propose. Research on these aspects of human resources is nearly nonexistent. For example, the shift from long-term care facilities to community-based treatments for chronic or severe mental illness raises serious problems for workers dislocated from “asylums” (National Institute of Mental Health 1992:45). Redeployment will not be a simple matter since the ideologies of those who have worked for years, sometimes their entire lives, in long-term care facilities center on the essential need for these institutions. They are skeptical, at best, about the success of current treatment policies which expect those under care

to live in the community. This problem is more complicated than mere inertia or the desire not to be redeployed in new forms of community care. These mental health workers may not be welcomed by others in different sectors of the mental health system who look at their methods and practice as archaic, ineffective, and dangerous.

This is not an isolated issue for mental health care. Most medical care providers were socialized under the tertiary care system of medicine. The dominant medical theory, particularly as played out in the United States, has never held great regard for preventive or social medicine. As we ask traditional hospital personnel to become more prevention oriented, we face substantial ideological barriers. At the same time they are being asked to cut back, to do more with less, and to watch their perceived ability to do what they were trained to do hampered by resource constraints, they hear discussions of the need for hospitals to expand “wellness” programs. Under the general theory of medical practice in which they were trained, devoting attention and resources to individuals who are not sick while denying necessary resources to those who are makes little sense. Not that medical care practitioners do not subscribe to the individually-focused “healthy behaviors” approach that characterizes the limited view of prevention in the United States. What they question is the priority for resources, the locus of “wellness” programs, and the wisdom of their role in it. As with the American population in general, prevention will be a “hard sell,” given the promise of germ theory to find the “magic bullet” at the other end.

None of the above discussion challenges the need for health care reform nor some of the shifts in practices noted above. What it does mark is the critical importance of a larger “contextualized” view of how change proceeds. Failure to deal with the human costs of social change, either to medical workers or to community caretakers, as well as to insurance providers, is unlikely to decrease long-term costs to the system or to bolster its success. This signals, again, that the current, nearly exclusive view of health care reform as an economic, system-based policy initiative endangers reform efforts. Economics offers the most powerful explanatory frame when things are *working*. But the very impetus for reform is based on a recognition that the system is not working. Health care reform, which has acknowledged, much to its credit, the failure of the current system for individuals as well as organizations, cannot be built solely on economic concepts. Under current conditions of rapid social change, reformulation of the social basis of organizations and institutions—and the perspective offered by medical sociologists which ties reform to larger changes in society and, in particular, to the community—offer an essential component for success. Even more importantly, a brand of medical sociology which often stands outside the established medical structure provides a critical stance on alternatives for change not likely to be considered from within.

#### WHY SOCIOLOGY PROCEEDS AT RISK WITHOUT THE LENS OF MEDICAL SOCIOLOGY: DILEMMAS AT THE CORE

As we discussed earlier, sociology as a discipline faces a number of problems. Here, we focus on three points that highlight the centrality of medical sociology to the rejuvenation of the discipline. First, issues of life and death strike at the heart of any society. It is no surprise that the sociologists who staked out divergent agendas for the field all found in morbidity and mortality pointed examples for their frameworks of society. Marx, Durkheim, and Weber all focused at one time or another on issues of health and illness, death and disease. The Chicago School in the 1920s and 1930s understood, as did Parsons in the 1950s, the centrality of contemporary socio-medical problems, related social institutions, and individual responses to the power and relevance of sociology. Ennis (1992), in his empirical network analysis based on section memberships, finds that contemporary medical sociology occupies a place near the core of the discipline, with links to social psychology and gender. If the parent discipline has lost its taste for these issues—and we argue later that it is not that simple—it does so at its peril. Our premise that the primary agenda of contemporary sociology lies in the description and understanding of the transition away from modern, industrial forms of society and of the new foundations and institutions of social life, points to medical sociology’s key role.

Sociological theorizing requires a base of empirical work to synthesize ideas into middle

range and grand theories.<sup>10</sup> Durkheim's overall scheme of the dual axes of social integration and social regulation as the bases of social structure were built on his inductive analysis of suicide rates. What is less well understood about Durkheim's work is that it relied on a decade of sociological investigation by Morselli in Italy and Masaryk in Czechoslovakia, among others, who built a body of systematic findings on suicide correlates. A more recent example is the study of professions. General theorizing about what characteristics mark the ascendance of an occupation to a profession has been pathbreaking but limiting. The ground-up work on the rise of the profession of medicine by sociologists, historians, and anthropologists established the basis of the sociological theory of professional dominance (e.g., Freidson's [1970] use of the Azande witchdoctor as a failed case) that has continued until quite recently to be the keystone of theorizing about particular professions or "the professions" as a general category (see Hafferty and Light this issue). Recently, the role of William Darrow as part of the multidisciplinary team which paved our understanding of the social epidemiology of AIDS highlights the power of seeing disease processes as rooted in social interaction and social networks (Valdiserri et al. 1992).

Second, the trend toward "interdisciplinary" or "multidisciplinary" efforts has blurred the lines of interest, explanation, and role of sociology in the social sciences and related professional schools. The case of utilization theory illustrates that medical sociology has always had a strong, unwavering, multidisciplinary tradition. But this case also shows that medical sociology has not always been successful in maintaining its distinct perspective. While dominant models brought medical sociology acceptance among socio-medical sciences, contemporary medical sociologists need to understand clearly their unique perspective. Medical sociology, as Bloom (1986) argues, has no need to fear for its survival. It is too essential. The findings in our studies hold, as they always have, a great deal of potential to create the sociological toolbox for the next era of knowledge and study.

Our third point is organizational and logistical, targeting the present and likely future power base of sociology. While medical sociologists have developed four basic roles (basic scientist of behavior; university teacher in sociology department; teaching collaborator in medical, nursing, public health, or public policy school; and policy analyst and consultant [Bloom 1986]), the parent discipline has always felt tensions over connections between its academic base, its potential for applied work, and its checkered connection to social reform. These tensions, at a minimum, result in a perception—made clear in numerous biographical anecdotes—of the failure of academic sociology to embrace those outside of the academy or even outside of sociology departments. Economists and psychologists, whether consciously or not, have placed their graduates in both the public and private sectors. The result is an institutional base of legitimacy and support that sociology clearly lacks. Sociology has given away subfields, no longer considered sufficiently "theoretical," for fear of being associated with "dirty," applied work. As some sociologists outside the academy quip, sociology engages in a systematic practice of "eating its young," or chewing up the potential of those who go into applied work. This explains why some medical sociologists identify themselves otherwise. Sociologists in "untraditional" roles often feel little loyalty to a discipline that doesn't seem to understand or respect their contributions and they respond, instead, by using identities that find reward in other distributional systems.

Not only is it an ironic position for the "science of society" to disparage its practitioners in the real world, but this position ignores the fact that much future opportunity for growth will come in employment with a strong vocational, not academic, orientation (see Akers [1992] on the parallel in criminology). Sociology may have more to worry about if it fails to find some way of integrating its major substantive bases (e.g., criminology, family, gender studies, and demography, as well as medical sociology) into the heart of its theoretical and institutional enterprises. No policymaker or individual in the real world cares about "sociology" per se; rather, they are interested in insightful answers to their real world difficulties.

Obstacles to providing "usable knowledge" are formidable enough (Lindblom 1990; Lindblom and Cohen 1981). They need no additional obfuscation from sociologists themselves who too often engage in a futile, damaging, and poverty-ridden approach that celebrates academic sociology or one approach within it. We ritually end our articles by stating their limitations, fostering a disciplinary timidity about policy implications. We have never offered

quick and easy answers, and that has been the right stance, but our obsession with the “less than perfect” data set or methods, which characterize all knowledge enterprises, appears to immobilize sociologists in regard to policy recommendations (see also Davis 1994). Here, medical sociology offers direction and inspiration for the parent discipline. Sociologists studying women’s health, for example, are a vanguard incorporating activism, scholarship, and policy impact (e.g., Bell 1987, 1994; Rothman 1986).

#### WHY MEDICAL SOCIOLOGISTS PROCEED AT RISK WITHOUT SOCIOLOGY: DILEMMAS IN THE SUBFIELD

The discussion above does not imply wholehearted embrace of current approaches in medical sociology. A medical sociology not in dialogue with the mainstream of the discipline loses its potential. Akers’ (1992:4) important distinction between a field of study and a discipline sometimes seems lost in discussions of the plight of medical sociology. Medical sociology is a field of study (i.e., a problem-defined arena); sociology is the discipline that provides its overarching perspective. A field of study cannot develop a unique perspective of its own, and its studies—in our case, focusing solely on health-related phenomena—will not suffice to maintain a place among the socio-medical sciences (see Eichorn and Bice [1973] on health services research).

Medical sociologists cannot take for granted the continuing applicability of sociological concepts or frameworks in which they were trained. If disconnected from the general discipline’s literature and findings across a wide set of areas defined by social institutions and social processes, the conceptual and methodological toolbox that medical sociologists bring to the study of health, illness, and healing will be limited, soon outdated, and perhaps misleading. This does not dismiss the importance of Straus’ (1955) *sociology in medicine* where sociological ideas and methodological skills are brought to the study of aging, HIV, hospital costs, etc.; rather, it questions whether a subfield that has lost its taste for reading broadly across other subfields of its own discipline can stay at the cutting edge in a multidisciplinary team. We suspect not. Medical sociology’s key contribution is to explore the broad connection among social institutions. As medical sociologists confine their reading to work about the specific socio-medical topics in which they are interested, knowing more and more about some health-related processes and institutions and less and less about others (save that one other institution or process that might be their “independent” variable of focus), they lose the power of the sociological perspective. This doesn’t preclude medical sociologists from doing relevant, solid work; it does, however, preclude them from doing cutting-edge syntheses. The movement toward multidisciplinary research, laudable, sometimes provocative, and always logistically complicated, requires a *greater* fundamental understanding of the concepts and tools each researcher uniquely brings to the table that are not present when individuals consider only particular disciplines.

This last point warrants expansion. For the continued viability and vibrancy of medical sociology we need to understand the general nature of social change and social institutions—to recognize, describe, and draw from these changes and institutions implications for health, illness, and healing. Here is where the myopia of some medical sociologists puts them at risk. For example, the work of Charles Tilly on revolution in eighteenth century France lies far afield from the day-to-day concerns of most, though not all, medical sociologists. Yet, his work (e.g., Tilly 1984, 1993) develops general notions of the multiple pathways that individuals and even societies travel to reach the same outcome, an insight directly applicable to theories of medical care use and the institutional state of reform (Pescosolido 1992). More closely related, Good (1993) argues that notions of “culture” and “health beliefs” used in our research, and even more so in that of epidemiologists who draw from sociology, medical sociology, and medical anthropology, are a generation behind their development in the generally focused, cutting-edge work in the other social sciences.

New, richer, and more complicated conceptualizations are emerging that demand new protocols. An example from an ongoing field study on HIV among drug users dramatically illustrates the limits of routine approaches and the role of sociology in offering general

conceptual insights. While proceeding with the design of a potential substudy examining the importance of the “birth order” concept from psychology, researchers asked one of their standing interviewers, a young woman living in Chicago, how many siblings she had. The response of “twenty-six” itself was stunning but, even more curious, the interviewer noted that she would not be able to list their ages or other basic information usually required for birth order studies. This raises subtle and not so subtle issues about the relevance of the birth order concept and dominant notions of family that continue to guide research. We know that the relationship of these siblings was based on a great number of “family” arrangements, formed and dissolved among the man and woman who were this woman’s biological parents (Judith Levy, personal communication). This reality forces a reconceptualization of the family—in general, work likely to come from sociologists of the family, not medical sociologists.

Current thinking in medical sociology, often guided by concepts and theories developed to address the emergence and development of modern society, must be realigned for the current era. This view forces a reconnection between the subfield and the parent discipline. But, under the notion of reciprocity, medical sociologists are obligated to contribute to rebuilding the sociological perspective. It is not enough to claim the “rights” of sociological training to do the best research possible on a socio-medical topic. With those rights comes the obligation to ensure that insights from medical sociology inform the larger discipline. If a “hollow” core develops in sociology, it will be the responsibility of medical sociologists as much as any other group. The discipline’s narrow orthodoxy on the importance of sociology *of* medicine cannot be replaced by a subfields’ orthodoxy on the importance of sociology *in* medicine.

Medical sociology’s obligation is at odds with rampant complaints, mentioned earlier, about the narrow focus of sociology journals. We have discussed this complaint with a number of past and present journal editors and reviewers who contend that the single major feature of failed submissions to sociology journals is their failure to frame the contribution in a sociology “of” rather than sociology “in” manner. If accurate, this position is defensible because the mission of the journals and their allegiance lie with the discipline, not socio-medical phenomena in and of themselves. We have heard analogous complaints from medical sociologists complaining about not being able to “crack” medical or public health journals. Both reveal holes in graduate training which seem to preclude medical sociologists from presenting their work in more than one frame.

## CONCLUSIONS

Medical sociologists have to reevaluate their currently held views about their relationship vis-a-vis their discipline, their sister social sciences, the bio-medical sciences, and public audiences. The nonparadigmatic approach that characterizes both medical sociology and its parent discipline presents problems when we attempt a succinct description of what we do to outsiders, particularly when other medical or social science paradigms have an elegant and simple (albeit from a sociological point of view simplistic and incomplete) answer that captures the attention of policymakers, providers, and the public. Our concern must return to how to address large scale social problems of health, illness, and healing in light of changing social conditions.

If sociology’s strength comes from a macro/micro and cross-institutional focus, its weakness comes from its factions, both theoretical and substantive, that necessarily arise from paring down large issues to manageable questions and studies. Contemporary sociologists sometimes seem much more comfortable embracing the disparate views and contributions of other disciplines than they do integrating different perspectives within their own. Complete integration within sociology seems neither possible nor advisable, yet recent discussion does not celebrate the banquet of possibilities. Rather, it forces a choice between one radical diet and another. This is narrow social science, uncharacteristic of the better chapters in sociology’s history and, we hope, of its future. Sociology’s continued success hinges on the richness of its theoretical and methodological toolboxes and flexibility in providing diverse and complex understandings of the world. Medical sociology, from its beginnings, has been very diverse and in this very diversity finds its strength and resilience.

Straus' (1955) notion of the distinction between the sociology "of" and the sociology "in" medicine has always described one fault line along which medical sociology is drawn. Sociologists who turn their attention to health, illness, and healing, as Mechanic (1968) pointed out long ago, can serve medical interests by increasing their acceptance and influence but run the risk of losing their own agenda in the short run and their place in the discipline in the long run. Conversely, sociologists can serve the narrow academic interests of the discipline and risk losing their relevance. The escalation of these opposing tensions hinders solutions. The issue is not one of pinpointing blame or deciding who is more correct. The view of some that sociology is a pure science in which applied fields such as criminology and medical sociology have no rightful place is historically inaccurate and unwise. Medical sociologists' desire for acceptance by other socio-medical sciences and policymakers seems overblown. Mechanic (1993) sees the power of social research in developing concepts and perspectives that shape how people come to conceptualize their world, its dilemmas, and potential solutions. As our health economist colleague, Deborah Freund, suggested to us, our problem lies in the absence of an easily articulated bottom line, a problem easily rectified. But here is the tension: Do we believe in a bottom line, one that masks the complexity of social life, social context, and their linkages—one that is devoid of the critical stance that many, if not most sociologists believe, lies at the core of our discipline? Probably we do not. The fragmented and unintegrated nature of sociology is more apparent than real because it reflects our wide and diverse attempts to grasp larger society and the influence of large social structures on the day-to-day lives of individuals. Yet with a shared understanding of the heart of the sociological perspective, we can work with the bricolage under conditions of continual change.

What then are the obligations of medical sociologists in their work? We argued earlier that it is not enough to say that the only obligation is to use the skills and perspectives at hand to do the best work possible. This does not mean that medical sociologists' primary or even secondary priority should be the revitalization of the discipline; occupational conditions determine priorities. However, as we described earlier, the decision to ignore the discipline entirely contains a logical fallacy. What seems to be missing among younger cohorts (perhaps partially due to medical sociology training programs that lack strong linkages to general sociology doctoral programs), is the recognition that the community of medical sociologists gathered together among (if not with) other sociologists cannot be replaced by groups such as the Association for Health Services Research with its dominantly economic concerns, or the American Public Health Association with its massive membership and substantive sections that further divide medical sociologists rather than bring them together.

Achieving comfort with medical sociology's contributions may require an acceptance of how we should be different, outside the mainstream, even marginal in our perspective, given both the individualism and economic psychology that underlie the personal ideologies of American policymakers and the public. Surrendering to the current dominance of economic theory in health policy or bio-psychology in mental health offers only short-lived success for sociologists. For example, bio-psychiatry does not reconcile the challenge of community-based care with the neutrality that science promised. The risk of being given a more serious diagnosis for the same presenting symptoms by individuals with different amounts of social power has not abated since Hollingshead and Redlich's (1958) study; it continues under the rationalized and scientific guidance of the Diagnostic and Statistical Manual (DSM) (Loring and Powell 1988).

We have argued that responsibility for change does not center solely on medical sociologists. There is no question that the discipline has to turn itself around. ASA, although less so than in the past, must retreat from its negative position toward its sections.<sup>11</sup> As the association feels increasingly "larger" to its practitioners, there must be communities of meaning that feel manageable to individuals. Mainstream departments must reassess their explicit and implicit socialization messages to students, that reify placement in academic departments of repute as the primary mark of "success." The "core" will have to stop disavowing its children and realize that no sense of loyalty can obtain to a disciplinary family following routine dismissal.

A reciprocal engagement with the discipline will have at least short term costs to medical sociology. The death knell for the field and its academic, professional, and applied practitioners will sound if it cannot dismiss the "snubs" that have built up historically and that

pervade the discussions of younger generations of medical sociologists. To move forward we must acknowledge the fundamental interdependence among all sectors and commit to rebuilding reciprocal relationships centered on understanding social life. Medical sociology must build a strong bridge between the conceptual world, the academic world (both disciplinary and multidisciplinary), and the real world. Given the potential of the moment, the contributions of sociology and medical sociology could not be more crucial.

## NOTES

1. The Committee on Medical Sociology was formed at Yale University in the early 1950s. The Medical Sociology Section within the ASA was formally established in 1962. Research Committee 15 (originally Medical Sociology) of the International Sociological Association was established in 1966 and renamed Sociology of Health in 1986 (see Gerhardt [1989] for a detailed history of ideas as well as organization).
2. The recent decision to close the Lab, the only intramural program in NIH devoted to social science research, signals a dangerous lack of understanding of the importance of sociology and social sciences, which current efforts urging reconsideration of the closure are designed to address.
3. We thank David Mechanic for pointing out the salience of training.
4. There have always been contrary strains in these knowledge systems. Because sociology has always prided itself on the lack of a single dominant theoretical paradigm, multiple avenues of research have been common. Here our focus lies in dominant trends.
5. Even the boundaries of disciplinary affiliations were not clearly drawn. Some commenting on previous drafts puzzled over the disciplinary home of Ozzie Simmons.
6. In some ways, it should be no surprise that the dominant utilization models have garnered so much attention from socio-medical scientists, policy-oriented scholars, and policymakers. They are succinct, elegant, analytically sophisticated and, most importantly, they implicitly view the individual as having freedom and knowledge and as making decisions by weighing costs and benefits in light of opportunities and constraints. Likewise, it should come as no surprise that these models have captured less and less sociological attention as they can be routinely applied to different age groups or conditions. Replication has never been a major source of sociology's motivation or strength.
7. Fred Wolinsky pointed out this opportunity and noted that the inherent foci race and gender offer important opportunities for sociologists.
8. By the mid-1970s, the developers of dominant models made attempts to incorporate both traditional or alternative practitioners (as did some of the Epidemiological Catchment Area studies) and the more dynamic notion of "episode" into their data collection efforts (e.g., Aday et al. 1980). However, little has ever been done with these data because, we would argue, the dominant framework does not offer a great deal of insight into how to think about or use this information.
9. For the first time in a long time current health care leaders may take into consideration what can be done in the community to prevent serious medical problems. Its character may be limited, in the sense that the focus on individuals' illness behaviors downplays the structural sources of unhealthy behavior, but this consideration is nonetheless there (see Link and Phelan this issue; also McKinlay 1984).
10. Most postmodern work suggests that the goal of even mid-range theory is neither possible nor desirable. The possibilities remain an open question while desirability reflects a value stance.
11. The existence or extent of the Association's negative position raised a good deal of contention among the sociologists reading our initial drafts. Sentiments ranged from a belief that the ASA has come to see sections as the key to future membership, to active hostility.

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