

Editorial

Retaining the sociology in medical sociology

In a memorable plenary presentation ‘Protecting our virtues: Medical sociology at 50’ delivered to the British Sociological Association (BSA), Medical Sociology Annual Conference in 2003, the North American medical sociologist Raymond De Vries cautioned the audience that their subject area was in danger of descending into a ‘slump’. However, reinvigoration is likely he insisted, if we remain true to our virtues. This, he argued, would involve not only ensuring that we explore connections between biographies and history—a task which has long been central to the sociological enterprise—but that we strive to be more creative and ‘playful’ with our work and ideas. Daringly he even suggested that we could pursue research that might be considered by some to be ‘useless’ (De Vries, 2003, p. 35), in the sense that it does not necessarily possess any clear connection with policy or practice. Such virtues, we might observe, are very much akin to retaining what C. Wright Mills calls a ‘sociological imagination’; a way of thinking that is vigilant to the significance of ‘events’ at the same time as being critical and imbued with a strong sense of the ‘social’ (Mills, 1959).

The virtues of *Social Science & Medicine* include its international reach and global dimension, its multi-disciplinarity, and the range of issues pertaining to health, illness and medicine that are explored in its pages. The wealth of methodologically diverse research that is published in its 24 issues each year is phenomenal. What distinguishes sociological analyses of these many and varied substantive issues are the conceptual and theoretical reflections that are generated from them. It is paramount that we make time to *reflect*, and to reflect at an appropriate level of abstraction, about the large quantities of data that are generated by others and ourselves. To ask questions such as: What are the links between the seemingly diverse areas of study that concern us?

Which conceptual tools enable us to gain an analytic purchase on health and medical issues? What do our research findings tell us about contemporary social formations and their transformations? What do contemporary social formations and their transformations tell us about our research findings? To do this is not always easy when the health problems that we are addressing are pressing and when everyone is (so very) busy, keen to publish quickly, and likely to be under pressure to swiftly turn projects ‘around’ to satisfy their funders. But enduring and influential sociological studies are those which yield *transferable* conceptual tools and theorisations and these are ultimately more likely to benefit the needs of patients, the health of populations, and the requirements of health care systems than are those studies which adopt *just* a ‘problem solving’ orientation.

From the above comments, it will be evident that the Medical Sociology Office of *Social Science & Medicine* is keen to encourage papers that are theoretically informed or inspired by traditional sociological concerns and/or more recent theoretical developments. In terms of the latter debates on globalisation, risk, complexity and chaos, mobilities, citizenship, embodiment, social informatics and so on may prove to be instructive for medical sociology. Indeed, perhaps some ‘translation pieces’—papers that usefully discuss contemporary social theory and assess how it may be of relevance to health, health care, illness and medicine—could be of value. This said the strength of medical sociology is undoubtedly solid empirical work. We certainly are keen to see this tradition continue but, crucially, we wish to see papers that generate *enduring* ideas and concepts rather than ones that simply present empirical findings, an aspiration which stands for the Journal as a whole (Annandale, 2007). Empirical research findings must therefore be

located in social—both local and global—contexts and broader social, cultural, and technological transformations need to be taken into account. Observations on the minutiae of social life—fascinating though they are—always need to be understood in relation to broader debates about the current state and changing nature of the contemporary social world.

Currently, there are many opportunities for engaging in critical sociological analyses of health and medical matters as is evidenced by the huge number of excellent papers we receive. There are exciting developments in a number of substantive areas of study and, although we cannot be exhaustive, these might usefully be grouped under the following headings: technologies, globalisation, inequalities, contested health and medical knowledge, and embodied sociology.

Contemporary developments

The Spanish sociologist [Castells \(2000\)](#) argues that biotechnologies, nanotechnologies and information and communication technologies (ICTs) form the critical contours of the contemporary period—what he calls the ‘network society’. Biotechnologies such as those associated with genetics, pharmaco-genetics, stem cell research, DNA testing and screening and so on, all generate a raft of social and ethical considerations. ‘Surveillance medicine’ (a notion that has been influential in medical sociology since the 1980s) takes on a new twist in the light of these developments. Privacy, autonomy, citizenship, the storage, handling and retrieval of data are all issues that are benefiting from sociological scrutiny. Clearly technologies are having consequences too for social relations and identity. For example, the sophistication and—in some parts of the world—the ubiquity of medical imaging and visualisation techniques (e.g. magnetic resonance imaging (MRI), surgical simulation and telemedicine) for the confirmation, communication and treatment of ‘disease’, ‘disorders’, and ‘behaviours’ gives rise to further reflections on the persistence of the biomedical paradigm. Whilst ethicists debate the dilemmas which technologies give rise to, critical sociology debates the potential for fundamental social injustices that can arise from a global economy which prioritises investments into technological advancements in ways that are perhaps inappropriate when we know that the major

determinants of morbidity and mortality are associated with poverty and insecurity.

The notion of a network society however, is too static for some social theorists. The British sociologist [Urry \(2003\)](#) suggests, for example, that the social world might be more accurately characterised by the notion of global complexity that foregrounds ‘mobilities’ over more traditional sociological focus on (more static) ‘structures’. Within the global arena, it has been suggested that nation states have become relatively ineffectual and that the regulation of populations, bodies, diseases, drugs, technological procedures, health professionals, and health care related industries has become ever more tenuous. *Social Science & Medicine* has contributed to these debates with papers exploring the nature and consequences of the migration of health care workers and people’s reception, perceptions and experiences of diseases such as SARs, TB and HIV/AIDS. Studies of the socio-economic and cultural transformations in Eastern European countries yield not only invaluable insights into the consequences for health and health care in those settings but also offer more durable conceptualisations of the impact of rapid major social changes on peoples’ everyday lives. In addition, the interplay between the shifting focus and expansion of commercial health and medical care organisations in local and global contexts and the experiences of health, illness and health care delivery also form an important vein of research in this regard.

Socio-economic and cultural transitions are also altering the contours of health inequalities—perhaps one of *the* most central strands of not only medical sociology but also the other disciplines represented in *Social Science & Medicine*. Overlapping with important epidemiological studies, the last few decades have witnessed research that has refined our analysis of social structures and health through the exploration of ‘variables’ associated with emotion, place, control, insecurity, power, trust, civic engagement and so on. Traditional sociological theory—most particularly neo-Durkheimian sociology—has been married with innovative statistical techniques in order to generate nuanced analyses of health inequalities. Appreciations of global complexities and—what the North American medical anthropologist [Emily Martin \(1994\)](#) calls—‘flexible cultures’ are also giving rise to a productive rethinking about established social divisions associated with ‘age’, ‘race’, ‘gender’, ‘class’, ‘education’, ‘place’ ‘locality’ and ‘income’.

For example, a concept such as gender which historically was simply operationalised in terms of a crude male/female dualism and then mapped on to health status, is now recognised to be increasingly fluid and mutable within late modern cultures. As Annandale (2005) points out, of particular salience for medical sociologists is the way late modern capitalism—and what she calls ‘the “new single system” of patriarchal capitalism’—both fosters and gains from this diversity of identities in ways that can be detrimental for women’s health. Furthermore, for both men and women, cultural images of ‘healthy bodies’, ‘fit bodies’, and ‘good citizens’ (be they healthy eating, non-smoking people who participate in exercise) are broadcast across the media and have the potential to create new social exclusions and spoilt identities. Health is therefore central (if often too implicit) to any sociological analysis of contemporary social forms.

Shifting structural hierarchies are mirrored by changing institutional hierarchies that, in turn, are affected by both *external* and *internal* challenges. ‘Expert systems,’ such as institutionalised medicine, are scrutinised by a growing number of social movements and the proliferation of information that appears throughout an expanding array of domains. Relatedly, the influence of the institution of medicine over the definition of disease and forms of treatment is being increasingly constrained by commercial enterprises who in turn contribute to the creation of new medical problems and (often costly) solutions. *Internal* challenges such as reforms of professional education and training and the audit and regulation of work practices also have consequences for health care systems. Trust, accountability, autonomy, governance and the changing roles of various health care workers are enduring themes in medical sociology which are currently benefiting from continuing sociological scrutiny that is sensitive to organisational environments. Concurrently developments relating to the social dynamics of risk communication in health care delivery between practitioners and patients (and their kin, carers and friends) are significant here. In neo-liberal societies self-care and patient choice have contributed to the demise of the one-dimensional figure of a patient and given rise to a multiplicity of ‘patients’, ‘users’, ‘consumers’, and ‘experts’ who are using an increasingly varied array of biomedical and ‘alternative’ forms of health care and ‘new’ health technologies. These new identities are accompanied by doubt; not least because their

positioning in relation to the use and ‘consumption’ of health care invariably raises questions about where risk and responsibility for health and health care lie. Similarly, at a collective level, there has been an increase in the number of new social movements coalescing around health and environmental injustice, the construction of diseases and the negotiation of disease causation. These groupings are contributing to, and filling the spaces created by, the fracturing of medical knowledge.

The fracturing of medical knowledge is further reflected in the fragmentation of medicines—and indeed some might say sociology’s prime object—the body. The physical, experiential, lived, virtual, and deconstructed body is explored through a variety of lenses which give rise to a diverse set of clinical gazes (back to technologies again). These technologies, which may include visualisation techniques or drug therapies, can foster new identities and yet disturb others. Furthermore, the boundaries between the physical and social body are disrupted and give rise to questions such as: What does it mean to be human? What is the body? Narratives of illness, health and experiences of health care are also providing invaluable insights into the consequences of these practices for both health providers and patients. Furthermore, they also contribute to an appreciation of contemporary *embodiment*. Again, we have seen papers in *Social Science & Medicine* that offer invaluable conceptual and empirical insight into the embodiment of health, illness and health and medical care. As the sociologist Mike Hepworth noted only a few years before his death in early 2007:

I think the way ahead for the sociology of the body in particular is through detailed empirical inquiry into variations of experience of the body within increasingly complex social arrangements; in other words, what is actually going on out there on the streets. (Hepworth, 2003, p. 37)

Detailed empirical inquiries form the core stuff of medical sociology and we encourage the full spectrum of research methods and, in addition to conventional styles of research, we welcome innovative approaches to generating data. The juxtaposition of disciplines within *Social Science & Medicine* provides fertile ground for such innovation. Indeed, much of the exciting work in recent decades in relation to health is that which is at the interface of sociology and/or social geography,

health economics, health psychology, social epidemiology, health policy and, of course, anthropology. The boundaries between the disciplines are blurred but nevertheless the interactive effect of disciplinary engagement can give rise to novel ways of producing, ‘seeing’ and interpreting data. One such example might be the ‘spatial turn’ within the social sciences that has produced further layers in the exploration of social inequalities in health through analyses which are sensitive to place, localities, and movements of information and people. Distinctions between the concerns and approaches of medical sociology and health policy and/or anthropology are not always ‘obvious’. For example, ethnographic studies which might be classified as ‘sociology’ in the UK might be regarded as anthropology in other countries. Certainly localised ethnographies—detailed descriptions of experiences of people’s lives which are cognisant of the interconnectedness of social, cultural, economic and political circumstances—have been and remain especially valuable for understanding health matters.

So at the Medical Sociology Office, we hope to respond to De Vries’s (2003) rallying call and help to protect our virtues by both encouraging and welcoming papers which report on studies which are empirically grounded and theoretically engaging. Theoretical pieces are also valuable and we especially welcome those that are able to help us reflect upon substantive developments and topical health

related issues. Certainly those studies which are matched by analytic insight and link their findings to their societal context offer the most exciting promise for the discipline.

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