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Medical Sociology and Its Changing Subfields

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The sociological study of health, illness, and healing systems in the US has expanded substantively and deepened theoretically over the past half century. While work in this area once fit under the single moniker of "Medical Sociology," we now use a range of alternative labels (e.g. Sociology of Medicine, Sociology of Health and Illness, Sociology of Health, Illness, and Healing, Sociology of Health, Health Sociology) and definitions to describe the field. Some definitions highlight topic areas:

> "Medical sociology is the study of health care as it is institutionalized in a society, and of health, or illness, and its relationship to social factors" (Ruderman 1981: 927).

> "The sociology of health and illness studies such issues as how social and cultural factors influence health and people's perceptions of health and healing, and how healing is done in different societies" (Freund et al. 2003: 2)

> "Medical sociology focuses on the social causes and consequences of health and illness" (Cockerham 2017: 4).

Others emphasize different aspects of the sociological perspective:

> "Medical Sociology is the subfield which applies the perspectives, conceptualizations, theories, and methodologies of sociology to phenomena having to do with human health and disease. As a specialization, medical sociology encompasses a body of knowledge which places health and disease in a social, cultural, and behavioral context" (Committee on Certification in Medical Sociology 1986).

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> "The most important tasks of medical sociology are to demonstrate and emphasize the important influence of cultural, social-structural, and institutional forces on health, healing, and illness…" (Weiss and Lonnquist 2016: 11).

> "An approach that emphasizes using the area of health, illness, and health care to answer research questions of interest to sociologists in general. This approach often requires researchers to raise questions that could challenge medical views of the world and power relationships within the health care world" (Weitz 2017: 346).

The many labels and definitions that have been offered suggest a lack of consensus on defining medical sociology's substantive scope and its most significant contributions to knowledge. Some suggest that it is "hard to find a comprehensible statement of what… medical sociology is" (Chaiklin 2011: 585). Others describe the field as a "loosely connected network of disparate subgroups" (Veenstra 2002: 748). This state of the field raises several fundamental questions. How can we characterize our field in a general and consistent manner? What are our contemporary disciplinary boundaries? What are our major subfields? In other words, who are we now, and what do we do?

In this chapter, we propose a disciplinary structure for medical sociology that attempts to answer these questions. By "disciplinary structure," we mean a representative model of our major subfields as defined by topic areas, theoretical orientations, and significant contributions to the study of health. All sciences invariably reflect on these important issues and, in doing so, define their scientific orientation and boundaries in relation to other sciences, including, for example, medical sociology (Bloom 1986; Gold 1977; Petersdorf and Feinstein 1980; Straus 1957), medical anthropology (Saillant and Genest 2007), health psychology (Baum et al. 2011), and health economics (Pauly et al. 2012). Explicit disciplinary structures are one way to set disciplinary boundaries, mark accomplishments, and direct future efforts toward a cumulative science. Substantive topics and concepts alone are too granular to signify a field's major organizing principles. As Zerubavel (1991) once pointed out, things become meaningful only when placed into categories, and the "islands of meaning" that are created in this process explain *what* matters to a particular social world (or in this case, medical sociology) and help to determine the *nature* of its social order (or field of knowledge). In short, it is through the process of classification that we establish our boundaries and identity and, by extension, distinguish ourselves from other fields within sociology and other disciplines concerned with health.

The identification of a disciplinary structure was once integral to the development of the field, as evidenced in Straus's (1957) classic distinction between the sociology *of* medicine and sociology *in* medicine. Six decades have passed since Straus offered his structure, and we believe it is time to consider a more contemporary scheme that acknowledges the expansion of our subject matter, the broadening of theoretical influences, and the resultant complexity. Our primary aim here is to stimulate a forward-looking conversation among medical sociologists by reviewing previous conceptualizations and proposing a new model to serve as a basis for discussion. Our model classifies medical sociology in terms of its major subfields as

defined by substantive topics, theoretical orientations, and scientific contributions. We review the unique contributions of each subfield while recognizing an underlying unity driven by common training in sociological theory and methods. We end with several recommendations for a more refined and directed conceptualization of the field.

There are several reasons why we should be having these discussions. When we define our major subfields and contributions to the study of health, we (1) claim our independence from other health sciences (e.g. medicine), (2) maintain our status in the marketplace of health research (e.g. as health psychologists and public health researchers publish more and more on socioeconomic inequalities), and (3) develop as a cumulative science through a formal recognition of the expansion of our field's purview. Before Straus (1957), for example, some questioned whether sociology should be considered a "third branch to medicine" (Boulton 2017: 242). When we stop reflecting and leave our subfields undefined, we lose track of our major contributions across generations of medical sociologists and in the broader interdisciplinary field of health research, leaving scholars from other health sciences (e.g. public health) unable to identify them. We also create intellectual vacuums for less fruitful discussions. For example, when we stopped discussing subfields in the late 1980s, we began the great "moniker debate" over whether to continue using the term "medical sociology" or to rename ourselves something else to be more inclusive of work related more to health than medicine. Instead of taking up that debate, we intend to redirect the conversation to how best to represent our disciplinary structure. Ultimately, we believe that focusing more on our major subfields and contributions to sociology and the broader study of health will support more productive and substantive conversations about what medical sociology has to offer.

Previous Subfield Models

The establishment of subfields within medical sociology was a major advance in its early development. In the 1950s, Straus (1957) proposed a two-subfield structure that included the sociology *of* medicine and sociology *in* medicine. These subfields were important because they (1) organized studies depending on the extent to which they served the interests of sociology vs. medicine and (2) sought to highlight the unique contributions of sociology to the study of health, illness, and medical practice. In the 1980s, Petersdorf and Feinstein (1980) suggested a more elaborate six-subfield model that was still based on sociology's stance vis-à-vis professional medicine, including sociology *in* medicine, sociology *of* medicine, sociology *for* medicine, sociology *from* medicine, sociology *at* medicine, and sociology *around* medicine. Still others advocated for a sociology *with* medicine (Bury 1986; Horobin 1985; Levine 1987). Although elaborations on Straus' original model never really took hold (Cockerham 1983; Hollingshead 1973; Ruderman 1981; Straus 1999; Wardwell 1982), we argue that, after decades of scholarship, the two-subfield model no longer adequately represents our contemporary disciplinary structure or our contributions to the study of health. For example, many medical sociologists no longer define themselves primarily in relation to medicine (whether critical of, or allied

with it), and areas of inquiry that have distinct sociological identities have become more prominent (e.g. social epidemiology). For these reasons, we take Straus' (1957) original concerns with disciplinary structure in a new direction by defining subfields that are distinguished by substantive topics, theoretical orientations, and contributions to the interdisciplinary study of health.

Handbooks and textbooks typically divide the field substantively. For example, the third edition of the *Handbook of Medical Sociology* (Freeman, Levine, and Reeder 1979) was organized into five parts: "Health and Illness," "Health Care Providers," "Individual and Organizational Behavior," "Health Policy Dimensions," and "Methods and Status in Medical Sociology." The most recent sixth edition of the *Handbook of Medical Sociology* (Bird et al. 2010) adopted a different set of three organizational categories: "Social Contexts and Health Disparities," "Health Trajectories and Experiences," and "Health-Care Organization, Delivery, and Impact." The *Handbook of Health, Illness, and Healing* (Pescosolido et al. 2011) offered yet another distinct seven-part scheme: "Rethinking Connecting Sociology's Role in Health, Illness, and Healing," "Connecting Communities," "Connecting to Medicine: The Profession and Its Organizations," "Connecting to the People: The Public as Patient and Powerful Force," "Connecting Personal & Cultural Systems," "Connecting to Dynamics: The Health and Illness Career," and "Connecting to the Individual and the Body."

When we turn to important textbooks, we find four major sections in Cockerham (2017) (Health and Illness, Seeking Health Care, Providing Health Care, and Health Care Delivery Systems) and four major sections in Weitz (2017) (Social Factors and Illness, The Meaning and Experience of Illness, Health Care Systems, Settings, and Technologies, and Health Care, Health Research, and Bioethics). In Weiss and Lonnquist (2016), we see a more complex structure with no major sections or organizational schemes. Although these formats are effective for textbook presentations of the literature, they are more a collection of topics than major subfields that might organize the field.

One of the challenges we face is defining our field's substantive scope and its most significant contributions to knowledge in a way that is contemporary, comprehensive, and efficient. Although Straus' (1957) original model was efficient, it no longer adequately represents the field. The organizational schemes of books are more contemporary, but their structures are inefficient in the sense that the categories are numerous and inconsistent across volumes. The compromise we propose is a modest elaboration on Straus (1957) that reflects contemporary developments in the field.

A New Four Subfield Model

Building on previous conceptualizations, Figure 1.1 identifies and describes four major subfields of medical sociology: (1) Social Epidemiology, (2) Social Psychology of Health and Illness, (3) Sociology *of* Medicine, and (4) Sociology *in* Medicine. These subfields are intended to represent the field according to substance, theory, and contributions to knowledge.

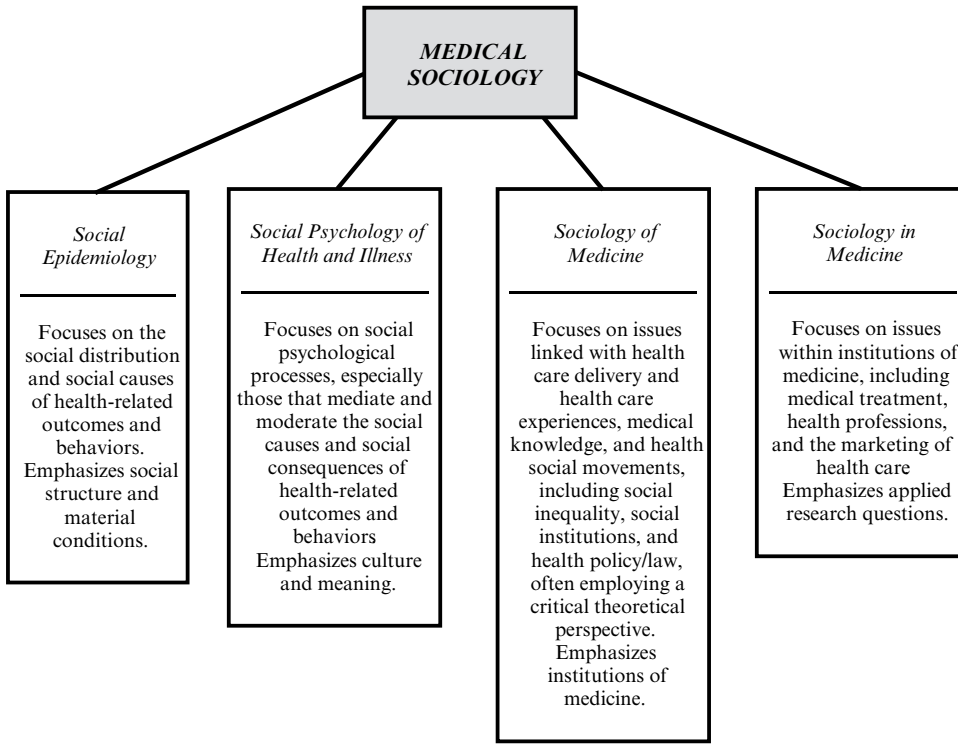

Figure 1.1 Major Subfields of Medical Sociology.

According to the ASA Committee on Certification in Medical Sociology (1986), our subject matter includes "*descriptions and explanations or theories relating to the distribution of diseases among various population groups; the behaviors or actions taken by individuals to maintain, enhance, or restore health or cope with illness, disease, or disability; people's attitudes, and beliefs about health, disease, disability and medical care providers and organizations; medical occupations or professions and the organization, financing, and delivery of medical care services; medicine as a social institution and its relationship to other social institutions; cultural values and societal responses with respect to health, illness, and disability; and the role of social factors in the etiology of disease, especially functional and emotion-related*."

Our proposed subfields are intended to capture this broad range of topics, but not to be mutually exclusive or exhaustive. We fully acknowledge that some researchers may identify with more than one subfield. We believe that the diversity of research conducted in our field has and will continue to challenge the representativeness of our proposed disciplinary structure. With this in mind, our aim is not to find a perfect representation of the field or to dismiss other organizational schemes. Instead, our aim is to create a representative structure so that we can see the scope of our field more clearly. What does sociology contribute to the study of health and medicine? We argue that our subfield model answers this question in a clear way that better reflects where we are today.

Social Epidemiology

Social Epidemiology has been defined as "the branch of epidemiology concerned with the way that social structures, institutions, and relationships influence health" (Berkman et al. 2014:2). Research along these lines goes by many names, including Population Health, Social Determinants of Health, Health Disparities, Health Inequalities, Health Demography, and Biodemography. In our model, the subfield of Social Epidemiology focuses on the social distribution and social causes of health-related outcomes and behaviors. Health-related outcomes typically include indicators of mental health, physical health, and mortality risk. Health-related behaviors usually refer to risk factors such as exercise, smoking, alcohol consumption, illicit drug use, and broader health lifestyles. Relevant language from the Committee on Certification in Medical Sociology (1986) includes "descriptions and explanations or theories relating to the distribution of diseases among various population groups" and "the role of social factors in the etiology of disease."

Although the term "Social Epidemiology" is primarily associated with the field of public health, researchers across the health sciences examine the social distribution and social causes of health-related outcomes. Sociological social epidemiologists distinguish themselves by their emphasis on structural arrangements as determinants of health. Syme and Yen (2000:373) explain that while the social epidemiologist in public health "is fundamentally interested in learning about the nature of human disease by studying social characteristics," the social epidemiologist in sociology "seeks to learn about the social characteristics of human populations by studying the occurrence of disease." Social epidemiologists in public health believe that poor health is a problem to be solved or good health a goal to be achieved. Social epidemiologists in sociology believe that health is a consequence of social arrangements, especially those represented in social inequality, institutional ties, social relationships, and social roles (Mirowsky and Ross 2003). Social epidemiologists in public health primarily use analyses of health to direct health intervention programs and policy. Social epidemiologists in sociology primarily use analyses of health to shed light on the nature and function of social arrangements that cause or contribute to ill health.

Another important distinction is the use of theory. Although some health demography is descriptive rather than theoretical, most social epidemiology in sociology aims to document and explain health inequalities in the service of advancing sociological theory. Contemporary sociological social epidemiology is often informed by macro-structural theories of inequality, including, for example, fundamental cause theory (Link and Phelan 2000; Phelan and Link 2013), health lifestyle theory (Cockerham 2005; 2013), constrained choice theory (Bird and Rieker 2008), and life course theories (Ferraro and Shippee 2009; O'Rand 1996). What distinguishes these theories from those that dominate other subfields is their emphasis on broad structural and institutional factors that generate health inequalities.

While social epidemiology in sociology regularly engages in theoretical applications, social epidemiology in public health appears less enthusiastic about theory. In a recent review entitled "Social Epidemiology for the twenty-first Century," Kawachi and Subramanian (2018:240) concluded that social epidemiology "is no longer just for mavericks in fields such as sociology or economics where 'theoretical' research is often privileged over 'applied' research." This language is interesting to us since, in

our judgment, the best analyses in sociological social epidemiology involve the use of theory. The conceptual framework provided by theory in social epidemiology in sociology is the medium through which reality is explained and understood. The use of sociological theory in empirical research is the key distinction between research conducted in sociology and public health. Social epidemiologists in public health are clearly able to distinguish their work from ours, but mainstream or generalist sociologists often view epidemiological research conducted in public health and sociology as typically "atheoretical," "applied," or simply "public health."

Social Epidemiology can also be distinguished from the other major subfields within medical sociology (discussed in greater detail below). While social epidemiologists describe the social distribution and social causes of health-related outcomes and behaviors, social psychologists of health and illness focus on social psychological processes, especially those that mediate and moderate the social causes and social consequences of health-related outcomes and behaviors. The Social Psychology of Health and Illness encompasses a range of theories that intersect with processes related to stratification and culture (Carr and Umberson 2013; George 2001; Kessler et al. 1995; McLeod et al. 2014; Schnittker and McLeod 2005; Simon 2000). Social Epidemiology and the Social Psychology of Health and Illness are nevertheless related through a natural scientific division of labor. Social epidemiologists identify social distributions and social causes. Social psychologists of health and illness analyze the social psychological processes that explain and modify the broader social distributions and social causes.

Social Epidemiology is more easily distinguished from the Sociology *of* Medicine and Sociology *in* Medicine. The Sociology *of* Medicine focuses on a range of theoretical issues related to institutions of medicine (Cockerham 2017). Sociology *in* Medicine focuses on applied issues within institutions of medicine, including medical treatment, health professions, and the marketing of health care (Cockerham 2017; McIntire 1894/1991; Weitz 2017). Social Epidemiology emphasizes the structures that drive health patterns within and across populations. The Sociology *of* Medicine and Sociology *in* Medicine focus on health patterns and practices within institutions of medicine and related social institutions. The Sociology *of* Medicine and Sociology *in* Medicine can also overlap with Social Epidemiology. Health and health-related behaviors are often tied to institutions of medicine. For example, gendered experiences within institutions of medicine (e.g. access to care) can contribute to broader gender disparities in population health.

Another way to see the contributions of Social Epidemiology is to review an excellent application of the subfield. Using data from the 1996–1997 Community Tracking Study and the pooled 1972–2000 General Social Survey, Schnittker (2004) examined "synergistic interactions between income and education" in the prediction of overall health status. The key question is whether the established association between income and health varies by level of education. The results of the study showed that "those with more education have better health for all levels of income, and fewer income-based disparities exist among the well educated than among the less" (Schnittker 2004: 286). We classify this study as Social Epidemiology because it focuses on the structural distribution of health and is primarily (not exclusively) descriptive in nature. In the end, this study contributes to the sociological study

of health by specifying the educational or human capital conditions under which income is more or less relevant for overall health status. This study is distinguished from public health because it engages theories derived from medical sociology and health economics to support its examination of the synergistic interactions between income and education. This work also emphasizes social structure rather than health processes or health-related interventions.

Social Psychology of Health and Illness

The Social Psychology of Health and Illness is concerned with social psychological processes, especially those that explain or modify the structural causes of health and health-related behaviors or through which their social consequences are realized. It corresponds most closely to the following description from the Committee on Certification in Medical Sociology (1986): "the behaviors or actions taken by individuals to maintain, enhance, or restore health or cope with illness, disease, or disability; people's attitudes, and beliefs about health, disease, disability and medical care providers and organizations." For some researchers in the Social Psychology of Health and Illness, health is a lens into more general social psychological processes; for others, social psychology offers theories and concepts that illuminate health-related processes. Regardless of orientation, social psychologists of health and illness direct our attention to proximate health-related processes, especially those at the level of interpersonal interaction.

This subfield is as broad as sociological social psychology itself, encompassing interactionist analyses of self and identity in illness (Charmaz 1991), experimental studies of the health implications of small group processes (Taylor 2016), and multilevel analyses of the social determinants of health (House 2002). What distinguishes research in this subfield from descriptive Social Epidemiology is its emphasis on process (i.e. how outcomes are accomplished) and on subjective experience. Process and subjectivity are relevant to a range of topics, encompassing the onset and course of illness and disease, and individual and social responses, including help-seeking. The Social Psychology of Health and Illness can also be contrasted with health psychology (Taylor et al. 1997). Much like the distinction between sociological and psychological social psychology, the fundamental difference is defined by the primacy given to the analysis of social arrangements versus individual dispositions.

While research in the Social Psychology of Health and Illness draws inspiration from diverse theoretical traditions, among the most common orienting concepts are stress, identity, and stigma. The stress process framework and its constituent concepts (stressors, social support, and coping) provide explanations for health inequalities inasmuch as social groups differ in their exposure to stressors and their access to resources for managing stress (Aneshensel 1992; Pearlin 1989; Turner et al. 1995). Identity processes have been invoked to analyze variation in stress responses. For example, research shows that racial/ethnic identity can moderate or buffer the association between discrimination and health (Mossakowski 2003; Sellers et al. 2003). Identity processes have also been shown to have broader application in studies of how self and identity change in response to illness (Charmaz 1983). Stigma responses become incorporated into illness identities, shape the course of illness, and influence decisions about help-seeking (Pescosolido et al. 2008).

Because of its breadth, studies in this subfield defy easy categorization. Studies can address a broad range of topics. They can be quantitative or qualitative; based on surveys, interviews, or experiments. We offer two examples that illustrate the breadth, as well as the common elements, of research in the Social Psychology of Health and Illness.

Carr and colleagues (2017) used data from the Disability and Use of Time supplement from the Panel Study of Income Dynamics to evaluate the extent to which marital/partner strain and support moderate the association of disability with emotions among older adults, and whether those patterns differ by gender. They found that relationship support helps to protect women with severe impairment from feelings of frustration, sadness, worry, and negative mood, but the same support was associated with heightened distress for men, perhaps because men find support threatening to their sense of competence. The buffering effects for women suggest that emotional support may foster positive reinterpretations of disability and provide emotional resources to manage adjustments to roles and activities. This study exemplifies the Social Psychology of Health and Illness in that it uses social psychological concepts to shed light on health-related processes while also yielding insight into the social psychology of gender.

In a very different study, Kaiser (2008) analyzed in-depth interviews of women with breast cancer to explore how they interpret and use the survivor identity. She observed that, although some women embraced the identity, others rejected it. Women who rejected the identity cited fear of recurrence, not being sick enough to justify the label, and discomfort with the implied social identity as reasons for the rejection. Kaiser (2008) concluded that cultural images of cancer survivorship can be alienating and distressing to some women with cancer. By applying the concept of identity to the cancer illness experience, Kaiser (2008) highlights the centrality of the self to the experience of illness and to treatment responses.

Although different in their theoretical underpinnings and methodological approaches, these two studies are nevertheless related through their use of social psychological concepts to analyze the processes through which social conditions produce health and illness and the individual and social responses that follow. Both show how structural arrangements and cultural beliefs shape proximate life experiences and, finally, health.

Sociology of Medicine

The term "Sociology *of* Medicine," as previously noted, refers to half of Straus's (1957) original two-subfield model. The term is still appropriate for the broad subfield that takes medicine and its various activities pertaining to health and illness as an *object* of study. The Sociology *of* Medicine is characterized as research and analysis of the medical or health environment from a sociological perspective (Broom et al. 2013; Cockerham 2017; Straus 1957). The most relevant language from the Committee on Certification in Medical Sociology (1986) that pertains to the Sociology *of* Medicine today is that it covers "medical occupations or professions and the organization, financing, and delivery of medical care services; medicine as a social institution and its relationship to other social institutions; cultural values and societal responses with respect to health, illness, and disability."

Initially, the Sociology *of* Medicine encompassed the Social Psychology of Health and Illness and those facets of Social Epidemiology pertaining to the effects of social structures on health – essentially everything except sociological work that occurred within medical and health-related institutions (i.e. Sociology *in* Medicine). With the emergence of these other subfields as distinctive entities in medical sociology, the Sociology *of* Medicine is now primarily centered on issues linked with health care delivery and health care experiences, medical knowledge, and health social movements, including social inequality, social institutions, and health policy/law.

In its original conception, the Sociology *of* Medicine was centered in university sociology departments and characterized as "academic" rather than "applied" because of its grounding in sociological theory. This is the subfield where theory originated with Parsons' sick role and where theory has been closely identified in medical sociology. Although other subfields, particularly Social Epidemiology and the Social Psychology of Health and Illness, consistently test theories of health causation, Sociology *of* Medicine applies a broader range of sociological theories related to structure, culture, and social institutions. For example, social epidemiological research on structural health inequalities by race, class, and gender can spill over into the Sociology *of* Medicine when those disparities are linked to inequitable distributions of health insurance and health care within institutions of medicine (Lutfey and Freese 2005).

The Sociology *of* Medicine is perhaps best represented by the emergence of research on medicalization (Conrad 1992), pharmaceuticalization (Abraham 2010), biomedicalization (Clarke and Shim 2011), and health-related social movements (Brown et al. 2013). For example, Conrad's work on medicalization has uncovered the role of the medical profession in defining previously non-medical problems in medical terms, usually as an illness or disorder requiring a medical intervention. Conrad and others subsequently found that the forces driving medicalization have shifted to include biotechnology (Clarke and Shim 2011), patients and consumers (Barker 2002; Brown et al. 2001), and mass media advertising and the profit incentives in managed care systems (Conrad and Leiter 2004). Such critical perspectives on the roles of capitalism and social control in health care is one of the Sociology *of* Medicine's most important contribution to Medical Sociology.

Sociology in Medicine

Sociology *in* Medicine is the subfield of medical sociology primarily focused on applied research within institutions of medicine, with substantive focus on medical treatment, health professions, and the marketing of health care (Broom et al. 2013; Cockerham 2017; Straus 1957). The sociologist *in* medicine is one who collaborates directly with physicians and other health personnel in studying the social factors that are relevant to addressing problems in health care settings. The work of the sociologist *in* medicine is intended to be directly applicable to patient care or to solving issues related to public health. In these ways, Sociology *in* Medicine can be characterized as applied research and analysis that is more motivated by medical problems than sociological problems. Sociologists in medicine usually work in medical schools, nursing schools, public health schools, teaching hospitals, public health

agencies, and other health organizations. They may also work for a government agency, such as the US Department of Health and Human Services or the Centers for Disease Control and Prevention, in the capacity of biostatisticians, researchers, health intervention planners, and administrators.

Straus's (1957) conception of Sociology *in* Medicine presented the emergent identity and hopes of a fledgling sociological sub-discipline. His survey of sociologists working on medical topics and in medical settings was one of several early publications (Anderson and Seacat 1957; Freeman and Reeder 1957; Mechanic 1966) that sought to claim a place and purpose for Sociology within Medicine's rapidly changing and culturally powerful institutional environment. The distinction between sociologists studying medicine from the outside (Sociology *of* Medicine) and sociologists located inside medical settings and engaged in collaborative work with medical insiders (Sociology *in* Medicine) remains relevant today. For Straus (1957:203), these two approaches tended to be "incompatible with each other." Correspondingly, Straus (1957) saw this tension as requiring those in the field to become "chameleons" in order to secure insider acceptance. Straus (1957: 203), argued that "there is a danger in this, for if the sociologist begins to talk like a physician, he [sic] may eventually come to act like a physician and even to think like a physician."

Straus' apprehensions were fundamentally about disciplinary identity and the dangers of over-identification with "the other" (i.e. physicians as an occupational group or medicine in general). More broadly, Straus and his contemporaries worried about the integrity of sociological objectivity along with the long-term independence of this new discipline. To read Straus and his peers (Bloom et al. 1960; Freeman et al. 1963) is to take a journey into the birth of a discipline at a time when neither acceptance nor a distinctive scholarly identity were foregone conclusions.

Now that medical sociology is a more established discipline, are Straus's concerns still relevant? How can we best understand the contributions of sociologists who work in medical settings? What can we say about the training model of sociologists who desire to work in medical settings to address problems of importance to Medicine using a sociological lens?

We believe that sociologists *in* medicine bring a unique perspective to the table (Constantinou 2015). In what might reflect a form of cultural bias, Medicine tends to define many of its educational and clinical challenges at the level of individuals rather than as reflections of organizational or structural challenges. Examples abound. "Problems" with learning outcomes, as reflected in student test scores on exams such as the National Board of Medical Examiners Licensing examinations, are "solved" by recruiting ever-higher scoring applicants. The recent upsurge of interest within Medicine regarding "burnout" (Dyrbye et al. 2017) has been followed by efforts to provide employees with tools to ameliorate its effects rather than to invest time and resources to address the structural conditions that might give rise to emotionally toxic work environments. Meanwhile, the possibility that organizational units, such as medical schools, might themselves suffer from burnout is not even on the radar. Even Medicine's recent attention to professionalism has remedially focused far more on teaching trainees and practitioners to be more professional, or to remediate "professionalism lapses" (a preferred term within medicine, but a sociologically evocative one) than on issues of contextual contributors, with concerns

of "organizational professionalism" only recently gaining traction. Medicine still requires a sociological perspective to balance the prevailing lens of individualism.

Ospina and colleagues' (2019) recent study of physician-patient communication is an excellent example of Sociology *in* Medicine. Using secondary data collected from a random sample of 112 clinical encounters, this study found that clinicians elicit the patient's agenda in only 36% of encounters, with physicians interrupting the patient's story 11 seconds into their meeting. Key concepts in this article include "shared-decision making," "patient-centered care" and "patient-physician communication," all of which can be linked to broader sociological concerns with the structure and dynamics of dyadic communication exchanges. Furthermore, studies on physician-patient communication remain a staple in the social science literature (Cortez et al. 2019; Oh 2017; Ong et al. 1995, 2000; Stepanikova et al. 2012).

Key Contributions

In summary, medical sociology contributes to sociology and other health sciences by examining (1) the social causes of health-related outcomes and behaviors (Social Epidemiology), (2) the social psychological processes that mediate and moderate the social causes and social consequences of health (Social Psychology of Health and Illness), (3) issues linked with health care delivery and health care experiences, medical knowledge, and health social movements, including social inequality, social institutions, and health policy/law (Sociology *of* Medicine), and (4) problems within institutions of medicine, including medical treatment, health professions, and the marketing of health care (Sociology *in* Medicine). By distilling our major subfields and key contributions through an efficient and representative structure, we are able to see that medical sociology makes the broader study of sociology more meaningful by establishing explicit links between important sociological concepts (e.g. social structure, social institutions, and culture) and health, health care, and human suffering. Mirowsky and Ross (2003:3) note, for example, that few people would care about social inequality "if the poor, powerless, and despised were as happy and fulfilled as the wealthy, powerful, and admired." We are also able to discern the primacy of social arrangements and social processes in the study of health and medicine, which is medical sociology's unique contribution to the health sciences. Specifically, we describe patterns of health and health-related behaviors with greater attention to the complexities of social arrangements than one often sees in fields like public health. We offer unique and compelling analyses of the material and subjective conditions that explain the broader social distributions of health than fields like health psychology and health economics. We contribute more critical analyses of health care systems than medicine. Our discussion of major subfields also suggests a number of ways in which we might further develop as a field.

Recommendations

In this section, we offer several recommendations for a more refined and directed conceptualization of the field. Some of our suggestions stem from our core argument that the sociological study of health could use a more contemporary disciplinary structure

that adequately represents the field. Others include more practical recommendations about graduate education. These recommendations are merely offered as possible directions for the field of medical sociology. Although these recommendations occurred to us, we realize they may be controversial to some. Our intent is to inspire even more discussions concerning the implications of our proposed model.

Recommendation #1. ***Explore explicit disciplinary structures***. It is difficult to develop as a field when our disciplinary structure is little more than a collection of concepts and topics under several field identifiers (e.g. Medical Sociology, Sociology *of* Medicine, Sociology of Health and Illness, Sociology of Health, and Health Sociology). It is true that our field has developed in significant ways. We have accumulated an impressive body of research. We have multiple journals. We have the second largest section in the American Sociological Association. However, our field is underdeveloped in other ways that are also important. As indicated by the range of labels and definitions used to describe our field, we have little consistency in research identities across researchers and in the ways we define the purview of our field. Because medical sociology is often defined in terms of concepts and topics that are often non-unique to our field (e.g. health, illness, medicine, social factors), Sociology in general and other health sciences are often unclear about the nature of our work or our unique contributions to the study of health and medicine. Disciplinary structures that define Medical Sociology in terms of major subfields and key contributions is an important step toward a more efficient and contemporary representation

of our unique contributions to the study of health.

Recommendation #2. ***Consider consistent research identities***. It is difficult to develop as a field without consistent research identities. As medical sociologists, we should consider identifying with one or more of the four major subfields. The consistent use of shared labels will eventually help to crystalize our disciplinary structure and to better demonstrate our contributions. It is insufficient to simply identify the subfields that represent research conducted in medical sociology. Identifying with major subfields reinforces the structure of the field by consistently signifying the nature of our work. This recommendation in no way limits the ways in which researchers might identify themselves or their work. For example, in some circumstances, it may make sense to claim expertise in health care or medicalization. Our recommendation is that researchers also recognize where their interests fit into a broader disciplinary structure that distills our major subfields and key contributions to the sociological study of health and medicine.

Recommendation #3. ***Consider consistent graduate program identities***. One potential strategy is for graduate programs to consider identifying as comprehensive or focused. Comprehensive graduate programs would represent the field as a whole. Focused graduate programs would represent one or more specific subfields. Precise program identities would contribute to more efficient graduate programs by dictating hiring decisions (who to hire), graduate recruitment strategies (who to recruit), and graduate curriculum (which courses and area examinations). For example, comprehensive programs could choose to require area examinations that cover the field whereas focused programs could require area examinations that correspond to selected subfields. Doing so would align examinations with faculty expertise, which is consistent with the American Sociological Association's *Code of Professional Ethics*.

Recommendation #4. ***Reconsider the role of Sociology in Medicine.*** Although we have excellent graduate programs in Social Epidemiology, Social Psychology of Health and Illness, and Sociology *of* Medicine, Sociology *in* Medicine is currently unrepresented in the graduate landscape. What role should Sociology *in* Medicine have in graduate education? Each year our graduates go on to work in medical schools, hospitals, government organizations, and health research firms. Non-academic job placements are likely to become even more common as the academic job market shrinks. We encourage conversations around the question of dedicating graduate courses or entire graduate programs to training graduate students to work in inter-disciplinary, inter-professional, and applied contexts. "Medical sociology's usefulness beyond its informative and educational function" has been called into question because our graduate programs are "still rather didactic and merely educational, not applied" (Constantinou 2015). Recent job ads for positions in institutions of medicine specify "a PhD in Psychology or Sociology with a specialty in Health Psychology or Medical Sociology." However, postings that encourage applications "from candidates in all disciplines… including the social and behavioral sciences…" are more and more common. Complicating this picture is a market that increasingly highlights skill sets rather than disciplinary background.

We also encourage conversations about how we can best support the long-term careers of sociologists placed in institutions of medicine. We may need to develop ways of embedding our graduates in ongoing training programs that are formed and nurtured not by medicine, but by sociology. When our graduates become disconnected from Sociology, the students we train so well may not remain sociologists for long. The Medical Sociology section of the American Sociological Association might consider devoting additional sessions and activities to applied medical sociology to maintain connections with sociologists in practice settings. Discussions along these lines could eventually facilitate the placement of even more graduate students in sparse hiring climates and increase our status across the health sciences. Success in these areas could lead to more resources being devoted to sociology programs in general.

Conclusion

In this paper, we argued that the sociological study of health in the US has failed to identify a contemporary disciplinary structure (an "island of meaning") that adequately represents the field. Instead of defining medical sociology conceptually, we defined its structure in terms of four major subfields: Social Epidemiology, Social Psychology of Health and Illness, Sociology *of* Medicine, and Sociology *in* Medicine. While recognizing an underlying unity driven by common training in sociological theory and research, we reviewed the unique contributions of each subfield. Specifically, medical sociology examines (1) the social causes of health-related outcomes and behaviors, (2) the social psychological processes that mediate and moderate the social causes and social consequences of health, (3) issues linked with health care delivery and health care experiences, medical knowledge, and health social movements, including social inequality, social institutions, and

health policy/law, and (4) problems within institutions of medicine, including medical treatment, health professions, and the marketing of health care. We also recommended efforts toward a more refined and directed conceptualization of the field, including the establishment of a more explicit disciplinary structure that is supported by consistent research identities, relevant graduate program, and greater attention to Sociology *in* Medicine. Ultimately, we argued for a more efficient and representative organization of the field that more clearly demonstrates our contributions to the study of health. This is not the final statement on the organization of medical sociology. Our hope is to reintroduce these discussions as a matter of regular discourse. Much has changed since Straus (1957), and even more developments are on the horizon.

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