

Accepted Manuscript

Fifty years of sociological leadership at *Social Science and Medicine*

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PII: S0277-9536(17)30662-7

DOI: [10.1016/j.socscimed.2017.11.007](https://doi.org/10.1016/j.socscimed.2017.11.007)

Reference: SSM 11481

To appear in: *Social Science & Medicine*

Received Date: 30 October 2017

Accepted Date: 3 November 2017

Please cite this article as: Timmermans, S., Tietbohl, C., Fifty years of sociological leadership at *Social Science and Medicine*, *Social Science & Medicine* (2018), doi: 10.1016/j.socscimed.2017.11.007.

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Fifty years of Sociological Leadership at *Social Science and Medicine*

Abstract

In this review article, we examine some of the conceptual contributions of sociology of health and illness over the past fifty years. Specifically, we focus on research dealing with medicalization, the management of stigma, research on adherence and compliance, and patient-doctor interaction. We show how these themes that originated within sociology, diffused in other disciplines. Sociology in Social Science and Medicine started as an applied research tradition but morphed into a robust, stand-alone social science tradition.

Medical sociology has always had a leading presence at *Social Science and Medicine*. The journal's founder and first editor-in-chief, Peter McEwan, was a sociologist with a mission to build bridges in the interdisciplinary field of the social studies of medicine. The first article of the inaugural issue, appropriately, offered an account of how public health officials defined the beginning of life. The next editors-in-chief – Mildred Blaxter and Ellen Annandale – were also high-profile medical sociologists. Over time, the journal gained a reputation as a valued resource for both clinicians and social scientists. While some early work drew from sociological theories, more research addressed health services issues geared toward clinicians. The range of topics, however, spoke to a wide range of interests; in an early issue, articles covered professionalization, legal aspects of medicine, medical education, alternative medicine, epidemiology even a case report of “pathological love.”

In a field that values inductive conceptualizations and sustained theoretical engagements, sociologists of health and illness provide innovative conceptual tools that define phenomena and then diffuse into other research disciplines. This cultural authority, or ability to define things the way they are (Starr, 1982), covers many influential concepts from Bourdieu's social and cultural capital used to examine social inequities in health to patterns in patient-doctor interaction. Concepts jumpstarting research further include the extensive tradition of capturing illness experiences using notions such as biographical disruption and illness narratives (Bury, 1982; Frank, 1995; Riessman, 1990) and research on the medical profession set out by Freidson (Freidson, 1970; Toth, 2015). There is the influential introduction and elaboration of the social model of disability (Albrecht & Devlieger, 1999; Verbrugge & Jette, 1994), and

investigations of trust and uncertainty in health care interactions and medical training pioneered by Renée Fox (Fox, 1957; Whitmarsh et al., 2007). A large body of research also flows from the Foucauldian-inspired research on governmentality and surveillance medicine at both the population and individual level (Armstrong, 1995; Hammer & Burton-Jeangros, 2013), and the role diagnosis plays in health care encounters (Jutel & Nettleton, 2011).

In this anniversary article reviewing 50 years of sociological scholarship in *Social Science and Medicine*, we highlight some of these conceptual bright spots. Our list is inspired by the highly-cited pioneering work done on central ideas in sociology of health and illness but it is inevitably partial and incomplete. It is also anachronistic, written from a contemporary perspective; an editor writing in, say, 1975 would likely include topics that have now been picked up by the journal's current sub-specialties. For instance, much research on medical education, which McEwan saw as an enduring preoccupation for *Social Science and Medicine*, has morphed into its own subfield. The most striking difference with the past may be that in the UK medical sociology is overwhelmingly based on qualitative research while social epidemiology focuses on quantitative methods, but in the US both methodological families fall under the rubric of medical sociology. *Social Science and Medicine*, however, follows the British model. Most of the manuscripts processed by the medical sociology office are therefore overwhelmingly qualitative (Timmermans, 2013).

Medicalization

The notion of medicalization is an elementary anchor in the social study of medicine. It refers to the shift of defining issues that were primarily considered to be non-medical as medical problems (Peter Conrad, 2007; Zola, 1972): fidgety children, for instance, receive an ADHD diagnosis, take medications, and are monitored from a medical perspective (Singh, 2004). Parents, teachers, and kids themselves deploy ADHD as a category to make sense of a wide range of behaviors. Suicide, to use a second example, used to be seen as a crime or a sin but has increasingly become viewed as a psychiatric disorder that is treated with medication and medical therapies. Medicalization works at the conceptual, interactional, and institutional level and describes an ongoing process that is possibly reversible; homosexuality is a prime example of a condition that is largely de-medicalized, while HIV may have become re-criminalized (Hoppe, 2014). The struggles to advance or counter medicalization bring a broad variety of stakeholders – such as pharmaceutical companies, health professionals, activists, policy makers, and researchers – together. For most researchers drawing from critical social constructivism, medicalization reflects a biomedical hegemonic power play that reduces social heterogeneity to medical essentialism. Alternatively, researchers drawing from Foucauldian poststructuralism view medicalization as a productive cultural force that reconfigures existing relationships within a medical framework and leads to unintended consequences. Though medicalization may be sought out by advocates of contested conditions hoping that a diagnostic label will open doors to medical treatment and social legitimacy (Barker, 2005), more typically there is greater concern about the growing “overmedicalization” of everyday life. Often promoted by the pharmaceutical industry (Greene, 2007), medicalization travels with

kindred terms such as pharmaceuticalization (S. E. Bell & Figert, 2012), biopower (Foucault, 1978), biomedicalization (Clarke et al., 2003), and geneticization (Arribas-Ayllon, 2016).

Much social science research examines the shifting contours by which specific conditions fall under medical jurisdiction or slip away, as well as the changing forces that drive medicalization – from the medical profession to advocacy groups and pharmaceutical companies. *Social Science and Medicine* has published more creative and original takes on medicalization. Most recently, Bröer and Besseling (2017) studied whether low mood is discussed in medical terms in everyday interaction. The authors trained students in focused observations of naturally occurring talk or interactions related to depression. They found a wide variety of daily discussions of low mood ranging from traditional medicalization (low mood consonant with categorization of medical depression), de-medicalization and normalization of low mood (taking a stance against medicalization), non-medicalization (not relating low mood to depression language), and normalization of depression labeling and treatment. This study of medicalization in everyday life offers a provocative contrast to most medicalization studies that focus on patients, clinicians, and treatments. Such studies in medical settings are susceptible to confirmation bias, meaning that medicalization may not be as encompassing as social scientists tend to assume. In another original contribution, Conrad and co-authors (2010) estimated the cost of medicalizing twelve conditions at \$77 billion, or about 4% of US domestic expenditures on health care in 2005. They included conditions that, since 1950, were placed under medical jurisdiction and for which cost-estimates exist. While much research then examines the medicalization of individual conditions, this manuscript then follows the money and

demonstrates a strong financial rationale that drives the growing expansion of medical jurisdiction.

Stigma

The scholarship on stigma brings a quintessential sociological perspective to health and illness because it highlights the categorical unequal burdens of certain conditions. Erving Goffman (1963) defined stigma as a deeply discrediting characteristic that reduces the bearer from a “whole and usual person to a tainted, discounted one” (p. 3), emphasizing that the discrediting legacy exists within social relationships and contexts rather than as essential characteristics of human beings. Goffman used stigma and stigma management as a means of distinguishing different kinds of social identities as they manifested in interactions with others, noting the social career of acquiring and managing identities and how stigma stratified the social world into insiders, outsiders, and various allies. He observed that people working or living closely with the stigmatized may acquire a courtesy stigma. One of his major insights was that in everyday interactions, it fell to the stigmatized not to confront the “normals” with their prejudices but to smooth over potentially awkward everyday interactions. Goffman also showed the limits of countering stigma; in order to fight stigma, the stigmatized first had to acknowledge that the stigma existed. While his reach was broad and included racial and ethnic stigma, many of Goffman’s examples came from the area of health and medicine. Indeed, these examples helped demonstrate the important distinction between two types of stigma: the obvious, discrediting, and difficult to hide stigma (such as having mobility disabilities due to

polio) where the major task is to manage impressions; and the discreditable, more occasionally experienced stigma (such as being hard of hearing) where the dilemma is to potentially pass as “normal” but risk being found out as being an impostor.

Goffman’s view of stigma as socially produced but deeply consequential resonated with medical sociologists. It allowed them to show that not all illness is the same; some illnesses come with a “second illness”, or the stigma associated with the disorder (Schulze & Angermeyer, 2003). That is, stigmatized conditions add the burden of inequality to being sick or disabled. Many scholars have taken up this idea and have found that such stigma applies to a wide range of issues. HIV among gay men, for example, was initially viewed by some as God’s punishment for a life of sin (Alonzo & Reynolds, 1995). People in wheelchairs may encounter prejudice when others associate their physical conditions with mental delays (Trani et al., 2016). Cancer may be viewed as a death sentence, causing people with this disease to be shunned from social engagements and experience a sort of social death (Peters-Golden, 1982). People labeled as obese may experience discrimination in school, the workplace, and personal relationships (Frederick et al., 2016). The social perception of a particular condition then spills over to the person who has the condition – rendering him or her morally tainted by the disease, traveling through a social network, and ultimately affecting the broader society through various opportunity costs.

Research has shown that stigma has both direct and indirect health consequences through multiple pathways. In a health services perspective, for instance, stigma is viewed as a barrier to health care delivery. People with stigmatized conditions may encounter obstacles to care seeking because they are rejected by mainstream care providers who may – deliberately or

unintentionally – exacerbate the stigma by modulating their interventions for patients that are perceived as personally responsible for their conditions (Bombak et al., 2016). In turn, patients may hide stigmatized behaviors, such as smoking, from health care providers (K. Bell et al., 2010) and avoid medical care and treatments (Poteat et al., 2013). Beyond such observable health behaviors, stigma may also lead to discrimination, stress, low self-esteem, anxiety, interference with recovery, social exclusion, substance abuse, and a shortened life-span (Livingston & Boyd, 2010).

The literature on stigma is now vast, international, and multidisciplinary. In the past decades, close to 2,000 articles related to stigma have been published in this journal alone. Sociologists have conceptually refined and expanded the literature on stigma, and some of those key expansions took place in *Social Science and Medicine*. One influential conceptual expansion occurred with the distinction between *felt* and *enacted* stigma. Felt stigma refers to the internalized feelings of having a stigma apply to the self (expressed as shame), while enacted stigma refers to acts of discrimination due to stigma (Scambler & Hopkins, 1986). This distinction originated in a study of stigma where researchers discovered that most people with epilepsy anticipated stigma even though few had experienced it. Even so, Jacoby (1994) found that while the difference between felt and enacted stigma matters, only a small minority of epilepsy patients reported stigma (see also (Whitley & Campbell, 2014). Barlösius and Philipps (2015) helped explain this discrepancy by drawing from Elias' distinction between stigmatization and stigma (Elias & Scotson, 1994) and Mead's discussion (1938) of the generalized other to explore how stigma is familiar to all and get internalized by some, even without experiences of overt discrimination. Their study of kids with and without obesity shows

that felt stigma undermines self-esteem and occurs through blaming the self for one's condition, thus making big kids acutely aware of their self-presentation in everyday interactions in light of how they think they are perceived. This anticipatory behavior is further elaborated with the social-psychological thesis of stereotype threat, where people feel they are at risk of conforming to stereotypes of their social group and change their behavior accordingly. Internalized stigma negatively correlates most strongly with other psychosocial variables such as self-esteem, self-efficacy, hope, quality of life, and social support (Livingston & Boyd, 2010). Felt stigma also has a corollary with courtesy stigma when parents of children with disabilities internalize their child's stigma associations as felt courtesy stigma (Craig & Scambler, 2006).

Elaborating on the felt stigma distinction, researchers have examined how stigma is deeply embedded in the cultural and moral life of sufferers (Yang et al., 2007). Stigmatization affects the stakes of a stigmatized person's local world: disease stigma may put money, reputation, health, life chances, or good fortune at risk. Stigma, then, can be thought of as socio-somatic and devastates the moral life of a family by burdening kinship ties. The observation that stigma threatens what matters most means that the cultural burden of stigma can be empirically observed. Thus, in a study of psychosis stigma among Chinese-American immigrants, respondents reported that a stigmatized mental condition affected marriage opportunities and plans to earn income. The financial vulnerability was accentuated due to debts accumulated from the migration experience and lack of health insurance. Yet, Chinese immigrants who were able to work were more likely to resist stigma (Yang et al., 2014).

Beyond internalized stigma, researchers have also examined structural roots of stigma. In a special issue of *Social Science and Medicine*, Hatzenbuehler and Link define structural

stigma as “societal level conditions, cultural norms, and institutional policies that constrain the opportunities, resources and wellbeing of the stigmatized” (Hatzenbuehler & Link, 2014, p. 2). Often the power to stigmatize entire groups is lodged in the state, such as state laws that do not confer protection to gays, lesbian, and bisexual (GLB) people. Researchers link the absence of these protective laws to mental health issues among GLB people and find that structural stigma contributes to psychiatric disorders that are independent of individual stigma. In another study, findings showed how the dismantling of the US welfare system made mental illness one of the few pathways to qualify for services (Hansen et al., 2014): according to ethnographic data, using mental illness to secure stable survival income was a marker of competence and social responsibility for people down on their luck, even if mental illness diagnoses came with risks like iatrogenic medication effects.

Link and Phelan (2014), drawing on Bourdieu’s notion of symbolic power, posited that structural stigma serves the interests of stigmatizers in more subtle ways. Most stigma management strategies at the interactional and structural level help maintain the power status quo. They point out that, when confronted with pervasive and negative cultural conceptions, people stigmatized due to mental illness tend to either withdraw from social life or live with lowered self-esteem. Stigma power, according to Link and Phelan, then helps keep stigmatized people down, in, or away. With some exceptions, most of the stigma research presumes a clear boundary between the stigmatized and the stigmatizers but again, as Goffman already noted, everyone is implicated in the stigmatization process. A study of an internet forum of mostly middle class women seeking fertility treatment demonstrates that they feel both stigmatized by infertility, and, in turn, that they denigrated fertile women, calling them names, mocking their

social status, and judging mothers as morally unfit, dangerous, or undeserving (Jansen & Saint Onge, 2015).

Where do stigma ideas come from? Working from mental illness stigma, a different conceptual framework examines the normative sources of stigmatizing attitudes from interactions at the micro level, the effects of social networks and treatment system at the meso level, and a macro level with medical images and broader national policies that may counter or reinforce stigma (Pescosolido et al., 2008). Yet, the influence of these factors is not necessarily unidirectional. For example, at the network level, having personal familiarity with a person with mental illness may lower stigma but knowing someone with a schizophrenic episode may instead increase stigma (Penn & Martin, 1998).

Goffman elaborated on how the stigmatized manage stigma in everyday interactions with covering and passing and how these strategies safeguarded the “normals” from confronting their prejudices. Much research in *Social Science and Medicine* has elaborated on how stigma can be resisted. One such line of research examines how public health officials – in an attempt to stop health-damaging behaviors such as smoking, drunk driving, or injury prevention – may run campaigns to deliberately stigmatize behavior. For example, a common icon of injury prevention campaigns is to portray a person in a wheelchair as the outcome to be avoided. In the name of prevention, disability becomes politicized as an unacceptable and preventable risk (Wang, 1992). The concern about whether public health could adopt stigmatization as a population health strategy was debated in a special issue of *Social Science & Medicine* devoted to Stigma, Prejudice, Discrimination, and Health. Bayer (2008) argued that deliberate or unintentional stigmatization can be a morally defensive, effective public health

strategy when the goal is to reduce public harms. He bolstered this position with the argument that since stigma is a matter of degree, stigmatization is defensible when proportionate to the public health goals as long as there is strong evidence that stigma will be an effective and robust equity safeguard. In a response, Burris notes that shaming makes bad policy and is intrinsically inhumane, regardless of the severity of the stigma. His conception of stigma, however, is much stricter and involves each of Link and Phelan's (2001) stigma components – labeling, stereotyping, separation, status loss, and discrimination.

Addressing smoking cessation with stigma may indeed reduce smoking rates but would generate harm for vulnerable groups “because stigma is a barbaric form of social control that relies upon primitive and destructive emotions” (Burris, 2008, p. 475). Bringing further evidence to this debate, Bell et al. (2010) explored why tobacco control policies aim to stigmatize. They explain that, unlike other drugs, tobacco is legally available and stigmatization is an alternative to prohibition. Tobacco control has also been framed as a means to protect bystanders from secondhand smoke. Nevertheless, those who are most vulnerable to smoking stigma are poor and it was only when hardcore smokers from lower socio-economic groups continued to smoke that stigmatization became easier, even though research also shows that lower income smokers perceive less smoker related stigma (Stuber et al., 2008). Smoking stigmatization, and stigmatization more broadly, may then be a driver of health inequities (see also (Parker & Aggleton, 2003).

More generally, in the context of resisting mental health stigma, Thoits (2011) distinguished between challenging and deflecting resistance strategies to stigma. Challenging strategies push back against stigmatizing structures through political mobilization and/or

interpersonal confrontations, while deflecting strategies minimize the negative psychological effects of stigmatization and maintain social order. Building upon Thoits, Manago et al. (2017), distinguishes between social and medical deflections and challenges, where social strategies address structural causes of stigma and medical strategies rely on the medical authority of a deficit model. The authors find that parents of children with disabilities flexibly appropriate, subvert, combine, and deploy different strategies in stigmatizing encounters.

Stigma-reduction interventions aim to change stigmatizers' beliefs and attitudes, often by refuting stereotypes, shifting causal attributions, and diminishing feelings of differentiation. In their review of efforts to erase the stigma of mental illness, Corrigan and Fong (2014) note that health-care providers believe that curing mental illness will lower stigmatization while advocacy groups hold that mental illness stigma is used to differentiate people as a manifestation of fundamental social injustices. They differentiate three stigma reduction principles that may influence the stigmatizer: protest, education and contact. Their review suggests that stigmatizers are more challenged by contact than education, and they note the potential unintended consequences of a medical fix. Using the US General Social Survey Mental Health module, Schnittker (2008) finds that tolerance of mental illness has not increased, in spite of a growing acceptance of a genetic model of mental illness. Media reports of genetic causes of depression leads to greater social acceptance, but reports about a genetic cause for schizophrenia do not moderate stigma due to the strong association of schizophrenia with violence. A genetic etiology also weakens the belief that mental illness is treatable. Indeed, these medical causes may reinforce the belief that the mentally ill are fundamentally different and merit differential treatment. As a medical education intervention, Metzl and Hansen (2014)

argue for teaching medical students insights in structural competency to make them understand how “social and economic determinants, biases, inequities, and blind spots shape health and illness long before doctors or patients enter examination rooms” (p. 127).

Most of this research shows that a full destigmatization of previously stigmatized conditions is difficult to achieve, in spite of extensive advocacy efforts to turn stigma into a cornerstone of identity politics (Anspach, 1979). Clair, Daniel, and Lamont (2016) examine how attempts at destigmatization depend on removing blame and drawing equivalences between in and out groups but due to the multidimensional nature of stigma such attempts may only affect some of the aspects of stigmatization. Using the example of HIV, they point to redefining disease as associated with amoral and risky behavior to a virus based etiology, combined with acceptance of queer sexuality, legal efforts to fight discrimination, and highly visible media campaigns. They note that destigmatization requires that new framings of the condition need to be perceived as credible and conclusive, map upon existing ideologies, and that the fate of the non-stigmatized and the stigmatized group need to be interlinked. Legal safeguards against stigmatization are particularly effective, but in order to pass such legislation the process of destigmatization needs to be far along.

Compliance/Adherence:

Although a wide range of professionals now study health from a sociological perspective – from clinicians and other health care providers to those with more theoretical interests – the physician-focused origins of the field lie within the medical profession (Hollingshead, 1973).

Thus, it is unsurprising that the study of patient behavior is rooted in traditional conceptions of authority and deviance. Of particular import is Talcott Parsons' influential conceptualization of the doctor-patient relationship, whereby patients enter a "sick role" (Parsons, 1951). According to Parsons, becoming sick caused people to enter a state of sanctioned social deviance in which they became dependent on the medical profession. To leave the social deviance of sickness behind, Parsons argued that patients must seek the assistance of a medical expert, trust this advice and adhere to the recommended treatment. In turn, the physician must be responsible for altruistically (without consideration for personal financial gain) and objectively (with neutral affect) policing the patient so that s/he may resume work-related contributions to society. Thus, Parsons' sick role theory characterized the patient as obligated to endure the physician's presumed moral discretion regarding treatment.

The conception of patients as deviant and dependent on medical professionals has informed an enormous body of literature based on those assumptions. One such line of inquiry that has resonated with scholars across many disciplines – and consequently, generated thousands of research articles – is centered on patient compliance with medical recommendations (Vermeire et al., 2001). Underlying the concept of patient compliance is the social deviance that Parsons linked to sickness many decades ago; if, as Parsons argued, patients are obligated to follow the doctor's orders in order to escape the social deviance of sickness, why do so many patients fail to do as instructed (Morris & Schulz, 1992; Vermeire et al., 2001)?

Reviews of patient compliance research state that patients' failure to follow medical advice can lead to huge financial burdens for the health care system, not to mention

consequences for public health (Morris & Schulz, 1992; Vermeire et al., 2001). Yet, despite the good intentions of such research – claiming to study compliance in the pursuit of improving health and reducing costs – this taken-for-granted terminology is inherently problematic for understanding patient behavior (Calnan, 1984; Stimson, 1974) and the experience of illness (Peter Conrad, 1985; Donovan & Blake, 1992). As research published in *Social Science & Medicine* has shown, compliance is an inadequate concept for investigating patient behavior and may be better understood as an ideology that assumes and justifies physician authority (Trostle, 1988).

Rather than considering patient behavior under the traditional terms of compliance – the obligation of the patient to carry out the doctor’s medical advice – scholars have argued that this line of research should assume a less paternalistic view. That is, studies of compliance should treat patients as active agents who have their own expectations of the doctor, can evaluate the doctor’s actions, and can make their own treatment decisions (Stimson, 1974). This more nuanced understanding of compliance recasts patients as independent and competent actors, and distances the illness experience from deviance. Consequently, the study of patient behaviors has gradually shifted from being physician-centric to more patient-focused. In Michael Calnan’s (1984) study of patient participation in early breast cancer detection programs, for example, the most influential predictor of whether or not a patient would participate in a screening program was not directly related to the physician at all; rather, Calnan’s findings showed that the patient’s intention to attend early breast cancer detection programs determined whether or not the patient would do so.

Like Stimson's (1974) earlier call for scholars to understand health behaviors from the patient's perspective, Calnan's study highlights the importance of acknowledging patient decision-making independently, rather than at the doctor's direction. As Donovan & Blake (1992) described in their study of patient non-compliance in rheumatology, patients actively manage their own medications in terms of a rational, cost-benefit analysis for each treatment they are offered. The authors explain that patients "are not 'blank sheets' when they arrive at clinics. They have many beliefs and theories which suggest courses of action, and these are moderated by information from others" (p. 512). Other studies that reevaluate compliance in terms of the patient's perspective have elucidated additional factors that inform patient behavior. Conrad (1985), for example, showed that for people with epilepsy, the meaning of medication management lies within self-regulation rather than compliance; what may appear to be "noncompliance" may actually be a form of asserting control over a disease that may otherwise feel uncontrollable.

Accordingly, papers in *Social Science & Medicine* have recommended for many years that attempts to improve rates of compliance should move beyond conceptions of unidirectional obedience in following the doctor's orders. Rather, scholars have called for the development of cooperative relationships between patients and doctors that, importantly, recognize patients' own decision-making abilities (Donovan & Blake, 1992). Findings from more recent studies of medication taking and compliance may even facilitate such a partnership by alleviating the burden of blame from patients and doctors alike; the reasons why people do not take their medicines as prescribed are not due to the failings of patients, doctors, and the systems they operate within, but due to the medications themselves (Pound et al., 2005). This

view of compliance, which encompasses a richer and more extensive understanding of the term than when it was first popularized, exemplifies the change that social science research can have on medicine. Just as research in *Social Science & Medicine* has helped shape the trajectory of compliance research, future studies will evolve along with the changing expectations, health care system structures, and technology that influence patient behavior.

Doctor-Patient Interaction

In parallel with the popularization of patient compliance research, Parsons' concept of the sick role (Parsons, 1951) inspired an even larger body of literature that has gradually – but fundamentally – reshaped expectations of medical professionals and the delivery of health care. After the publication of *The Social System* in 1951, scholars almost immediately took issue with the limitations of Parsons' normative conceptualization of the doctor-patient relationship. Szasz & Hollender (1956) for example, drew attention to the variations that exist within doctor-patient interactions based on the severity of patients' sickness and whether the treatment will be invasive (such as surgery) or can be self-managed (medication only). Particularly since the 1970s, studies of doctor-patient interactions have burgeoned into a vast domain of research that has attracted the interest of many disciplines, including medicine itself (Heritage & Maynard, 2006).

Other scholars have since endeavored to clarify the nuances of doctor-patient interactions beyond “the Parsonian emphasis on the functional significance of institutionalized patterns in medicine, the benign treatment of the complementarities of the physician-patient

relationship, and the bland endorsement of medical authority” (Heritage & Maynard, 2006, p. 353). Rather than taking for granted the disparate roles of the authoritative doctor and passive patient, as Parsons described, publications in *Social Science & Medicine* have unveiled how and why these roles exist. Research on the specific content of doctor-patient communication, for example, has brought to light some of the factors that reinforce classic doctor-patient dynamics. In a review of literature pertaining to communication between doctors and cancer patients, Jim McIntosh (1974) described the ways in which doctors’ judgment of and orientation to the patient can constrain communication behaviors like information giving. McIntosh found that in general, doctors remain in control of communication by withholding details about the patient’s condition, often preferring “to tell as little as possible for as long as possible” (p. 171) – despite the fact that patients overwhelmingly reported a desire for information. Given that patients’ lack of medical training can leave them unable to consistently identify what it is they need to know, patients may not always seek information from the doctor. As McIntosh explained, patients’ inaction is then used by doctors to validate the assertion that patients do not want to be informed. In more recent decades, this line of inquiry has drawn attention to additional dimensions of communication that allow doctors to uphold their positions of authority. Ford et al (1996), for instance, showed that clinicians asked few open and psychosocial questions and did not leave space for patients to express their feelings or initiate discussions. Although the clinicians in this study did provide patients with a large volume of biomedical information, by forcing patients into a responsive position they maintained a position of power in the interaction.

These studies illustrate how Parsons' conceptualization of the doctor-patient relationship – though inadequate in its overly general characterization of complex human interactions – did represent an empirical reality of medical authority. By bringing the reality of doctor-patient interactions into focus, however, scholars have used research about the actual content of medical encounters as a spring board for reimagining expectations of what communication between doctors and patient *should be*. In particular, scholars have called for doctors to pay greater attention to the individual circumstances of each patient as well as the particular reasons why they sought the aid of a doctor in the first place (Zola, 1973). Studies in *Social Science & Medicine* have offered numerous suggestions for improving doctor-patient interactions, such as proposing patient-centered frameworks of doctor-patient communication (Ong et al., 1995), advocating for “more training in social and psychosocial sophistication for any physician who has contact with patients” (Zola, 1973, p. 686), and arguing that greater patient participation in decision-making is justified (Guadagnoli & Ward, 1998). Accordingly, there has been a steady shift away from the paternalistic paradigm towards a more balanced ideal of patient-centeredness (Heritage & Maynard, 2006).

One popular model of patient-centered care is shared decision-making, where both doctor and patient share information, preferences, and participate jointly in making a treatment decision. *Social Science & Medicine* has long been at the forefront of research on this topic, not only publishing influential theoretical contributions about shared decision-making (Charles et al., 1999; N. Mead & Bower, 2000), but also establishing the potential benefits of this approach (Gattellari et al., 2001) and identifying ways to accommodate patients who may have difficulty participating in their medical care (Garcia-Retamero & Galesic, 2010). In her

study of doctor-patient interactions in family medicine, for example, Moira Stewart (1984) highlighted the impact that patient-centered care can have on patient outcomes. Audiotapes of 140 doctor-patient interactions and follow-up interviews with patients revealed that higher frequencies of patient-centered behavior from doctors were associated with higher rates of reported compliance with treatment and improved patient satisfaction with the consultation. Furthermore, Stewart found that specific patient-centered behaviors from the physician – such as initiating a discussion by explicitly requesting the patient’s opinion – had more impact on the outcome than did patient behavior. Together, this literature highlights the enduring power of medical professionals in doctor-patient interactions; even within more patient-focused models of care, doctors’ behavior can still determine the outcome of the visit. Studies that advocate for the widespread adoption of shared decision-making, however, suggest that doctors can wield this power in a more beneficial way through patient-centeredness than paternalism.

While other studies in *Social Science & Medicine* have corroborated findings that patients are more satisfied when they share in decision-making (Gattellari et al., 2001), they have also shown that the desirability of patient-centeredness is not as cut-and-dry as it may seem. Just as patient compliance research can ignore the relevance of the patient’s perspective, reports of patient satisfaction may also overlook the nuances of individual preferences regarding shared decision-making. For example, Gattellari et al reported that even though patients were generally more satisfied when sharing in making decisions with their doctor, the distinction between their preferred and perceived roles in this process was critical to these positive outcomes (Gattellari et al., 2001). Moreover, other scholars have noted that there is

tremendous variation among measurements of patient satisfaction, making the significance of this measurement less meaningful (Hall & Dornan, 1988).

The instability of prevalent patient-centered concepts, like patient satisfaction, points to a larger problem within the study of doctor-patient interaction. As Heritage & Maynard (2006) described in their review of the literature on doctor-patient interaction research, “Abstract statements about this relationship almost universally gloss the complexity and specificity of the actions and responses that make up the medical interview” (p. 353). This issue has grown even more complicated as technology continues to advance; the introduction of computers, the internet, and more medical interventions present additional variables that can make doctor-patient communication even more difficult to pin down. As past studies have pointed to the importance of acknowledging the complexity of the medical encounter on the interpersonal level (Lupton, 1997), future studies must delve deeper into the specifics of doctor-patient communication even as it becomes more entangled with external forces like insurance and reimbursement structures of health care systems.

Conclusion

Over time, sociological research in *Social Science and Medicine* has transformed from a collection of studies highlighting the social aspects of medical care in pursuit of better health care into a stand-alone body of scholarship exploring how health and illness affect people’s lives – at any stage of the life-course, and at both individual and collective levels. Even if health care is one focus of contemporary sociological research, sociologists tend to decenter the

physician's gaze as the primordial authoritative point of view and instead recover the voices of patients, families, and communities. At the core of much sociological research are the existential issues of living when body or mind break down and when social networks are shocked or disturbed. Many ideas that began as medical sociology have, little by little, been picked up by other disciplines. The conceptual, methodological, and theoretical contributions have found their way not simply into the sister offices of the journal, but also into allied fields such as bioethics, nursing research, and patient counseling. In the context of a rapidly shifting health care system, growing inequalities in mortality and morbidity, and a flurry of different financial incentives that render care profitable, much work remains to be done.

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