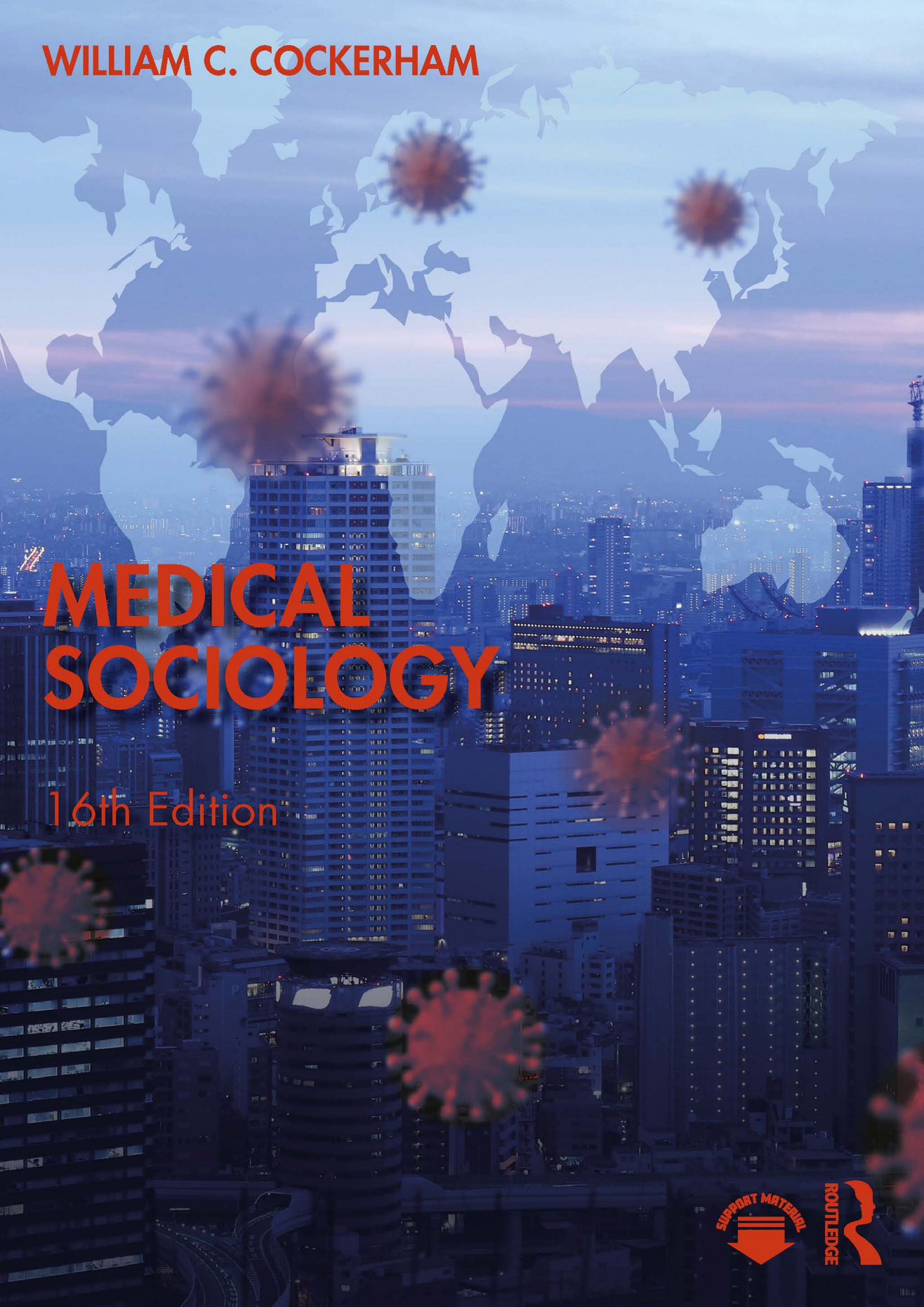
WILLIAM C. COCKERHAM

MEDICAL SOCIOLOGY

16th Edition



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MEDICAL SOCIOLOGY

The most comprehensive major academic textbook available on its topic, this classic text presents the most important research studies in the field. The author integrates engaging first-person accounts from patients, physicians, and other health-care providers throughout the text. Since the book's inception, its principal goal has been to introduce students to the field of medical sociology and serve as a reference for faculty by presenting the most current ideas, issues, concepts, themes, theories, and research findings in the field. This 16th edition is heavily revised, with updated data and important new additions.

New to this edition:

- Updated chapter on the social causes, impacts, and responses to the COVID-19 pandemic (Chapter 3)
- Analysis of the widening ten-year gap in average life expectancy in American society between the wealthy and well-educated and the poor and less-educated (Chapter 4)
- Expanded discussion of the effects of racism on physical and mental health (Chapter 6)
- Additions to health lifestyle theory of pandemic behavior and the digitalization of society (Chapter 8)
- New developments in doctor–patient interaction, including the use of genomic data and artificial intelligence (AI) technology in medical care (Chapter 10)
- The endangered Affordable Care Act (Chapter 16)
- Review of key issues in different types of health-care delivery systems (Chapter 17)

William C. Cockerham is Distinguished Professor of Sociology and Chair Emeritus at the University of Alabama at Birmingham, and Research Professor of Sociology at the University of Maryland, College Park. He previously held a joint appointment in sociology and psychiatry at the University of Illinois at Urbana-Champaign. He is past President of the Research Committee on Health Sociology of the International Sociological Association, and formerly served on the editorial boards of the *American Sociological Review*, the *Journal of Health and Social Behavior*, *Society and Mental Health*, *Social Currents*, and other journals. Dr. Cockerham has published numerous peer-reviewed papers in academic journals and is author or editor of 20 books. His most recent books from Routledge include *Sociology of Mental Disorder* (2024), *Sociological Theories of Health and Illness* (2021), and *The COVID-19 Reader: The Science and What It Says About the Social* (2021).

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Medical Sociology

William C. Cockerham

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To Cynthia, and to Laura, Geoffrey, Sean, and Scott and their spouses George, Erin, Lilia, and April, and their children Laurinda, Haley, Mckenzie, Quinn, Anthony, Lia, Leo, Michael, and Max, and the beginning of yet another generation, Ben and Stetson.

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PREFACE

This is the 16th edition of a book first published in 1978—a long time ago—that went on to arguably become the standard textbook in medical sociology. This edition represents an updated version addressing the aftermath of the COVID-19 pandemic. Care was taken to include the most recent and relevant information for medical sociologists and their students. The first edition was written in Urbana-Champaign, Illinois, when I was a new assistant professor in sociology and medicine at the University of Illinois. This edition was completed in Takoma Park, Maryland, in the vicinity of the University of Maryland, College Park, where I am a research professor in the Department of Sociology. Previously, I was a research scholar of sociology at the College of William & Mary in Williamsburg, Virginia, after retiring from the University of Alabama at Birmingham as a distinguished professor of sociology and chair emeritus.

Overall, this book has stood the test of time, holding its position for more than 45 years in a competitive marketplace and seeing other textbooks on the subject come and go while this one held its place. This book changed significantly over the years, as medical sociology itself changed. Especially important now is its focus on the social effects of the worldwide COVID-19 pandemic that is included in this edition and will continue to be a major topic in medical sociology because of its substantial impact on society.

As noted in other editions, it was an honor to have this book included on the International Sociological Association's list of "Books of the Century" in 2000. More recently, in 2018, the book was included on wiki.evzid.com's "Top Ten List of Best Sociology Textbooks." There is now an international edition in English published in India by Routledge in New Delhi. Earlier editions were translated into Spanish by Lourdes Lostao of the University of Navarra in Spain, who is again translating it with David Griffiths for publication by Ediciones Parainfo in Madrid. A nother translation is in Mongolian by Sengedorj Munkhbaatar of the National University of Mongolia and published by Pearson Education Asia in Ulan Bator.

This book was also one of ten Western (American and French) sociology books selected by Huaxia Publishing House in Beijing in 2000 to be translated into Chinese to meet the growing demand for sociology books in China at that time. The translators were Yang Hui and Zhang Tuohong of Beijing Medical University. Translations of subsequent editions into Chinese were carried out by Yuoping Guo and Baoyen Yang for the People's University Press, and a Chinese simplified translation was made by Yiliao Yu Shehui for Pearson Education Asia. The book was also published in English in Beijing by the Peking University Press.

Other Chinese-language versions were published in Taiwan by Yeh Yeh Book Gallery, translated by Rosa Ho, a former graduate student, and also by the Wu-Nan Book Company, translated by Chou-yen Cho and Jia-hwa Xiao. Hojin Park, MD, translated a Korean edition published in Seoul by ACANET. The growth in translations and readership signals an ever-increasing interest in medical sociology on a global scale.

Since its inception, this book's principal goal has been to introduce students to the field of medical sociology and serve as a reference for faculty by presenting the *most* current ideas, issues, concepts, themes, theories, and research findings in the field. This edition—the 16th—continues this approach.

The material contained in its pages is my own responsibility in terms of perspective, scope, topics, and style of presentation. Nevertheless, I am sincerely grateful to several people for their assistance in preparing the 16 editions of this book. I want to acknowledge the insightful comments of those colleagues who served as reviewers. For sharing their views and helping improve the quality of this book over many years, my appreciation goes to Kathleen D'Alfonso, University at Buffalo, State University of New York; Lori Anderson, Tarleton State University; Melvin Barber, Florida A&M University; Linda Liska Belgrave, University of Miami; Paul Berzina, County College of Morris; Deirdre Bowen, University of Washington; Donna Burnell, Alabama A&M University; Ann Butzin, Owens State Community College; Herbert Bynder, University of Colorado at Boulder; Christine Caffrey, Miami University (Ohio); Robert Clark, Midwestern State University; John Collette, University of Utah; Spencer Condie, Brigham Young University; Wendy Cook-Mucci, Tennessee Tech University; Morton Creditor, University of Kansas Medical Center; Norman Denzin, University of Illinois at Urbana-Champaign; Nancy DiMonte, Farmingdale State College; Karen A. Donahue, Hanover College; Barry Edmonston, Cornell University; Anne Eisenberg, SUNY–Geneseo; M. David Ermann, University of Delaware; Christine Fay, Elms College; and Eliot Freidson, New York University.

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Additionally, I would like to express my thanks to my editor at Routledge in the United States, Dean Birkenkamp, who provided outstanding advice and support for this edition and other books, along with Lewis Hodder in the UK and others such as Rebecca Pearce who prepared a detailed pre-revision report. I would like to publicly acknowledge the loving support and advice of my late wife, Cynthia (1946–2022), for being a good sport over the years about the time that has gone into this project.

I would also like to recognize the valuable book holdings, academic journals, and online resources significant in researching various topics provided by the American Sociological Association; the World Health Organization; Lister Hill Library of the Health Sciences, University of Alabama at Birmingham; the Royal Society of Medicine Library in London, England; the Swem Library at the College of William & Mary in Williamsburg, Virginia; and the McKeldin Library at the University of Maryland in College Park, Maryland.

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PART I

Introduction

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CHAPTER 1

Medical Sociology

FIGURE 1.1 The social determinants of health has become an increasingly important area of study in medical sociology, medicine, and public health.

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LEARNING OBJECTIVES

- **Explain how social factors are determinants of health and disease.**
- **Recognize why medical sociology's development differed from those of other sociological specialties.**
- **Understand why disease threats have changed over time as society has evolved.**

Health and society are intertwined. How and where you live impact on how long you live and contribute to how healthy you are throughout the successive stages of your life course. This is because the social context of your life determines the risk of exposure, the susceptibility to a disease, and the course and outcome of many illnesses—regardless of whether they are infectious, genetic, metabolic, malignant, degenerative (Holtz et al. 2006), or mental (Cockerham 2024). It can therefore be said that "society may indeed make you sick or conversely promote your health" (Cockerham 2025:1).

Although once thought of as secondary or distant influences on health and disease, it is now well-established that social conditions and behaviors are fundamental causes of healthiness (Link and Phelan 1995; Phelan and Link 2013, 2015). This is due to the human body operating as "an information collecting and processing system" (McDowell 2023:162). The body responds physiologically to social settings, social behaviors and relationships, lifestyles, personal habits, living environments, and stressful and joyous events. It does so in ways that help or harm health. An individual's gene expression, immune system, physical growth and brain plasticity in childhood and adolescence, neurological and hormonal responses, and allostatic load (the cumulative effect of chronic stress on the body and mind) are some of the pathways through which the "social" environment gets "under the skin" to affect the functioning of the body (Blane et al. 2013; Geronimus 2023; McDowell 2023; Meloni 2019; Segall and Fries 2017). As Nancy Krieger (2005, cited in McDowell 2023:193) fittingly observes, "*[b]odies tell stories about the social conditions of their existence*" (italics added).

Recognition of the significance of the relationship between social factors and levels of health and life expectancy characteristic of various individuals, groups, social classes, and societies has led to the development of medical sociology as a major substantive area within sociology. As an academic discipline, sociology is concerned with the social causes and consequences of human behavior. Thus, it follows that medical sociology focuses on the social causes and consequences of health, illness, and disease. Medical sociology brings sociological perspectives, theories, and methods to the study of health-related situations. Areas of investigation include determining the social causes and outcomes of health, along with analyzing health-related social behavior, health disparities, social patterns of health and the utilization of health services, the social role of health organizations and institutions, social policies toward health, and similar topics linking social variables to health-related situations.

This book aims to introduce readers to the field of medical sociology, sometimes called the sociology of health. In this introductory chapter, we will provide a broad overview by looking at the social determinants of health, how medical sociology originated and developed, and go on to define "health" before examining contrasting ideas about health and social behavior. Next is a discussion of modern medicine and the regulation of the body, followed by a review of the evolution of medical sociology's interface with medicine seen in sections on the public's health, the germ theory of disease and the search for "magic" bullets, medicine's return to the "whole" person in the treatment of chronic diseases, and the re-emergence of infectious diseases.

The Social Determinants of Health

The relevance of social determinants for health and longevity has become increasingly apparent not only in sociology (Cockerham 2025; Hummer and Hamilton 2019; Ratcliff 2017) but also in medicine (Daniel, Bornstein, and Kane 2018), public health (Graham and White 2016; Holt-Lunstad 2022), and social epidemiology (Krieger 2024; McDowell 2023). The term *social determinants of health* refers to social practices and conditions (such as lifestyles, living and work situations), social class position, stressful circumstances, poverty, and racial discrimination, along with economic variables, such as unemployment versus well-paying jobs, political policies and government benefits, and religious factors that affect health. Social determinants not only foster illness and disability but also enhance prospects for coping with or preventing disease and maintaining health. To put it simply, the "social determinants of health are nonmedical factors that can affect a person's overall health and health outcomes" (Daniel et al. 2018:677).

Social factors are also important in influencing how societies organize their resources to cope with health hazards and deliver health care to the population at large. Individuals, groups, social classes, and societies typically respond to health problems in a manner consistent with their culture, norms, and values. Social and political values influence the choices made, institutions formed, and funding levels provided for health. The social aspects of health and health care comprise the subject matter of medical sociology.

The Development of Medical Sociology

The origin of medical sociology is in medicine, not sociology (Cockerham 2021). Its beginnings in medicine can be traced initially to the influence of three prominent German physicians: Rudolf Virchow (1821–1902), Salomon Neumann (1819–1908), and Alfred Grotjahn (1869–1931). All three linked medicine to the need for a socially oriented perspective in health care. As the late British historian Roy Porter (1997) makes clear in his authoritative history of medicine, Virchow was among the first in medicine to identify a close connection between health and social environments. Earlier, in 1842, in a public health study, Edwin Chadwick (1800–1890) had connected sickness to poverty in Great Britain. Virchow did the same when he investigated a typhus epidemic among a suppressed Polish minority in the Prussian province of

Upper Silesia in 1847 that later became part of Germany. Typhus results from bacteria spread to humans in unhygienic settings by infected fleas, chiggers, and lice that cause fevers, rash, severe headaches, and stupor interchanging with delirium. It can be fatal. Virchow observed that such epidemics mainly affect "oppressed groups" and noted that "[t]he improvement of medicine would eventually prolong human life, but the improvement of social conditions could achieve this result more rapidly and more successfully" (Porter 1997:415). In his view, both medical *and* social measures were needed to promote health and overcome disease.

Famous in medical science for his discoveries in cellular pathology and experimental physiology and a dominant figure in medical circles in Berlin, Virchow went so far as to declare in 1848 that "medicine was a social science" (Porter 1997:643). To improve health over the long term, Virchow maintained that there were times when the physician's responsibility was to serve as an "attorney for the poor" and advocate for healthier living situations (Porter 1997:415). Neumann took up a similar theme when he argued that medicine, at its core, was a social science after finding a strong connection between poverty and poor health in Berlin in 1862 (Bloom 2002). To him, poverty and poor health went hand in hand.

Grotjahn, on his part, studied sociology. He did so while a first-year medical student by taking a course at the University of Kiel taught by Ferdinand Tönnies (1855–1936), author of the 1887 sociological classic *Gemeinschaft und Gesellschaft* (*Community and Society*). Tönnies apparently was not a good lecturer, so the two of them and another student taking the class roamed the city together, discussing the sociological implications of what they observed. Grotjahn later became one of the founders of the German Sociological Association, published the book *Social Pathology* in 1912, which correlated specific diseases with various social conditions, and founded social hygiene as a branch of medicine.

Further advances took place in the United States. John Shaw Billings, organizer of the National Library of Medicine and compiler of the *Index Medicus* (a medical database), had written about hygiene and sociology as early as 1879. The term *medical sociology* first appeared in 1894, not in a sociology journal, but in a medical journal (the *Bulletin of the American Academy of Medicine*), in an article titled "The Importance of the Study of Medical Sociology." It was written by a physician, Charles McIntire, on the relevance of social factors for health and given as a keynote address at the American Academy of Medicine meeting in 1893. McIntire was the first to name this area of knowledge "medical sociology." Some credit him as medical sociology's founder. According to Norman Hawkins (1958:18), a medical sociologist at the University of Texas Medical Branch at Galveston and author of the first textbook on medical sociology:

> A careful and protracted search reveals no pronouncement on the subject prior to McIntire, and it is very unlikely that the term could have occurred much earlier. . . .
>
> In view of the social and medical climate then existing it is not surprising that McIntire's paper should have been written, nor that it should have been written by a physician. What is truly striking is the clear vision which suggested a future framework for action.

The American Academy of Medicine also published, from 1895 to 1918, the *Journal of Sociologic Medicine*, which featured papers on medical education and various health-related topics, such as diet, sleep, and cancer, along with news about medical organizations and societies. Other early works by American physicians included *Essays in Medical Sociology*, a Christian-oriented book on sexuality, sexually transmitted diseases, and overpopulation written in 1902 by Elizabeth Blackwell. This is the first book to have *medical sociology* in its title. Blackwell was the first woman to graduate from an American medical school (Geneva Medical College in New York). The all-male student body admitted her as a practical joke when the faculty passed the admission decision on to them by asking for a vote on whether to accept her as a medical student. She finished at the top of her class (Porter 1997).

Then there was James Warbasse, another medical doctor, who published a book in 1910 called *Medical Sociology: A Series of Observations upon the Sociology of Health and the Relations of Medicine.* It discussed a broad range of topics on the social aspects of medical practice and included a discussion of physicians as a unique social class unto themselves. Warbasse organized a Section on Sociology for the American Public Health Association in 1909 that lacked sociologists and was composed almost entirely of physicians and social workers (Bloom 2002). Where was sociology at this time? Its focus was elsewhere. Physicians had taken the subject matter of sociology and applied it to their field, rather than the other way around. Medical sociology was conceived as a domain of study and given a name in medicine.

The first research project on health conducted by a sociologist appeared in 1906. It was led by the eminent Black scholar W. E. B. Du Bois (1868–1963). His findings, published as Atlanta University Publication #11, "Health and Physique of the Negro American," was based on two centuries (1700–1900) of data from several sources. Included were US Surgeon General reports; US Census data; life insurance company statements; records from various cities; data obtained from Black pharmacies, hospitals, and physicians; and the physical measurements of 1,000 Hampton University student volunteers (Wright 2016:45–47). The results showed infant and adult mortality rates among Blacks in decline, especially deaths from tuberculosis, a deadly disease at that time. Blacks were found to not be physically inferior to Whites. However, the study was not widely disseminated or became well-known. According to one source at that time, neither the Black medical profession nor the educational world was ready for it, and Whites were hostile to it (Wright 2016:47). It was Du Bois's only research on health and was not linked to a non-existent medical sociology.

Interest in medical sociology, however, began to appear among sociologists with a medical background somewhat later in the early twentieth century. Bernard Stern (1894–1956), a lecturer in sociology at Columbia University who had attended medical school in his native Austria before dropping out for health reasons, published *Social Factors in Medical Progress* in 1927. He used William Ogburn's (1922) theory of social change, which featured technological development as *the* cause of change, to explain medicine's history. Next came Lawrence Henderson's 1935 paper on the physician and patient as a social system, which influenced Talcott Parsons in formulating his concept of the sick role years later. Henderson was a physician and biochemist at Harvard College who became interested in sociological theory and changed careers to teach in the

new social relations (sociology) department when it was formed in the early 1930s (Bloom 2002). Parsons was one of his students.

Medical sociology did not begin in earnest until after World War II, in the late 1940s, when significant federal funding for conducting sociomedical research became available. Under the auspices of the National Institute of Mental Health, medical sociology's initial alliance with medicine was in psychiatry. A basis for cooperation between medical sociologists and psychiatrists existed because of earlier research on urban mental health in Chicago in 1939, conducted by Robert Faris (a sociologist) and H. Warren Dunham (a psychiatrist). A particularly significant cooperative effort that followed was the publication in 1958 of *Social Class and Mental Illness: A Community Study* by August Hollingshead (a sociologist) and Frederick Redlich (a psychiatrist). This landmark research, conducted in New Haven, Connecticut, produced substantial evidence that social factors could be correlated with different types of mental disorders and psychiatric care. Persons in the most socially and economically disadvantaged segments of society were found to have the highest rates of mental disorder in general and excessively high rates of schizophrenia—the most disabling mental illness—in particular. This study attracted international attention and is the most important of the pioneering studies on the relationship between mental disorder and social class. The book played a key role in the debate during the 1960s, leading to the establishment of community mental health centers in the United States.

Funding from federal and private organizations also helped stimulate cooperation between sociologists and physicians in researching problems of physical health. In 1949, the Russell Sage Foundation funded a program to improve the utilization of social science research in medical practice. One result was the publication of *Social Science in Medicine* (1954) by Leo Simmons (a sociologist) and Harold Wolff (a neurologist), emphasizing the role of socially induced stress on disease causation. Other work sponsored by the Russell Sage Foundation came later, including sociologist Edward Suchman's book *Sociology and the Field of Public Health* (1963), detailing how sociology could be applied to public health practice. Consequently, when large-scale funding first became available, the direction of work in medical sociology in the United States was concentrated on studies that could be applied to the practical needs of medicine in treating patients and public health in solving community-level health problems. The development of a theoretical basis for the sociological study of health, similar to that of other subdisciplines in sociology, was yet to come.

Unlike law, religion, politics, the economy, and other societal institutions, medicine did not influence how society was formed, structured, and functioned. Karl Marx (1818–1883), Émile Durkheim (1858–1917), and Max Weber (1864–1920), the most prominent classical social theorists whose concepts helped establish sociology as an academic field, did not emphasize connections to biology and medicine in their theorizing. Durkheim ([1895] 1964), for one, had argued that biological accounts alone could never be sufficient explanations of social behavior.

Yet as noted by Australian medical sociologist Fran Collyer (2012, 2015), the trio of Marx, Durkheim, and Weber did not ignore what became the subject matter of medical sociology. They did consider health, disease, and physicians in some of their

sociological writings, which Collyer clarifies. Durkheim ([1897] 1951), as an example, analyzed European suicide rates between 1850 and 1891, which is his only work having a direct application to medical sociology. He found that people were more likely to commit suicide when the social relationships that should have meaning in their lives were weak and less likely when they were strong. Also, Marx's close collaborator, Friedrich Engels ([1845] 1973), connected the poor health of the working class in England to capitalism, the harsh working conditions of early industrialization, and the squalid living environment of the working class in a treatise published in 1845. But there is no evidence that the leading classical theorists formulated theories concerning health and medicine, recognized medical sociology as a potential field of sociological inquiry, deliberately promoted it, organized it, gave it a name, or were even aware of it as a potential subdiscipline (Cockerham 2021:36–37).

Medical sociology did not emerge as a full-fledged area of study in sociology until the late 1940s and reach a significant level of development until the 1960s. The subdiscipline had come of age in an intellectual climate far different from sociology's more traditional specialties, which had direct links to nineteenth- and early twentieth-century social thought. As a result, it faced a set of circumstances in its development that differed from those of other major sociological subdisciplines. It had come into existence through the convergence of two branches of knowledge, medicine and sociology, each with very different orientations, histories, and goals, with medicine having the dominant role in medical sociology's origin.

What this meant for medical sociology in its early development was the pressure to produce work that could be applied to medical practice and the formulation of health policy. This pressure originated from government agencies and medical sources, which either influenced or controlled funding for sociomedical research but had little or no interest in sociological theories. Yet theory is important. Why? Theories organize and categorize variables, explain past and present outcomes, and provide conceptual models about what causes those outcomes (Reynolds 2007). Not only do theories describe what happened in the past or happens in the present but also explain *why* things happen the way they do or will happen when certain conditions exist (Műnch 1994:4). Sociological theory has a significant role in medical sociology because its theories reflect a sociological perspective that delivers a unique outlook (the sociological "gaze") in investigating and explaining health-related social phenomena. This perspective distinguishes the subdiscipline from virtually all other scientific fields engaged in the study of health and illness (Cockerham 2021). It interprets the "social."

However, the tremendous growth of medical sociology in the United States and Europe would have been difficult without the substantial financial support for applied studies provided by the respective governments. For example, in the United States, where medical sociology has developed most extensively, the emergence of the field was greatly stimulated by the expansion of the National Institutes of Health in the late 1940s. According to Hollingshead (1973), who participated in some of the early research programs, the establishment of the National Institute of Mental Health was instrumental in encouraging and funding joint social and medical projects.[1]

Parsons

A critical event occurred in 1951 that oriented American medical sociology toward developing and utilizing theory. This was the appearance of Talcott Parsons's book *The Social System*. This book, written to explain a relatively complex structural-functionalist model of society in which social systems are linked to corresponding systems of personality and culture, contained Parsons's concept of the sick role. Unlike other major social theorists preceding him, Parsons (1902–1979) formulated an analysis of the function of medicine in society. He presented an ideal representation of how people in Western society act when sick. The merit of the concept at that time is that it defined the norms and social values appropriate to being sick and described a patterned set of behavioral expectations for both the sick person and others who interact with that person, including physicians. Parsons also pointed out that society invests physicians with the function of social control, similar to the role filled by priests and the police, to serve as a means to control deviance. In the case of the sick role, illness is the deviance, and its undesirable nature reinforces the person's motivation to be healthy and seek help if sick.

In developing his concept of the sick role, Parsons linked his ideas to those of Durkheim and Weber. Parsons was the first to demonstrate the controlling function of medicine in a large social system, and he did so in the context of classical sociological theory. Having a theorist of Parsons's stature rendering the first major theory in medical sociology called attention to the young subdiscipline—especially among academic sociologists. Not only was Parsons's concept of the sick role "a penetrating and apt analysis of sickness from a distinctly sociological point of view" (Freidson 1970:62), but it was also widely believed in the 1950s that Parsons and his students were charting a future course for all of sociology through the insight provided by his model of society (Johnson 1975).

However, this did not happen. Parsons's model was severely criticized over the next two decades, and his theoretical perspective is no longer prominent. Nevertheless, he provided a theoretical concept that stimulated debate among sociologists and gave medical sociology intellectual recognition during its early development in the United States. This was needed because the institutional base for sociology in America was in universities, where the field was established more thoroughly than anywhere else in the world. Parsons's views on society did not turn out to be the optimal paradigm for explaining all sickness behavior. However, he was the leading figure in providing the initial theoretical substance for the emergence of medical sociology as a full-fledged academic specialty, which ranks as one of his most important and lasting contributions. In doing so, he attracted the participation of other sociologists to the possibilities of formulating and testing theoretical models explaining the social characteristics of health and illness.

The Applied Versus the Theoretical

The direction initially taken by medical sociology as it gained momentum is summarized by Robert Straus (1957). Straus suggested that medical sociology was divided into two separate but closely interrelated subfields: sociology *in* medicine and sociology *of*

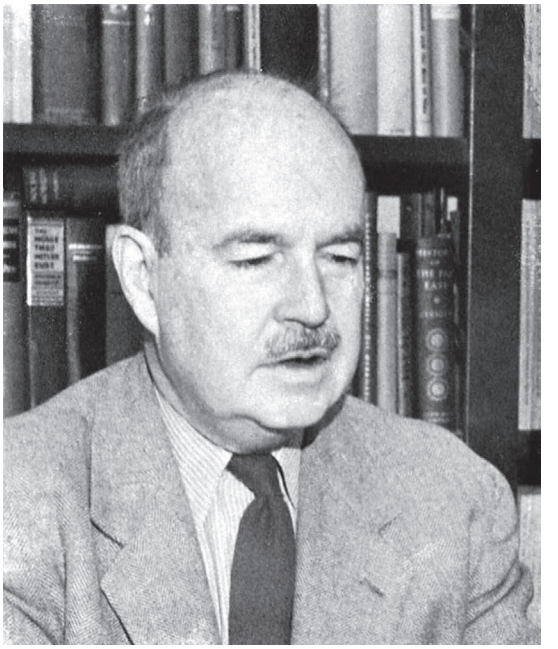

PHOTO 1.2 Talcott Parsons.
Source: Granger—Historical Archive/Alamy.

medicine. The sociologist in medicine collaborates directly with physicians and other health personnel in studying the social factors relevant to a particular health problem. The work of the sociologist in medicine is intended to be directly applicable to patient care or to solving a public health problem. Some of the tasks are to analyze the social etiology (cause) of health disorders, the differences in social attitudes as they relate to health, and the ways in which the incidence and prevalence of a specific health disorder are connected to such social variables as age, gender, socioeconomic status, racial/ethnic group identity, education, and occupation.

The analysis is intended to assist health practitioners in addressing health problems. Thus, sociology in medicine can be characterized as *applied research and analysis primarily motivated by a medical issue* rather than a sociological problem. Sociologists in medicine usually work in schools of medicine, nursing, and public health; 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 (HHS), the Centers for Disease Control and Prevention (CDC), or the World Health Organization (WHO) in the capacity of researchers, biostatisticians, health and epidemic intervention planners, and administrators.

The sociology *of* medicine has a different emphasis. It deals with such factors as the organization, role relationships, norms, values, and beliefs about health as forms of human social behavior. The emphasis is on the social processes that occur in health-related circumstances and how they contribute to our fund of knowledge about medical sociology and our general understanding of social life. The sociology of

medicine shares the same goals as all other areas of sociology and may consequently be characterized as *research and analysis of the medical or health environment from a sociological perspective*. Most sociologists of medicine are employed as faculty in the sociology departments of universities and colleges, but also schools of medicine and public health.

However, problems were created by the division of work in medical sociology into a sociology of medicine and a sociology in medicine. Medical sociologists affiliated with sociology departments in universities were in a stronger position to produce work that satisfied sociologists as good sociology. However, sociologists in medical institutions had the advantage of participation in medicine and research opportunities unavailable to those outside medical settings. Tension temporarily developed between the two groups over whose work was more important. This situation resolved itself as three major trends significantly reduced the differences. First, regardless of whether a medical sociologist works in a health-care or academic setting, much of the research in the field deals with topics that have practical utility. This development is largely because of the willingness of government agencies and private foundations to only fund health-related research that can help solve problems or improve health conditions. Second, many of the better studies, including those in medical settings with a practical focus, use sociologically based theoretical models to illustrate the utility of their findings.

And third, a growing convergence between medical sociology and the general discipline of sociology took place. Medical sociology became too large and popular to ignore. This situation is aided by the fact that all sociologists share the same training and methodological strategies in their approach to research. Theoretical foundations common throughout sociology are increasingly reflected in medical sociological work, and many of the theories unique to medical sociology likewise include components drawn from sociology's common theoretical core (Cockerham 2005, 2013a, 2013b, 2021, 2025; Cockerham and Scambler 2021; Collyer 2012, 2015, 2023; De Maio 2010; Frohlich and Abel 2014; Scambler 2012, 2018; Thoits 2011).

Moreover, many health issues investigated by medical sociologists call for knowledge of social processes outside the sociomedical realm. For example, studies of health-care reform may require consideration of the larger sociological literature on social change, political power, social class, and the welfare state, while research on job-related stress may require familiarity with occupational structures. Thus, much of the success of medical sociology is linked to its ability to utilize the findings and perspectives of the larger discipline in its work and to contribute its theories and findings, in turn, to general sociology.

More than six decades have passed since Straus divided work in medical sociology into two areas of interest. Since then, the field has changed and expanded, requiring an update. According to Terrence Hill and his colleagues, William Cockerham, Jane McLeod, and Fred Hafferty (Hill et al. 2021), medical sociology now consists of four major subfields that illustrate its current orientation. As shown in Figure 1.2, these subfields are (1) social epidemiology and (2) the social psychology of health and illness, which have been added to current versions of (3) the sociology *of* medicine and (4) sociology *in* medicine.

In the Hill et al. model, the subfield of social epidemiology focuses on explaining how health and disease are socially distributed and structured, along with determining the social causes of health-related behaviors and outcomes. The social psychology of health and illness is concerned with the social psychological processes that explain or modify health and health-related behaviors, such as stress. It also covers self-concepts and social identities that result from illness and disability. The sociology *of* medicine refers back to Straus's (1957) original two-subfield model. It focuses on medicine and its various activities 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. It is now primarily centered on issues linked with health-care delivery and experiences, medicalization and medical knowledge, and health-related social problems, such as health disparities and inequality, access to care, and health policy and law. Sociology *in* medicine is retained, as well as a subfield of medical sociology, which primarily focuses on applied topics seen within medicine, including clinical care, doctor–patient interaction and communication, relationships between health professions, and the marketing of health care.

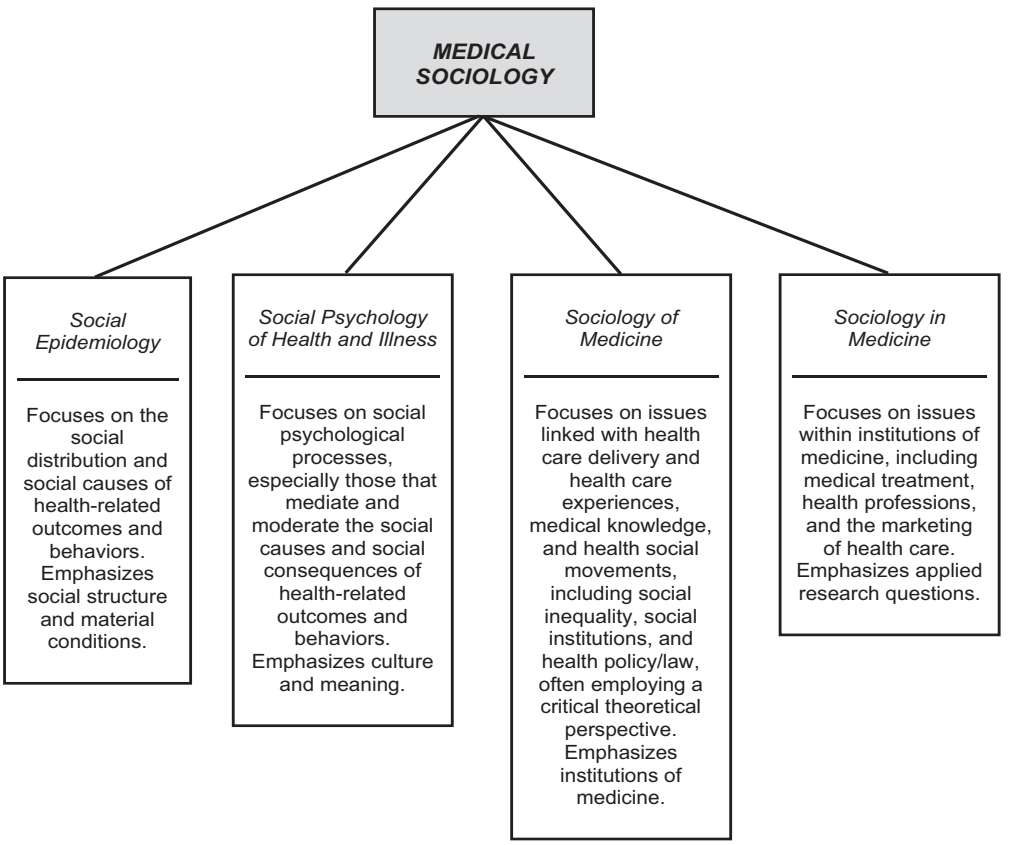

FIGURE 1.2 The major subfields of medical sociology.
Source: Hill et al. (2021).

At present, medical sociologists constitute one of the largest and most active groups of scholars doing sociological work. Medical sociologists constitute the third-largest section of the American Sociological Association and the largest sections of the British and German sociological associations. About one out of every ten American sociologists is a medical sociologist. In Germany, the German Society for Medical Sociology, an organization solely for persons working in medical sociology, has had more members than the German Sociological Association. In Europe as a whole, medical sociologists provided the basis for the European Society for Health and Medical Sociology, established in 1983. Earlier, in Asia, the Medical Sociology Section of the Sociological Association of Australia and New Zealand was founded in 1967, and the Japanese Society for Health and Medical Sociology was established in 1974. The Canadian Society for the Sociology of Health was formed in 2008. Additionally, the Research Committee on the Sociology of Health (RC15) of the International Sociological Association, established in 1959, has members worldwide.

Not only have the numbers of medical sociologists continually increased, but the scope of matters pertinent to medical sociology has also broadened, as issues of health, illness, and medicine have become a medium through which general issues and concerns about society have been expressed (Hill et al. 2021). Numerous books and scientific journals focusing on medical sociology are now published throughout the world as the field continues to expand internationally.

Defining Health

Before proceeding, what is meant by the term "health" should be made clear. There is no single, all-purpose definition of *health* that fits all situations, but there are many concepts, such as health being a state of normality, the absence of disease, or the ability to function. The WHO defines *health* as a state of complete physical, mental, and social well-being, and not merely the absence of disease or injury. This definition calls attention to the fact that being healthy involves much more than simply not being ill or injured. Being healthy also means being physically fit, having good relationships with friends and family, being able to function, and having a sense of well-being.

What this means is that many people view health as the capacity to carry out their daily activities. That is, they consider health to be a state of functional fitness and apply this definition to their everyday lives. Good health is clearly a prerequisite for the adequate functioning of any individual or society. If our health is sound, we can engage in numerous activities. But if we are ill, distressed, or injured, we face the curtailment of our usual round of daily life, and we may also become so preoccupied with our state of health, control of pain, feelings of nausea, being handicapped, and so forth that other pursuits are of secondary importance or even meaningless. Therefore, as microbiologist René Dubos (1981) and others (Blaxter 2010) once explained, *"health" can be defined as the ability to function*. This does not mean that healthy people are free from all health problems, but it means that they can function to the point that they can do what they want to do. Ultimately, suggests Dubos, biological success in all its manifestations is a measure of physical and mental fitness.

Contrasting Ideas About Health

Attempts to understand the relationship between social behavior and health originated far back in history. Dubos suggested that primitive humans were similar to animals in that they, too, relied upon their instincts to stay healthy. Yet some also recognized a cause-and-effect relationship between doing certain things and alleviating symptoms of a disease or improving the condition of a wound. Since there was so much that early humans did not understand about the functioning of the body, *magic* became an integral component of the beliefs about the causes and cures of health disorders. An uncritical acceptance of magic and the supernatural permeated practically every aspect of primitive life. So it is not surprising that early humans thought that evil spirits caused illness. Primitive medicines made from plants or animals were invariably used with some form of ritual to expel the harmful spirit from a diseased body.

During the Neolithic period, 4,000 to 5,000 years ago, people living in what is today the Eastern Mediterranean and North Africa are known to have engaged in a surgical procedure called *trepanation*, or trephining, which involved boring a hole in the skull to liberate the evil spirit supposedly contained in a person's head. The finding by anthropologists of more than one hole in some skulls and the lack of signs of osteomyelitis (erosion of bone tissue) suggests that the operation was not always fatal. Some estimates indicate that the mortality rate from trepanation was low—an amazing accomplishment, considering the difficulty of the procedure and the crude conditions under which it must have been performed (Porter 1997).

One of the earliest attempts in the Western world to formulate principles of health care based upon rational thought and the rejection of supernatural phenomena is found in the work of the Greek physician Hippocrates. Little is known of Hippocrates, who lived around 400 bce—not even whether he authored the collection of essays that bears his name. Nevertheless, the writings attributed to him have provided several principles underlying modern medical practice. One of his most famous contributions, the Hippocratic Oath, is the foundation of contemporary medical ethics. Among other things, it requires a physician to swear that he or she will help the sick, refrain from intentional wrongdoing or harm, and keep confidential all matters pertaining to the doctor–patient relationship.

Hippocrates also argued that medical knowledge should be derived from an understanding of the natural sciences and the logic of cause-and-effect relationships. In his classic treatise *On Airs, Waters, and Places*, Hippocrates pointed out that human well-being is influenced by the totality of environmental factors: living habits or lifestyle, climate, the topography of the land, and the quality of air, water, and food. Concerns about health in relation to lifestyles and the quality of air, water, and places are still very much with us today. In their intellectual orientation toward disease, Hippocrates and the ancient Greeks held views more in line with contemporary thinking about health than was found later in the Middle Ages and the Renaissance.

Much of the medical knowledge of the ancient world was lost during the Dark Ages that descended upon Europe after the fall of the Roman Empire in the fifth century. The knowledge that survived in the West was largely preserved by the Catholic Church. The church took responsibility for dealing with mental suffering and adverse social

conditions, such as poverty, whereas physicians focused more or less exclusively on treating physical ailments. The human body was regarded as a machinelike entity that operated according to principles of physics and chemistry. The result was that both Western religion and medical science sponsored the idea that the body was like a machine, disease was a malfunction of the machine, and the doctor's job was to repair the machine.

A few physicians, such as Paracelsus, a noteworthy Swiss doctor who lived in the early sixteenth century, showed interest in understanding more than the body's physical functioning. Paracelsus demonstrated that specific diseases common among miners were related to their work conditions. But Paracelsus was an exception, and few systematic measures were employed to either research or cope with the effects of adverse social situations on health until the late eighteenth and early nineteenth centuries.

Modern Medicine and the Social Determinants of Health

Modern medicine traces its birth to Western Europe in the late eighteenth century. In analyzing the history of French medicine at this time in his seminal book *The Birth of the Clinic* (1973), French social theorist Michel Foucault noted the emergence of two distinct trends in medical practice—what he called "medicine of the species" and "medicine of social spaces." *Medicine of the species* pertained to the strong emphasis in Western medicine on classifying diseases, diagnosing and treating patients, and finding cures. The human body became an object of study and observation in order that physiological processes could be demystified and brought under medical control. Physicians perfected their so-called clinical gaze, allowing them to observe and perceive bodily functions and dysfunctions within a standardized frame of reference. Clinics were established to treat patients and train doctors, providing the clinic with the optimal setting for physicians to exercise authority and control over their patients while practicing their craft.

The medicine of social spaces was concerned not with curing diseases but with preventing them. Prevention required greater government involvement in regulating the conduct of daily life—especially public hygiene. Physicians served as advisers in the enactment of laws and regulations specifying standards for food, water, and the disposal of wastes. The health of the human body thus became a subject of regulation by medical doctors and civil authorities as social norms for healthy behavior became more widely established. Foucault found that scientific concepts of disease had replaced notions that sickness had metaphysical (religious, magical, superstitious) origins. Disease was no longer considered an entity outside the existing boundaries of knowledge but an *object* to be studied, confronted scientifically, and controlled.

The Public's Health

Awareness that unhealthy social conditions and lifestyles could cause disease spread through common sense and practical experience. A most significant development occurred when it was realized that uncontaminated food, water, and air and sanitary

living conditions could reduce the onset and spread of infectious diseases. Before the advent of modern medicine, high mortality rates from infectious diseases such as typhus, tuberculosis, scarlet fever, measles, and cholera were significantly lowered in Europe and North America through improved hygiene and sanitation. Thus, the late eighteenth and early nineteenth centuries are conspicuous for the systematic implementation of public health measures.

Noting the link between social conditions, lifestyles, and health, some nineteenth-century European physicians argued that improvement was necessary in the living situations of people experiencing poverty. They advocated governmental recognition of the social as well as medical nature of measures undertaken to promote health. Virchow, as noted earlier in this chapter, had insisted that medicine was a social science. He argued not only that the poor should have quality medical care but also that they should have free choice of a physician. Improved medical care was to go hand in hand with changed social conditions, leading to a better life. However, these proposals had little effect outside Virchow's colleagues. His views were seen as too liberal by many European rulers and politicians of the period, who feared that social reforms would erode their power and lead to revolution.

Nevertheless, the decline in deaths from infectious diseases in the second half of the nineteenth century was mainly because of improvements in diet, housing, public sanitation, and personal hygiene instead of medical innovations (Porter 1997, 2006). The decline in infant mortality was due more to improved nutrition for mothers and better care and feeding for infants than to upgraded obstetric services. Deaths from typhus also fell dramatically without a specific medical cause due to improved public sanitation and hygiene (Hempel 2020). A similar drop in mortality from typhoid and dysentery occurred because of better-quality water and food safety.

The Germ Theory of Disease and the Search for "Magic Bullets"

Most physicians in the 1800s were primarily interested in treating patients and improving medical technology. They were not necessarily concerned with social reform. However, the medical doctors of the time had a history of only mixed success in curing human ailments. But as Porter (1997:428) reported, "the latter part of the nineteenth century brought one of medicine's true revolutions: bacteriology." Louis Pasteur, Robert Koch, and others in bacteriological research decisively confirmed the germ theory of disease and uncovered the cause of a host of diseases, including smallpox, typhoid, tetanus, and diphtheria, along with the vaccines providing immunity. Alexander Fleming followed up these advances in 1928 with the discovery of penicillin—the first antibiotic. Drug production became industrialized, which allowed mass production. The tremendous progress in the development of internal medicine, anesthesiology, pathology, immunology, and surgical techniques convinced physicians to focus exclusively upon a clinical medicine grounded in scientific laboratory procedures. Thus, the practice of medicine in the twentieth century rested solidly upon the premise that every disease had a specific pathogenic cause, the treatment of which could best be accomplished by removing or controlling that cause within a biomedical framework.

Medicine's thinking was dominated by the search for vaccines as "magic bullets" that could be shot into the body to prevent, control, or kill all diseases, according to the description of this period in history provided by Dubos (1959). Because research in microbiology, biochemistry, and related fields resulted in the discovery and production of a large variety of drugs and drug-based techniques for successfully treating many diseases, this approach became medicine's primary method for dealing with the problems it was called upon to treat.

Return to the "Whole" Person

By the late 1960s, polio and smallpox were largely eradicated, and infectious diseases had been severely curtailed in most of the world. This situation produced a major change in the pattern of diseases, with chronic illnesses—which, by definition, are long-term and incurable—replacing infectious diseases as the major threats to health. Sandra Hempel (2020:8) provides an account of a medical student thinking about a career in infectious diseases who was warned away by their professor, saying that such diseases were largely overcome and there was nothing else left to do in that field of medicine.

This epidemiological transition occurred initially in industrialized nations and then spread throughout the world. It was characterized by the emergence of chronic diseases such as cancer, heart disease, and stroke as the leading causes of death. Heart disease and cancer became more prevalent as people lived longer. Despite the vast sums spent on cancer research, no magic bullet has yet been found to cure it, although chemotherapy is sometimes successful in shrinking tumors. As for heart disease, Porter (1997) noted the comments of a prominent British doctor who observed in 1892 that cardiac deaths were "relatively rare." However, within a few decades, coronary heart disease had become the leading cause of death in Western society with the aging of the population. New diagnostic techniques, drugs, and surgical procedures were developed, including heart transplants, bypass surgery, insertion of stents, and angioplasty.

Also, as Porter (1997:585) states, "[p]ublic understanding of risk factors—smoking, diet, obesity, lack of exercise—improved, and lifestyle shifts made a fundamental contribution to solving the problem." Between 1970 and 1990, heart disease mortality in the United States decreased by 50 percent, and this trend continued into the twenty-first century. Life expectancy in many regions of the world has almost doubled since the Spanish flu pandemic of 1918 (Johnson 2021). For example, in the United States, the average person lived 47.3 years in 1900.

Over the course of the twentieth century, longevity increased by another 31.5 years (41 percent), to reach an average lifespan of 76.8 years in 2000. Another two years were added by 2019, bringing life expectancy in the United States to 78.8 years—only to have the COVID-19 pandemic interrupt that pattern and be primarily responsible for a decline back to 77.0 years in 2020 and 76.1 years in 2021. By 2023, however, US life expectancy had improved to 79.7 years in the aftermath of the pandemic.

The transition to chronic diseases meant that physicians were increasingly called upon to deal with the health problems of the "whole person," which extend well beyond

singular causes of diseases, such as germs or viruses. Although the COVID-19 pandemic disturbed this focus, it remains paramount. Medical doctors are required to treat health disorders more aptly described as "problems in living," dysfunctions that involve multiple factors of causation, not all of them biological in origin. Social and psychological factors influence not only whether or not a person becomes sick but also the form, duration, and intensity of the symptoms. Consequently, modern medicine is increasingly required to develop insights into the social behaviors characteristic of the people it treats, including what they do during a pandemic.

Also, it is not uncommon for an individual suffering from a chronic disease to feel perfectly normal, even when irreversible damage to organs and tissues is occurring. Because of the irreparable damage done to the body by a chronic disease, patients may be required to permanently change their style of living. Health practitioners need to know how patients with chronic diseases can control their symptoms, adjust to changes in their physical condition, and live their lives without stress. This is in addition to all else that physicians need to know about the behavior and lifestyles of individuals that influence whether they are likely to develop chronic disorders in the first place.

According to Porter, it was not only radical thinkers who had appealed for a new "wholism" in medical practice; many of the most respected figures in medicine were insistent that treating the body as a mechanical model would not produce true health. Porter (1997:634) described the situation as follows:

> Diseases became conceptualized after 1900 as a social no less than a biological phenomenon, to be understood statistically, sociologically, and psychologically—even politically. Medicine's gaze had to incorporate wider questions of income, lifestyle, diet, habit, employment, education and family structure—in short, the entire psychosocial economy. Only thus could medicine meet the challenges of mass society, supplanting laboratory medicine preoccupied with minute investigation of lesions but indifferent as to how they got there.

At this time in history, it is clear that social behavior and social conditions play a critical role in causing or spreading disease. Harmful health lifestyles involving poor diets, lack of exercise, smoking, alcohol and drug abuse, stress, and exposure to infectious diseases like HIV/AIDS or COVID-19 can lead to sickness, disability, and death. Positive health lifestyles—the reverse of the practices previously listed—help lessen the extent of health problems, better control these problems when they appear, or allow the individual to avoid them until the onset of old age. However, adverse social conditions, such as poverty and living in run-down neighborhoods, promote health problems and reduce life expectancy. Several sources additionally report that the poor are more likely to engage in lifestyle practices that promote ill-health and less likely to engage in habits that forestall illness-inducing situations (Cockerham 2021, 2023; Hummer and Hamilton 2019).

In sum, people living in poverty are exposed to more unhealthy situations in their daily lives and find themselves in circumstances where there is less opportunity for a healthy life. They may confront more stress, have inadequate diets and housing, and

live in areas where industries pollute the environment with cancer-causing agents or other chemicals causing skin and respiratory disorders. They may have greater exposure to infectious diseases because of crowded living conditions, parasites, insects, and vermin, along with greater exposure to viruses. To be poor, by definition, means to have less of the good things in life. It also means the possibility of having more of the bad things, and with respect to health problems, this is the case. The poor have the highest rates of disease and disability, including heart disease, of any socioeconomic group (Atkinson 2024; Burdette et al. 2017; Carpiano, Link, and Phelan 2008; Cockerham 2021; Hummer and Hamilton 2019; McDowell 2023).

Understanding the impact of lifestyles and social conditions on health has become increasingly important in preventing or coping with modern health disorders. This situation has promoted a closer association between medicine and the behavioral sciences of sociology, anthropology, and psychology. Medical sociologists are increasingly familiar figures not only in medical schools but also in schools of nursing, dentistry, pharmacy, and public health, as well as in the wards and clinics of teaching hospitals. Medical sociologists now routinely hold joint teaching and research appointments between sociology departments and departments in various medical- and health-related educational institutions or are employed full-time in those institutions. They also work full-time in research organizations like the CDC and the WHO.

The Re-Emergence of Infectious Diseases

While chronic diseases were attracting the most attention, infectious diseases resurfaced with a vengeance. A new challenge for medical sociology today is researching the surprising re-emergence of infectious diseases, especially COVID-19, as a significant threat to human health and the conduct of social life. The term *newly emerging* or *re-emerging infectious disease* is currently used to refer to this phenomenon. In the late 1960s, as previously noted, there was a widespread belief that some infectious diseases were on the verge of extinction, and the remainder were controllable through immunization or treatment with antibiotics. In 1967, the surgeon general of the United States had, in fact, declared that infectious diseases were no longer a significant problem for Americans, saying that it was "time to close the book on infectious disease as a major health threat" (Armelagos, Brown, and Turner 2005:755). We now know this was wrong. Some pathogens have shown a remarkable ability to resist antibiotics, certain disease-transmitting insects have successfully resisted pesticides, and humans have created ecological disturbances uncovering new viruses.

For example, some previously unknown and deadly viruses such as HIV, Lassa fever, the Marburg virus, Ebola, and Zika have emerged from areas of tropical rainforests or savanna penetrated by the expansion of human settlements. Viruses like SARS and COVID-19 have found it easier to jump from wild animals to humans (Cockerham and Cockerham 2021). A problem with newly emerging diseases is that their appearance is unpredictable, their pathogenesis is initially unknown, and they are often difficult to control in the early stages because of a lack of effective vaccines and government unpreparedness. Other epidemics result from old diseases resurfacing, such as cholera and polio. Even the bubonic plague of the Middle Ages reappeared to cause a death in Mongolia in 2020.

The potential for the spread of infectious diseases has been significantly enhanced in today's world by the globalization of trade and travel (Cockerham and Cockerham 2010, 2021; Oldstone 2010; Osterholm 2005). Air travel, in particular, makes it easy for infected people or shipments of diseased animals to move from one continent to another, spreading their viruses as they go. A cough or a sneeze from an infected but symptomless passenger could pass a respiratory infection to another passenger or someone else that would not appear until days after that person reaches their destination. Since the 1980s, there has been a cavalcade of viruses emerging year after year, and at the end of 2019, the COVID-19 virus initiated a new age of pestilence and reprioritized research in medical sociology.

The resurgence of infectious diseases forecasts a shift in the research perspective of medical sociologists from a relatively exclusive concern with chronic illnesses to considerations of both chronic and infectious diseases. Lifestyles and social behavior play an important role in the transmission of infection, including sexual activities, drug use, travel, dietary habits, and living situations. Therefore, the study of social factors relevant to the prevention and spread of infectious diseases takes on increased importance for medical sociologists in the twenty-first century.

Summary

Throughout history, human beings have been interested in and deeply concerned with the effects of the social environment on the health of individuals and the groups to which they belong. Today, it is clear that social factors play a critical role in health, as the greatest threats to the health and well-being of individuals stem largely from unhealthy lifestyles, high-risk behavior, disadvantaged living conditions, and newly emerging diseases. Sociology's interest in medicine as a unique system of human social behavior and medicine's recognition that sociology can help health practitioners understand their patients better and provide improved forms of health care have begun to bring about a convergence of the mutual interests of the two disciplines. More and more, medical sociologists are on the staff of medical institutions and participate in medical research projects. Medical sociology courses, concentrations, and degrees are now offered more frequently by universities and colleges. The extensive growth of sociological literature in academic medicine is further evidence of the rising status of the medical sociologist. Although a considerable amount of work remains to be done, the medical sociologist is in the enviable position of participating in and influencing the development of an exciting, significant, and developing field. This book provides an overview of medical sociology and its major topics of interest.

Critical Thinking Questions

1. Medical sociology originated in medicine instead of sociology. Explain why.
2. Although medical sociology largely developed outside of mainstream sociology, it became fully integrated within the larger discipline. What factors changed its course?
3. Explain why medical sociologists are interested in studying newly emerging infectious diseases. What is sociological about such diseases?

Suggested Readings

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Note

1 For historical discussions of the development of medical sociology, see Bloom 2002; Cockerham 2013a, 2013b, 2021a, 2021b; Cockerham and Scambler 2021; Collyer 2012, 2015, 2023; Collyer and Scambler 2015; and Giarelli 2017.

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