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Toward a Sociology of Medicine

Bernhard J. Stern

ABSTRACT

This paper, first presented in 1951, promotes the emergence of a sociology of medicine.

Criticisms of sociology have been of two general varieties. There have been those who have been scornful of its abstract theory spinning, its formulation of categories without content and of generalizations without purpose other than seemingly to afford their makers with intellectual exercise in semantic subtlety. Others have been critical of the banality of its illustrative matter, the inconsequentiality of the problems it tackles concretely. It has been felt that sociology has dealt with problems too large to handle with its present skills or those too trivial to bother with, out of a larger context. These antithetical criticisms have had one basic premise in common. They have assumed that if sociology is to justify its designation as a science, it must contribute insights, principles, theories, and methods which will permit more effective prediction of human behavior and of cultural change and facilitate manipulation and control of social situations.

Address delivered at the annual meeting of the Eastern Sociological Society held at Yale University, March 31, 1951.

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The field of sociology of medicine offers a stimulating area of research for sociologists who accept this definition of the function of their discipline. Its problems are vital ones and its data are sufficiently capable of controlled observation to enable the sociologists to test the validity of current concepts and to permit the formulation of new principles. Its range of problems are amply diverse to engage the attention of sociologists interested in historical, anthropological, institutional approaches; in studies of acculturation and cultural change; in research on the behavior of small or large groups involving leadership, bureaucracy, cooperation, competition, and other social processes, in community studies; in social classes and social structures; in demography and ecology; in mass communication; in attitude studies; in culture and personality; in social control and sanctions, in fact, in the entire gamut of conventional topics under which sociologists are prone to classify their major interests. The sociology of medicine permits the fruitful marriage of theory and practice; it is both speculative and practical, analytical and constructive.

In projecting the recognition in college curricula of the sociology of medicine it is not proposed that it be confined within the conceptual frame of the tradition of what has come to be called social medicine. It is worth noting in passing as sociologically significant that the idea of medicine as a social science arose during the struggles of the middle class for political and social rights in Germany during the 1840's, which had repercussions in a medical reform movement. It was at that time that the German physician, Salomon Neumann, formulated its basic premise that "medical science is intrinsically and essentially a *social* science, and as long as this is not recognized in practice we shall not be able to enjoy its benefits, and shall have to be satisfied with an empty shell and a sham."[1] After a short period in Germany during which this sentiment captured the interest of a group of notable physicians and suffused their work with heightened social sensitivities and social responsibility, it almost passed out of currency when the middle class attained its objectives. It was revived in England and the United States as a by-product of the pressures of the working class for social security legislation and for wider recognition of their democratic right to share more fully in the vast economic and cultural advances of the period. In both cases social medicine was associated with progressive movements that brought larger groups of people into the orbit of medical services, as they widened the conception of social participation and responsibility and put greater demands upon those who possessed political, social and financial power.

Social medicine is no longer a bold idea. There is now an Institute of Social Medicine at Oxford and a chair of social medicine at Edinburgh, and a *British Journal of Social Medicine*. In 1947 a short Institute on Social Medicine was held by the New York Academy of Medicine. There are various lecturers in

social medicine at American medical schools. In 1950 Leonard A. Scheele, Surgeon General of the U.S. Public Health Service could declare that "all public health workers, worthy of the name, recognize a social component in the health problems that confront them."[2]

Yet the concept of social medicine remains vague and ill-defined. In its most developed form it remains largely a groping effort on the part of the medical profession and other health workers to deal with the fact that a patient is a personality, has a family and is a member of society, when considering his health and diseases. It does not seem too audacious to assume that since this is already taken for granted by sociologists who have not been obliged to work their way tortuously from an absorption with specific diseases of special organs to an understanding of the patient as a whole and to the social context of health and disease, we may demand more mature formulations of principles and more concrete guidance from a sociology of medicine. The historic interest of sociologists in comparable fields involving the relation of humans to their environment provides special funded knowledge that should facilitate progress in this area.

The time is opportune for the emergence of a sociology of medicine. Recent social developments and prodigious advances in medical science and public health have led to the transformation of medical practice, with consequences that make the help of the sociologist imperative. Issues requiring the help of the sociologist arise because medicine functions in a changing social context resulting from concentration of economic power; technological developments that involve urbanization with its housing, educational and recreational problems and changing levels of living; mechanization with its effects on working conditions and industrial and occupational hazards; the passing of the closely knit neighborhood and of the integrated community that influences standards of social responsibility, and the authority and competence of local handling of social services. Among the important developments in medicine and public health are: (1) broadening of the concepts and skills of medical science; (2) growth of medical specialization; (3) rise of the modern hospital and health center; (4) aging of the population; (5) movements for more effective distribution of medical services; (6) possibility of the realization of a functioning program of preventive medicine. The relevance of each of these developments to a sociology of medicine will be considered briefly.

1. Medical science in going beyond exclusive concern with communicable diseases involving external agents of infection to devote increased interest in deficiency and degenerative diseases has focused attention more decisively upon the patient as a person, as a member of a family, of a status group, and of a social class. This requires fuller understanding on the part of the physician of the impact of culture upon the patient in such matters as the significance

of economic and psychological strains, of poverty and its sequelae, of class and other social coercions, of irrational sanctions and dreads, of cultural prides and prejudice, of the influence of war tensions upon disease incidence, of the disparity between social myths and cultural realities, and of the consequences of the struggle for survival and status in a competitive, class-structured society, the acquisitive values of which pervade and influence directly or indirectly all phases of the American cultural pattern and the life cycle of the patient.

2. Medical specialization consequent upon advances in medical knowledge, has posed important sociological problems involving professional status and role, interprofessional relationships, the relation between the specialist and the general practitioner, and the development of group practice, the effectiveness of the patient-doctor relationships, medical ethics, and the place of the cultist in the contemporary medical scene.

3. The rise of the modern hospital and health center as the primary agency of medical practice, research and teaching has raised a host of sociological problems that have theoretical as well as practical interest. These include where a hospital should be located and what its size should be to be most effective, and what its tie-up to the community should be. There are also the problems of authority relations between the staff and the lay boards of directors, between the professional and administrative staff, between physicians and nurses and technicians and medical social workers, and between physicians in the practice of group medicine within the hospital. The relation of the hospital to voluntary health associations and to prepayment plans invites the aid of the sociologist as do the problems of hospital *esprit de corps* and the formulation of codes of hospital ethics.

4. The aging of the population has wide consequences. Here it will be noted only that it increases the rate of chronic diseases and thus changes the physician-patient relationship, which varies greatly depending upon the age and nature of the illness of the patient.

5. There are many sociological problems in the quest for more effective distribution of medical services to bridge the gap between medical knowledge and medical practice for all persons in society whether they belong to low or high income groups or are on relief, whether they reside in rural or urban areas, whether they are white or Negro. The ensuing controversies over proposals for the solution of this problem involve inquiries into the relation of the medical profession to the State; the relation of medical services to public welfare; the relation of curtailment of social services to war preparations; the relation of the local to state and federal governments; the dynamics of social movements; the function of pressure groups; the techniques of propaganda; the measurement of public sentiments; the tenacity and the vested interests of established groups and practices;

the power relationships within such professional organizations as the American Medical Association and devices of control which such organizations utilize.

6. Programs of preventive medicine are in transition from potential to actual realization. The focus of medicine is changing from the control of disease to the maintenance of health. Health education which would facilitate this achievement has therefore become more important as a factor in health services. Sociologists can be helpful in this field which has long been plagued with irrational myths, rituals and cults. Sociological histories of these cults that analyze the insecurities to which they appeal and the interests that utilize them make excellent studies. Moreover, problems of changing food habits, of methods of preventing contagion, of determining the occasions to consult a physician, and of alerting against industrial and home hazards, involve skill in the manipulation of tenacious attitudes and behavior patterns. Controls over communicable diseases, of the water supplies, waste disposal, and smoke and smog are sociological community problems. Social engineering and planning are implicit in any basic program for the prevention of industrial accidents and occupational disease and for assuring healthful working conditions in mines, mills, and factories. Moreover effective promotion of legislation in this field requires a knowledge of social structure and social classes and of all phases of political sociology.

Studies have been made by sociologists for at least the last 25 years which impinge and throw light on all the fields suggested in this attenuated and by no means definitive listing. Some extend beyond these categories into the area of the sociology of knowledge such as historical studies of the impact of diverse social economies and culture patterns upon medical science and the role and status of the physician, and of medical change upon other sciences and upon cultural change; and research in the cultural and scientific backgrounds of medical innovations and factors which impede or accelerate receptivity in professional circles and among the general public.

The time has come to systematize these studies into a body of knowledge and a definite academic discipline. Lecture courses and seminars should be introduced into university curricula that will stimulate wider interest and further research studies. A demand is beginning to develop for trained personnel in this field. It is the task of sociology departments to stimulate and satisfy such a demand.

Notes

[1]Cited by George Rosen, "Approaches to a Concept of Social Medicine. A Historical Survey," in Milbank Memorial Fund, *Backgrounds of Social Medicine* (New York, 1949), p. 9.

[2]Leonard A. Scheele, "Cooperation Between Health and Welfare Agencies. A Health Officer's View," *Public Health Report*, Vol. 66, February 9, 1951, p. 163.