

Time for Creative Integration in Medical Sociology*

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The burgeoning of medical sociology has sometimes been accompanied by unfortunate parochialism and the presence of opposing intellectual camps that ignore and even impugn each other's work. We have lost opportunities to achieve creative discourse and integration of different perspectives, methods, and findings. At this stage we should consider how we can foster creative integration within our field.

It is impossible to survey the field of medical sociology without being impressed by its remarkable growth in the United States and in many other parts of the world. We know, of course, that medical sociology did not spring forth anew in the 1950s, that it was not solely an American phenomenon, and that interest in the social aspects of health had been evident in previous centuries in a number of disciplines in various countries. In France, Germany, and the United Kingdom, workers in social medicine, social hygiene, public health, and sociology were keenly aware of the dynamic and intimate relationship between social conditions and health. Claus (1983) and Bloom and Wilson (1979) have reminded us of the contributions that figures such as Rudolph Virchow, Solomon Naumann, Henry Sigerist, and Bernhard J. Stern have made to our understanding of the social determinants of health.

But never has medical sociology burgeoned so richly as it has in the last few decades. One is struck with the plethora of topics that engage the research interests of medical sociologists. In fact, the growth of the field has been so pronounced that Medical Sociology constitutes one of the largest sections in the American Sociological Association, while interest in medical sociology is also expressed by sociologists in other sections concerned with such issues as mental health, gender, and social psychology.

It is not my intention here to explain the flowering of medical sociology in recent decades or to delineate the range of its subject matter. I will not summarize the notable achievements of medical sociologists or their contributions to the larger sociological discipline. I do want to draw attention to a problem, however, that has accompanied the rich and abundant benefits of our growing diversity and specialization. I am referring to a form of intellectual parochialism that splinters medical sociology and impedes productive discourse and the creative integration of our subject matter.

There are some unifying strands within medical sociology, certainly, one of which resides in the field's pervasive critique of the biomedical perspective. Despite wide differences among medical sociologists in choice of theory, method, and subject, many share the belief that their discipline equips them to correct the formulations and perspectives of the biomedical model. Sociological criticisms of strictly biomedical explanations of the origins of disease are also embodied in health policy recommendations that go beyond the provision of health services to address the importance of social determinants in health. Sociologists have even helped modify the definition of health, from one based only on physiological and biochemical markers to one that also incorporates individuals' social role performance, daily functioning, and well-being.

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Paradoxically, as Pearlin (1992:2) informs us, one consolidating force in medical sociology also divides us into two large clusters of "structure seekers" and "meaning seekers." The former "seek to reveal structure in social life and its consequences for health" while the latter "seek to reveal the meaning of social life and its bearing on health." Acknowledging that these are not monolithic groupings and that the distinction is not to be viewed rigidly, Pearlin indicates how they differ from one another in topics selected, theoretical frameworks, styles of work, and scholarly standards. "Structure seekers," for example, may be more prone to quantitative survey methods and causal explanations. "Meaning seekers" may use more qualitative methods and strive to deepen our understanding of a specific phenomenon by exploring respondents' definitions and accounts.

What is troublesome for medical sociology is that these groups not only compete with one another for resources and recognition but often ignore and sometimes even deride each other. It will not serve medical sociology to develop intellectual cults that impugn each other's work. We must not forego opportunities to inform, enlighten, and enrich one another. We should avoid the disparaging images of medical sociology that we may foster among other disciplines, funding agencies, and the public.

The fragmentation that accompanies diversity has not been confined to medical sociology, of course, but has pervaded the entire discipline in the absence of any overarching paradigm. As sociology has grown, we have made use of multiple frameworks and methods for examining a diverse array of social phenomena. At the same time, creative integration of theory or method is hard to achieve, and individual scholars may find it easier and more rewarding to exploit one specific theoretical framework or perspective (social constructionism, conflict theory, functionalism, critical sociology, ethnomethodology, say) or to rely exclusively on one familiar research method (sample survey, quasi-experiment, "depth" interview, focus group, systematic observation, say). Arguably, it is not easy to achieve genuine intellectual integration or synthesis, and efforts to do so may appear mechanical, ritualistic, even impossible *per se*. Considering our limited resources, the benefits of a singular approach fully exploited, compared with less thoughtful eclecticism, are apparent. But relying only upon one approach at the present state of our knowledge can also limit understanding of specific phenomena under study and of their context (as with some large sample surveys) or of the distribution of phenomena and of their relationship to other variables (as with some small sample interview-based studies).

If we were to pose a practical problem to medical sociologists, such as judging the respective merits of market forces versus government regulations in improving health care, many would respond that each has its respective function, that we would need to learn the conditions under which each form of control is more appropriate, and that some integrated formulation would be desirable. We should display similar circumspection as we view and assess the different perspectives and methods within medical sociology. Instead of ignoring or shunning findings produced by a perspective or method that differs from our own, we would learn more about the capacities of our own approaches and increase our explanatory power by examining and weighing the implications of data produced by other methods, even those at variance with our own. More rather than less data may bolster our confidence in the validity of a specific interpretation. As Liebersson (1992) reminds us, a single data set is not enough to resolve theoretical issues.

We shall deepen our understanding by becoming more cognizant of the concepts, methods, and findings of different tributaries in medical sociology. Even if various findings spring from strikingly different paradigms, are we to assume that these findings bear no relation to one another? That findings from paradigm A cannot inform paradigm B? If integration in medical sociology is not within easy grasp or, as some may argue, not even theoretically possible, can we at least move toward more constructive dialogue? Is it not time for the different schools within medical sociology to move from merely abiding to actually talking with one another? If scholars harbor fundamental differences about the legitimacy of subject matter and of research questions, let this be ascertained and understood through serious, animated discourse among colleagues who share at least some basic common conceptions of the discipline. We might remind ourselves of the benefits of earlier debates concerning positivism in sociology and behaviorism in psychology.

Let me give one simple example of creative integration, one that involves combining methods of data gathering and analysis. An important development in recent years has been to include the patient's own judgment of functional performance and sense of well-being as a major component in measuring health status. One of the most frequently used psychometric instruments to measure generic health status has been the new 36-item short form, the so-called SF-36, which measures such components as vitality, physical functioning, social functioning, bodily pain, and mental health. The instrument has been designed to be self-administered or administered by trained interviewers in person or by phone (Ware et al. 1993). The SF-36 has been used widely in many studies and has demonstrated high levels of validity and reliability in differentiating populations. Groups that differ in their scores on the SF-36 also differ in their morbidity experiences, their use of health services, and their health care expenditures.

Crucial is the extent to which responses to the SF-36 are valid for people of different ethnic and cultural backgrounds. Thus, although the SF-36 has been translated into several languages (Ware et al. 1994), it cannot be assumed that the translations capture the meanings, experiences, and priorities of different ethnic groups; that they agree on what constitutes functional effectiveness, role performance, and well-being; or that they assign the same importance to specific cognitive, emotional, or behavioral characteristics.

Investigators in Boston at present are employing a range of in-depth qualitative interviews and modes of analysis to ascertain the role of ethnicity in defining functional status and well-being. A small number of Puerto Ricans, Chinese Americans of Cantonese descent, African Americans, and Irish Americans are identified in their respective neighborhoods. They are interviewed in depth for two hours and are then given the SF-36 to complete. They are interviewed again for two hours and serve as informants regarding the meaning of their responses to specific items on the SF-36. Interview data are audiotaped and transcribed, and are analyzed with the aid of a qualitative software package (Amick and Lerner 1993).

Though the study is still in progress, investigators are concluding that, for these ethnic groups, family functioning, caregiving to family members, and spiritual ease constitute crucial components of functional performance and well-being. It must be noted that the investigators use more than one research method and integrate standardized and qualitative methods and analysis. As a result, Amick and Lerner can suggest additional items for inclusion in standardized tests and expand and even revise our conception of functional performance and well-being.

In the same vein, many of us are becoming more hospitable to the contributions of other disciplines to our own subject matter. Those of us who work on the social determinants of health, for example, find that analyses are sometimes more fruitful when we understand, or at least inquire into, the psychological and biological mechanisms through which social factors influence health status. We must discard lingering reservations that making use of the concepts and findings of other disciplines represents faltering allegiance to our sociological discipline.

I realize that the general plea for integrative efforts is not new and has long been expressed by various sociologists. I do not wish to overstate the value of a consensualist approach or to overlook the benefits of intellectual controversy. Some colleagues in medical and other branches of sociology have already made progress in integrating different methodologies and conceptual frameworks. One can point also to the field of social psychology, where the general disciplines of sociology and psychology converge, as an impressive demonstration of integrative achievements. And one can point to the synthetic work of some of the most eminent figures in sociology.

I believe it is a propitious time to promote more creative integration within medical sociology. This will require that we not only foster greater catholicity of spirit but also look more closely at the composition of faculty in our departments and the breadth of training we provide students.

REFERENCES

- Amick, Benjamin C. and Debra J. Lerner. 1993. "An Intensive Study of Functioning and Well-Being in Five Ethnic Communities." Unpublished proposal. The Health Institute, New England Medical Center.
- Bloom, Samuel W. and Robert N. Wilson. 1979. "Patient-Practitioner Relationships." Pp. 295-96 in

- Handbook of Medical Sociology*, 3d ed., edited by H. Freeman, S. Levine, and L.G. Reeder. Englewood Cliffs, NJ: Prentice-Hall.
- Claus, Lisbeth M. 1983. "The Development of Medical Sociology in Europe." *Social Science and Medicine* 17(21):1591-97.
- Lieberson, Stanley. 1992. "Einstein, Renoir, and Greeley: Some Thoughts About Evidence in Sociology." 1991 Presidential Address. *American Sociological Review* 57:1-15.
- Pearlin, Leonard I. 1992. "Structure and Meaning in Medical Sociology." *Journal of Health and Social Behavior* 33:1-9.
- Ware, John E., Jr., Kristin K. Snow, Mark Kosinski, and Barbara Gandek. 1993. *SF-36 Health Survey*. Boston, MA: The Health Institute, New England Medical Center.
- Ware, John E., Jr., Barbara Gandek, and the IQOLA Project Group. 1994. "The SF-36 Health Survey: Development and Use in Mental Health Research and the IQOLA Project." *International Journal of Mental Health* 23:49-73.

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