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Urban Hospitals as Anchor Institutions: Frameworks for Medical Sociology

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Abstract
Recent policy developments are forcing many hospitals to supplement their traditional focus on the provision of direct patient care by using mechanisms to address the social determinants of health in local communities. Sociologists have studied hospital organizations for decades, to great effect, highlighting key processes of professional socialization and external influences that shape hospital-based care. New methods are needed, however, to capture more recent changes in hospital population health initiatives in their surrounding neighborhoods. The authors describe three promising sociological frameworks for studying the changing hospital: (1) the study of professions, (2) social network analysis, and (3) community-based participatory research. The authors argue that future analyses of hospitals and health outcomes must move beyond the internal-external dichotomy to see hospitals as complex institutions that are increasingly entwined with communities and subject to changes in state regulation.

Keywords
social science, hospital, population health, research methods, medical sociology, neighborhoods

More than 20 years ago, a group of prominent scholars observed that "American health care is in a state of hyper-turbulence characterized by accumulated waves of change in payment systems, delivery systems, technology, professional relations, and societal expectations" (Shortell, Gillies, and Devers 1995). Likening this turmoil to an earthquake, they argued that the epicenter was the hospital. Today, the hospital remains in a state of transition. Shaping the conceptual contours of these changes is the oft-mentioned "triple aim," which identifies improving the health of surrounding communities, enhancing patient experience, and reducing the per capita cost of care as key goals of American health care (Halvorson, Tanski, and Yackel 2017; Whittington et al. 2015).

Although health care scholars have written extensively on the triple aim and its goals, sociologists have rarely considered the dramatic impact these changes could have on how we understand hospitals as urban institutions. This is curious considering the sociological tradition of studying hospitals as sites for professional socialization and the enactment of medical hierarchies.

Charles Bosk (2014), in his Leo G. Reeder address, awarded by the medical sociology section of the American Sociological Association, emphasized the significance of the hospital as a lab for sociological research:

> In the hospital, all preexisting forms of social inequality are found in their most concentrated and toxic forms. If one is interested in exploring how social groups manage uncertainty, define acceptable risk, account for unexpected adversity, and rationalize why virtue is so often unrewarded while evil so often goes unpunished, a better site for inquiry than the hospital is difficult to imagine.

Bosk's questions are central to the mission of medical sociology, but the importance of hospitals extends beyond the focus on the clinical relationships that occur inside these institutions. Sociologists have been at the forefront of challenging the current medical model of disease and emphasizing the role that social factors play in the development of

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illness, but sociological methods have not yet been applied to understanding the important role that hospitals play in urban communities as anchor institutions and collaborators in population health. Although hospitals have historically influenced communities through their presence in neighborhoods and through physical expansion, we argue that the application of sociological research methods to hospital-community engagement is particularly needed now as rapid changes in health care occur. These changes are pushing hospitals to focus on improving health outcomes in their surrounding neighborhoods and not merely the needs of individual patients entering their facilities.

Recent research has explained why these hospitals have started the turn toward the social determinants of health. A key stimulus has been changing reimbursement structures that reward value instead of the mere provision of a service. These policy reforms incentivize hospitals to look outward to communities with the key goal of preventing admissions in the first place. This policy dynamic is moving hospitals from sites primarily concerned with acute care to prevention (Chee et al. 2016). Another change includes new legal requirements for nonprofit hospitals in exchange for tax exemption. These new reporting requirements are meant to encourage progress in identifying and addressing pressing health needs in local communities (Rosenbaum 2013). Although these changes may appear to be minor adjustments in the financial and tax statuses of hospitals, they stand to reshape the role of clinicians and the dominance of the medical model within hospitals. Sociologists are well equipped to capture how these developments could fundamentally alter the identity of the hospital.

U.S. hospitals, the majority of which are urban and non-profit, are beginning to supplement their traditional focus on the provision of direct patient care, engaging their communities in the areas of disease prevention and the social and environmental factors that underlie population health (Marmot et al. 2008; Marmot and Wilkinson 2006; Phelan, Link, and Tehranifar 2010; Ross and Mirowsky 2001). The programs in which hospitals are engaging—community gardens, crime reduction, employment initiatives, and safe and affordable housing programs, to name just a few examples—are each of great sociological interest. They are especially important and timely as race- and class-based health disparities in U.S. cities persist for indicators ranging from infant mortality to life expectancy (Braveman et al. 2010). Although the traditional focus has long been on improving access to medical services and addressing medically underserved communities, health experts are increasingly recognizing that inequities in the social determinants of health continue to rise even in seemingly medically overserved communities, which is to say, those communities located proximate to hospitals and health care centers. Even more worrisome, and for reasons that are as yet little understood, these disparities are often at their most extreme in the neighborhoods just beyond hospital campuses. Sociological methods are ideal for assessing changing hospital

engagement with surrounding neighborhoods and providing a more expansive depiction of hospitals.

This article has two key goals. First, we reconsider some of the assumptions underlying previous sociological work on hospitals, arguing that hospitals have been described primarily as contained, inward-facing institutions focused on clinical care. Second, building on recent research, we propose a programmatic case for studying hospitals in light of their dynamic and changing relationships with communities. We assert that sociologists are well placed to produce this body of research. Specifically, we explain how three common sociological approaches can be helpful in examining the contemporary urban hospital amid their changing relationships with surrounding communities. Although not advocating for one model over the others, we suggest that each offers a unique vantage point for urban medical researchers. The resultant analysis allows sociologists to better capture the sustained externalizing of traditional hospital activities.

Institutional Norms versus External Forces: The Depiction of Hospitals in Sociology

Sociologists have long been interested in hospitals, seemingly because they provide an opportunity to tell a sociological story about institutions and the organizational relationships that arise within them. Without claiming to provide a systematic overview of sociological findings on hospitals, in this section we evaluate the key assumptions sociologists have tended to make about urban hospitals. We argue that the most prominent sociological studies of hospitals focus on the clinical care that hospitals provide within hospital walls, where professional norms, socialization, and roles can be clearly elucidated. Although sociological research has accounted for various external forces, including policy changes and economic constraints (Light 2000; Starr 1982), the focus has tended to remain on how clinical activities and social norms have been shaped within the hospital and left the binary of internal (hospital) and external (community) forces largely intact.

Goffman's (1961) influential *Asylums* exemplifies the sociological focus on hospitals as contained research sites. Although certainly not the first sociological study of a hospital, this book introduced the resonant concept of the "total institution" to describe the culture of institutions that are separated from the external world while detailing the defined roles and lived experiences of health care providers and their patients within mental institutions. In Goffman's account, institutions provide a rare opportunity for studying socialization in a setting wherein external forces are limited in their impact.

By the second half of the twentieth century, the dominant social science paradigm regarded hospitals as powerful, complex organizations with a unique internal logic stemming from professional norms, disciplinary practices, and

social regulation. While recognizing the importance of social connectivity and environment, this paradigm led many sociologists to direct their focus inward, casting hospitals as closed systems. For example, Wilson (1963) and Freidson (1963) emphasized increased expansiveness, organizational complexity, and a movement toward the rationalization of labor and expertise within hospital walls. Despite being increasingly enmeshed in external environments, the modern hospital, as Rosen (1963) argued, set medical care as its "primary goal . . . governed chiefly by scientific-technological norms and the requirements of organizational rationality and economy."

A parallel literature in medical sociology has reinforced the hospital's centrality to the medical field and described how institutional cultures constrain and mold the behavior of medical actors. Early studies of medical education, for example, detailed a "hidden curriculum" in which doctors learned professional norms and reproduced medical hierarchies (Merton, Reader, and Kendall 1957; Becker et al. 1961; Hafferty 1998). In his study of professions, Eliot Freidson (1970) continued this analysis of professional socialization, documenting the relationship between elite expertise and training and the cultivation of professional power. Other sociologists capitalized on the uniqueness of hospitals as a setting for sociological research. For example, scholars have examined social rituals around death and dying and attempts to maintain professional legitimacy among uncertainty or medical failure (Bosk 1979; Fox 1959). Others have focused on end-of-life decision making and hierarchies of power between attending physicians, residents, and nurses (Anspach 1997; Zussman 1992).

This more organizational and institutional approach is not, of course, the only way sociologists have examined hospitals. Driven by changes in government organization of medical care and economic demands within capitalism, researchers have also captured how practices of clinical medicine are shaped by external forces as well. Zuckerman (1983), for example, pushed an examination of how changes in increasingly "complex, turbulent, and constrained" external forces, especially economic, led hospitals to develop corporate cultures characterized by intense corporate rationalization, a movement that led to the decline of traditional "freestanding, autonomous hospitals" and toward rapidly consolidating "multi-institutional systems." Quadagno (2000) also documented how state intervention into the organization and funding of health care can produce rapid institutional changes such as desegregating clinical care.

Notably, Donald Light's (2000) work on "countervailing powers" expanded our understanding of how external forces challenged the autonomy of physicians, especially the rise of managed care companies. Countervailing powers also include state intervention and economic changes, which help contextualize how internal norms, behavior, and roles are reshaped within hospitals. Sociologists such as Paul Starr (1982, 2013) have similarly described external forces, facilitating an understanding of hospitals in historical context and in light of recent policy changes. According to Starr (1982), "few institutions have undergone as radical a metamorphosis as have hospitals in their modern history" (p. 145). Hospitals, for example, moved from institutions that primarily provided charity care for the poor to lucrative businesses that served the rich, they "only belatedly gave thought to the people in between" (p. 159) and have been "reconstitut[ed]" to become sites of steadily increasing technical sophistication that reflected the class, race-based, and religious conflicts taking place in American society.

More recent scholarship has uncovered the specific impact of health care reform on reimbursement structures in clinical care and how these changes have reshaped trust in providers and end of life care (Kaufman 2005; Mechanic and McAlpine 2010; Starr 2013). Sociologists have also added to the fast growing quality improvement literature with a particular focus on framing recent programs to reduce errors and expenditures as attempts to maintain accountability to a variety of clinical, consumer, and government stakeholders (Wiener 2000). Other scholars have focused on external factors such as federal funding, market characteristics, and research infrastructure which produce very different organizational environments in hospitals. In so doing, sociologists have linked important variations in the socialization of young physicians, clinical outcomes, and medical relationships to institutional factors such as profit status, teaching and research mission, and urban or rural location (Burns and Wholey 1991; Flood 1994; Menchik and Jin 2014; Mumford 1970).

Despite a robust body of research outlining the forces shaping contemporary changes in health care institutions and the ways in which professional autonomy and medical hierarchies have been reshaped, research remains primarily focused on hospitals as sites for clinical care. Uncaptured in sociological scholarship is the changing shift upstream to focus on the social determinants of health and their effect on health outcomes. The previous foci of sociological research on hospitals—the attempts to maintain professional autonomy among clinicians, the socialization received in hospitals, the interaction between doctors and patients—have been disrupted by a growing emphasis on population health. Hospitals and the administrative and clinical actors within them are being reshaped as a result of this changing focus. As hospital activities shift toward more community-oriented models, there is an opportunity for sociologists to reconfigure the hospital as a site for research on social norms and socialization that extends beyond hospital campuses into neighborhoods and communities.

Envisioning Hospitals as Community Partners: Three Promising Frameworks

Recently, sociological studies have begun to document the ways in which hospitals are embracing population health strategies and investing in preventive health interventions

(Skinner et al. 2017). Additional research has highlighted the historic relationships hospitals have developed within their local communities and the need for hospitals to repair damage caused by expansion or strengthen existing ties with residents to be effective in executing population health interventions (Franz et al. 2018). Most important, this emerging body of research documents the hospital as an institution that is being challenged to expand activities beyond traditional clinical care. But sociological frameworks are needed to fully interrogate the modern hospital as both a site for clinical care and an engaged anchor institution. In this section, we articulate three distinct, yet complementary frameworks that promise to aid in these efforts. In addition, we propose specific research questions that are central to understanding the hospital in an era of population health.

From Medical Students to Boundary-spanning Roles: The Professions and Organizations Framework

Sociologists have long been interested in complex professions and organizations. Mayntz (1965) noted that the mid-century focus on studying hospitals (along with schools and prisons) reflected the rise of the study of organizations more generally. Both Talcott Parsons (1951, 1963) and Everett C. Hughes (1955), different yet similarly influential mid-twentieth-century sociologists, examined medical organizations (Freidson 1960) and focused on organization and role as two of primary concepts for examining social life. Followers of both traditions were interested in hospitals as organizations (Fox 1959), including the splintering of the medical field (i.e., into specialties, smaller clinics, and group practices) leading to changes in the doctor-patient relationship (Reeder 1972), increased consumerism (Haug 1983), how people understand medical bureaucracies (Davis 1963), the transmission of increasingly specialized, scientific and authoritative knowledge, the development of careers, modes of advancement, and legitimacy placed upon in-house practices (Freidson 1970; Sloan 1980). *Boys in White: Student Culture in Medical School* (Becker et al. 1961) famously cast the medical school as an organization for socialization, a "factory" in which physicians are products, while also attending to a more nuanced analysis of how medical students conform in some ways, and "get by" through creative interactional strategies (Merton et al. 1957). This emphasis has continued with more recent studies examining the organizational dynamics of hospitals, as well as their relationship to hospital survival and physician authority (Menchik 2014; Ruef and Scott 1998). Recent scholarship on roles and professions tends to focus on uncertainty, risk, and susceptibility to institutional pressures (Kalleberg 2009).

As hospitals and communities become more entwined, considerations of asymmetries in professional power become newly and acutely important. Previous to the arrival of the changing hospital we are describing, power was primarily an internal consideration. Professional and organizational identities, like the facilities that contained them, were largely clinical, with the major nodal points of identity formation composed of key actors, such as physicians, nurses, technicians, patients, office staff members, and managed care organizations. Now, however, the integration of hospitals and hospital employees into communities is provoking new questions about power. To a significant degree, the extent to which a hospital will or will not open itself to integration with local communities will depend on its ability and willingness to critically rethink its own power relations and identities. As we would expect, this is not an easy undertaking. What does it mean to be a clinician when that profession now requires engagement beyond hospital walls and expertise that is largely nonclinical?

Similarly, structures of authority that previously accompanied the physician's identity vis-à-vis patients, namely, that physicians were trained professionals and patients were expected to be compliant recipients of care, are now being reworked in ways that give greater weight not only to patient experience but to communities' assessments of their own health needs. Medical education, in some instances, is being restructured to facilitate these new professional relationships (Franz, Skinner, and Murphy 2016; Jones et al. 2001). But although hospitals may be expected to work collaboratively with communities, they remain highly capitalized, elite institutions. To date, sociologists have not yet grappled with what this means within the context of the professions and organizations literature. As a result, they have heretofore missed an opportunity to bring their scholarly tools to bear on the question of what is happening to professional and organizational identities as hospitals—the primary institutions of socialization—change.

Several possibilities exist for doing so. Sociologists could further emphasize the growth of "community relations" in the medical profession. This requires a new focus on the specific phenomena introduced within contemporary health care institutions, broadening "community relations" from its traditional place as a public relations concern to thinking about new material investments and programming. For example, although some health services scholars have paid attention to returning health services to the community (Ko, Murphy, and Bindman 2015), sociologists might play a role in reconceptualizing workforce strategies in response to new population health investments. The professions and organizations framework is poised to expand and deepen this literature and specifically answer questions concerning hospital activities related to population health. Studies, for example, could further document how hospital personnel expand (or resist expanding) to meet the needs of the local community and provide pipelines for employment and improved communication.

One promising area of research might be in tracking innovative health care professions emerging in response to larger changes in population health care, inside and outside the

hospital, examining the types of employees being added in fields such as community health, government relations, and population health, among others. Recent research has shown how boundary-spanning professions such as community case workers and health care navigators can be trained in new cultural competencies and reduce risk and facilitate access to primary care for diverse populations by helping direct at-risk populations through the increasingly complex organization of the U.S. health care system (Andrulis and Brach 2007; Natale-Pereira, Nevarez, and Jones 2011).

The emerging role of hospitals in population health provides sociologists with an opportunity to study organizations as they develop new roles that transcend the hospital institution and require engagement with local residents and community-based institutions. For example, conducting required needs assessments in the local community requires substantial resources, including dedicated employees to file reports and develop community health programming in response to documented needs. Increasingly, hospitals are finding that these positions must be full time. In addition, changes in health care financing are altering health care professions and organizations. For example, hospitals have established a range of new positions, from vice president of community relations and chief of population health to crime prevention/community outreach officer, as well as a host of health care interpreters and community health workers/navigators.[1]

Evaluating the Health Care Ecology: Social Networks

Social network approaches offer powerful analyses of the structural and social relationships that underlie behavior and social patterns. As Smith and Christakis (2008) noted, "social network studies characterize the web of social relations around an individual, including, most importantly, who the contacts are and the nature of the ties that connect them." Within health care more specifically, scholars have used different types of social network analysis to identify sources of social capital and support, disease transmission, and health behavior among other factors that affect health outcomes (Luke and Harris 2007). Within hospitals specifically, social network analysis has been used to understand how new medical technology is adopted and the transmission of knowledge related to innovation (Christakis and Fowler 2011; De Brun and McAuliffe 2018). For example, researchers have used social network analysis to identify influential physicians within an organization in order to improve the use of innovative technology, such as custom order sets (Wernz, Zhang, and Phusavat 2014). In public health settings, social network analysis has been used to improve communication

around the effectiveness of interventions and increase the adoption of evidence-based principles (Yousefi-Nooraie et al. 2012).

The use of social network analysis in medicine expands upon the influential "ecological model," which identifies multiple levels of social relationships at work in the production and treatment of illness. From this perspective, individual-level factors and behaviors can be understood in connection to health care institutions such as hospitals, neighborhood and community dynamics that relate to the social determinants of health, and alongside health care policies (Kelly 2006). Although social network analysis has been applied significantly to understanding and improving clinical care outcomes, this model is well suited to transcend institutional or organizational factors and detail the role that individual and structural factors play in shaping health and health care. Because social network analysis is used to assess what sociologists have long characterized as the social ties that unite individuals, institutions, and other social actors, it has potential to aid our understanding of hospital engagement of their surrounding communities (Simmel 1955).

Scholars are now tracing the important relationships hospitals develop to improve population health (Casalino et al. 2015; Kurtzman 2015), and there is an increasing urgency for extending social network analysis to the study of hospitals as they expand their community health activities and engage community organizations (Franco et al. 2015). Recent studies document how academic and community partnerships have arisen in response to significant health needs and the role that public health departments play in community health partnerships (Krumwiede, Van Gelderen, and Krumwiede 2015; Wilson et al. 2014). In particular, existing cross-sector connections within communities provide an opportunity for hospitals to expand their traditional focus and collaborate on efforts to reduce health disparities and promote prevention (Dupre et al. 2016). Studying hospitals' traditional and changing social connectivity as they undertake projects in population health captures a critical aspect of the changing hospital itself. As hospitals push outward, the connections they forge with smaller, local facilities, nonmedical institutions, and the dynamic nature of the communities they serve are important for scholars to document. Beyond documenting this change, deeper sociological analysis could advance the scholarly literature on social networks to more fully account for the nature and mechanics of emerging connections between hospitals and communities.

The nascent literature on hospitals and community involvement shows that hospitals are establishing initiatives that extend beyond their traditional roles as acute medical care providers and which require the cultivation of new relationships. Existing examples include hospitals directing attention to the prevention of illness by strengthening health education, facilitating weight loss programs, and implementing other preventive health activities (Hogg, Mays, and Mamaril 2015). As hospitals address the social determinants of health as part of their community

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[1]These examples are from data collected as part of a three-city research project and forthcoming book on hospitals and communities in which the authors are currently engaged.

engagement, initiatives have effectively reduced crime, boosted local employment, increased and improved housing stock, and addressed food access by developing community gardens and supporting local healthy food outlets (Burke et al. 2014; George et al. 2015).

This growing involvement may fundamentally change the role hospitals play in communities and encourage new ties with neighborhood residents, other local businesses, and community organizations. The term *anchor institution* has traditionally been applied to educational institutions and businesses whose presence contributes to economic development in neighborhoods, and yet scholars increasingly cast hospitals as important community organizations (Skinner et al. 2017). Although the social networks and anchor institutions literatures rarely converge, as hospitals take a more expansive and active role in community development, such an intersection could be fruitful. Scholars must better understand and conceptualize the influence of hospitals as anchor institutions, from potential harms caused by gentrification to improvements in neighborhood economic stability.

Collaboration in Research: Participatory Frameworks

Participatory models have gained attention from scholars, clinicians, and community organizers for their potential to encourage collaborative relationships between public planners, health care providers, researchers, and community residents (Horowitz, Robinson, and Seifer 2009). This methodology has been used widely and quite notably by Paul Farmer in his work in Haiti and increasingly in dedicated centers for university-community research partnerships (Buys and Bursnall 2007; United Nations 2012). What makes this approach distinct from the two above is that community members are an integral part of the research team, instead of merely subjects of research. Within this framework, several methodological strategies are used to promote collaborative research projects. Community-based participatory research (CBPR), community engaged research, and participatory action research have been the most common approaches in community health research (Koch and Kralik 2006; Michener et al. 2012; Minkler and Wallerstein 2008). According to the principles of CBPR, community members should participate in every phase of research, from developing the research question to collecting, analyzing, and disseminating data (Israel et al. 2011). Participatory researchers aim for outcomes that are directly consequential to communities and for interventions to arise out of existing community assets.

Community-based participatory researchers use this model to address a variety of health concerns and document the strengths of various stakeholders in these interventions. This technique may be particularly relevant for hospitals, which are often located in urban neighborhoods, but historically have not emphasized community representation in institutional research or decision making. In fact, community members often perceive hospitals as working against community interests (Franz et al. 2018). In response to evidence that clinical care alone is not effective at driving population health improvement and local pressures for hospitals to participate in economic development of neighborhoods, some hospitals have turned to collaborative research methods to address local health needs. For example, in one recent published project, a hospital collaborated with local churches and an academic research team to provide cancer education and reduce racial health disparities (Beck et al. 2007). The research group solicited information from congregations regarding health concerns and used this information to guide a collaborative intervention. The group then trained congregants to serve as community health workers who, in turn, provided health education to community members. Other examples include hospitals working with local residents and community health workers to prevent chronic illness, reduce both violent crime and hospital readmission, and engage in widespread health promotion activities (Enard and Ganelin 2013; Peretz et al. 2012).

A fundamental premise of participatory approaches that distinguishes it from other sociological methods is that power dynamics inherent in traditional research approaches must be disrupted by allowing communities to drive research studies. CBPR, in this sense, is not a classic methodology that we merely recommend be applied to the study of the changing hospital. Instead, we argue that this approach has emerged precisely as part of a larger collaborative health movement aimed at addressing health disparities caused by social factors. To this extent, CBPR is premised on the very changes that are affecting hospital activities to which we call attention. This methodology is uniquely suited to study the changing hospital in that the perspectives of local residents are at the foundation of this approach. The broad participation of community members allows hospitals to better understand what health problems are of greatest to concern to residents and what residents expect for hospitals to do in the neighborhood. Although the social networks approach provides a valuable context for understanding the diverse network of social connections between hospitals and communities, participatory approaches provide insight on how hospitals and their relationships with communities are interpreted by different stakeholders.

This method is particularly relevant for studying hospital efforts to improve population health given recent requirements to conduct community health needs assessments in consultation with local communities (Rosenbaum 2013). Hospitals are responding to these requirements unevenly and in different ways. Although some are following the letter of the law and appear concerned only with compliance, others are becoming partners in community initiatives, including those that address social determinants of health that are not traditionally medical in scope. These partnerships will also

require expanding research teams to include community members. As hospitals undertake population health initiatives and seek to understand health disparities within their communities, CBPR may offer an opportunity to collaboratively address community-level problems and develop hospital-community research partnerships.

Taking note of the growing emphasis on community advocacy in research, researchers should continue to examine how hospitals are integrating community perspectives into their population health work. In doing so, they would capture emerging hospital and community partnerships and provide an explanatory framework for understanding how they are being established and facilitated. Important questions remain concerning the types of health problems on which hospitals feel comfortable collaborating with local residents and organizations. Although some evidence is available regarding the community outreach behavior of different types of hospitals (Ferdinand, Epane, and Menachemi 2009), understanding the strategies hospitals are using to partner with community organizations will be particularly valuable. Hospital characteristics such as location, size, and profit status will likely affect partnering behavior; researchers should collaborate further on CBPR teams to develop partnerships, or study the process itself.

Other areas of research include investigating the mechanisms for communication between hospitals and local communities, including the use of health advisory boards or other community-run groups (Newman et al. 2011). Preliminary research on community benefit agreements, arrangements made between prospective developers and community members, suggests that local residents might summon support from anchor institutions, such as hospitals in the midst of development projects, to address local needs (Simmons and Luce 2009). Additional evidence suggests that changes at the level of health care policy making and financing have led to new partnerships between hospitals and local health departments, other medical institutions, and a variety of community and social service organizations (Laymon et al. 2015). Participatory approaches to studying hospitals may provide openings for understanding changing relationships between hospitals and communities, and how local residents are working alongside hospitals to identify important needs and develop community health initiatives to improve population health.

Conclusion and Recommendations for Future Research

Having outlined three ways of studying the internal and external forces shaping the contemporary hospital, there is no need to make the case for one perspective over the others. Rather, by offering three avenues for future research we can now return to our central question: how to study the changing relationship between hospitals and their communities? To begin this methodological turn, and responding to the

"triple aim" that has shaped so much thinking about the present moment in American health care, we have introduced a triad of our own—drawing on literatures in organizations and professions, social networks, and participatory approaches—for studying the changing hospital. This triad provides useful approaches for acquiring a multifaceted understanding of the evolution as well as current state of urban hospitals.

Sociology has a particularly important role to play in examining the nature of changing hospital-community relations. Although the changing American political and policy climate could make any broad claims on the contemporary health care landscape a challenge, our goal has been to synthesize existing literature on the relationship between hospitals and their communities. Tracking changing hospital dynamics requires understanding these institutions within the dominant social forces of both corporate consolidation and moves to population health. Accordingly, future analyses of hospitals and health outcomes must begin by deconstructing the internal-external dichotomy, which is increasingly reinforced artificially under an analytic assumption that hospital activities and responsibilities are contained within brick and mortar walls, with communities located beyond them.

The new hospital will increasingly be characterized by the actions it takes to address the needs of surrounding neighborhoods. Despite a long and complicated history, many American hospitals are charting new territory. Casting hospitals as evolving institutions, shaping and being shaped by social networks and accountable to their surrounding communities, will allow a more nuanced understanding of hospitals as dynamic medical institutions equipped to respond to new knowledge and changing health care issues. The benefits of such an approach could be many for both the future of medical sociology and health policy planning. Sociologists stand to capture the dynamic role of hospitals as they engage new health care activities and fill new spaces within urban communities.

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