

To tell the truth. A critical trend in medical sociology – an introduction to the problems

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Abstract

Introduction and objective: The presented analysis is a reconstruction of the origins, inspirations for development, and theoretical foundations of the critical and unmasking trend in Polish and Western medical sociology.

Abbreviated description of the state of knowledge: As a part of the critical medical sociology initiated in Poland by Professor Magdalena Sokołowska, a diagnosis of the (dys)functionality of contemporary medicine is carried out, emphasizing pathologies in the realization of its basic social functions, both at the level of systemic and institutional solutions, as well as stressing their consequences which include *inter alia* social health inequalities. Within the critical sociomedical research orientation, the diagnoses of the social role of medicine and distortions in the ways it is exercised are placed in the broad structural, political, and cultural contexts, which makes it possible to point to the principal causes of the analyzed phenomena.

Summary: The crucial ‘value added’ of critical sociological analyses of medicine and health policy are directives intended to humanize medicine and health systems in contemporary societies, taking social and cultural realities into consideration. We understand the humanization of medicine in terms of its better adjustment to human needs that emerge in the situations of illness and being ill, with the simultaneous guarantee of universal and equal access to medical services.

Key words

medical sociology, sociology of health and illness, sociology of medicine, sociology of health policy, critical sociology

INTRODUCTION

Medical sociology developed in the context of a special, ‘double’ reference framework co-created by general sociology and medicine. Sociology is a leading indicator of the scientific identity of medical sociology, being its conceptual, methodological, and theoretical mother-discipline [1]. Relationships between the subdiscipline and medicine are more complicated because, from its inception, medical sociology representatives conducted parallel studies, building two kinds of diametrically different relations between the two disciplines: on the one hand, those oriented towards solving practical problems in medical practice, and on the other – studies with a critical and unmasking orientation, meant to expose dysfunctions in medicine and in its formal institutions.

OBJECTIVE

The present study aims to present the part of the research field of medical sociology which focuses on critical analyses of medicine and health systems in contemporary societies. The main objective of the study is to reconstruct the origins, inspirations for development, and theoretical foundations of the critical and unmasking trend in Polish and Western medical sociology.

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MATERIALS AND METHOD

One of the consequences of the emergence of a critical trend in medical sociology was the conflict of research attitudes of medical sociologists, which became the subject of analysis by Robert Straus, one of the world pioneers of the subdiscipline. He observed that a sociologist starting critically-based research ‘of medicine’ may lose the indispensable objectivism when he/she has built strong scientific and institutional bonds with medicine, whereas a sociologist who is active in the applicative, pro-medical trend of ‘sociology in medicine’, may jeopardize good relationships with medical professionals – his/her research partners, when making them the object of critical analyses [2]. When seeking a solution to this dilemma, Straus introduced in 1957 the now classical dichotomy which distinguishes the applicative ‘sociology in medicine’ (closer to medical sciences) and the critically-oriented ‘sociology of medicine’, closer to general sociology [2]. The significance of this distinction goes far beyond the virtue of summing-up research activities undertaken at the early stage of medical sociology’s development, thus being an important step in the process of defining the cognitive identity of the new sociological subdiscipline. Straus’s dichotomy legitimized sociomedical investigations with an applicative profile, at the same time, however, pointing to critical studies ‘of medicine’ as their important counterbalance ensuring a close relationship of the new subdiscipline with its ‘mother discipline’ – general sociology. Making sure that the autonomy and humanistic specificity of the new sociological subfield was retained, Straus defined ‘the demarcation line’ between medical sociology and medicine.



We should, however, dwell longer on Robert Straus's concept of 'sociology of medicine'. This kind of sociomedical research activity covers studies on the 'organizational structure, role relationships, value systems, rituals, and functions of medicine as a system of behaviour', and furthermore, studies on medical professions and, it should be emphasized, the organizational structure of the healthcare system. While carrying out analyses with such characteristics, the sociologist 'stands apart and studies medicine as an institution or behaviour system' [2]. Straus also voices his view on the conditions for the efficacy of this type of studies, stating explicitly that 'this type of activity can be best carried out by persons operating from independent positions outside the formal medical setting' [2]. This statement thus 'refers' the analytical trend in question to sociological scientific institutions that are able to ensure and protect, both financially and institutionally, the researcher-sociologist's independence of medicine – a discipline unquestionably far stronger than sociology. And, although from the perspective of experience gained during over sixty years of the existence of medical sociology, Robert Straus's postulate does not seem a *sine qua non* condition for the carrying out of critically oriented sociological analyses; it should be emphasized that it was for these very aspirations that a leading representative of 'sociology of medicine', Eliot Freidson, consistently avoided scientific medical affiliation throughout his scholarly career [3].

When Robert Straus's dichotomy was becoming widely disseminated, the analytical trend of 'sociology of medicine' in American medical sociology was clearly outlined, owing above all to Talcott Parsons, whose work *The social system* first defined from a sociological perspective the role played by medicine in society as an institution of social control [4]. Medicine was treated as the crucial element of the 'health system' in society, responsible for maintaining balance in the social system, despite diseases that imply disorders in exercising social roles [5]. Field studies with a critical leaning oriented towards diagnosing the functionality/dysfunctionality of medical institutions and doctor/patient relationships, were conducted in the USA already at the earliest stage of the subdiscipline's development, i.e. in the period after WW2. It was the scholars who undertook this subject who were the first to call themselves 'medical sociologists' [6]. Paradoxically, the object of the most effective reception, however, were the studies with such characteristics carried out by a sociologist who was not a medical sociologist – Erving Goffman. We have in mind his 1961 study, *Asylums*, which contains the results of the qualitative analysis on the functioning of American state mental hospitals, including the description of the widely known concept of 'total institution' [7]. This work substantially contributed to the humanization of mental hospitals in particular, and hospital services in general. As part of the trend of critically-oriented sociological analyses 'of medicine', a number of analyses were carried out demonstrating the limited influence of medicine on society's health condition indicators: they suggested that of dominant significance in this respect were not so much interventions of clinical medicine as social factors outside its competencies [8]. These studies also had a clear application value because they strengthened the tendency to build 'new public health' in medicine, together with its applied branch – health promotion, which placed emphasis on the social origins of health and inspired the entry of sociologists into this area, who, with the growing store of evidence proving the social

origins of health, took effective actions for transforming health promotion into a multidisciplinary domain grounded in the achievements of social sciences. The studies that proved the limited effect of medicine on society's health condition also made up the context conducive to the emergence of the non-medicocentric research orientation in medical sociology, which was characterized by a pluralist approach to the resources determining health and illness, which took lay people's health activities into consideration [9].

General sociological inspirations for critical medical sociology. Polish medical sociology emphasizes the strong identification of the subdiscipline with the main trends in general sociology [10, 11]. If we adopt a chronological order in the presentation of the origins of critical medical sociology, then the 'historical pioneer' of the approach in question would without doubt have to be a former disciple and associate of August Comte – Claude Henri de Saint Simon (1780–1825) [12]. The pivot of his earlier reflections (1813) was *inter alia* a diagnosis of the social crisis that Europe experienced during the transition from feudalism to the industrial age. It was then, according to Saint Simon, that the community of ideas disintegrated, social activities of the community lost their cohesion, while the people entered a period of mutual hostile conflicts. The contemporary great social change, Saint Simon believed, brought the advantage of destructive elements over those that built harmony and order. The key to remedying the 'social evil' would be a fundamental reorganization of communal life, the basic repair factor being a new social philosophy meant to integrate the atomized community into a whole by giving it a functional and cohesive character [13, cf. the chapter *Kryzys i środki jego rozwiązania* (Crisis and ways of solving it)].

We will confine ourselves to the foregoing symbolic example from the past, and will now seek historically closer points of reference in 20th century sociology. One of the influential proponents of the 'critical theory' was Robert S. Lynd, a founder of field study investigations in the 1930s [12]. Field studies by Robert and Helen Lynd (1924–1925, 1935) showed that there were considerable social and economic inequalities in a small community – the city of Muncie in Indiana, USA. The main parties in the conflict were the working class and the business class. The economic crises of the 1930s hit the former far harder, producing fear, anger, and feelings of frustration and rejection. These emotions and mental states did not, however, arouse the need to jointly fight for their interests [14].

After WW2, the eminent representatives of 'critical and radical' sociology were members of the Frankfurt School, *inter alia* Max Horkheimer, Theodore M. Adorno, Herbert Marcuse, and Charles Wright Mills, who originally followed the tradition of American social thought. The common feature of representatives of critical sociology was the conviction that the duty of social researchers was initially to 'enlighten' the so-called ordinary people by explaining the essence and characteristics of the society they lived in and the rules that governed it, as well as to point out that the dominance by 'the power elite' (the ruling groups) was not irreversible and inviolable. The idea of 'enlightening society' was also associated with the idea of transforming it [14].

Another figure representing the radical and critical trend in social studies was the above-mentioned Max Horkheimer; his diagnoses of German capitalism of that time prompted



him to formulate a demand that the social order should be changed (in the mid-1930s the ideal espoused by those circles was no longer the Soviet version of socialism). The studies begun in the early 1930s on the attitudes and social consciousness of hired labourers and regular workers conducted by the Frankfurt School representatives allowed Horkheimer and his associates to conclude that the German workers would not be the social force with which it would be possible to effect the desirable and expected social change; consequently, the milieu able to play the role of the 'transformation factor' would have to be sought for elsewhere. Consequently, scholars representing this orientation focused their attention on the intelligentsia [14].

To sum up, the assessments of the social reality, which was observed, studied and interpreted by Max Horkheimer and other critical trend representatives, made them arrive at pessimistic conclusions: the then technical and technological society was conducive to the reification of the individual, his progressive alienation, feeling of deprivation, etc. The human thought was used mainly for utilitarian purposes, the human being increasingly treated in an instrumental way. The civilization of consumption and materialism reduced the individual to 'one-dimensionality' (H. Marcuse) [15].

The best-known exponent of the American version of 'critical sociology', without doubt, was Charles Wright Mills (1916–1962), a sociologist from a simple, farmer background, who consistently tried to study, understand, and represent the interests of so-called ordinary people. Already as a student under the supervision of H. Gerth at the University of Wisconsin, he encountered the German sociological school (Max Weber); he also studied Marxist thought, which brought him closer to some of the ideas of the Frankfurt School. The practical outcome of his sociological investigations was his radically critical evaluations of American society contained in the book *The Power Elite* (1961). Mills pointed out the progressive polarization of American society, concentration of the economic strength, political and military power, and the striving for ideological rule. The masses (here the new middle class) were increasingly passive, divided, and incapable of articulating and defending their own interest, which is why American democracy cannot be revived. The progressive arms race additionally polarized and incapacitated the masses, thereby strengthening the rule of the military-industrial complex. Ordinary people cannot count on the support of intellectuals or corrupt union leaders.

Although the assumptions of Ch. W. Mills's 'radical critical sociology' came in for massive criticism by the sociological mainstream, his ideas became increasingly popular and widely accepted by some elements of the radicalized American society [14]. 'The opportunist conservative American mainstream sociology', Mills believed, 'is one of the forces that sustained and legitimized the position of political, economic, and ideological power centres'.

One of the eminent contemporary continuators of critical sociology is without doubt Jürgen Habermas (born 1929). The analysis of his version of 'critical sociology' will also bring us closer to the sociology of health, illness, and medicine. As J. Mucha emphasized, one of the basic 'research problems in Habermas's critical macrosociology appears to be a permanent crisis of society of developed capitalism' [16]. Habermas's reflections also refer to the way university education fulfills (or does not fulfill) the social mission for which universities were established. Habermas, in his critical analysis of the

higher education system, says that these institutions are gradually becoming vocational schools, supporting and consolidating the existing system, at the same time losing the function of creating critical thought that could initiate the development of a new, better social order. Under these circumstances, the only way out is to radically democratize universities and colleges, and to eliminate the manifestations of academic authoritarianism [14]. As has been said earlier, the interpretation of Jürgen Habermas's sociological thought may lead us towards sociomedical analyses.

An interesting and inspiring attempt to apply and adapt Jürgen Habermas's theory to the analysis of the terms: health – illness – medicine, is offered by a Manchester University sociologist, Gemma Edwards [17]. She utilizes the analysis of late capitalism for the objectives which are set within medical sociology. At this juncture, she points to the inspiring role of Habermas's foregoing concepts in, for example, analyzing the medicalization process. Therefore, the critical approach enables investigation of the adverse effects of overmedicalization, the outcome of which is the rise of civil movements fighting for respect for the autonomy and independence of lay people in matters of health and illness. Edwards stresses that the importance of effective control of health and the health care system (here: National Health Service) stems from the elementary fact that 'Health is a central aspect of everyday life' [17]. The adoption of the perspective in question also makes it possible to analyze transformations of the 'state-bureaucratic' health care system (hospitals, nursing homes, organization of the work of general practitioners, institutions assisting the mentally ill, etc.), and to accurately assess the results of commercialization, privatization, and the growing influence of 'corporate medicine' on health and illness.

Contemporary capitalism, Edwards believes, produces more and more conflicts between the 'system' and 'ordinary people'. The public health service is increasingly transformed into the maximum-profit-oriented corporate economic apparatus geared towards exploiting customers-patients. Under these circumstances, the foundations of a public, widely available health service (NHS) are jeopardized, the NHS having been the symbol of the Welfare State and the social benefit of the working class for years. That is why it is necessary to form new social movements against colonization (of society) [17]. Therefore, the mobilization of ordinary people to change the social consciousness and the postulate about self-organization in order to protect health interests in confrontation with the system, is an urgent social task and a pressing moral issue in the context of defending the range of services provided by the public health system [17].

Another particularly important point of reference in attempts to reconstruct the 'critical-radical' trend, this time in Polish sociology, was the concept of five functions of sociology authored by Adam Podgórecki. It should be remembered first that collaboration between this eminent sociologist and Magdalena Sokołowska lasted from the late 1950s, the time when they met while staying in the USA as Ford Foundation fellowship recipients (we write about this elsewhere: [18]). It should be emphasized that the long-lasting scholarly and personal contact between Sokołowska and Podgórecki resulted in that in her study *Zastosowania socjologii w medycynie* (Applications of sociology in medicine) she used, *inter alia*, the terms borrowed from his book *Charakterystyka nauk praktycznych* (Characteristics



of practical sciences) (1962) (see Sokołowska's note opening her study *Zastosowania socjologii ..., op cit.* [19]). We believe that the typology of five functions of sociology is not only a theoretical construct useful to a social researcher, but it also demonstrates Podgórecki's interest in the character of American critical sociology, in particular in the concepts of A. W. Gouldner and Ch. W. Mills [20]. Podgórecki reminds us that sociology – a science about regularities governing the collective behaviours of people – can perform five fundamental functions: diagnostic, apologetic, unmasking, theoretical, and sociotechnical (social engineering) (authors' emphasis).

In keeping with our interests, we will be concerned with two of the above. According to the founder of social engineering, the unmasking function may have two meanings: in the first, unmasking consists in showing 'some features that are seemingly not easy to perceive' [20], or pointing to certain variables difficult to apprehend which, however, underlie social phenomena (this is so-called methodological unmasking). Another kind of unmasking is defined by the author as 'emotional or evaluative'; in this case, the issue is 'to point out certain actual motivations that are deliberately or unconsciously concealed' [20]. Podgórecki specifies that unmasking consists in revealing features or attributes that are difficult to observe directly, and that 'emotional unmasking' mainly comes down to (...) revealing motives that one might wish to carefully hide' [20]. When characterizing his studies on journalists dealing with the subject of observance of the law in the Polish People's Republic, Podgórecki states:

"Opening society's eyes" to the social and legal problems, exposing the spreading social evil (noticed earlier than can be done by the insufficiently enterprising administration), illustrating the social flaws by expressive and vivid short-cuts (...) these are the tasks to which journalists attach special attention [20].

Thus, in this context, the interest of sociology focuses on the subject matter essential for the community but also sensitive at the same time. From the perspective of 'methodological correctness', the problem is also the introduction of 'evaluative categories', which 'pure science' should avoid. However, Podgórecki emphasizes, evaluative judgments 'need not belong to the language of this science; they may be consciously isolated from this language' [20]. The author also adds that highly significant, but at the same time 'sensitive' social issues, may yield cognitively valuable results, including those with theoretical values. Podgórecki's concepts become even more distinctive if they were referred to one more of the foregoing functions (apologetic), which is a special warning to the sociologist – that science should never exercise this role. It consists in active participation in all manner of manipulations: collecting some data and ignoring others (the 'inconvenient' ones), in idealizing and 'praising' some situations for non-scientific purposes while passing over other facts, events, and opinions in silence. The most frequent manipulation mechanism is 'deliberate justification of an *a priori* adopted view' [20]. Therefore, the sociologists should never use exclusively convenient and selectively chosen arguments for a thesis accepted in advance. To sum up this part of our argument: we tried to show, using several selected examples, the origins, evolution and functions of the critical orientation in general sociology.

It should be added that some of these exemplifications refer to the research field of medical sociology (e.g. the above-discussed concepts of J. Habermas).

Magdalena Sokołowska as the forerunner of critical medical sociology in Poland.

Polish medical sociology was historically closely connected with its Western equivalents. When writing about the ties of this subdiscipline with Western science, A. Ostrowska observes that:

Aspirations connected with membership of the European Union were, at the same time, accompanied by reflection on Polish interests, loyalties and hopes associated with North America. This repeatedly provoked the question whether 'we should be closer' to Europe or the United States. These issues seem very far away from the problems dealt with by medical sociology, yet in a more general aspect they show that Poland's striving to be 'westernized' has always had its separate American and Western European contexts (...). Western Europe, on the one hand, and the United States on the other, performed the model-making functions in Poland in many aspects of life, including science [21].

The above quotation makes us realize once again that unlike other 'socialist bloc' countries Polish science (including social disciplines) had good relations in the past with its Western counterparts. This applied in particular to medical sociology 'westernized' by the initiator of this type of studies on the European scale – Magdalena Sokołowska.

In this paper, however, we are less interested in the Western models of 'critical medical sociology' (after all, well-known to Polish sociologists already in the 1960s) than in their Polish equivalents and adaptations (see for example [22], in particular, the chapter *The epidemic of modern medicine: 15–31; [23]* – especially the most critical part *Medico-political struggle*; and the book also written in the spirit of critical medical sociology by Vicente Navarro *Class Struggle, The State and Medicine* [24]). It should be also made clear that the discussion of all the many Western publications that are part of the critical trend with so many representatives would obviously go beyond the limits of this text; they were commented on in another article [25]. Under these circumstances we will focus attention on presenting the views of two authors who influenced (to a different degree) the view of successive generations of sociologists of health and illness. They are Magdalena Sokołowska and Zdzisław Bizoń. This choice may appear asymmetrical because we are comparing here the series of articles by the founder of Polish medical sociology with a very important (in our view) although somewhat forgotten text authored by professor of psychiatry Zdzisław Bizoń. It should be emphasized, therefore, that we believe that the extensive and erudite study by Bizoń, which is theoretical and historical, is one of the best and most inspiring sociomedical texts written in the first decade of the subdiscipline's development. We might add that despite the passage of time, Bizoń's arguments have not lost their relevance.

The publication of Magdalena Sokołowska's *Granice medycyny* (Limits to medicine) [26] in 1980 can be regarded as the crucial moment in the development of the critical approach to problems related to health, illness, and medicine



in Polish medical sociology. Referring to the views of the most important representatives of the so-called 'anti-medical movement' in the Western countries, the author attempted to assess the functionality and dysfunctionality of the contemporary medical system, and outlined the mechanisms of advancing medicalization perceived as the phenomenon jeopardizing *inter alia* the development of social strategies for coping with health problems. In the chapter *Orientacja inżynierska* (Engineering orientation), Sokołowska refers to the views of René Dubos, the author of *The mirage of health*, as the context justifying the thesis about the insufficient, development of basic health care (as compared with 'technical' medicine) and the ecological model of the relationships between man and the environment where he or she lives. The spectacular development of 'engineering orientation' in medicine based on advanced diagnosis and clinical treatment – surgical or pharmacological – dominates, in her opinion, other methods of solving health problems, both in the social and individual dimensions. Applying the consequences of the excess of engineering orientation in medicine to the individual level, the author describes the process of the dynamically progressing specialization of medical professions. The number of medical specializations growing with the development of medical technologies caused the prestige of general practitioners to drop significantly. The diminishing interest among medical students in the opportunities to work with the patient as part of the basic health care goes hand-in-hand with the prevailing view that the doctor's profession consists in narrow- and highly-specialized clinical treatment of severe cases. What seems to be the core of the criticism by Sokołowska is the conviction about the danger of marginalization of the comprehensive approach to the patient and fragmentation of the treatment process. This problem is manifested in the absence of a system that would ensure some kind of continuity of communication, both with the patient and between doctors representing different specializations, which calls into question the chance of meeting the demand for 'overall health care'. The change in understanding the role of the doctor, who is currently seen primarily as an expert specialized in a 'fragment of the body', and the identification of medical specialization only with 'true medicine' challenges, in Sokołowska's view, the idea of the 'physician of the whole man' and pushes the general practitioner into a minor position. The patient is thereby deprived of chances of adequate care consistent with individual needs. Sokołowska places particularly strong emphasis on the term 'care' as opposed to 'treatment', pointing out that the care for patients requires special predispositions and knowledge of non-medical disciplines: sociology, psychology, and anthropology [26]. However, the concentration of funds and organizational efforts in the area of specialist health care causes 'the whole edifice of health service to shatter. It is becoming a giant with feet of clay and is dysfunctional' [26].

The disproportion, criticized by Sokołowska, between the 'engineering orientation' and primary health care also has its broader, social consequences. Emphasizing the problem of the 'individualization' of the medical system, she describes the inadequate development of 'the ecological orientation', which takes into consideration sociocultural and economic factors as the principal indicators of society's health condition. She points out that this inadequacy is the more so felt that we – as developed countries – are affected by an increase

in the incidence of so-called civilization diseases [26]. An element of the critical assessment of the medical system in the context of overemphasis on the 'technical-scientific' function is Sokołowska's argument that:

At all stages of human history, what was most significant for human health was man's interaction with the environment. The developed societies owe their present health standard first of all to ecological conditions, sanitary supervision, and birth control' [26].

She goes on to observe that: 'Present-day medicine does not appreciate and cannot study human lifestyles and behaviours as hypothetical causes of diseases' [26]. In this way, Sokołowska stresses that medicine in its present shape, primarily oriented towards highly specialist treatment which marginalizes the overall, ecological approach to the process of treatment and care, is an ineffective measure for coping with the basic health challenges of our time.

According to Sokołowska, the dysfunctionality of the contemporary medical system consists not only in the failure to notice the need for developing strategies (alternative to the engineering orientation) for reducing health problems, but also in generating huge costs with a simultaneously low effectiveness [26]. Sokołowska writes that: 'Medicine cannot be put on a par with health, and it is not so that the more medicine, the more health. Medicine is associated with health only partially'. She adds that although it is not easy to demonstrate a relationship between medicine and health, there are data which confirm that a significant increase in expenditure on health service was reported when there was practically an almost total drop in the rate of deaths because of infectious diseases in modern societies. This fact, she believes, undermines the widespread view that it was exclusively medical measures that contributed to this significant decrease in this type of diseases.

Sokołowska gives many other examples corroborating the inefficiency of contemporary medical systems, e.g. in 1974, ca. four billion dollars was spent in the US on ca. 2.4 million unnecessary operations that resulted in 12,000 deaths. It should be emphasized that while assessing the efficacy of the contemporary medical system and its actual capabilities in reducing health problem, Sokołowska does not make categorical proposals that expenditures on health service be reduced and relocated to other sectors or systems of operation. She refers here to the views of the American scholars J. B. and S. M. McKinlay [see 8], according to whom spectacular advances in medical knowledge and technologies are not sufficiently translated into a real reduction of incidence and mortality rates of most contemporary diseases. For that reason, the previous ways of operation should be systematically assessed, and further uncontrolled spending on the medical system should be restricted [26].

The next chapters of Sokołowska's *Granice medycyny* (Limits to medicine): *Medycyna zagrożeniem* (Medicine as a threat) and *Problem medykalizacji społeczeństwa* (The problem of medicalization of society) are the principal elements of her critical analyses. The first chapter compares the main themes of the growing 'medical discourse' (mainly in the US) for over a decade. One of the aspects of the phenomenon she describes is the problem of insufficient social supervision over medical practices, procedures applied, the advisability of recommended treatment as a consequence of the widespread



view that it is only doctors who can speak of medical issues, and public judgments directed at doctors being interpreted as unprofessional attacks by lay people.

When discussing the problem of iatrogenicity in medicine, Sokołowska also refers to the issue of efficiency of medical institutions and points out health hazards that they produce, which arise on the one hand from negligence of the medical personnel in hospitals and medical centers, and on the other hand, from the unjustified and not always thoroughly tested medical techniques [26].

What makes Magdalena Sokołowska the pioneer of the critical trend in Polish medical sociology is also the analysis of the medicalization phenomenon. She describes the mechanism of 'the expansion of medicine' and points to the particularly high prestige of the doctor's profession in this country and the associated large range of social power that he/she has which, in turn, determines the widespread tendency to define and treat non-medical phenomena as cases requiring medical intervention [26]. When describing what medicalization is, Sokołowska points out 'an increase in the number of attitudes and behaviours that have been defined as illness, their treatment being regarded as falling within the scope of medicine' [26]. Therefore, the essence of the expansion of medical discourse is the 'multiplication of diseases' and, Sokołowska writes: 'people's growing expectations and requirements concerning wellbeing and other values called health' [26]. This process leads, she believes, to the danger of 'individualization of illness' and excessive focus on biomedical methods of fighting health problems [26].

The manner in which Sokołowska writes about medicalization goes beyond the narrow understanding of the term. She regards the expansion of medicine as something more than 'doctors' usurpation' only, it is a phenomenon determined by the sociocultural context: a special predisposition of American society towards interpreting specific social problems in medical terms. Emphasizing this 'bottom-up' character of medicalization, Sokołowska does not ignore analyses of this phenomenon as the consequence of the influence of medical circles and medical institutions. In this context, she refers to the views (with some reservations) of Ivan Illich in his *Medical Nemesis. The Expropriation of Health* [22], in which the author advances explicitly critical theses about the iatrogenic influence of the 'medical establishment' on health, and even about contemporary medicine generating diseases. Sokołowska also cites the findings of P. M. Strong, who describes in detail the mechanisms of doctors' 'professional imperialism': *inter alia* the monopolization of services, marginalization of other medical professions and lay people, dissemination and establishment of medical interpretations of social problems, individualization of health problems, or making patients dependent on medical help and pharmacological treatment [26].

When characterizing medicalization processes, Sokołowska again directs attention to the growing anti-medical views – mainly in the US – as an expression of opposition towards technicalized, bureaucratized, iatrogenic, and expensive medicine. Initially, Sokołowska observes, criticism referred to the negative effect of medical institutions upon the patient, their oppressive and segregative nature, the problem of labelling the patients, and 'constructing' disorders (chiefly mental ones). As Sokołowska stresses, anti-medical views emphasizing the need of demedicalization were not

exclusively theoretical digressions; on the contrary, they were an impulse to start many social initiatives inspired both by the circles of young doctors and by minority or feminist groups, or by the disabled, which resulted in some changes in the ossified medical system: *inter alia*, democratization of the doctor/patient relationship, or the introduction of the provision on the patient's right to information and its confidentiality [26].

Summing-up her remarks concerning medicalization, Sokołowska emphasizes that this is a highly complex phenomenon and is difficult to assess unequivocally. She even cautions against over-simplification, and against relating single cases to the whole medical system, as well as against an unequivocally negative assessment of the whole medical environment. Nevertheless, the fact that Magdalena Sokołowska devoted so much space to the problems of 'expansion of medicine' makes her, without doubt, the precursor of the critical trend, as mentioned above. Moreover, it should be stressed that it was only in recent years that medicalization became the subject of more systematic analyses by Polish medical sociologists, which confirms the conclusion that her *Granice medycyny (Limits to medicine)* is a ground-breaking and still relevant book.

Many remarks made by Sokołowska in the *Granice medycyny* were repeated and expanded *inter alia* in her *Socjologia medycyny* ('The Sociology of medicine'), published in 1986. When discussing the issue of health policy in modern societies, she refers to the views of Ivan Illich on a larger scale than in *Granice medycyny*. She describes his criticism of contemporary medicine, which has aroused unrealistic expectations of the possibility of curing even the most severe diseases, has extended medical interpretation over social problems, and which produces diseases and reduces the patients' competencies to cope with health problems [10]. She also cites Illich's typology of iatrogenic errors, which he divided into clinical iatrogenesis (resulting in illness or death), social iatrogenesis (dependence on medical care and creation of artificial demand for medical services), and structural iatrogenesis (medicine as a system that hampers the development of other forms of support in health and illness) [10].

When examining, in turn, the issue of the reform of health care in Western countries, Sokołowska presents the views of V. Navarro, who, in a way in opposition Illich's views, places main emphasis on criticizing the capitalist system and the social inequalities it creates. Medicine and the whole medical system has become, in Navarro's evaluation, another area dominated by the economy of profit while health has been downgraded to being a commodity that the poor cannot afford [10]. In the discussion on the shape of the health care system, Sokołowska appears to take a stand in between and to support the approach which was represented at that time by the World Health Organization (WHO), which emphasized *inter alia* the necessary development of preventive medicine and the re-orientation of present-day medicine towards strengthening primary health care [10]. Sokołowska wrote several times about the insufficient development of such health care. She examines this problem *inter alia* by referring to the criticism of the total institution authored by E. Goffman [10], and by pointing to the inefficiency and poor adjustment of present-day hospitals to taking care of terminal patients [10]. In this context, Sokołowska presents the organizational outline of the functioning of medicine in the future which would be based on two pillars:



One of them would be ecologically-oriented environmental medicine (...). The other (...) would be a type of holistic care, the primary, psycho-sociomedical care of man as a whole. Between the two pillars, specialized clinical treatment would occupy its due position [10].

Sokołowska stresses that the essence of the model is the change in proportions consisting in some reduction of the 'hypertrophied' (in her opinion) clinical-technical function of the contemporary medical system [10]. What is conducive to the realization of the idea of 'socialized medicine' is, according to Sokołowska, a growing scepticism observable in many countries towards medicine and the doctor's profession, and the development of 'consumer orientation' of those using medical services (the patient as a conscious and critical consumer) [10].

In Part V of the *Socjologia medycyny* (The Sociology of medicine), entitled *Medicine and social control*, Sokołowska continues her discussion on the dysfunction of contemporary medical systems in the Western countries and on the problem of 'medical control', which she signalled in the *Limits to medicine*. The controlling function of medicine is manifested, Sokołowska believes, in the process of legitimizing illness and in exercising professional control. The grounds for medical expansion, therefore, is the doctor's exclusive power to confirm the appearance of disease and the patient's status, and to decide what is and what is not a disease; while on the other hand, the progressive professionalization and institutionalization of medical practice leads to an essential change in the relationship with the patient, who is a passive, subordinate recipient of medical services in this system. The superior position of medicine and its representatives in the structure of social power results, according to Sokołowska, in widening inequalities in access to health services, in inadequate care, inhibition of the development of support forms (alternative to clinical-technical ones) in health and illness, and in the individualization of health problems [10].

Eliot Freidson as the initiator of sociomedical analyses of dominance and authority of medicine. The vast array of critical sociomedical studies describing the social functions of medicine accords an important position to Eliot Freidson's achievements concerning the sociological specificity of medical profession, including its dominance and autonomy in the domain of health and illness [27]. Criticism of medicine by this eminent second-generation medical sociologist was expressed *inter alia* in building a model of the social construction of illness and illness behaviour, which emphasized interpretation processes occurring within the 'lay referral system', described in Freidson's writings as a kind of counterbalance to medical dominance in the area of health and illness and, at the same time, as a factor deconstructing this dominance [27, 28]. This type of influence of the 'lay referral system' on the social position of medicine was not so strongly marked in the context (described by Freidson) of the late 1960s and early 1970s as is the case at present. Without risking an error, we can, however, recognize that Freidson's intuitions about the role of the 'lay referral system' regarding the complex of health and illness issues (formulated, which is seldom remembered, in the characteristic context of the US medical system), anticipated many phenomena described in medical sociology in the 21st century, whose common denominator is

the increasing causative power of lay people on the question of health and illness, and the loss of medicine's exclusivity regarding the creation and deconstruction of illnesses.

In a number of analyses, medical sociologists show that the processes of creating medical nosological units are also inspired bottom-up, including social movements lobbying for the medical legitimacy of all kinds of states of 'non-health', e.g. functional health disorders [29, 30]. Dwelling longer on this theme, we might add that the symptoms of erosion of medicine's dominance regarding health and illness are also seen by medical sociologists in the doctor/patient relationship, in which they describe a gradual shift towards the partnership model of treatment relations with a simultaneous weakening of the traditional paternalistic model characterized by the doctor's dominance [31, 32]. Another manifestation of the weakening dominance of medicine regarding health and illness is the growing phenomenon of ignoring offers of medical therapy, and using various forms of non-medical treatment instead (or complementary to medicine) [33, 34]. Sociomedical analyses examining the issue of the erosion of medicine's dominance regarding health and illness, however, are not confined to diagnosis only, but have also a valuable explanatory virtue in seeking the causes of the foregoing tendencies. They are seen *inter alia* in consumerist tendencies in health care, which became manifested particularly clearly in the 1980s, as a result of which the patients gained awareness that they could make informed subjective choices concerning medical services [35].

An important factor that accelerated the foregoing process of medicine's loss of dominance was also a far easier availability of expert medical knowledge made possible owing to computerization and widespread access to the Internet. The outcome of these changes was the challenging of the medical profession's exclusive access to expert knowledge, this exclusivity being the crucial condition of not only the dominance of medicine in the problem domain of health and illness, but also being seen as an important determinant of the autonomy of medical profession [36]. This process of 'democratization' of medical knowledge [35] strengthened the empowerment of lay people in matters of health and illness, who thereby gained competencies necessary for playing an active and critical role in health care processes.

'Sociology of health policy' as an appropriate continuation of the trend of 'sociology of medicine' in present-day realities. In the course of the evolution of sociomedical research problems concerning the social functions of medicine, Robert Straus's [2] formula of 'sociology of medicine' gradually became too narrow because it did not reflect the actual problem area of this analytical trend, which also covered other, non-medical entities that played an increasing role in health care processes, including insurance companies and other payers of medical services. Medicine's loss of dominance in this area became a fact, especially in the context of attempts begun in the 1970s to reduce the costs of health care in Western countries, the attempts inspired by the fact that in many cases expenditure on medical systems during that period began to exceed 10% of the GDP in those countries. In respect of funding and efficiency of medical systems, the analytical trend representatives examined *inter alia* the problems of controlling the costs of health care (market vs. State), analyzed relationships between equal access to medical services (or absence of this) and the



efficiency of health care (equality vs. efficiency). They also studied the related problem of widespread availability of health care (health care as a right) and the role of the State in guaranteeing health care [37].

It is distinctly clear, therefore, that sociological analyses of the social functions of medicine must also take into consideration the role of other, non-medical entities shaping health policies, and indirectly impacting (often in a destructive way) on the ways of practicing clinical medicine – the entities belonging both to the public sector (State) and private (payers of medical services, insurance companies, etc.) [37]. This extension of the area of sociomedical analyses was inevitable because, even if medicine retained its dominant influence on the clinical aspect of its activities (this is no longer total dominance because there are evident effects of non-medical administrative and political decisions here), it has without doubt lost its exclusive influence on the form and manner of functioning of health care systems that came under the influence of other sectors [38]. Eliot Freidson defines the foregoing phenomenon using the terms ‘deprofessionalization’ and ‘proletarianization of medicine’ [39], which unquestionably indicate that the dominance of medicine in the complex of health and illness problems, particularly from the aspect of macrosocial solutions, is a thing of the past. Therefore, there is no doubt that the formula of ‘sociology of medicine’ is still adequate in sociological studies on medicine as a social institution and studies on formal medical institutions, but it turns out to be no longer relevant as a formula for present-day research into the functioning of medical systems. As a result, suggestions to complement and broaden it have been made by introducing a new division containing the ‘sociology of health policy’, within which health policy is treated as the subject of sociological research, and containing the applicative trend ‘sociology in health policy’, within which the sociologist contributes to building the assumptions of health policy [40]. This new, relatively little-known term in medical sociology, defining a new analytical area of the subdiscipline, refers us to the broader, multidisciplinary research trend termed ‘health policy research’ and adopted by representatives of many disciplines, including economists, physicians, political scientists, epidemiologists, etc.

At this point a question should be asked about the special and unique contribution of sociology to this research area. When seeking an answer, we should refer to the views of Eliot Freidson, who maintains that the ‘value added’ resulting from the activities of sociologists in this domain refers to the unique knowledge of ‘nature and functioning of human institutions’, and, furthermore, ‘social processes (...) in the various milieus in which health care takes place’. Freidson points out that sociology is competent in the contextualization of these problems, i.e. in placing them in a broad political and cultural context [39]. Freidson is not the only one to hold this view. An analogous stance is taken by Howard Waitzkin, who emphasizes the close ties between the form and functioning of health care systems, and the social structure, thus stressing that all attempts to take remedial actions that ignore this relationship are doomed to failure [41]. An analogous phenomenon can be also found in the most recent sociomedical publications referring to recent trends in sociological theory. For example, I. R. Jones points out that:

health and health care cannot be reduced to technical considerations of measurement and evaluation. They

are a fundamental part of the lifeworld/system-world problematic, and as such are profoundly political [authors’ emphasis] [42].

We obtain here an important directive for sociomedical critical and unmasking research which, in light of the foregoing theses, should not be confined to diagnosing/describing the state of affairs, but should seek to answer the question about the fundamental causes of the existing state of affairs.

(Dys)functionality of medical systems as a category of analysis of medical sociology interpreted by Zdzisław Bizoń. In his study, *Wzorce adaptacji systemu medycznego do zmian społecznych* (Adaptation patterns of the medical system to social change), published in the monograph *Socjologia a zdrowie* (Sociology and health) [43], edited by M. Sokołowska, J. Hołówka, and A. Ostrowska, Zdzisław Bizoń [44] critically analysed present-day medicine which he treats as a kind of social system determined by functional ties with other systems and larger system complexes. In particular, Bizoń points to the possibility of implementing objectives for which this system has been established and the ability to adapt consisting in ‘regulation of its relationships with the supersystem in accordance with the temporally changing properties and requirements of the supersystem (...)’ [44].

While discussing the problem of functionality of the medical system, Bizoń stresses that the subject of his analysis is medicine of ‘the Euro-American cultural circle’ [44] and its capabilities to efficiently treat/alleviate ailments, to provide health care, and enhance society’s health. Assessing this aspect of the functioning of the medical system Bizoń carries out a critical analysis of its historical development and remarks that for many years medicine had fairly limited capabilities to respond to health problems (offering ineffective and even harmful therapies); consequently, it was largely a dysfunctional system. Despite this original dysfunctionality, the medical system was able, by skillfully using certain adaptive mechanisms, to successfully develop its structures and strengthen its position in society. The first mechanism which allowed the system not only to survive but also to gain special prestige and the ability to exercise social power, was that it concealed dysfunctionality and faked functionality (e.g. by avoiding internal supervision, distorting or failing to provide the required data). Obviously, Bizoń observes, this strategy worked only for a certain time because, when applied over a long period, it can result in significant disruption of the dependence relationship with other systems (supersystem), or in the rise of the next, secondary dysfunctions of the medical system itself (e.g. its inefficiency), or even jeopardize the survival of the system [44]. That is why the preservation and further systematic strengthening of the position of medicine (understood, as mentioned above, as a social system) could be possible by the use of the next adaptive mechanism: ‘intensive, many-sided and extremely efficient social and political activity of (...) “actors” of medical actions, i.e. medical groups and professions (...)’ [44].

As a result of this ‘non-medical’ activeness the prestige of the medical circles grew, and new privileges and protections against possible charges of negligence were gained. This is how the myth of effective, objective and rational medicine was created which, owing to social engineering, compensated for actual dysfunctionality regarding medicine’s fundamental purpose, which is the treatment and protection of health [44].



The next part of Bizoń's considerations is devoted to a detailed discussion of the manipulation techniques of the medical system, whose development he interprets as 'an incessant struggle for social prestige and appropriate influence or power (authority)' [44]. Strategies used in this respect, on the one hand, are social-organizational and political, but these are also intense ideological-propagandistic measures. The history of the development of medicine provides many examples of exerting pressure, seeking favours from influential circles, attempts to eliminate or marginalize competitors by, for example, sanctioning professional competencies by law or by creation of deontological codes [44]. In his analysis of the tactics of widening their influence by the medical circles, Bizoń states that: 'The profession appears to owe the obtention and strengthening of its autonomy more to the application of a socio-political strategy than to the effects of medical practice' [44].

Equally effective, according to his view, were various strategies for direct influence on social opinion through creating a positive image of medicine (ideological-propagandistic activities). One of the methods of 'mythologization' of medicine mentioned by Bizoń is to idealize the role and personal characteristics of the doctor as an omnipotent, competent altruist meeting the highest ethical standards, the consequence of which, *inter alia*, is excessive and unrealistic expectations of doctors, and later the patient's frustration.

Another listed strategy is to create and disseminate the image of medical interventions as indispensable, necessary, and irreplaceable, as well as to dramatize disregard for a doctor's recommendations or refusal to see a doctor (the use of fear) [44]. Another method of enhancing the prestige of the medical circle is also to influence people's emotions and beliefs, e.g. through 'the presence of medical representatives at the most solemn or dramatic events in human life (birth, death, accidents, collective disasters, etc.)' [44]. In this way, the medical milieu spreads the influence and the vision of the world, in which man, as the object of 'medical indoctrination', treats medicine as a criterion for his life decisions, and medication as a means of soothing existential dilemmas.

Another technique serving to justify the special position and role of the medical system and its representatives, according to Bizoń, is the strategy for manipulating values which consists *inter alia* in reference to superior values in order to protect particularistic interests. A frequently used device is to identify the interest of the medical profession with the interest of patients (e.g. arguments that undermine the doctor's prestige, in fact, act to the patient's detriment). Another aspect of the strategy for manipulating values is to appropriate and include them in the scope of medical competence: e.g. physical appearance (plastic surgery), physical activity (sports medicine), or sex life (sexology as a medical discipline). Other 'abuses' of medicine consist, according to Bizoń, in manipulating scientific knowledge. Medicine, he claims, first of all is an intervention discipline based on action, knowledge being its theoretical background. This gives rise to situations in which the efficacy of the applied diagnostic and treatment methods, as well as prevention programmes, is not always confirmed by reliable scientific data [44]. Moreover, Bizoń maintains that medical knowledge is 'a medley of information and evaluative assessments, a specific mixture of concepts as well as descriptive and normative propositions' [44], which is conducive to the use of a defence mechanism by the medical system, to rationalizing applied procedures and justifying

failures (an example of such tactics is to attribute the credit for lengthening life expectancy to medicine exclusively [44]).

Continuing his discussion on the form and character of conflicting relations between medicine/medical profession and the systemic environment, Bizoń analyzed the way the medical system adapted to 'macro-systemic' transformations that occurred during the last century (industrialization, urbanization, globalization, technological progress, new demographic trends, the spread of education, etc.). These new interrelated phenomena and processes caused medicine, if it wanted to retain its previous position, to develop new adaptation techniques [44]. Medicine responded to some of these 'macro-systemic impulses' by adaptation and thereby managed to preserve its functionality; yet, when facing other challenges it was unable to implement appropriate methods, or even failed to see them, such as:

democratization of human relationships, increased purchasing power of the mass consumer, diminished intellectual distance between the doctor and most of his patients, increased demands and criticism on the part of (...) the growing importance of some values (egalitarianism, productivity, and ultimately health as a common good) [44].

The foregoing prompted Bizoń to conclude that the medical system proved dysfunctional first of all in adaptation to social and environmental challenges, whereas it coped better in the area of technology and scientific development. He sought for the causes of this state of affairs in the established, stable and rigid 'institutional-professional' subsystem:

The profession has gained such a significant degree of autonomy that any supervision of its activities is reduced exclusively to self-supervision [44], whereby the interest in the needs of the supersystem and willingness to make concessions for it were considerably weakened. The first important successes in fighting infectious diseases in the history of medicine additionally enhanced the prestige and authority of medical profession, and preserved and reduced adaptation capacities of the medical system. Self-sufficient and closed medicine insensitive to external signals thus deepened its dysfunctionality, yet the absence of flexibility did not jeopardize medicine itself because its shortcomings, errors and deficiencies were noticed and felt first of all by external observers. Adaptation and care to retain functionality essentially consisted in simulated actions that are of peripheral significance and do not reach the core of the medical system. However, the continuing growth of needs and health awareness, as well as a significant increase in the number of chronic diseases and disabilities in modern societies made this form of medicine appear not only inconvenient, but this absence of adaptation caused the emergence of a new kind of dysfunction: the absence of capabilities to meet the health needs of a large portion of society [44]. Therefore, while in the past the dysfunctionality of medicine meant inefficacy of treatment in the first place, now it is (...) a series of barriers between the system and the requirements of the social environment (...) [44].

One of the most important barriers being the financial barrier.



It thus turns out that, as Bizoń argues, the functionality of the medical system did not increase despite the far greater efficacy of treatment; on the contrary, dysfunctions became deeper and new ones emerged, as mentioned above [44].

According to Bizoń, disparities between the growing possibilities of treating patients, scientific and technological development, and the capabilities to really satisfy the health needs of the whole society resulted in many countries, above all in the USA, in antagonized relations between the medical system threatened by the loss of its privileges, and the political system, which seeks to prevent possible social unrest. As a result of the clash of interests of political forces on the one hand, and the medical circles on the other, in recent years there arose (as assessed by Bizoń) a new compromise 'adaptation model': the idea of environmental medicine doing away with the rhetoric of the opposites, which both parties used, and it allowed them, at least partly, to limit responsibility of both medicine and State authorities for the health of society. A manifestation of these tendencies, *inter alia*, is the wide support of the US federal authorities for programmes of environmental medicine, the aim of which was to initiate and develop cooperation between health care services and public services (e.g. the 1963 Act on community mental health centers). The medical environment's acceptance of these kinds of system changes can be interpreted, as Bizoń sees it, as another kind of adaptation in the history of medicine to the new requirements of the macro-system in order to protect one's own interests by avoiding the nationalization of the health care system. One might ask, therefore, whether the idea of environmental medicine is proof that medicine is evolving towards the social model, or whether it may be a new form of the spread of medical influence. This question was left open by Zdzisław Bizoń [44].

The critical approach in medical sociology as exemplified by analyses of the US medical system: selected problems.

Sociomedical critical/unmasking, and at the same time reform-oriented analyses, are exemplified by the debate co-created by American medical sociologists on the functioning of the US health care system, a debate significantly boosted by changes in the US health care organization, designed and implemented by the Obama administration (we are especially interested in The Patient Protection and Affordable Care Act of 2010). Before we refer to some theses proposed in this critical trend, it should be remembered that the inspiration for the medical system reforms being implemented in the US is about the fact that 46 million Americans are not covered by health insurance, which is paradoxical in the light of the dramatically high expenditure on the medical system in that country, which amounts to 18% of Gross Domestic Product [45]. It is said in discussions on the social consequence of this state of affairs that this situation considerably accelerates social inequalities in health in American society [46]. We will dwell longer on the thesis, which differs from the eagerly repeated propositions in medical sociology, formulated based on British and Canadian experience, that the egalitarian formula for the functioning of the medical system does not guarantee reduction of social inequalities in health. The American experience shows something completely different. There is no doubt that inequalities in the availability of medical services are of little consequence as far as new incidences of civilization diseases are concerned (obviously, because this is first of all about people's lifestyles); however, the importance of this phenomenon becomes critical if we

take into consideration the relationships between the state of health/quality of life, and the availability and quality of medical care of persons suffering from chronic diseases. In such cases (the frequency of which is known to be rising dramatically because of the 'epidemiological shift'), access to and the quality of medical treatment directly translates into the life expectancy of patients, and determines the probability of the occurrence of secondary health disorders, e.g. in type 2 diabetes, which would be possible to avoid in the situation of optimum medical care [47]. In light of the foregoing, there is no doubt therefore that inequalities in access to medical services – incidentally, socially determined – are a significant cause of social inequalities in health, particularly with respect to chronic diseases that require long-lasting medical care [47].

When pointing out the participation of American medical sociologists in the discussion on the functioning of the American medical system in the first and second decade of this century [37, 46, 47, 48], it should be emphasized, however, that conducting this type of analysis has an established tradition under American realities which goes back to the beginnings of medical sociology in that country, and that the conceptualization of basic analytical categories of medical sociology was carried out as part of it. The object of sociomedical studies undertaken in the US in the early second half of the 20th century were microsocial processes underlying the functioning of the American health care system, including *inter alia* the mechanisms of how patients reached the health care system, and illness behaviour (D. Mechanic), the functioning of medical institutions examined in the light of patient-medical personnel relationships (J. Roth, E. Goffman), the issues of social networks impacting health and illness behaviour (E. Freidson), and others [48].

At the stage of its then development, medical sociology significantly contributed to understanding the social aspects of medical care, pointing out the disparities between demand and its actual utilization [48]. The disparity was explained by focusing either on individual characteristics (see D. Mechanic's concept of illness behaviour), or on broader social influence (see E. Freidson's concept of 'the lay referral system'). Therefore, without risk of error, we can state that in the context of sociological analyses of the American health care system, the basic analytical categories of medical sociology were largely developed, having been subsequently verified in the contexts of other medical systems.

SUMMARY

This project is a continuation of earlier research initiatives realized at the sociomedical centre in Lublin, Poland, aimed at presenting the cognitive identity of Polish medical sociology to English-speaking scholars [11, 18, 33]. In summing-up this analysis concerning the sociology of medicine and the derivative trend of sociology of health policy, we would like to refer to the opinion of Mary Ruggie, expressed in the American context. In her view, sociologists who discuss health policy in critical terms and identify 'irrationalities and contradictions that confound health care in the US, as well as the many inequalities it has created and exacerbates, not only in health', significantly contribute to building a socially committed version of sociology, defined by Michael Burawoy in 2005 as 'public sociology' [37]. We would like our research initiative to dynamize this trend in Polish and European medical sociology.



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