During more than three decades of scholarship on American medicine, Eliot Freidson has both contributed to and advocated a distinctive variety of medical sociology: one that applies structural perspectives to medical institutions and remains detached from medicine's own viewpoints and assumptions. This article reviews Freidson's legacy to six substantive arenas in the study of medical institutions. It then examines the evolving status of the type of scholarship Freidson championed. Conventional wisdom holds that medical sociology is in the doldrums because applied work has supplanted discipline-grounded research. This article suggests a counterhypothesis: Institutionally oriented medical sociology is no less prevalent than in the past; rather, the perceived salience of this type of work has declined because of trends within sociology at large.

The Study of Medical Institutions

ELIOT FREIDSON'S LEGACY

SYDNEY HALPERN
University of Illinois, Chicago
with
RENEE R. ANSPACH
University of Michigan

Eliot Freidson is best known within sociology for his challenge to functionalist theories of professions. He writes in *Profession of Medicine* (Freidson, 1970a) that what distinguishes professions as a class of occupations is not a body of knowledge or service ideals—emphasized in the prevailing literature—but, rather, control over the technical content of work. Technical control, what Freidson calls autonomy, means that only members of that profession can judge the quality of practitioners' work. Occupations gain autonomy through political persuasion and the patronage of social elites. Thus the power of professions arises from social and historical processes. American medicine's struggle for autonomy won it preeminence within health care organizations and dominance over both patients and ancillary professions.

Clarifying the nature of professional power, a centerpiece of Freidson's work, is by no means his only legacy. Since the late 1950s, Freidson has

WORK AND OCCUPATIONS, Vol. 20 No. 3, August 1993 279-295

produced a substantial body of scholarship in medical sociology including more than 60 articles, four edited books, and five sole-authored volumes. He addresses a wide range of topics: the organization of medical practice, lay and professional control of doctor's performance, conflicts in the doctor-patient encounter, relations among health care professions, the expansion of medicine's terrain to encompass a widening array of social problems (a phenomenon called medicalization). This work is unified by an overriding concern with the structure of medical institutions and its social consequences.

Freidson was an outspoken advocate for this variety of scholarship. He criticized much of contemporary medical sociology for assuming the viewpoint of health care providers rather than the perspective of sociology. Commenting on the field, after a stint as editor of the *Journal of Health and Social Behavior* (*JHSB*), Freidson (1970a) observes that the most studies derive their research agenda from medicine.[1] Invoking Robert Straus's (1957) distinction between sociology *in* medicine and sociology *of* medicine, Freidson argues that the field is dominated by work that applies social-science technique to questions of concern to physicians (sociology *in* medicine) rather than work that subjects medicine to sociological scrutiny (sociology *of* medicine). He also criticizes researchers who, while examining health care institutions, take physicians' claims at face value or adopt the commonsense individualism that typifies medical ideology. To develop a genuine sociology of medicine, Freidson insists, researchers must do three things: approach medicine as detached outsiders, apply structural perspectives to medical institutions, and use conceptual tools generic to the broader discipline of sociology. Freidson adheres to these prescriptions in his own research.

The theoretical essay is his preferred mode of scholarship. Two of Freidson's monographs present original data: *Patients' Views of Medical Practice* (Freidson, 1961) and *Doctoring Together* (Freidson, 1975). Three of his books—*Profession of Medicine* (Freidson, 1970a), *Professional Dominance* (Freidson, 1970b), and *Professional Powers* (Freidson, 1986a)—are analytic essays building on existing empirical literatures. Freidson often elaborates structural implications of other scholars' observations that remain undeveloped in the original. He draws on a wide array of research but has a particular affinity for work of Chicago-trained interactionists. A student of Everett Hughes, Freidson's intellectual roots lie in the traditions of Chicago sociology. Freidson shares Hughes's emphasis on the exigencies of work and his skepticism toward medical ideologies. A good number of Freidson's core insights originate with Hughes (1984): that professions seek social mandates for exclusive rights to their work; that practitioners and clients have conflicting viewpoints and interests; that physicians relegate "dirty work" to subordinate occupations; that, according to professionals' claims, only colleagues

can identify practitioners' errors. But what in Hughes's hands are sensitizing concepts, Freidson weaves into coherent theory.

Freidson pursues his structural analysis of medicine at three analytic levels. At the macrolevel, he examines the terms of medicine's social mandate. At an intermediate level, he explores the texture of medical work and the content of its culture. At the microlevel, he addresses physician decision making and the clinical encounter. His work is distinctive in that it draws numerous links among these levels of analysis. Freidson elaborates the implications of professional power for the quality and character of medical services. The result is a medical sociology that raises public-interest questions while keeping both feet in sociology.

CONTRIBUTIONS TO A SOCIOLOGY OF MEDICAL INSTITUTIONS

The following overview of Freidson's work on medical institutions is organized around six substantive foci. I present these in a rough chronological order. The review comments briefly on the intellectual antecedents of Freidson's contributions and on subsequent research building on his scholarship.

PRACTICE ORGANIZATION AND PATIENT CARE

One of two central foci of Freidson's early writing is the organization of medical practice and its consequences for patient care. He first develops the theme in *Patients' Views of Medical Practice* (Freidson, 1961) and in a contemporaneous article (Freidson, 1960). This work examines numerous structural features of medical practice but, following Chicago-school sociologist Oswald Hall (1946), places particular emphasis on referral networks. The cornerstone of Freidson's analysis is his distinction between client-dependent and colleague-dependent medical practices. In client-dependent practices, patients use lay referral networks and select physicians on the basis of recommendations from other patients. In colleague-dependent practices, doctors rely on professional networks as their major source of referrals. Having distinguished network types, Freidson elaborates implications for the quality of care, patient satisfaction, and client control over medical practice.

Freidson argues that quality of care is higher in colleague-dependent practice because, in these settings, physicians are more attentive to prevailing medical opinion and their work is more observable to other doctors. However, patient satisfaction is higher in client-dependent practices because, when doctors depend on lay referrals, they are more attentive to patients'

wishes and clients have more leverage over physician behavior. Ironically, quality of care and patient satisfaction are inversely related.

Freidson's work on practice organization has generated relatively few sociological studies. Questions about quality of care and patient satisfaction have been taken up by the field of health-services research and this work addresses circumscribed policy issues. Sociologists have examined how the structure of lay referral networks influences the use of medical services (e.g., Pescosolido, 1992; Suchman, 1965). In addition, Millman (1977) and Anspach (1993) explore conflicting treatment ideologies among groups of health care professionals, building on Freidson's insight that structural location shapes providers' attitudes and behaviors.

LAY AND PROFESSIONAL CONSTRUCTIONS OF ILLNESS

A second major concern in Freidson's early writing is the clash between lay and professional concepts of both illness and the doctor-patient encounter. He explores these themes with empirical data in *Patients' View of Medical Practice* (Freidson, 1961) and expands his theoretical discussion in *Profession of Medicine* (Freidson, 1970a). Building on studies showing cultural variation in becoming sick and seeking help (Mechanic, 1962; Zborowski, 1952; Zola, 1966), Freidson adds that there are distinct lay and professional cultures of illness.

This dichotomy of cultures has several implications. On the one hand, the content of lay culture and its congruence with professional beliefs determine whether patients consult health care providers and what type of services they obtain. On the other hand, because of their divergent cultures, physicians and clients often bring fundamentally different expectations and agendas to treatment encounter. Here Freidson draws on his own observations and on qualitative studies of clinical settings (including Davis, 1960, 1963; Glaser & Strauss, 1965; Goffman, 1961; Roth, 1963). Physicians want patients to cooperate with the treatment and typically adopt a stance of professional detachment. Clients may seek to have caregivers more involved with their problems, may want more information than physicians wish to provide, and may fail to comply with treatment. The result is conflict and negotiation between doctor and patient. Several structural factors affect the outcome of this bargaining including patient's social status and the organization of medical practice.

In his account of the doctor-patient encounter, Freidson integrates observations of interactionist researchers into a general analytic statement. He extends this analysis into a critique of Parsons's (1951) formulation of the sick role. Freidson concurs with several of Parsons's assertions: that it is

useful to view illness as a type of deviance; that physicians act as agents of social control; that doctor-patient interaction is shaped by societal norms. But where Parsons views role expectations as embedded in American culture as a whole, Freidson sees expectations as situationally shaped and varying across setting. And where Parsons sees the roles of physician and patient as complementary and harmonious, Freidson points out that doctor-client interaction is often conflict laden and discordant.

The literature of conflict and bargaining in the doctor-patient relationships has grown during the past two decades. Recent work addresses an expanding range of issues including how treatment personnel manage bothersome patients (Lorber, 1975; Mizrahi, 1986), how physicians control the medical interview (Fisher & Todd, 1983; Mishler, 1985; West, 1983), and gender dynamics in the consulting room (Fisher, 1986).

PROFESSIONAL SELF-REGULATION

Professional regulation of physician performance is a recurring theme throughout in Freidson's work on American medicine. He introduces the subject in articles coauthored with Buford Rhea during the mid-1960s (Freidson & Rhea, 1963, 1965), sharpens his arguments in *Profession of Medicine* (Freidson, 1970a), expands his empirical observations in *Doctoring Together* (Freidson, 1975), and reconsiders the subject in the 1980s when responding to claims about professional decline (Freidson, 1983, 1984, 1986a, 1986b). In framing this issue, Freidson invokes terms of medicine's social mandate. He argues that professional autonomy creates a tacit social contract. When society grants an occupation freedom from outside evaluation, that occupation assumes responsibility for ensuring that its members practice ethically and competently. Freidson then asks what is both an empirical and a policy question: Does medicine adequately regulate physicians' performance?

Freidson examines professional regulation in a variety of medical settings using data from secondary sources (e.g., Goss, 1961) and from his own studies of prepaid group practices (Freidson, 1975; Freidson & Rhea, 1963). He reports that social control is constrained by limitations in the visibility of colleagues' performance. Many errors go unobserved because of the organization of medical work. But even when physicians observe poor performance, they are reluctant to impose sanctions on colleagues. This reluctance has its roots in professional culture. The medical ethos—what Freidson terms *the clinical mentality*—promotes a sense of responsibility to one's own clients but not to the broader community of patients. It also emphasizes the uncertainty of medical work, fostering a sense of shared vulnerability to

reproach. When physicians do overcome their aversion to criticizing colleagues, the social controls they impose are almost exclusively informal in nature. The most frequently used regulatory mechanism in group-practice settings is the informal "talking to." In community settings the primary form of social control is the personal boycott whereby physicians stop referring patients to a poorly performing colleague. But although this protects clients' physicians involved in the boycott, it fails to protect the public at large.

Since the mid-1970s, several studies of social control within medicine have appeared. Millman (1977) reports that in community hospitals, review committees, whose charge is regulatory, actually function to normalize physicians' mistakes. Bosk (1979) studies an elite surgical training program and finds that, although technical errors are typically forgiven, house staff are generally punished for committing normative errors. Professional regulation continues to generate debate with researchers now addressing the impact of changes in the health care system on physicians' autonomy.

MEDICALIZATION

Freidson's analysis of medicalization is a significant legacy from the middle years of his career. In *Profession of Medicine* (Freidson, 1970a) he offers one of the earliest explanations for why and how American medicine has subsumed a widening array of social problems within its domain. This explanation builds on a diversity of scholarship including Parsons's (1951) account of illness as deviance and of America's culture of health (Parsons, 1958), labeling theory (Szasz, 1964), and Freidson's own notion of medical dominance (Freidson, 1970b).

Freidson points to a number of forces that enable medicalization to occur. Following Parsons (1958), he argues that the emphasis on achievement in American values predisposes us to see deviance as disturbance of capacity and a matter of ill health. Medical culture also contributes. The clinical mentality favors action over inaction and faith over skepticism. It fosters a bias toward illness and, coupled with medicine's social preeminence, encourages physicians to apply medical perspectives to a widening panoply of conditions.

The actual process of medicalization involves both physicians and laymen. Doctors function as "moral entrepreneurs"—a term borrowed from Becker (1963)—actively seeking out new varieties of disease and molding public policy and opinion. Lay social movements crusade to define new conditions as illness arguing that this will solve social problems or render treatment more humane. If medicalization is motivated by humanitarian aims, its consequence is to further professionalize social control.

A substantial literature on medicalization has emerged since the 1970s. This work includes numerous case studies, theoretical accounts of underlying processes, and discussions of the social consequences (for examples, see Conrad & Schneider, 1980; Halpern, 1990; Zola, 1972). Recent scholarship on medicalization is ably reviewed by Conrad (1992).

RELATIONS AMONG HEALTH PROFESSIONS

Another of Freidson's important contributions from the late 1960s and early 1970s is the first sociological analysis of interrelations between medicine and other health occupations. He develops this account in an essay, "Paramedical Personnel" (Freidson, 1968), and the two volumes, *Profession of Medicine* (Freidson, 1970a) and *Professional Dominance* (Freidson, 1970b). Freidson notes that the health care labor force is ordered into an occupational hierarchy with medicine controlling the division of labor. Ancillary professions are themselves stratified with an occupation's position related to the social status of its members—its gender and social class composition. This occupational hierarchy, Freidson continues, is vulnerable to challenge as subordinated occupations move to better their standing. Conflicts between medicine and lower-tier occupations are widespread. Nursing and other health occupations have attempted to constitute themselves as full-scale professions by establishing professional institutions and by fostering professional attitudes among their rank and file. But the terms of physicians' social license impede most such efforts. Medicine's authority to diagnose and prescribe places it in a position of interoccupational primacy. Its mandate allows physicians to direct and assess the work of others while not being subject to reciprocal evaluation.

As long as medicine retains its authority to supervise ancillary professions, these occupations cannot become full-scale professions, no matter how well trained their members or how skillful their leadership. Freidson concludes that professional standing is possible only if such an occupation comes to control an area of work separable from the main body of medicine and practiced without routine contact with physicians.

The past two decades have seen a good number of empirical studies of the health-occupations hierarchy. Scholars examine the social and institutional underpinnings of medicine's interprofessional dominance and the history of interprofessional disputes (e.g., Brown, 1973; Gritzer & Arluke, 1985; Kronus, 1976; Larkin, 1983). Andrew Abbott (1988) provides a fully articulated theory of interprofessional relations suggesting that conflicts over work jurisdictions are routine occurrences engendered by intellectual, technical, and organizational change. Halpern (1992) explores the impact of intrapro-

fessional processes on the outcome of such disputes. Freidson's work on the medical division of labor is an early and seminal contribution to a still growing arena of scholarship.

EVOLVING STATUS OF MEDICAL DOMINANCE

Shortly after publication of *Profession of Medicine* (Freidson, 1970a) and *Professional Dominance* (Freidson, 1970b), sociologists began debating the evolving status of medicine's power. Has the profession sustained its position of dominance, as Freidson suggests, or has it lost ground in post-1960s America under the pressure of cultural and structural change? Freidson's work has been only one of the intellectual currents stimulating the controversy. Critics are also reacting to theories of postindustrial society that depict professional and scientific expertise as increasingly preeminent (Bell, 1973).

Two theoretical camps initiate the challenge to the professional dominance perspective. Deprofessionalization theorists, most notably Marie Haug (1973), argue that medicine has lost power in the face of encroachment by competing professions, diffusion of professional expertise, and an increasingly knowledgeable and skeptical public. Trends in educational attainment narrow the knowledge gap between providers and clients, whereas popular attitudes generate new demands for professional accountability. Following a somewhat different tack, proletarianization theorists maintain that doctors have become wage earners subject to bureaucratic control (Oppenheimer, 1973). Later critiques of medical dominance stress alterations in the organization and financing of health delivery. McKinlay (1977) faults Freidson for not addressing either medicine's changing relation to the state or shifts in the ownership and control of health care organizations. He and others argue that government cost-cutting measures and making medical institutions into corporations have undermined the autonomy of physician decision making (McKinlay & Stoeckle, 1988; Starr, 1982).

Freidson responds to these arguments in a series of publications appearing in the early and mid-1980s (Freidson, 1983, 1984, 1986a, 1986b). His focus is the consequences of health system trends for the control and regulation of medical practice. Freidson is unimpressed with the claim that medicine's position has substantially eroded. He notes that regulation still takes place internal to the profession but acknowledges that its character has changed. Regulation has become increasingly rationalized and formalized. Furthermore, its implementation has become the purview of professional elites (including academic physicians and practitioner-administrators) and is out of the reach of rank and file doctors. The result is stratification within

medicine and heightened tensions among groups of practitioners with divergent levels of power.

The debate over professional dominance has generated a growing literature (e.g., Hafferty & Wolinsky, 1991; Light & Levine, 1989). Over time, proponents have refined their concepts and sharpened their arguments. But there has been surprisingly little empirical work on the subject. The arena is likely to remain a lively one as researchers bring to bear new data on the consequences of institutional change for physicians' prerogatives.

SHIFTING FATE IN A CHANGING DISCIPLINE

Freidson makes seminal contributions to six arenas in the study of medical institutions. His work has been important in stimulating several new research foci. In other areas, he makes significant additions to already accumulating literatures. Younger scholars are continuing work in the tradition of institutionally oriented medical sociology. But what about the vitality of the type of scholarship Freidson championed? Has the study of medical institutions come to assume a preeminent place within medical sociology as Freidson had hoped? Commentaries on the state of field suggest not.

A spate of articles critical of medical sociology appeared during the 1970s and 1980s (e.g., Cockerham, 1983; Gibson, 1972; Gold, 1977; Johnson, 1975; Pflanz, 1974; Wolinsky, 1980). This literature echoes Freidson's earlier complaints. It depicts medical sociology as atheoretical, divorced from the discipline, and dominated by applied research. These authors typically support their portrayals with categorizations of journal articles or conference papers. Gold finds evidence of "medical bias" in 60% of the articles in the *JHSB* between 1960 and 1976. Gibson (1972) reports that 61% of papers on medical topics presented at the 1972 American Sociological Association (ASA) meetings used no sociological theory. Wolinsky (1980) classifies 89% of the *JHSB* articles published between 1975 and 1977 as sociology *in* medicine rather than the sociology *of* medicine. Cockerham (1983) finds that only 10 of 171 articles in the *JHSB* between 1977 and 1981 attempt to construct or clarify theory. Not only is medical sociology largely without theory, the literature suggests, it had become more so over time. Several writers see a progressive shift toward applied research since the specialty's inception in the 1950s. Wilson (1970) argues that in the field's formative years, discipline-grounded research predominated but, by 1970, work was even balanced between sociology *of* and sociology *in* medicine. According to Wolinsky (1980), the trend continued so that, by the 1980s, research adopting medical perspectives predominated.

When addressing why medical sociology has become increasingly applied, commentators emphasize two factors. One is the employment of sociologists in medical settings where "sociological research is highly dependent upon medical requirements, sponsorship and approval" (Cockerham, 1983, p. 1514). Physicians find sociologically grounded research to be troublesome and strongly "prefer a medical sociology that is adjunct to medical activity and accepting of its basic premises" (Mechanic, 1990, p. 89). When "employed by the very institutions they study," sociologists' autonomy is easily compromised (Cockerham, 1983, p. 1514).

Observers point to the funding imperatives as a second factor pushing the field toward applied research. In the early period of the specialty's development, several foundations and governmental agencies—most notably the Russell Sage Foundation, the National Institute of Mental Health (NIMH), and somewhat later, the National Center for Health Services Research (NCHSR)—financed a broad range of research at the interface of sociology and medicine (Cockerham, 1983; Freeman, Borgatta, & Siegel, 1975; Hollingshead, 1973; Johnson, 1975). But the funding climate began to change in the 1970s and altered dramatically in the 1980s (Bloom & Zambrana, 1983; Mechanic, 1990). Russell Sage adopted new programmatic foci. The NCHSR narrowed its priorities to highly circumscribed policy issues with an emphasis on health economics. The NIMH cut its support for general social science and shifted its focus to biological models.[2] The trend is toward targeted, policy-relevant funding. These developments have made it more difficult to obtain support for basic, sociologically grounded research.

In summary, conventional wisdom holds that, notwithstanding continued scholarship of the type Freidson advocates, medical sociology has become progressively more applied as sociologists have dispersed to medical settings and come under the pressure of targeted funding priorities. Institutionally oriented medical sociology is alive but increasingly overshadowed by theoretical, policy-driven research.

This account may be intuitively satisfying to students of medical institutions, particularly those of us who have tried recently to secure funding for qualitative research. But I could find no solid data to support the contention that medical sociology has become more applied during the past several decades. None of the authors classifying articles actually provided evidence of change between two periods in the specialty's development. Nor was I tempted to categorize articles over time.[3] Journal articles alone are not representative of medical sociology. Many of the important contributions to the study of medical institutions have been books.[4] Assessing trends in the relative prevalence of pure and applied work from a combination of books and articles is an impractical task.

Meanwhile, two other considerations cast doubt on the contention that a trend toward applied work has occurred. First, available evidence fails to support the suggestion that medical sociologists have migrated from sociology departments into medical settings. My data come from two sources: a directory of the ASA Medical Sociology Section for 1989-1990 and a 1956 survey for the ASA Committee on Medical Sociology conducted by Robert Straus.[5] In 1990, 36% of section members worked in academic departments of sociology, 9% in other social science departments (e.g., business, public administration, urban affairs, social welfare), 44% in health-related settings (including hospitals and public agencies and in schools of nursing, public health, medicine, pharmacy, and allied health). Among self-reported medical sociologists in 1956, 31% "had their primary base within an academic department of sociology or an allied field," whereas 51% were situated in hospitals, public agencies, or academic departments of medicine, nursing, or public health (Straus, 1957). (The remaining respondents in both groups worked in voluntary organizations, professional associations, foundations, or corporations.) Comparison of the two data sets reveals a tenfold increase in the number of medical sociologists. But these researchers are no more likely to be working in medical settings in 1990 than they were in the mid-1950s. Indeed, if there is a trend at all, it is for an increasing portion to be located within departments of sociology.

Second, further scrutiny of the state-of-the-field literature suggests it was a mistake to take complaints about a rise in applied work simply at face value. The authors of these articles seek to improve medical sociology's standing within the discipline whole by promoting sociologically grounded research. Depicting growth in atheoretical work is, at least in part, a rhetorical device for advancing arguments about what type of scholarship ought to be fostered and highly valued. Underlying this advocacy is anxiety about the continued status of institutionally oriented medical sociology. The 1950s and 1960s saw the production of an especially rich body of path-breaking scholarship on medical institutions. This work touched central concerns within the broader discipline. But in the 1970s, observers voiced fears that the study of medical institutions was losing momentum. Several remarked that some of the early seminal contributors had left the medical sociology and that "no new theories [had] emerged to rival earlier contribution of Parsons, Becker, Freidson, Goffman, Scheff, Suchman, Glaser and Strauss" (Cockerham, 1983, p. 1518; also see Johnson, 1975). Advocates of discipline-based research were worried that the salience of institutionally oriented medical sociology was decreasing.

Thus the question to be asked is not why applied research supplanted discipline-based research but, rather, why the perceived impact of institu-

tional research declined. It may be that scholarship on medical institutions published since the early 1970s is simply not as good as earlier work. Literature on the sociology of science suggests that work produced in the middle and later stages of a field's development may be less innovative than initial research. The role of later scholars is often confined to elaborating and extending earlier seminal contributions (Mulkay, Gilbert, & Woolgar, 1975). But if this is the case, I suggest that other dynamics are operating as well, dynamics involving changes within sociology as a whole.

The significance of medical sociology in the 1950s and 1960s rested on a historically specific disciplinary constellation. During this period, medical sociology was a primary locale for debates between the discipline's dominant theoretical perspective, functionalism, and an energetic challenger, interactionism. Scholars from both groups oriented their studies of medicine toward issues in deviance and the sociology of the professions, among the discipline's leading substantive arenas. Given sociology's theoretical and substantive foci, work in medical institutions was at the core of the discipline. But changes within sociology during the past two decades have undermined the centrality of medical sociology to the broader discipline. Sociology has grown in size, theoretical diversity, and substantive specialization to the point of fragmentation (Becker, 1986; Becker & Rau, 1992; Collins, 1986; Turner & Turner, 1990). Deviance and professions have ceased to be pivotal substantive fields. And there are no longer core theoretical debates in sociology for which scholarship on medical institutions might have relevance. In short, the impact of institutionally oriented sociology has declined because the disciplinary constellation once giving this work broader significance has disappeared.

The notion that institutional studies have lost ground to sociology *in* medicine may have its origins in two contrasting characteristics of these research segments. First, although recent scholars of medical institutions have dispersed their efforts across numerous substantive arenas, sociologists in fields like social epidemiology have tended to concentrate on focal problem areas. According to Johnson and Wolinsky (1990), 40% of the articles in the *JHSB* from the mid-1970s through the mid-1980s were in the single area of stress research. Funding priorities are undoubtedly one factor promoting this concentration of studies. During the same period, contemporary institutionally oriented medical sociology has no comparable single focus. Although work on medical institutions has always been diverse, decentralization of graduate training in sociology has furthered the dispersion of substantive and theoretical concerns. In the 1950s and 1960s, many of the key figures in the study of medical institutions trained at a small number of graduate departments (most notably, Harvard and Chicago), held common

theoretical commitments, and maintained fairly cohesive colleague networks. Scholars entering the field during the past two decades trained at a diversity of departments; they lack the cohesive networks and shared theoretical grounding typical among Freidson's generation. Second, sociologists studying medical institutions and those in fields like epidemiology have fundamentally different research styles. Many institutionally oriented medical sociologists conduct qualitative studies, function as solo researchers, and publish books rather than articles. The pace of scholarship is relatively slow and cross-citation somewhat sporadic. Researchers doing sociology *in* medicine tend to employ quantitative methods, work in groups, publish articles at a fairly rapid pace, and generate large numbers of cross-citations. As a result of these contrasting structural and stylistic features, the study of medical institutions may be less readily visible than sociology *in* medicine. The latter work undoubtedly generates larger citation counts—a conventional measure of disciplinary impact and stature—than institutional research. But the fundamental problem for institutionally oriented medical sociology is not its size or status relative to applied research but rather its own position within the broader discipline.

Disciplinary segments go through ebbs and flows. Both internal processes and dynamics in surrounding disciplines affect their rise and fall. Given the continued fragmentation of sociology as a whole, it cannot be expected that the study of medical institutions will regain the centrality it once held. But there are some auspicious developments. Abbott's (1988) volume may revitalize the sociology of professions. Meanwhile, the study of medical institutions has taken some promising new directions. There is growing interest in the historical development of medical institutions (Brown, 1985; Halpern, 1988; Starr, 1982), science and technology (Bell, 1986; Fox & Swazey, 1992; Katz Rothman, 1986), and ethics and decision making (Anspach, 1993; Zussman, 1992). Whether in the limelight or the shadows, the tradition of institutionally oriented medical sociology continues.

NOTES

1. Freidson was the first editor of *JHSB* after it became an American Sociological Association (ASA) organ in 1967. The journal originated in 1960 as the independent publication, *Journal of Health and Human Behavior* (Hafferty, 1990).

2. Other National Institutes of Health Agencies now support work in the social and behavioral sciences including the National Institute of Aging (funding research on the life cycle and well-being) and the National Institute for Child Health and Human Development (providing grants for population studies). Funds have been available for general research in these behavioral science areas.

3. Possible classifying schemes are highly subjective and I anticipated finding numerous articles that defy categorization. Schemes used in the past may have declining relevance; Cockerham (1983) suggests that the distinction between sociology *in* medicine and sociology *of* medicine is no longer useful because researchers are now examining applied health issues in sociological terms.

4. Wardwell (1982) notes that medical sociology texts—which draw on both articles and books—place greater emphasis on institutional analysis than on applied research.

5. I am indebted to Janet Hankin for providing me with a diskette copy of this otherwise undistributed 1989-1990 section directory. The percentages reported here for those years exclude full-time students, professionals employed outside the United States and Canada, and individuals who fail to respond to the section-directory mailing. Of the 1,446 individuals on the 1989-1990 section mailing list, 360 provided no employment information. The 1956 data were collected for a directory of the Committee on Medical Sociology. Straus was secretary-treasurer of the committee, which was formed in 1955. This group was a precursor of the Medical Sociology Section of the ASA, established in 1959 (Bloom, 1990). Straus (1957) located and surveyed 162 individuals working in medical sociology; 110 responded to his inquiries.

REFERENCES

Abbott, A. (1988). *The system of professions*. Chicago: University of Chicago Press.

Anspach, R. (1993). *Deciding who lives*. Berkeley: University of California Press.

Becker, H. S. (1963). *Outsiders*. New York: Free Press.

Becker, H. S. (1986). What's happening to sociology. In H. S. Becker (Ed.), *Doing things together* (pp. 209-220). Evanston, IL: Northwestern University Press.

Becker, H. S., & Rau, W. C. (1992). Sociology in the 1990s. *Society*, *30*(1), 70-74.

Bell, D. (1973). *The coming of post industrial society*. New York: Basic Books.

Bell, S. E. (1986). A new model of technology development: The case of DES. In J. A. Roth & S. B. Ruzek (Eds.), *Research in the sociology of health care* (Vol. 4, pp. 1-32). Greenwich, CT: JAI.

Bloom, S. W. (1990). Episodes in the institutionalization of medical sociology: A personal view. *Journal of Health and Social Behavior*, *31*, 1-10.

Bloom, S. W., & Zambrana, R. E. (1983). Trends and developments in the sociology of medicine. In J. Ruffini (Ed.), *Advances in medical social science* (Vol. 1, pp. 73-122). New York: Gordon & Breach.

Bosk, C. (1979). *Forgive and remember*. Chicago: University of Chicago Press.

Brown, C. (1973). The division of laborers: Health professionals. *International Journal of Health Services*, *3*, 435-444.

Brown, P. (1985). *The transfer of care*. New York: Routledge & Kegan Paul.

Cockerham, W. C. (1983). The state of medical sociology in the United States, Great Britain, West Germany, and Austria: Applied vs. pure theory. *Social Science and Medicine*, *20*, 1513-1527.

Collins, R. (1986). Is sociology in the doldrums? *American Sociological Review*, *91*, 1336-1355.

Conrad, P. (1992). Medicalization and social control. *Annual Review of Sociology*, *18*, 209-232.

Conrad, P., & Schneider, J. W. (1980). *Deviance and medicalization*. St. Louis, MO: C. V. Mosby.

Davis, F. D. (1960). Uncertainty in medical prognosis, clinical and functional. *American Journal of Sociology*, *66*, 41-47.

Davis, F. D. (1963). *Passage through crisis*. Indianapolis, IN: Bobbs-Merrill.

Fisher, S. (1986). *In the patient's best interest*. New Brunswick, NJ: Rutgers University Press.

Fisher, S., & Todd, A. D. (Eds.). (1983). *The social organization of doctor-patient communication*. Washington, DC: Center for Applied Linguistics.

Fox, R., & Swazey, J. (1992). *Spare parts*. New York: Oxford University Press.

Freeman, H., Borgatta, E. F., & Siegel, N. H. (1975). Remarks on the changing relationship between government support and graduate training. In N. J. Demerath, O. Larsen, & K. F. Schuessler (Eds.), *Social policy and sociology* (pp. 297-305). New York: Academic Books.

Freidson, E. (1960). Client control of medical practice. *American Journal of Sociology, 65*(4), 374-382.

Freidson, E. (1961). *Patients' views of medical practice*. New York: Russell Sage.

Freidson, E. (1968). Paramedical personnel. In D. Sills (Ed.), *International encyclopedia of the social sciences* (Vol. 10, pp. 114-120). New York: Macmillan.

Freidson, E. (1970a). *Profession of medicine*. New York: Harper & Row.

Freidson, E. (1970b). *Professional dominance*. Chicago: Aldine.

Freidson, E. (1975). *Doctoring together*. New York: Elsevier.

Freidson, E. (1983). The reorganization of the professions by regulation. *Law and Human Behavior, 7*(2/3), 279-290.

Freidson, E. (1984). The changing nature of professional control. *Annual Review of Sociology, 10*, 1-20.

Freidson, E. (1986a). *Professional powers*. Chicago: University of Chicago Press.

Freidson, E. (1986b). The medical profession in transition. In L. H. Aiken & D. Mechanic (Eds.), *Applications of social science to clinical medicine and health policy* (pp. 163-179). New Brunswick, NJ: Rutgers University Press.

Freidson, E., & Rhea, B. (1963). Processes of control in a company of equals. *Social Problems, 2*(2), 119-131.

Freidson, E., & Rhea, B. (1965). Knowledge and judgment in professional evaluations. *Administrative Science Quarterly, 10*(1), 107-124.

Gibson, G. (1972). Theory vs. applications at ASA: A view of the issues. *Health Services Research, 7*(3), 243-253.

Glaser, B. G., & Strauss, A. L. (1965). *Awareness of dying*. Chicago: Aldine.

Goffman, E. (1961). *Asylums*. New York: Anchor.

Gold, M. (1977). A crisis of identity: The case of medical sociology. *Journal of Health and Social Behavior, 18*, 160-168.

Goss, M.E.W. (1961). Influence and authority among physicians in an outpatient clinic. *American Sociological Review, 26*, 39-50.

Gritzer, G., & Arluke, A. (1985). *The making of rehabilitation*. Berkeley: University of California Press.

Hafferty, F. W. (1990). Comment: Looking for the right stuff. *Journal of Health and Social Behavior, 31*, 231-239.

Hafferty, F. W., & Wolinsky, F. D. (1991). Conflicting characterizations of professional dominance. In J. A. Levy (Ed.), *Current research on occupations and professions* (Vol. 6, pp. 225-249). Greenwich, CT: JAI.

Hall, O. (1946). Informal organization of medical practice. *Canadian Journal of Economics and Political Science, 12*, 30-41.

Halpern, S. (1988). *American pediatrics*. Berkeley: University of California Press.

Halpern, S. (1990). Medicalization as professional process: Postwar trends in pediatrics. *Journal of Health and Social Behavior, 31*, 28-42.

Halpern, S. (1992). Dynamics of professional control: Internal coalitions and cross-professional boundaries. *American Journal of Sociology, 97*(4), 994-1021.

Haug, M. (1973). Deprofessionalism: An alternative hypothesis for the future. *Sociological Review Monograph, 20*, 195-211.

Hollingshead, A. B. (1973). Medical sociology: A brief review. *Milbank Memorial Fund Quarterly, 51*, 531-542.

Hughes, E. C. (1984). *The sociological eye: Selected papers*. New Brunswick, NJ: Rutgers University Press.

Johnson, M. (1975). Medical sociology and sociological theory. *Social Science and Medicine, 9*, 227-232.

Johnson, R. J., & Wolinsky, F. D. (1990). The legacy of stress research: The course and the impact of this journal. *Journal of Health and Social Behavior, 31*, 217-225.

Katz Rothman, B. (1986). *The tentative pregnancy*. New York: Viking.

Kronus, C. (1976). The evolution of occupational power. *Sociology of Work and Occupations, 3*(1), 3-37.

Larkin, G. (1983). *Occupational monopoly and modern medicine*. London: Tavistock.

Light, D., & Levine, S. (1989). The changing character of the medical profession: A theoretical overview. *Milbank Quarterly, 66*(1), 1-23.

Lorber, J. (1975). Good patients and problem patients: Conformity and deviance in a general hospital. *Journal of Health and Social Behavior, 16*, 213-225.

McKinlay, J. B. (1977). The business of good doctoring or doctoring as good business: Reflections on Freidson's view of the medical game. *International Journal of Health Services, 7*, 459-487.

McKinlay, J. B., & Stoeckle, J. D. (1988). Corporatization and the social transformation of doctoring. *International Journal of Health Services, 18*(2), 191-205.

Mechanic, D. (1962). The concept of illness behavior. *Journal of Chronic Disease, 15*, 189-194.

Mechanic, D. (1990). The role of sociology in health affairs. *Health Affairs, 9*, 85-97.

Millman, M. (1977). *The unkindest cut*. New York: William Morrow.

Mishler, E. (1985). *The discourse of medicine*. New York: Ablex.

Mizrahi, T. (1986). *Getting rid of patients*. New Brunswick, NJ: Rutgers University Press.

Mulkay, M. J., Gilbert, G. N., & Woolgar, S. (1975). Problems areas and research networks in science. *Sociology, 9*, 187-203.

Oppenheimer, M. (1973). The proletarianization of the professional. *Sociological Review Monograph, 20*, 213-227.

Parsons, T. (1951). *The social system*. New York: Free Press.

Parsons, T. (1958). Definitions of health and illness in the light of American values and social structure. In E. Gartly Jaco (Ed.), *Patients, physicians and illness* (pp. 165-187). Glencoe, IL: Free Press.

Pescosolido, B. A. (1992). Beyond rational choice: The social dynamics of how people seek help. *American Journal of Sociology, 94*(4), 1096-1138.

Pflanz, M. (1974). A critique of Ango-American medical sociology. *International Journal of Health Services, 4*(3), 565-574.

Roth, J. (1963). *Timetables*. Indianapolis, IN: Bobbs-Merrill.

Starr, P. (1982). *The social transformation of American medicine*. New York: Basic Books.

Straus, R. (1957). The nature and status of medical sociology. *American Sociological Review, 22*(2), 200-204.

Suchman, E. (1965). Social patterns of illness and medical care. *Journal of Health and Social Behavior, 6*, 2-16.

Szasz, T. S. (1964). *The myth of mental illness*. New York: Harper & Row.

Turner, S., & Turner, J. (1990). *The impossible science: An institutional analysis of American sociology*. Newbury Park, CA: Sage.

Wardwell, W. I. (1982). The state of medical sociology—A review essay. *Sociological Quarterly, 28*, 563-571.

West, C. (1983). *Routine complications*. Bloomington: Indiana University Press.

Wilson, R. N. (1970). *Sociology of health*. New York: Random House.

Wolinsky, F. D. (1980). The nature of the field. In *The sociology of health* (pp. 38-53). Boston: Little, Brown.

Zborowski, M. (1952). Cultural components in response to pain. *Journal of Social Issues, 8*, 16-30.

Zola, I. K. (1966). Culture and symptoms—An analysis of patients' presenting complaints. *American Sociological Review, 31*, 615-630.

Zola, I. K. (1972). Medicalization as an institution of social control. *Sociological Review, 20*, 587-604.

Zussman, R. (1992). *Intensive care*. Chicago: University of Chicago Press.