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The Medical Sociologists' Contribution to the Interdisciplinary Geriatric Assessment Unit: A Sociology "With" Medicine*

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ABSTRACT

Observations are drawn from field experience to explicate the role of the medical sociologist within geriatric clinical practice—a case presentation of a sociology "with" medicine. *A sociology "with" medicine is presented as promoting the institutionalization of medical sociology as a special field within, yet independent of, medicine. The aim is to promote initiatives which generate and test social theory while expanding collaboration with medical clinicians, researchers, and educators to maximize the application of social scientific data to patient care. The goals of specialized geriatric practice are then described. Next, the substantive functions and activities of the medical sociologist in a geriatric team practice are identified. Finally, the potential problems faced by medical sociologists in gaining legitimacy in clinical practice are discussed.*

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Although medical sociology has produced a convincing body of basic and applied data relevant to understanding health services and illness, medical sociologists often feel disregarded because there is no one-to-one relationship between the discovery of new knowledge and its clinical application (Mechanic and Aiken, 1986:2). The theoretical and methodological contributions of medical sociology to patient care are not well understood by many medical administrators, researchers, educators, and practitioners (Niklas, 1982). Much of our social knowledge is thought to be too abstract and dubious to be helpful to medical practice in a meaningful way (Light, 1992). Sociological insights and data periodically inform medical practitioners' views of a problem, but more often, applicable findings are periphery to medical practice.

Currently, a growing body of health care providers are noticing the extent to which their success with patients is affected by *social psychological* factors ordinarily seen as outside of their area of professional expertise (Mechanic and Aiken, 1986). Many physicians, for example, now recognize that their medical decision making does not just flow from a routine, scientific calculus, but rather is done by considering patients' social roles, values, and particular social settings and resources (Levine, 1987). Few, if any patient care decisions are purely medical (Zola, 1991).

Geriatric assessment team practices have proven to be amenable to the consideration of social science data for addressing medical practice concerns. Many geriatric clinics have developed on the basis of an interdisciplinary exchange of ideas. Geriatric team members have a growing awareness of the relevance of the social contexts of their patients' interpersonal behavior, social networks, and economic circumstances (Levine and Freeman, 1989; Waitzkin, 1991). These interdisciplinary settings are ideal for demonstrating and implementing the contributions of the medical sociologist to patient care decision making.

The purpose of this article is, first, to explicate the role of the medical sociologist within geriatric clinical practice—a case presentation of a *sociology "with" medicine* (Levine, 1987). Then, the goals of specialized geriatric practice are described. Next, the substantive functions and activities of the medical sociologist in a geriatric team practice are identified. Finally, the potential problems faced by medical sociologists in gaining legitimacy in clinical practice are discussed.

Observations are drawn from field experiences. Although the functions of the medical sociologist described below should be applicable to many medical contexts, examples from practice in an interdisciplinary geriatric assessment outpatient clinic best illustrate the goodness of fit between patient care and the practice of sociology within medicine.

Toward a Sociology "With" Medicine

As the aging population continues to grow, health care administrators are recognizing the need for expert practitioners in the field of aging. The increase in the proportion of frail elderly raises a number of important sociomedical questions regarding the motivations, satisfaction, and coping abilities of older people, their social networks, their caregivers, and the appropriate responses to their needs (Freeman and Levine, 1989). Through a focus on the multidimensionality of health, illness, and humane patient care practice, the medical sociologist can contribute to the medical care needs of the elderly while generating critical data for testing basic sociological theory. This multidimensional practice focus is not well established. However, the appropriate contribution of the medical sociological practitioner is still unfolding.

During the early development of medical sociology in the United States, it was common to differentiate between sociology "in" medicine and the sociology "of" medicine (Straus, 1957). The question of the appropriate relationship between sociology and medicine persists today. The relationship began with sociology providing information solicited from the medical profession. Sociology "in" medicine is the title given to research structured to serve medical interests. From this perspective, emphasis is on chronic diseases and their impact on mortality; mental illness; benefits derived from technological advances and therapy; and, more recently, on disease prevention (Susser, Watson, and Hooper, 1985). This type of work usually stresses research design and data collection while addressing issues of practical concern identified by the *client*. Within the discipline of sociology, sociologists engaged "in medicine" often raise the suspicion of colleagues who feel that such purely applied activity lacks theoretical substance and development (Freeman and Levine, 1989).

Critics of sociology "in" medicine prefer to view medicine as a source of data for generating and answering sociological, rather than medical, questions. They see the sociology "of" medicine as concerned with using medicine as an arena to study important social processes, such as stratification, organization, control, professional socialization, and policy. In other words, the sociologist *chooses* to make the medical arena the dependent variable so as to contribute to the formulation and reformulation of theory. Although there is often no particular concern, in this type of research, about developing insights applicable to medical practitioners, this is considered an appropriate sociological pursuit. The one major distinction between the sociology "in" and "of" medicine is whether the sociologist

works with a medical definition of problems or with sociological definitions (Larson, 1990; Wardwell, 1982).

Within the last ten years, it has become increasingly popular to view the practice of medicine more holistically. Many sociologists are advocating a broad sociology "of health" rather than a narrow sociology "of medicine" (Conrad, 1990; Twaddle, 1982). The sociology of health is studied as a multidimensional concept, including physical, social psychological, emotional, and even spiritual aspects of subjective experience. The focus of research extends to all social structures that affect subjective experience, including family, industry, education, and the environment (Wallace, 1990). In terms of an "of health" perspective, the term "medical sociology" connotes a more bounded field, implying a focus on institutionalized structure, including occupations, special functions, certain organizations, power relationships, and structured interactions. Advocates of an "of health" perspective argue that they are not restricted to models viewing health and health care as a function of the medical care system and practitioners.

These seemingly disparate parts of the sociology-medicine-health relationship are actually more unified than sometimes portrayed. This is, in part, because medical sociologists have become more applied. We have learned that "the interplay between theory and practice improves both" (Mechanic and Aiken, 1986:3). Clinical studies of practical problems sharpen theoretical thinking and bring it closer to reality; good theory suggests dimensions of applied problems that enrich investigative comprehension (Clark, et al., 1989; Larson, 1990). The different dimensions of medical sociology have advanced one other. We are no longer just concerned with what medicine does "to" its patients but rather with what it does "with" them (Zola, 1991:11). Practicing medical sociology equates what sociologists do "with" medicine and equates medicine "with" health care (Zola, 1991:12).

A sociology "with" medicine encompasses the various factional components of medical sociology described above. A sociology "with" medicine promotes two separate but related ideas (Bloom, 1990:7): (1) the institutionalization of medical sociology as a special field independent of medicine is both advantageous and necessary for maintaining the integrity of the sociologists' initiative; and (2) the continuation and expansion of collaboration with medical educators, clinicians, and researchers is vital for the effective application of social scientific data to medicine in action, or patient care.

This approach illustrates the importance of the independent pursuit of research utilizing the medical system and practitioners to generate and test sociological theory. Furthermore, the sociologist practicing "with-in" a medical context also serves a variety of broad medical interests and works

toward developing specific insights applicable to medical practice. Incorporating processes that bring patient subjective experience into our research agendas insures that sociological practitioners continually gather pertinent data that maintain the independent interests of social and medical scientists. The medical sociologist working "with-in" medicine combines the pure/basic and applied aspects of sociology—at once attending to both concerns with knowledge production and hypothesis testing, and problem solving using available generated information (Larson, 1990). In this sense, the interests of sociology and medicine become inextricably intertwined.

To a certain extent, the movement toward a sociology "with" medicine is enhanced by a broad shift in interest, validating the study of linkages between social and medical contexts. A shift to an integrated social-medical-health emphasis is evidenced by macro level changes already taking place, from a preoccupation with improved health care access and utilization to a recognition that the costs of medical care must be faced. Health care cost inflation is perpetuated by the demographic trend of an aging population seeking and receiving medical care (Fox, 1985). Because of concerns about costs, medical practitioners, researchers, educators, and administrators must develop a broader view of health care and quality of life. Quality of life is an increasingly popular goal of medical care involving older patients (Pearlman and Uhlman, 1991). Freeman and Levine (1989:4) suggest that the "distance that medicine and medical sociology have traveled is evident now in the emergence of quality of life as an overriding social dimension of judging health and illness...."

Geriatric Patient Care

Social, behavioral, and medical practitioners now realize that living beyond the years of functional independence results in compromised health and social well-being (Brody, 1989), or "dysquality" (Weiss, 1985). Current multidisciplinary dialogue pays increasing attention to preserving the quality of care and life (Fink et al., 1987) and achieving an ideal mix of medical care and social support (Clair, 1990a). The goal of integrated social and medical efforts should be to improve quality of life and long-term care decisions rather than simply to achieve reductions in utilization of acute and chronic services.

Interdisciplinary geriatric assessment units have been established on the premise that they are more attentive to the co-morbid nature of old age and issues concerning the quality of life and long-term care. Such clinics repre-

sent a complex array of patients with interacting physical and psychosocial functional disabilities (Clair, 1990a; Silliman, 1989). As a result, health care and service providers in many geriatric settings are becoming sympathetic to multidisciplinary perspectives. The complex nature of these clinics allows medical sociologists to oversee the implementation of social science research while enhancing patient care quality and promoting cost effectiveness.

Because of cost inflation pressures, the Health Care Financing Administration and the Physician Payment Assessment Commission appear committed to developing a payment system encouraging the growth of outpatient clinics. This commitment, along with the overall sensitivity of specialized geriatric care to functional ability, quality of life, and long-term care support, seems to ensure the continued development of such clinics.

The bulk of the current literature supports the growth of these interdisciplinary clinics by demonstrating their overall effectiveness in elderly patient care (Epstein, et al., 1990; McVey, et al., 1989; Pinholt, et al., 1987; Rubenstein, et al., 1984; Williams, 1987; Williams and Williams, 1986; Williams, et al., 1987). Research on geriatric clinics documents their superior effectiveness in: (a) diagnosing physical functioning, (b) managing medication use, (c) making better placement decisions as compared to general care facilities, and (d) lowering short-term death rates.

It is clearly not enough, however, for an interdisciplinary geriatrics assessment team to simply diagnose physical and mental disease and functional disabilities (Rubenstein, 1987). On a practical level, once a patient becomes ill and requires care, the largest challenge is not simply making the diagnosis and prescribing appropriate treatment (Mechanic and Aiken, 1986:7-9). As important as diagnosis and treatment might be a greater challenge lies ahead. Patients and family must be, motivated to accept and implement treatment strategies and life-style regimens that not only help limit incapacity and promote continued functionability, but also generate social psychological well-being. Furthermore, geriatric outpatient clinic providers must be prepared to assist family caregivers in developing the support needed to care for their often-disabled loved ones. The framework used to assess patient illness and treatment is undergoing fundamental change not only because of the escalation of medical care costs, but also because of the blurred boundaries between medicine and other sectors of social life. Major societal changes in values, life styles, household structures, and health beliefs are pressuring medical institutions to consider patient care and treatment in a holistic context.

Physician/sociologist Howard Waitzkin (1991) alerts us to the prevalence of these "social" problems within geriatric clinical settings and

encounters. When patients approach a physician for help, they represent a *social* context along with their physical problems. Waitzkin (1991) demonstrates that some of the most interesting features of geriatric assessment involve concerns about matters that appear peripheral to the goals of clinical medicine. When elderly patients' personal troubles arise in the intimacy of the patient-doctor relationship (e.g., isolation, financial difficulty, death of family members, adjustments to retirement), physicians often deal with these social issues by focusing on physical complaints while conspicuously failing to address a patient's underlying *social psychological* problems.

The documentation of social issues should, whenever possible, explain something about the patient's well-being and support networks, just as the clinical diagnosis explains something about the patient's physical symptoms. The social psychological aspects of patient care are of intrinsic concern to the medical sociologist. Drawing on this assumption and clinical experience, fundamental activities are identified through which the medical sociologist practitioner can contribute to both medical and sociological research agendas to improve patient care.

The Medical Sociologists' Contribution to Geriatric Assessment

This section will describe the multiple roles a medical sociologist can serve in a geriatric clinic setting. The practice of "sociology with medicine" presented here requires foremost that the sociologist be a researcher. Simultaneously, however, the sociologist must also play the roles of consultant and teacher. Examples of activities of substantive focus that many medical sociologists are capable of undertaking are then described. Issues of (a) clinical efficacy/patient satisfaction; (b) communication patterns; (c) compliance/adherence; and (d) roles and norms are of basic sociological research interest and, in addition, have practical implications for medical practitioners, educators, and researchers—thus meeting the basic objectives of a "sociology with medicine."

Functions

The basic objectives of geriatric assessment units are to promote healthy aging and to prevent or minimize morbidity and disability. Most of these outpatient clinics are staffed with interdisciplinary providers, including all or some of the following: board-certified general internists with specialization in geriatrics, geriatrics fellows, residents and acting interns, a clinical

nurse specialist in geriatrics, a registered nurse, a social worker, a pharmacist, an optometrist, an audiologist, a dietitian, and a clinical psychologist.

This team approach to geriatric patient care usually does not include the services of a medical sociologist, although the functions that a medical sociologist can serve in, working "with-in" geriatric assessment, are diverse. Most medical sociologists joining geriatric teams can simultaneously serve the three roles of researcher, consultant, and teacher (Lee, 1979; also see Straus, 1979, and Wirth, 1931, for similar typologies).

As a researcher, the medical sociologist brings quantitative and qualitative skills to the data available through participation in the clinic (Mechanic, 1989). Many medical sociologists have developed triangulated research skills to conduct field observations, interviews, and quantitative assessment of medical records.

There are a number of ways in which the medical sociologist can develop a research agenda that contributes to social, medical, and clinical knowledge. For instance, besides collecting basic socio-demographic data on the patient and primary caregivers, the medical sociologist can adopt a strategy that includes collection of data on variables such as depression; locus of control; social activity and support; strain; life events; complete IADL and ADL information; baseline morbidity data on hospital admissions, stays, and number of days confined to bed because of illness; and physical, social, and indicators of psychological well-being. Although much of this information seems of obvious importance, most of this data is not generally gathered, even in specialized geriatric assessment units. To further assess the larger social context of illness, the medical sociologist can conduct a post-encounter assessment of the physician-patient-caregiver interaction by interviewing the patient and caregiver while asking the doctor to answer the same Likert scale items through a questionnaire. Patients can then be followed to obtain information on adherence and health outcomes, at one- and six-month intervals, for example. Ideally, the data collected is of use to the clinic, but is also of the medical sociologist's choosing.

The sociologist's consultant role involves assisting other health care and service providers in parts of their work for which the sociologist has special knowledge. Consultive contributions are periodically requested as the medical sociologist participates in the study of cases and their treatment along with medical practitioners. This means that the medical sociologist is involved in rounds and discussion of actual cases with the interdisciplinary team.

The teaching component of the medical sociologist's role is equivalent to systematic instruction. The medical sociologist provides practical and

theoretical instruction. For instance, just as a clinical psychologist can train health care providers to recognize and intervene with senile dementia, the medical sociologist can train these providers to interact better with elderly patients and one another. In general, instruction focuses on sensitizing physicians and other health professionals to how the values of biomedicine affect the patient's life-world.

Balancing these three roles is a dynamic process that leads to the generation of hypotheses and theory building. The research-oriented medical sociologist obtains detailed information from the patient and family members, data that even similar practitioners, such as the social worker and psychologist, do not collect as part of their initial interview. The medical sociologist, by operating from a research perspective, ends up collecting data that contributes to the diagnostic work-up, benefiting health care providers, patients, and their family members.

Activities of Substantive Focus

For the medical sociologist, there are several fundamental areas of investigation that directly impact geriatric patient care while also being of basic sociological research interest. We can even go so far as to say that almost any theory, process, or phenomenon explicated in the social psychological literature has application to patient care activities. Fundamental social structural and processual concepts relevant to the medical care context include roles, norms, and communication patterns. The health care provider who understands these elemental social issues is better equipped to practice medicine.

(a) *Clinical Efficacy/Satisfaction.* One specific objective of the medical sociologist can be to study the clinical efficacy of a geriatrics outpatient clinic and determine whether it provides important positive impacts on patient functioning and well-being. Determining which physical and psychosocial factors hold the most promise for effective intervention and identifying those conditions that seem most problematic for outpatient interventions is important to any study of clinical efficacy. With proper training in discourse analysis, previous efficacy research can be extended by incorporating data on patient satisfaction with geriatric assessment, general health care, and provider communication style. Communication is a fundamental social psychological process. Any efficacy study should ideally include a satisfaction with communication component. Given the debilitating condition of geriatric patients, the family caregivers' experience and satisfaction with

physicians become important components to sociological research. Communication analysis is a form of methodological training not possessed by other team members, since they primarily perform diagnostic functions. Thus, the medical sociologist is ideally situated to contribute this expertise to the assessment team.

Because interdisciplinary geriatric assessment units generally include psychosocial components designed to grapple with patient social problems (Epstein, Hall, Fretwell et al., 1990; Rubenstein, Josephson, and Wieland et al., 1984), we should expect that the processing of social contextual concerns here will be different than in nonelderly specialized clinics. This concern is particularly important since many researchers have shown that psychosocial disorders are more prevalent among the elderly than among other age groups (Greene et al., 1987; Maletta, 1983).

Effective communication is important for fully managing a patient's illness and efficiently promoting health. Effectiveness of communication and attentiveness of practitioners to patient concerns appear to be the strongest predictors of how patients will evaluate care received (Cleary and McNeil, 1988). When psychosocial issues are dealt with during the medical encounter, patients are more satisfied with the visit and, ultimately, their health status will improve (Greene et al., 1987). The assumption here is that effective doctor-patient communication is at the foundation of any set of clinical efficacy standards.

(b) *Direct Assessment of Communication Patterns.* Buttressed by a consumer movement, a so-called "geriatrics revolution" currently confronts the practice of medicine. Elderly patients and their families are demanding more responsive care. Although many of the communication and social problems exemplified in medical encounters do not occur uniquely among the elderly, such problems will become more commonplace as demographic patterns continue to shift. The policy challenges raised by an aging society are beginning to attract some response. To what extent a critical vision will extend to the discourse of geriatric medicine remains unclear (Waitzkin, 1991).

The medical sociologist can provide evidence demonstrating the fundamental communication problems among patients and physicians and, increasingly, between physicians and caregivers, who play a vital role in geriatric medicine (Glasser, et al., 1990). The existing literature on geriatric medical encounters reflects more theoretical than empirical findings.

What doctor-patient care relationship studies indicate for patients in general is that positive outcomes are associated with a highly infor-

mative communication style and opportunities for patient and caregiver participation in decision making. Additionally, patients want doctors to respond favorably to their questioning and show sensitivity to their social-psychological well-being. Whether this expansive mode of communication—one requiring attention to the psychosocial as well as the physical aspects of illness—can be achieved for elderly patients remains an empirical question (Cook, Coe, and Hanson, 1990). Preliminary results suggest that physicians are less responsive to elderly patient concerns than is desirable (Greene et al., 1987). Despite the fact that the elderly generally have a greater number of problems than younger patients do, physicians tend to spend less, rather than more, time with older patients (Allman, et al., 1993).

In addition, despite the sizable literature on interactions between patients and physicians (Mishler, 1984; Waitzkin, 1991) and the growing literature focusing on older patients and their doctors (Haug & Ory, 1987; Greene et al., 1987), relatively few studies have gone beyond this dyad to examine the unusually important role of family members in the medical care of older patients (Clair, 1990b). Several theoretical papers (Adelman, Greene, & Charon, 1987; Coe & Prendergast, 1985; Silliman, 1989) have argued that this triadic relationship is especially critical in examining the medical care of elderly patients. Dementia is one example of a triadic encounter where family caregivers play an especially important role due to the patients' limited competence and the uncertainties of diagnosis, course, and management (Haley, et al., 1992).

Because of such special issues that arise in the medical care of geriatric patients, the study of relative satisfaction and dissatisfaction with medical care as perceived by the family caregiver is of great importance. This is an area in which the quality of practitioner care has implications not only for addressing the problems of burden experienced by families, but also for assuring that caregivers appropriately manage patients' medical care.

The potential benefits of generating research data so that successful medical interviewing skills can be integrated into teaching curricula are enormous. Patient satisfaction depends in part on the quality of the medical encounter (Lipkin, et al., 1984). The accuracy and completeness of the information elicited by care providers are a function of medical interview techniques (Carter, et al., 1982). With effective techniques, the physicians' spectrum of concerns expand (Engel, 1980). When physicians learn to focus on listening to the patient

rather than directing the patient, much new information becomes available. For instance, major, as opposed to initial, complaints can be clarified and addressed (Barsky, 1981) and psychosocial complaints and maladjustments can be put into proper context within the care process (DeVries, et al., 1982).

(c) *Compliance/Adherence.* Compliance with treatment is probably the most studied aspect of the social psychological dimension of the care process. This is because all of the knowledge and skills of the physician, as well as all of the power and resources of the medical establishment, are rendered impotent by a simple act of noncompliance, such as not taking medication (Blascovich, 1982; Kessler, 1991). The best diagnosis is worth nothing if there is a failure to follow through with treatment plans. A sociology with medicine, while focusing on compliance in terms of patients who do not adhere to physician directives, is also likely to identify ways in which the issue of compliance reflects the social control exerted by medical practitioners.

Unraveling the dynamics of labeling and the operation of stereotypes is an important aspect of research and application. Like other human beings, physicians are likely to treat patients in stereotypical ways based on the patient's age, sex, race, and occupation. We know that elderly and lower-class persons are reluctant to interrupt and ask questions during the medical encounter, which suggests that more information should be provided by the medical practitioner (Waitzkin, 1984). There is also evidence that communication difficulties exist between doctors and their geriatric patients (Beland and Maheux, 1990).

Medical practitioners should become more aware of sociolinguistic differences among age groups and social classes. Instead of labeling some patients as incompetent, practitioners should make extra efforts to increase the information they provide to these patients. With this sensitivity, treatment strategies can be used with enhanced comprehensiveness and compliance (Kimball, 1982).

How the medical record and caregivers contribute to the labeling process of patients (Clair, 1990b) is also an important concern. Does information in the medical record bias even new patient-physician interactions? Do caregivers unintentionally establish elderly patients as unreliable historians, thus undermining the patient-physician relationship? Physicians can benefit from a knowledge of statistical generalizations about categories of patients, but this knowledge should stimulate questions rather than lead to unfounded conclusions. Research findings on special populations need to be used astutely in order to benefit individual

patients. Physicians, through techniques that usually have to be taught to them, must learn to establish whether a specific patient fits the statistical pattern; to merely assume so is to stereotype.

(d) *Roles and norms.* This is the traditional focus of sociology, and is, perhaps, the most difficult and abstract information to disseminate to medical practitioners. It is important that health care providers understand that while each medical interaction has a degree of spontaneity, the rules governing the procedures and content of interactions are largely constrained by prior expectations (Clair, 1990b). In addition to a biomedical domain, there is a system of values and norms that structure and guide interactions and that enjoy some continuity over time and from place to place (Strauss, et al., 1985). One consistent assumption is that the physician will control the course of action and that the patient will be in a dependent position. One might say that they have an investment in the patient role, since full attention rests upon the ability to perform this role well.

The general form of role relationships is highly structured from the point of view of health care and service providers, who deal with sick patients during their normal job activities. Recent research suggests that physicians also bring established attitudes to their interactions with elderly patients (Beland and Maheux, 1990). From the patient and caregiver perspective, however, role relationships and expectations often seem to be freshly invented and to lack a history (Clair, 1990b). Interaction, for providers, is highly structured, with few surprises. Interaction for patients and caregivers, on the other hand, unfolds with more anticipation. This perpetuates physician control and patient and caregiver dependence. The pervasiveness of habituated experience during medical encounters suggests that instances of autonomy and innovation are rarities for patients and their caregivers.

Medical sociologists may bring behavioral tendencies to the physician's attention and encourage the physician to take the role of the patient and caregiver and try to role-play the interaction. Role-taking is certainly acknowledged as a basic process in most interactionist treatments of social life (see Hewitt, 1991; Kearl and Gordon, 1992). Similarly, physicians can encourage their geriatric patients and caregivers to share their self-diagnoses with them. Such role-taking between status unequals may have limited technical effectiveness, but such efforts will be likely to reduce the social distance between interactants by encouraging the patient and caregiver to participate more fully in the health care process (Schwalbe, 1986).

Discussion

As medical sociologists, we are continually challenged to generate distinctive and useful contributions to our discipline. There is a growing expectation from within our own discipline, and also from other disciplines, that our findings should also benefit medical practice (Colombotos, 1988). The position developed here is that our contribution is dynamic, and best accomplished by generating research questions that are field validated, uncovering valuable data through innovative methodological approaches. What is proposed here is an ideal situation, in which sociologists work "with" medical providers to apply empirical knowledge to patient care activities. There are increasing opportunities for medical sociologists to work in this capacity, especially in geriatric settings. Fortunately, the continuing development of interdisciplinary geriatric assessment units and calls for clinical research in aging involving social and behavioral scientists (Lonergan, 1991) provide sociological practitioners the opportunity to establish working ties "with" medicine, demonstrating that the *promise* of medical sociology can be replaced by *hard evidence* of its utility (Freeman and Levine, 1989).

Sociological practitioners also currently find themselves able to gain access to clinical settings through self-initiation and advocacy. As practitioners, we have not yet been fully embraced by physicians as partners in the clinical setting. Such partnership is still only possible by invitation, and many sociologists will find it difficult to gain such access, since an invitation implies that others in the medical context clearly understand the distinct contributions that a sociological perspective can provide (Bloom, 1989; Hunt and Sobal, 1990). Even interdisciplinary geriatric team members may be hesitant to welcome this new perspective, because of intrinsic differences in disciplinary thought and the potential overlap in substantive activities, generating potential displacement issues. While most sociologists will need to continue to request inclusion in clinical practice settings, eventual invitations from innovative medical leaders will help ease entry into such settings, while legitimating our body of knowledge.

The legitimation of the medical sociologist in clinical settings is important because it relieves the pressures of dual loyalties (Kleinman, 1980; Scheper-Hughes, 1990). Medical sociologists in the clinical context must often take a stance that is intrinsically divided. This is a dilemma that simultaneously requires the medical sociologist to be collegial, by expressing concern with the practical resolution of clinical problems, while at the same time remaining autonomous, by generating sociological theories of illness and care capable of withstanding disciplinary scrutiny. Although both participation

invitations and self-initiated clinical access run the risk of making the sociologist indebted to the host's interest, they help legitimize and lend credibility to the fact that the clinically applied medical sociologist legitimately shifts between patient and practitioner perspectives, being an advocate for both. This holistic research approach allows the medical sociologist to generate data on patient care processes despite the fact that the interests and goals of doctors and their patients do not always coincide; this fact, too, is worthy of empirical attention (Allman, et al., 1993).

In general, there is a value to the medical sociologist working with medicine, to the extent that the sociological imagination and language represents another frame of reference allowing help-receivers and help-providers to construct a useful reciprocal language. Delineating how these social actors conceive and conceptualize their life worlds is a significant contribution of medical sociologists.

Proponents of varying patient care philosophies must recognize that many illnesses entering the clinic represent tragic personal experiences with the social world. The intellectual diversity of medical sociologists makes them capable of inspiring integrative efforts to knit together, empirically and conceptually, the seemingly disparate aspects of patient care. A critical medical sociology discourse asks what medicine might become if, beyond its biomedical goals and values, we begin to comprehend how unmet needs and the psychosocial stresses of everyday life can generate multiple illness symptoms within individuals. Until the psychosocial context of medical encounters is given explicit attention in research and teaching, doctors will continue to "be as mystified as their patients about the ingredients of effective medical care" (Eisenberg, 1988). Recent mandates have been put forth to try to ensure the proper development of humanistic qualities in physicians (American Board of Internal Medicine, 1991; American Medical Association, 1991).

The theory and method of the social sciences must also be integrated into the medical educational and research establishment if physicians are going to be able to respond effectively to *patient* illness as a *human* experience. We might then begin to build a basis for a truly "social" medicine and a critically applied social scientific research base, addressing the social, behavioral, political, and ethical ramifications of medicine and medical care (Scheper-Hughes, 1990:194).

Placing sociological ideas "with-in" the context of clinical practice can lead to a clarification and broadening of the patient care process. The disciplines of medicine and sociology will thus be enhanced, while elderly members of society will receive more comprehensive and humane patient care.

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