From Isolation to Inclusion

Reprioritizing Patient Care through Peer Support

by

John Michalczyk III

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Table of Contents

Acknowledgments

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I leave the reader with his insightful quote by my mentor:

> This reminds us of advice we were given many times by professors and mentors and colleagues alike, to always keep a journal and write everything down—not only because writing comes with writing, but also because if you don't write it down, you have no reason to believe that what you observed actually took place. As our friend Andrew Arato once said about the

malleability of the historical past, “yet, something really did happen…” a narrative about something that you have observed, something that has happened, something that has existed outside of your individual consciousness as much as within (Williams 2018:153-154).

Preface

As care for type 1 diabetes continues to evolve, so too does our understanding of what it means to live "well" with this condition. Over the past decades, advances in technology, therapeutics, and clinical knowledge have transformed outcomes in remarkable ways. Yet some of the most meaningful progress has come not solely from medical innovation, but from the growing recognition that optimal care is achieved through collaboration.

Type 1 diabetes is unique in medicine because individuals living with it must make countless decisions each day—adjusting insulin based on food, exercise, stress, sleep, or illness among many other factors. Much of diabetes care occurs outside the clinic, requiring people to develop extraordinary expertise in managing their condition. This reality creates a different relationship between healthcare professionals and patients: clinicians become not only prescribers, but also educators, coaches, and long-term partners helping individuals with type 1 diabetes gain the confidence and skills needed to make critical daily decisions.

The demands of diabetes management can be physically and emotionally exhausting. Diabetes care is truly a team sport, rooted in partnership among patients, families, and healthcare professionals built on shared knowledge, trust, and mutual respect. This collaborative model recognizes people living with diabetes as active participants in their care and helps reduce the stigma that has too often accompanied the diagnosis.

The Joslin Diabetes Center has long stood at the intersection of discovery and care, helping shape the modern foundation of diabetes management. From the beginning, Dr. Joslin and his team recognized the importance of education, nutrition, exercise, and patient empowerment alongside insulin therapy. Visiting nurse programs brought diabetes education directly into patients' homes, while camps and peer-support initiatives created communities where children and families could learn, connect, and thrive together.

Looking forward, the continued development of peer support models and the concept of the "expert patient" remain essential to the future of diabetes. People living with diabetes are not only recipients of care, but also educators, advocates, and collaborators whose lived experiences help shape more compassionate, patient-centered care and better outcomes for the entire community.

In his thesis—*From Isolation to Inclusion: Reprioritizing Patient Care for Type 1 Diabetes through Peer Support*—John Michalczyk Ph.D underscores a growing truth in modern diabetes care: peer support is not ancillary, but essential to successful self-management and quality of life in individuals living with type 1 diabetes. Through support groups, culturally responsive education, and shared lived experience, individuals living with diabetes can challenge stigma, rediscover personal identity, and build resilience. Drawing from both the history of the Joslin Diabetes Center and contemporary peer-support initiatives, this work highlights an important evolution in diabetes management—one that increasingly recognizes the value of the "expert patient" and the transformative power of partnership, community, and shared experience.

This dialogue among diabetes history, present practice, and future possibility underscores a central truth: improving life with type 1 diabetes requires not only medical expertise, but also the voices and experiences of those who live with the condition every day.

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Introduction

Healthcare today in America faces multiple challenges. Although America holds the Number 1 position in its level of scientific and medical technology, it is Number 7 globally in sustainability. The cost of healthcare and insurance has risen exponentially, at times out of the reach of the poor, disabled and marginalized, leaving them non-insured. This is also the case in the US since health insurance relies on employment, differing from other countries that enjoy universal healthcare coverage. In the case of struggling unemployed diabetics, the cost of insulin and supplies drastically impacts upon their lives, resulting in difficult choices, medication or rent? Patients sometimes experience pre-existing conditions, for example a severe disability, that exclude them from necessary coverage. Furthermore, the frustrating search for a primary care physician to serve as an advocate in these situations may result in risking insulin usage or expensive visits to Urgent Care clinics Perhaps this shortage may also rise out of more physicians desiring to move to "concierge healthcare" which could offer a patient more prime time coverage, as it were, but place the less fortunate at a disadvantage.

Healthcare and The Evolution of Medical Sociology

This study from the lens of medical sociology as well as from a Type-1 diabetic examines the way medical professionals and individuals with chronic illness can currently at times work together, while at other times find themselves operating at cross-purposes. This inconsistency of purpose and effectiveness stems in part from the ways in which long-standing societal and medical

traditions influence attitudes toward, and understanding of, difference. This study focuses on developments of theories in medical sociology that reframe traditional positions of authority and expertise, once understood and examined solely from the perspective of the medical institution and professionals. It then centers on more inclusive approaches that acknowledge the authority and expertise of patients, and a more active and aware society. The historical background, built upon stark distinctions in knowledge and the power relationship of doctor and patient, expert and non-professional, brings clarity to the ongoing challenges caused by illness that result in the labeling of stigma, disability, and difference. An alternative to the medical model for addressing the disruption that emerges with diagnosis and treatment can be found in non-professional expertise and involvement, specifically, support groups. This study concludes with analysis and personal observations of the active roles of the lay community in the reorganization of a functioning society that achieves greater effectiveness and stability in daily living through a commitment to restoring balance and equality across the social structure.

Medical sociology continues to develop since first recognized in the United States during the 18th and 19th centuries, as a field with a focus upon issues of public health and social reforms that contained a moral perspective on the individuals within the larger society.[1] Currently, medical sociology cannot stand alone as an isolated subset of sociology in general. Given the complexity of our society in the 20th and 21h centuries, it relates to all areas of our

[1] See Samuel Bloom, *Word as Scalpel: A History of Medical Sociology* (2002), in which he traces the evolution of the field.

community, including labor, marriage, psychology, education, race, class religion and gender. One glance at a journal of contemporary sociology indicates how far the field has advanced since the early studies of health, wellness, institutions and stigma.

Over time, the emphasis has evolved from the hands-on public service areas of concentration as noted by Samuel Bloom: "In the mid-19th Century, initially 'social science' was identified with advocacy and reform, with a focus on the poor" (2002:12). Medical sociology, as we know it today, evolved rapidly in the mid-to-late 20th century, with more consistency with an academic and analytic approach, and with less focus upon connection with and observation of doctors. The social stigma associated with medical conditions was inextricably linked to the inequalities of class, and by extension, race and gender, and put in place the power/ authority component, whether with the individual and the physician, or with certain affected populations with the institution. This cemented the disparity and at times stereotypical acceptance of certain social guidelines with assigned roles and practices. In the 21st century, the field has expanded beyond identifying and researching illness and the ways in which members of the medical institution respond to the diseases, with a greater awareness of the socio-political and economic factors that contribute to illness, stigma, and prejudice.

Interdisciplinary in its evolution, medical sociology intersects with many health-related fields and disciplines, which lead to new theories that build upon a redefined approach to the understanding of disability and stigma, as Cockerham notes:

> Medical sociologists now exercise their craft in a variety of settings, as full-fledged professionals, often working as colleagues on research projects with professionals in medicine, public health, nursing, and other health-related fields. Furthermore, research and teaching in medical sociology, in both universities and health institutions, are increasingly similar in the application of sociological theory and usefulness in addressing problems relevant to clinical practice. In sum, medical sociology has evolved into a mature, objective, and independent field of study and work, supported by a vast literature. It constitutes one of the largest and most important subdisciplines in modern sociology (2013:14).

Going beyond health-related disciplines, Coleman in "Stigma: An Enigma Demystified" already encourages interdisciplinary collaboration in the eighties:

> We need more cross-disciplinary research from researchers who do not commonly study stigma. For example, a joint project among historians, psychologists, economists, and political scientists might examine the relationship between economic climate, perceptions of scarcity, and stigmatization. Other joint ventures by anthropologists and economists could design research on how much income is lost over a lifetime by members of a stigmatized category (e.g., blind, deaf, overweight), and how this loss adversely affects the CNP and the overall economy (1986:230-231).

Forty years later, this has become a hallmark of social science inquiry, producing essays on the national and international front as well as journals dedicated to cross-disciplinary study in medical sociology such as *Health: An Interdisciplinary Journal for the Social*

Study of Health, Illness and Medicine or the *Journal of Medicine and Philosophy*.

> Professionals and patients rally around common goals but then their actions show a shift in priorities. When embodied and put into practice, norms might clash, diverge, shift, or coexist in contradiction, collaboration, or tension. Norms highlight the important question of what the multiple purposes are of health care interventions (Timmermans and Haas 2008:671).

This shift in priorities is no longer limited to medical professionals and patients, as the field of medical sociology demonstrates by moving beyond the traditional physical restrictions of the hospital setting, doctor's office, or operating room. These venues created equally restrictive labels that perpetuated stereotypes and stigma upon not only the patients, but also on the larger non-professional society. Though the effects of medicalization linger, priorities in medicine and priorities in social science research constantly shift in response to calls for greater transparency from the institution with the expectation of greater participation from individual members of the social structure. Clarke comments on the need for vigilance from all parties, along with attention to responding to all patients' needs:

> Stratified biomedicalization both exacerbates and reshapes the contours and consequences of what is called "the medical divide"-the widening gap between biomedical "haves" and "have-nots" (Abate 2000b). Surveillance, health maintenance, increased knowledge, and extended health and biomedical responsibilities for self and others are, however, promoted for all…this imperative to "know and take care of thyself…" (2003:184).

As healthcare continues to undergo reform, conversations and analyses of diagnosis and disability that once were more private and often fostered isolation and passive acceptance, become part of the larger public discourse. Clear communication of the medical issues that contribute to the perpetuation of stigma and prejudice through an interdisciplinary approach can not only allow for breakthroughs in the field of medical sociology. It can also have a positive effect for the healing of the patient and civil society, as recognized by Becker:

> The dynamic interactions between the forces of society, culture, history, and the individual are highly complex. Thus, the multidisciplinary perspective has much to contribute to the study of stigma. As social scientists, we need to look within, between, and beyond our own social group, culture, and historical era (1997:56).

The perspectives developed by Coleman, Becker, Timmermans, Haas, and Cockerman identify the changes in the field of medical sociology that are redefining priorities for a more expansive approach to future research. This call to broaden theories within medical sociology recognizes the value of connecting that which traditionally had been studied purely from a medical perspective to an array of social structures and common human experiences. Once labeled with a diagnosis of disability, individuals in their everyday lives existed in isolation under the judgment of medical and professional authorities. As current studies move away from the severe limitations of the medical model and outdated theories on authority, difference, and expertise, medical sociology can also move past the restricted nature of earlier research. In a limited manner, this prioritized the medical institution and the authority

of the medical professionals and compromised not only the patients by perpetuating stigma and inequality but also extended outward to compromise functioning within the larger society.

A theory of medical sociology that is more inclusive and interdisciplinary can benefit scholarship and society, by offering opportunities to reassess aspects of both medical tradition and scholarly research. Critical to this new approach is re-establishing the individual within society, as equal to, not better or less than, the other members of the community. Experience contributes to understanding that expertise is not determined by those in authority, and identity is not challenged by difference. The goal throughout this work is to weave together a new approach to understanding disability through scholarly research and data analysis, by adapting and building upon these evolving social theories and then putting them into practice. This will be achieved through an ethnographic study of two support groups, which contains both objective and subjective analyses.

In this research, the support group also takes on a symbolic meaning of future possibility of living without stigma in a multi-faceted, civil society, not limited by, but rather enhanced through, difference. This interpretation of commonality and collective experience stands in stark contrast to the traditional medical model, whether as defined in the doctor-patient relationship or the sick role that fosters isolation and exclusion from society. In their differentness from the accepted norm, by existing outside the established medical institution, support groups offer an alternative view for their members with a sense of connection among members, not limited to disease and disability. Not only a symbolic or theoretical resource, support groups also serve as

pragmatic resources that can counter the oppressive nature of disease and disability with common experiences, understanding, and compassion--quality of life concerns, improved education about access to health care, and advocacy surrounding personal, professional, social, and political issues.

Like a multi-faceted society that exists through the interconnectedness of social, political, economic, and ethical issues, so too, medical sociology has evolved exponentially in a more complex amalgam of institutions that focus on the health of the individual as well as of the community at large. The wellness of society depends on the wellness of the patient, and the wellness of the patient depends on the collaborative functioning of a healthcare system that includes an array of professionals. Wellness as a goal can be viewed practicing the rudiments of care studied by the pioneers of the field. Cockerham recalls that in its earliest stages of development as a discipline, "much of the research in medical sociology was dependent upon the sponsorship of physicians" (2017:14). Physicians observed, developed, and published their findings about their profession.

Today, however, healthcare viewed by medical sociologists is delivered through a sophisticated ecosystem where each area and function has some reliance on the other. The patient seeking medical help has dependence upon a vast array of professionals and staff, including doctors, nurses, social workers, insurers, translators, pharmacists, physical and occupational therapists, among others. All of these perform and at times depend significantly upon a range of technology. Presently, an ill patient, whether in an emergency crisis or a regular office visit, has a greater possibility of restoration to health than even a decade or

two ago. An even greater possibility certainly than when Parsons and Goffman began to enlighten society about the nuances of the medical profession and its relation to all aspects of our lives more than a half century ago.

As medical sociology better defined its place within the larger academic field of sociology in the late 20th Century, interests and research expanded beyond the constraints of a purely "medical" jurisdiction, with those stigmatized by illness, poverty, and racial inequality, to include other characteristics of the discipline based upon relational dynamics of human behavior. Bosk's reflection upon his own experience as a medical sociologist in his early years with a focus on "the institution" of industrial sociology connected to resident physicians reflects a similar change in the discipline in the last twenty years. He describes the important shift from isolation as an observer of physicians within the setting of the institution to active 'witnessing' of patients and families, very much involved in all aspects of their healthcare (2014:381). Similarly, Bloom acknowledges the shifts in areas of focus from science and medicine to politics, economics, and civic responsibility:

> Medical sociology, as a general rule, followed a path parallel but slightly behind national trends in science and higher education. At the same time, relations between mainstream science, medicine, and social science were unstable…From 1945 onward, the pace of research development quickened and diversified. Guided by strong leaders, the relationship between medicine and social science intensified, but the pattern of its interest split the next fifty years in half. The first half was dominated by several quests: for a scientific epidemiology, for

> a viable theory of the social psychology of interpersonal relations in therapeutic institutions, and for analysis of the sociology of the professions. The second half, beginning in the seventies, turned in focus toward socioeconomic and sociopolitical explanations of health services delivery and the organization of both the traditional and new health care institutions (2002:247).

The shift from specialized and limited studies within a highly structured system and medical profession to an interdisciplinary and more public approach builds upon, revises, and expands the role of and research within the field of medical sociology. A critical addition to the sub-specialty thus comes from the inclusion of a range of researchers and scholars from other academic fields. Similar to disability studies, medical sociology is recognizing the benefits for research and policy that comes with bringing together specialists and scholars from other disciplines. With different theories and approaches to the central concerns of medical sociology, an important aspect for these studies emerges through ethnography, the emerging relationships that are built upon thoughtful analysis and re-telling of the experiences of individuals living with disability and difference, as observed by Terry Williams:

> We like to use the term "being there" to sum up this idea that no matter how much time we spend in the field, we never passively observe the field, but we also never participate exactly like an insider. And this complicated dialectic only exists as an expression of a relationship between the ethnographer and people in the field--which we can understand as an unpredictable work of art, or just simply as *life*. Ethnography indeed claims, against positive science, that

> the control of the environment in which research takes place only yields partial knowledge…ethnography seeks not to control the environment, but rather to understand the situation as it unfolds, all at once, perhaps messily…ethnography also asserts that, when faced with such complex situations as social persons in a maelstrom of forces, processes, and interactions that exist well beyond the individual, observation as a stand-alone method can only allow for a partial glimpse of the social world. This is what we mean by *being there* (2018:80-81).

Sociologists' approaches to Health and Wellness

In recent years, this type of cross-discipline collaborative work, with a shift in understanding "the people in the field," has enriched the discipline and encouraged new interpretations of traditional theories and methods, as well as innovative approaches toward complex social problems. Lennard Davis offers his theory rethinking the abnormal, and "the concept of the norm" through a literary and historical lens of scholarship. He shifts the focus from "the construction of disability to the construction of normalcy, because the 'problem' is not the person with disabilities; the problem is the way that normalcy is constructed to create the 'problem' of the disabled person" (1997:3). 'Difference' can be seen, from another perspective and moves outward from an isolated experience of the minority living with disabilities to the commonality of the human experience, as shared and recognizable. For Davis, the individual scholar's re-interpretation of personal experience and research adds another contribution to the field, with his thought-provoking call for "reversing hegemony of the normal and instituting alternative ways of thinking about the abnormal" (17).

Concerns about healthcare, as well, and the business of healthcare that minimizes the patient in order to maximize the wealth of the healthy community (health insurers, pharmaceutical corporations) are also subjects for study within the field today. Preserving the value of the individual as a member of a civil society, by replacing the debilitating label of stigma and devaluing of the person, with normalcy and equality of human identity becomes the challenge with "the biomedicalization of health itself, (for) in commodity cultures, health becomes another commodity, and the biomedically (re)engineered body becomes a prize possession" (Clarke 2003:171).

Bosk looks back on his career as a medical sociologist, reflects on the changes he has experienced, and advocates for connecting the research of these professionals to a more active role in affirming the need for advocacy and reform:

> The discourse on health care has radically altered. We now talk about health care as a commodity purchased in a competitive marketplace rather than as a public good. As sociologists, we have an obligation to highlight those patient populations whom market solutions are likely to serve poorly. We also need to remind policymakers that there are alternatives to viewing health care as a marketplace commodity like any other (2014:378-379).

When Talcott Parsons, in *The Social System* (1951), presents his theory of functionalism as an understanding of society, with a system in which each individual has a role to contribute to the general functioning of all, he establishes theories that classify roles of doctors and patients, in a two person/dyad interaction. This type of interaction solidifies the disparity between the active,

professional and healthy member of the community and the passive recipient of care, unequal in knowledge and ability. With his research on illness, and specifically, with his focused and unequal definitions, Parsons elevates the status of the medical professional almost to a category more than human, while stripping away the basic humanity of the patient struggling to live with difference and illness.

In his extensive work on identity and functioning within societal roles, including his analysis of the "sick role," Parsons creates terminology that becomes associated with stereotyping the doctor-patient relationship, by authorizing institutional control, and limiting the individual's role to one-dimensional, as determined by the medical professional. His early contributions give shape to an evolving field of study, most critically, his work on identifying roles within society.

Bloom's analysis of the current professional identity of medical sociology acknowledges the central role of Parsons, while acknowledging that much has changed in the understanding of medicine and medical sociology:

> Pressures to apply sociology's skills to the understanding of health services and health care policies have always existed and in recent years are a dominating force, associated with the transformation of American medicine into a corporate form. Sixty years ago, the dominant form of medical practice was the opposite…and Talcott Parsons and Robert K. Merton focused their attention on the doctor when they analyzed the place of medicine in the social system of the Western world. The dominance of the doctor was the preeminent characteristic of

> medicine at that time, just as the corporate organization of medicine highlights the present…Medical sociology has developed in a trajectory that follows its parent discipline but with reference always to the changing institutional dynamics of medicine (2002:273).

Over time, as medical sociologists continued their analyses, some, including Eliot Freidson, questioned the binary and overly simplistic definition of the "sick role," choosing to redefine Parsons' narrow model, in order to allow for increased agency for both the individual and the social system. In *Profession of Medicine (*1970/1988), Freidson addresses the nuances of illness and the dynamics of unequal authority within and outside of the medical institution, and furthers the understanding of the roles of patients, their advocates, and healthcare professionals. He also recognizes the negative ramifications of overly glorifying the role of the physician to the detriment of the patient. Freidson's critical studies re-examine the tradition of the discipline and demonstrate a reassessment of traditional roles, reflecting the on-going changes within culture and society. Re-envisioning the concept of expertise allows for increased involvement and effectiveness within the treatment process and fosters a more inclusive social structure.

Starr, Abbot, and others build upon Freidson's work, examining the challenges facing the medical profession and the way the profession takes measures to preserve a sense of authority and legitimacy:

> The cultural authority of the profession, emphasized by Starr (1982), Freidson (1986), and Abbott (1988), was shaken by the early 1970's, when a spate of books and articles appeared about the social pathologies of professional dominance just

> mentioned, as well as the neglect of the poor, of those with chronic conditions, and of public health issues (e.g., Greenberg 1971; Ehrenreich and Ehrenreich 1971; Kennedy 1972; Nixon 1971) (Donald Light 1988:202).

Another example of the ways in which theories and research in medical sociology are connected to cultural shifts that require on-going review and can lead to fine-tuning within the field, while uncovering new areas of inquiry, can be seen in the re-emergence of patterns of social inequality and stereotyping by the majority of a society in crisis. These are the present and future challenges in the United States. Parsons' clearly defined attributes contribute to the acceptance of inequality of societal roles during times of crisis and uncertainty and permits complacency within the larger institution.

Contemporary sociologists now look to innovative use of technology and connections with other disciplines to improve quality of life for patients and those living with disabilities, or in some way, marginalized from daily social interactions, as well as to a study of ways by which to influence policy and policymakers. This influence can be seen in the medical field or in government service.

Of critical importance in this new approach is the providing of more opportunities for patients and advocates, not only in getting through the treatment process, but also by reconnecting more dynamically with the larger community. Recent theories of expanding roles previously assigned only to healthcare professionals, now include patients and advocates, who though technically not trained in healthcare, often possess significant

knowledge and expertise through personal experience. Outside of a focus on the medical setting, institution and system, relevant studies that address the importance of correct treatment of individuals and appropriate guidelines for participating within a functioning society that medical institution, can be found in the work of social theorist, Andrew Arato:

> We understand that "civil society" as a sphere of social interaction between economy and state, composed above all the intimate sphere (especially the family), the sphere of associations (especially voluntary associations), social movements, and forms of public communication. Modern civil society is created through forms of self-constitution and self-mobilization. It is institutionalized and generalized through laws, and especially subjective rights, that stabilize social differentiation. While the self-creative and institutionalized dimensions can exist separately, in the long term, both independent action and institutionalization are necessary for the reproduction of civil society (Cohen and Arato 1997: ix).

There are institutional responses to the 2020 experience of Covid-19, leading to increased racial tensions and socio-political unrest that too easily place the blame on the indifference and inaction of those victimized by external social factors that reflect elements of Parsons' understanding of social interactions. Whereas Parsons focuses on the essential functions in society, offering a basic view of authority and illness, the 19th century views associated with the evolving discipline of sociology and medicine are heavily moralistic in defining ordinary members of society. In Bloom's work, these echoes evoke the moral judgment view of illness for vulnerable members of the larger society that willingly merged

misfortune with moral choices and life circumstances, judging "that sickness, disease and poverty resulted from immorality; and that conversely health, wealth and happiness were proof of one's adherence to the moral laws" (2002:28).

Such extreme views which foster stigma and prejudice can be found in the current challenges of responding to the recent pandemic and resulting instability today. As with earlier studies that helped establish the field of medical sociology by focusing upon specific crises and life-threatening events, the current situation once again brings to light the tensions and inequalities surrounding class, race, and illness. The crisis and society's response to the disruption and uncertainty caused by these health concerns reinforce the value of continued research in this field, especially with respect to stigma and illness, race and class inequality.

Although many reoccurring themes permeate current society, there have been some notable changes in approach, as medical sociology plays a role in larger socio-political and healthcare-related concerns for all members of society. Earlier studies in the field focused upon general issues of public health for the less fortunate, as noted earlier, and were contained for the most part, within analyses of the doctors and medical institutions, as with Becker's study of medical students in *Boys in White* (1961). These studies, however, were viewed as 'doing' sociology within a healthcare-related setting, not readily recognized as a specific field of its own. As Timmermans muses in *Contemporary Sociology*:

> I wonder how hospital administrators would react to modern-day researchers trying to repeat the classic medical ethno-

> graphies from Renee Anspach and Charles Bosk. Outsiders mingling with staff and patients on patient wards would inevitably have access to some kind of patient information. It seems easier to deny permission (2004:739).

Medical sociology first emerged with studies in public health and medicine, and remained linked with social reform within the framework of the medical institution for many decades. Currently it is much more closely aligned with mainstream sociology, with an interdisciplinary focus, strengthened through cooperative efforts with and recognition by the American Sociological Association. The creation of the *Journal of Health and Social Behavior*, extensive collaboration with NBME (psychosocial aspects of health and illness), and eventual formal acceptance in NIMH training program collaboration, are recognized by Bloom (2002:256).

The exploration and evolution of this stylized approach in social research has gained momentum and recognition, and has established itself as a distinctive academic pursuit, stemming from key classical principles in sociology, while branching out into previously uncharted areas.[2] The roots of this study can be traced back to the scholarly work of a pantheon of pioneers in this area, including Talcott Parsons (1951), Erving Goffman (1959), Michel Foucault (1960, 1975), Irving Zola (1971), Renée Fox (1957, 1977), Paul Starr (1982), Eliot Freidson (1967), Peter Conrad (2005), Bruce Link and Jo Phelan (2008), Gil Eyal (2015, 2019), Joan Tronto (2013),

[2] The strongest institutional role for medical sociologists has been in traditional Sociology Departments. Most medical sociologists appear to be working outside of medical institutions, with exception of schools of public health, policy analysts, and consultants (Bloom, 277).

Andrew Arato (1992), and Stefan Timmermans (2011, 2020), among others.

This review includes works from the canon of medical sociology that progresses from the general concept of health and illness in a societal context, to more particular case studies of chronic illness. It specifically focuses on Type-1 diabetes and the ways in which an inclusive approach to healthcare, through a redefining of authority and expertise, can reduce both stigma and prejudice, and restore health, not only to the individual, but also to the larger community. This study will further develop personal insights as well as scholarly research concerning the ability of the patient with diabetes to participate in self-help sessions with peer support that will supplement, not replace, professional care by a physician.

Goffman's work on social aspects of communication and interaction in 1959 remains central to understanding both the earlier established practices within the medical institution and within the larger social structure of community. Goffman's theory of impression management, as developed in his *Presentation of Self in Everyday Life* (1956), identifies the fluid nature between health and illness, while also exploring the concept of normalcy. As he begins to explore the wide scope and variances of illness and health, Goffman presents an alternative view of what matters in social interactions. No longer restricted to clearly established roles within the medical institution and outside of it, Goffman focuses upon possibilities for functioning individuals in a society, offering vocabulary that provides agency for any social actor, in this case, patient and advocate, to respond to the pre-existing views within the medical community that previously have been given complete authority. His use of theatrical terms moves away from rigidity of

the binary role, to eliminate the masks and costumes, for example, as seen in the doctors' white coats as supreme authority, to reveal the underpinnings and once hidden structures that comprised the roles of doctors and patients. In his work on stigma, Goffman offers a different perspective that pushes back against the traditional "sick role," and fosters engagement within the social system.

Goffman's work on stigma in 1963 offers new ways of interpreting the inequalities within society and acknowledged the importance of stigma in all aspects of society. Phelan, Link and Dovidio in "Stigma and Prejudice: One Animal or Two?" (2008:359), develop their analyses of the effect of stigma and prejudice, and the connections with race, gender and physical difference. Along with Goffman's models on stigma, the earlier work of Allport's models of prejudice (*Nature of Prejudice*: 1954) identifies the desire for conformity as dominating the social structure.

Medicalization

As a social theorist, Michel Foucault illustrates the relationship of power to knowledge, a key theory in his *Discipline and Punish: The Birth of the Prison* (1977). In *Archaeology of Knowledge* (1969), he analyzes a similar construct of power in terms of medical discourse. Recognizing the inextricable link between power and knowledge, Foucault contributes to the body of medical sociology by introducing the power of classification on the most subtle of levels. His understanding of behavior in detail deconstructs traditional roles of power dynamics in society, as can be seen in his *Abnormal Lectures* (1975), in which he examines and applies aspects of medical knowledge in psychiatry to the justice system. Foucault

further advocates a more holistic approach to medicine, in a sense reverting to a classical perspective of the relationships of body-mind-spirit, as described by Hancock (2018:439). Here Hancock indicates how power (Sluga 2011) is "a central feature of human action" and underlines Foucault's efforts to elucidate the importance of an analysis of the subject with regard to medicine:

> By drawing out these conceptualizations of power, Foucault's work contributes three critical points to the formation of medicalized subjectivities: (1) the issue of medicalization needs to be discussed both in terms of both specific practices and holistically (in terms of the carceral archipelago); (2) we need to think about how we as human beings are "disciplined" and "subjectivated" through medicalization, as discourses, practices, and institutions are all crystallizations of power relations; and (3) we need to reflect on how we can "resist" this process of subjectification, as "power comes from below" (Foucault, 1978, 94) and patients shape themselves through practices and "technologies of the self" (Foucault, 1988). Ultimately, Foucault's work does not merely assist us in refining our analysis; rather, it is essential for conceptualizing the broad processes of medicalization in contemporary society (2018:439).

In *Medicine as an Institution of Control*, published in 1972, Irving Kenneth Zola, a key figure in medical sociology, introduces the term, "medicalization," revealing the ease with which the power of medical institutions and healthcare expands on its own authority. In his early analysis of such a far-reaching license within the medical community that classifies individuals as patients in any capacity deemed appropriate, without any oversight, Zola