Some Remarks on the Dialogue between Sociology and Medicine

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The comment I offer here is in the way of an item on the aide-memoire of those of us who are engaged - or should be engaged - in the dialogue with the medical profession to which Margaret Reid referred in her editorial of the Newsletter (No. 1.4).

It would indeed seem that those in the medical profession favourably disposed to sociology‘s inclusion in the medical teaching effort champion sociology‘s respectability on the basis of a vulgar positivistic view of the discipline. So when meeting medical challenges about what we think we're contributing in our teaching we find that we confront at least two styles of reaction. One is that blanket hostility, the ‘impenetrable armour of medical professional culture' which stereotypically medical sociologists have incorporated into their own professional sub-culture. The other is the (initially) unexpected support offered in terms which Margaret Reid reminds us is exemplified in the Todd Report‘s view of the operation. We break off the main offensive, in order to re-build the bridge with these signatories to the alliance. For those allies are surprised and hurt when we round on them to deny that sociology is a science, at least according to their views of science. Which brings us to domestic matters. For in entering the dialogue we have yet a number of things to sort out amongst ourselves.

Rodney Coe presents the following characterisation of the part we are to play in the dialogue:

> *"Since medical sociology is an applied field, it is incumbent upon sociologists to demonstrate their value by solving problems which result in a product with a clear practical utility for their 'client' — in this case the medical profession."* [1]

I see this as counter-productive. For it accords with and builds upon precisely that medical perception of sociology which as Margaret Reid rightly points out ignores the virtues of recent revivals and developments within the discipline.

First, I take issue with the designation of medical sociology as an applied field. That Coe is explicitly writing a text in the sociology <u>of</u> medicine is I think significant. For while Straus's distinction when stated has an immediate appeal, it becomes decidedly blurred at all sorts of edges when elaborated. (When operating as a sociologist <u>in</u> medicine, do we ignore all the insights of work in the sociology of medicine, or at least Bowdlerise them? Are we to keep a kind of index of dangerous ideas which might corrupt those we are attempting to help teach, or those with whom we are research collaborators? Like good Longfords all, we could justifiably be accused of protestations that conceal a fear for our own (professional) comfort were the dirt to become public). Clearly Straus‘s distinction is but another expression of that between pure and applied sociology. It is because this distinction is spurious that I consider Coe's remark misplaced. Sociology is a discipline in process. A static model of pure on the one hand, to be applied later, on the other, <u>may</u> be appropriate in the natural sciences, but represents one of the very features of the view of sociology here considered problematic. In

the nature of social existence, theories and their application are telescoped to become coincident, such that we have to think of what we do in terms of a relationship between theory and practice which in actuality exist simultaneously, albeit at different categorical levels. Quite simple, however, it emerges from that truism that we are capable of thinking about what we do. As sociologists. we do sociology as we teach and as we research - and as we live and work, for our lives become imbued with the insights derived from our work dealing as it does with the very stuff of life. [2]

An integral part of our work as sociologists is not only continually to make sense of social action from the cultural point of view of the protagonists, but also to exercise continued vigilance, reflexively, of our acculturated selves at work. We have also to ask whether the view of our work held by others does not in part derive from the efforts of those within our ranks. If we do not accept the scientistic view of sociology, then what is incumbent on us is to work out, publicly, how and why we do not accept it and embark an the difficult task of developing an account of ourselves that more closely portrays our preferred mode of operations.

As a small start in this direction I return to the quotation from Rodney Coe. A major theme of medical sociology's examination of its place in the world, is its continued, although sometimes muffled, refusal to accept categories defined for it by the medical profession. [3] We mistake our purpose if we take as unproblematic, a5 Coe seems to do, the designation of the medical profession as our "client". [4]

Sociology has a (notorious) tradition of championing the underdog; a tradition often is a serious danger of romanticising and sanctifying the downtrodden. The poor, the misfit. the deviant is often such because he cannot fight back; he cannot fight back against the investigative curiosity of the sociologist either. That the deviance of Poulson and Watergate emerge not in the course of sociological enquiry but as national scandals reflects nothing more nor less than power. Our relationship with the medical profession, both as we experience it, and as our own literature testifies, is one in which they have more power than we have. Disconcerting as it is, we must not allow this to divert us to a view of that profession as our clients. They are no more our clients than are people at risk of accident crossing the road, than nurses, than hospital secretaries, than patients, than people who smoke… Freidson admits the moral entrepreneurship of sociology‘s view of medicine. Incautiously, perhaps, I submit he is too apologetic. For if there is any meaning to the utility of sociology, it must lie in precisely its own view of the world, however discomfiting, however revelatory, however congratulatory. Sociology persists, as part of its enterprise in refusing to accept others' taken-for-granted.

Let me be not misunderstood. I am no more advocating the cause of the (medically) downtrodden, than rejecting the claim to our exclusive attention of the point of view of the powerful. If we have anything to learn from the labelling perspective of deviance, it is that we cannot view the deviant in isolation from those who so designate him, and those who succeed in making their designation stick. We have to focus on the processes and consequences of the interaction between all parties.

A consultancy view of the task is doubly misleading. Clearly it is readily available, since in one way or another, we are employed by, sponsored by, or at least need the acquiescence of the medical profession, or its agents. We should strive not to let this cloud our sociological judgement, such that we fail to see the situation as one of a conjunction of professional cultures of unequal power. It is misleading further, for thereby we fail to see that the designation of any category as client is yet a version of an expression of medical sociology as applied to sociology.

In some sense, the injunction I imply, namely to have worked out an identification of purpose, is prior to the actual engagement in dialogue, if only to avoid feeling swamped. However, identities develop in interaction. We can start to develop the alternative view of ourselves which we seek to promote if we attempt to bear in mind the kind of themes I have dealt with, not only in domestic discussion in Newsletter, but in the range of context in which we find ourselves face to face with members of the medical profession.

[1] Rodney Coe: Sociology of Medicine, McGraw Hill, 1970, p.23

[2] We are socialised into the sociological culture no less so than doctors who as we are so fond of reminding students, are taught not only pre- and clinical- sciences at medical school, but also the manner of behaving of the medical profession.

[3] Obviously this is a fundamental feature of all sociology, no matter the substantive area.

[4] Nicknames stick. We identify ourselves variously as medical sociologists, sociologists of medicine, etc. Let us watch that we do not start accepting our own emergent taken-for-granted which allows us to forget the task. This task, cumbersomely and programmatically, is to be expressed as the sociology of any social situation in which the designation of health and illness (terms themselves problematic) is an issue.

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