

THE SOCIOLOGY OF HEALTH

Some Questions

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. . . in the social sciences as elsewhere generalization is at once a test of and a stimulus to minute and realistic research. The generalizations will not endure; why should they? They have not endured in mathematics, physics, and chemistry . . . The social sciences must be detached from the conduct of business, the conduct of politics, the reform of this, that, and the other, if they are to develop as sciences, even though they continuously need contact with the phenomena of business, the phenomena of politics, the phenomena of social experimentation.¹

Abraham Flexner

Reflecting society's growing concern in the second half of the nineteenth century with health and social welfare, several closely related disciplines dealing with these issues have gradually evolved. The concern of these scholarly fields was initially with improving the social and sanitary conditions of the population, the control of infectious disease or the resolution of health-related social problems. The theoretical insights and methodologies of the incipient disciplines have become more sophisticated through time, and as Henry E. Sigerist has observed, their ideas "crept in through the back door, more or less haphazardly" into the curricula of medical faculties.² During the past two decades social scientists in increasing numbers have been using the front door of the medical academy and as may be expected of any incomer, their entry has been welcomed

and found to be mutually satisfactory in some universities; in other instances it has resulted in enmity and withdrawal.

This innovation in medical education and research has now taken place in several nations. What is not clear from these various attempts at collaboration between the disciplines is the nature of the social forces that foster or hinder an effective relation from developing in some settings, and the extent to which what has been written by those concerned may reflect circumstances peculiar to a given academic department or nation or has a more universal coinage. This review examines the role of a subspecialty, the sociology of health, as it has evolved in Canada, and compares its past and current status with the state of the discipline in the United States where most of this type of scholarly introspection has occurred.

A second question raised here revolves around the process of accommodation that occurs as social scientists and health workers begin to collaborate with each other. The academic sociologist now faces a dilemma in how his present role is structured and perceived by others. These issues include the extent to which he is going to reproduce students in his own image or to fit them for opportunities in nonacademic settings, whether he can or should remain relatively aloof from a world that increasingly demands the coordination and critical appraisal of his activities and the extent to which, to achieve optimal insights and relevance, he must take a larger role in what he is studying to attain sufficient comprehension of what is happening around him.

Comfortably ensconced in his traditional style of work the sociologist, like any other worker, can be expected to resist some of the changes that are recasting his role. But he retains his current occupational stance at risk for unless he learns to accommodate to altering circumstances, his contribution as a scholar and to society may diminish and lose its social relevance. The sociologist working in a medical setting is an example of some of the strains involved when the processes of collaboration and accommodation with another profession occur as well as sug-

gesting institutional alternatives that may facilitate the effectiveness of interdisciplinary enterprise.

THE DEVELOPMENT OF THE SOCIOLOGY OF HEALTH IN CANADA

The growth of the sociology of health as an academic discipline in Canada mirrors to some extent the emergence of the field as a whole in this country as well as comparable trends elsewhere. At a conference on Social Policy and Social Sciences in 1953, a large group of British sociologists and physicians reviewed investigations in social medicine. From this nucleus has grown the Medical Sociology Group of the British Sociological Association, now numbering over 250 members.³ A somewhat parallel sequence occurred in the United States. In 1955 an Informal Committee on Medical Sociology was convened that subsequently became, in 1960, the Medical Sociology Section of the American Sociology Association. By 1971 the Section had over 800 members. More recently (1971) a new group, the Association of Behavioural Science and Medical Education was formed. Because no Canadian counterparts exist as yet, these several associations serve as organizational focal points for many Canadian medical sociologists.

That this analysis focuses primarily on the growth of the sociology of health in Canada reflects the limited extent to which the other social or behavioral sciences have been involved in comparable interdisciplinary programs. In its 1962 survey of medical education, the Group for the Advancement of Psychiatry found several clinical psychologists, one sociologist and two social workers teaching Canadian medical students on a full-time basis.⁴ Little change has occurred since then in respect to the inclusion of anthropology, political science, economics and to a lesser extent social psychology in the medical curriculum, a trend that will likely change only slowly in the future.

During the 1950's sociologists collaborated on a "by invitation" basis in the curriculum of approximately one-fifth of American and Canadian medical schools. One of the earliest

full-time appointments of a sociologist to a Canadian medical faculty was that of Odin W. Anderson in 1949 to the Department of Psychiatry and Preventive Medicine at the University of Western Ontario. By 1961 six of the Canadian medical schools offered some instruction in the social sciences to their students, although still only one full-time sociologist was working in a medical school. Writing almost a decade ago in attempting then to review the state of the field, it was suggested that although this specialty was insecure and unproven, it held great expectations for the future and "time holds the verdict for their fruition."⁵ In 1961 fewer than a dozen scholars could be identified in this field, a number that has now grown to between three to four dozen individuals. Today, virtually all medical schools in the country have social scientists on their faculties; four have departments or divisions of social or behavioral science. Two of the five dental faculties are developing programs in social dentistry, one involving a sociologist, the other a dentist with postgraduate training in sociology. Similar trends are occurring in the nation's schools of nursing. An exception to this trend are the two graduate schools of public health that have not yet established posts for sociologists or anthropologists.

At the University of Toronto, for instance, several professors and the allied staff of the medical faculty's Department of Behavioural Science offer graduate seminars dealing with different aspects of the field (Sociology of the Professions, Sociology of Health and Medicine and Sociology of Health Service System) and a growing number of Ph.D. candidates are engaged in health-related dissertations. Although the compendium of research in this area is incomplete, and many vital areas remain unexplored, most of the research studies reported have been started since 1960. In areas concerning public policy, several social scientists have served as members or research directors to such programs as the Royal Commission on Health Services, the Royal Commission on Bilingualism and Biculturalism, the Ontario Committee on the Healing Arts, Commission on the

Canadian Public Health Association and the Association of Canadian Medical Colleges.

These developments in the sociology of health and the allied social sciences would not have occurred so rapidly during the past decade without strong encouragement from a few leaders in medical education. In addition, the growth of the field has been prompted further by a widespread recognition that the increasing rationalization of Canadian health and welfare services (e.g., family allowance, old age pensions, universal medicare and hospitalization programs) poses problems in which the involvement of the social sciences may be useful. When Abraham Flexner visited the University of Toronto's Faculty of Medicine in March, 1909, the central concern of educators at that time revolved around the lack of unity and standards in the training of American and Canadian physicians. He, however, perceptively predicted the sequence of change in the transformation of medical education that has occurred during succeeding decades.⁶

The reconstruction of our medical education . . . is not going to end matters once and for all. It leaves untouched certain outlying problems that will all the more surely come into focus when the professional training of the physician is once securely established on a scientific basis. At that moment the social role of the physician will generally expand, and to support such expansion, he will crave a more liberal and disinterested educational experience.

Flexner's report, coupled with the deep concern of many medical educators, triggered a quiet revolution in medical education that resulted in a sharp reduction of the number of medical schools and an increased emphasis on the science and technology of medicine. The predominant concern of medical education in this period is reflected in the limited role played by a specialty such as psychiatry, which had an average of 30 to 40 hours set aside for instruction out of 4,000 curriculum hours in a four-year medical course. As specialization within medicine grew, areas such as pediatrics, psychiatry and social

medicine, which are concerned with the cognitive and social aspects of human behavior, were gradually accepted during the 1930's and 1940's as an integral part of the training of medical students.

These several converging trends—society's greater concern for health and welfare, the emergence of sociology in Canada and the acceptance of socially oriented medical specialties—stimulated the convening of a Workshop on Social Science and Health in Canada in 1969, which was attended by over 70 participants. Subsequently a second workshop was held in 1970, a third is planned for 1971. Five years ago when a suggestion was made by a staff member of a philanthropic foundation that such meetings might be sponsored, the proposal received mixed reactions from sociologists and physicians. Some respondents felt that:

“social scientists in this country are not yet ready to expose themselves to a joint encounter;”

“there is a lack of interest in health and welfare studies on the part of social-behavioral scientists and even more important, there may be a lack of appreciation by medical and allied professions of the social implications of much that is currently developing;”

“I do not think we need a forum . . . for the discussion of ideas by medical sociologists. American journals and meetings are sufficient for this purpose;”

“I doubt that there are a sufficient number of interested scholars in the country to make a proposal of bringing them together.”

The amount of interest in these workshops coupled with approximately 15 per cent of sociologists in the country having some form of interest or involvement in the field suggests that these reservations are no longer valid.⁷

A GRAMMAR OF PREPOSITIONS: OF AND IN

Whether the innovation of the social sciences in medical education has taken root is mainly a function of the type of sponsorship proffered by academic leaders. In some medical

schools professors are still skeptical about the relevance or utility of these disciplines. Obviously in these settings such programs have not been started. In other faculties two discernible trends have evolved: some in which social science programs have been started, others in which a strong public espousal of the merits of these topics has not yet been matched by the creation of relevant teaching units. In the latter case questions of the professional competence of the academic newcomers and the need to share responsibility for topics that have already been pre-empted by physicians may well be the issues at stake. Where these programs have been tried, strong leadership typically has come from the dean of medicine and the chairmen of several key departments. Several of these sponsors, as might be expected, have had a deep interest or formal training in pediatrics, psychiatry or social medicine, all specialties epitomizing the social and psychological components of medical practice.

Every institution and each occupation evolves distinctive patterns that establish who is recruited, who gets ahead, what constitutes the special prerogatives of positions at different levels and the types of tasks performed. When these questions are asked about the role of sociologists in medical schools certain patterns emerge. Regardless of their present affiliation, whether in an autonomous department of behavioral science or as a professor working directly under the aegis of the dean's office, most of these teachers previously served an apprenticeship as a junior member of a department of psychiatry or preventive medicine. In the few instances where such programs have been discontinued, reappointments not made, or that have resulted in manifest dissatisfaction on both sides, the social scientists involved have usually had none or limited health-related experience.

In addition to a clash in the career expectations of the sociologist and the physician, the ascriptive attributes of these individuals may be substantively different. Typically the sociologist is relatively young, occupationally highly mobile, often a recent graduate who rarely has taken postgraduate training and one out of four is a woman.⁸ Their lack of self-assuredness and

limited knowledge of complex health issues often ill suits them to act realistically as collaborative peers with health workers. In contrast, the physicians with whom the sociologist may be expected to work in a university setting change their jobs less frequently than do sociologists, are usually specialists, male and middle-aged. On these grounds alone a superordinate-subordinate set of relations between the disciplines might well be expected to develop, as well as a differential knowledge of and involvement in university affairs. That more sociologists in health activities may be women than is the case in either sociology departments or medical faculties serves to reinforce the male-female patterns of authority so characteristic of the North American medical profession.

These differences in attributes and conceptual outlook, which may make some social scientists unsuited for close collaboration with physicians, may, it has often been contended, serve to safeguard their objectivity. In 1956 Robert Straus distinguished between the sociology of medicine and sociology *in* medicine. Subsequently, he has suggested that:⁹

these two types of medical sociology tended to be incompatible with each other; that the sociologist of medicine might lose objectivity if he identified too closely with medical teaching or clinical research while the sociologist in medicine risked serious role conflict and jeopardized his none too secure acceptance if he tried to study his colleagues.

One of the major dilemmas, then, which may be encountered by those sociologists working in medicine, is what constitutes their reference group and whether they become in Merton's terms "cosmopolitan" or "local" professionals. The former "place loyalty to their profession . . . above their loyalty to their employer," whereas the latter adopt the perspective and values of their new institutional setting.¹⁰

This argument has been adopted in part by Freeman, Levine and Reeder in their appraisal of "The Present Status of Medical Sociology" in 1963, who suggested that sociologists *in* medicine may develop certain protective rationalizations for their role

such as: their involvement is a precondition to undertaking more valid work in the future; research support is more accessible; or a "good" scholar can elicit the sociologic relevance of any problem, no matter how mundane it is.¹¹ They conclude that for the sociologist who contemplates working in medicine, "it is dangerous . . . to proceed without safeguarding his professional identity."¹² Freidson's condemnation of such involvement is even sterner as he concludes that "collaborating with medicine in its institutionalized tasks requires adopting that distorted view with all its deficiencies." He counsels that the sociologist should pursue "the same detachment and suspension of commitment that it is inclined to adopt in the study of folk or primitive medicine."¹³ Harsh words indeed. This contention as developed lacks the safeguards of comparison and control for what has happened to sociologists working in other settings and, because of the recent emergence of the field of the sociology of health, while it may be valid, it still remains conjectural.

As argued by these scholars it is unclear why, for instance in the study of medical practice, the objectivity of the sociologist is any more accurate or relevant when he is an uninvolved bystander than when he is an active participant observer.¹⁴ Each method of inquiry is amenable to uninformed and biased interpretation of what is being observed. There is little doubt that in the selection of issues explored in the sociology of health only a narrow range of potential topics has been studied. This state of affairs is not peculiar to this field. It may be asked for instance why Roethlisburger and Dickson studied workers, not management; why the consortium of scholars involved in *The American Soldier* analyzed soldiers, not officers or wartime policies; or why the outpouring of reports on voter preference and community studies have not concentrated on political decision-making and lobbies, but dealt instead with the accessible lay citizen? In all of these cases and others, it would appear that the scholars involved may have had an equally "distorted" perspective of the larger issues at stake.

These several authors who have commented on the state of

medical sociology have had second thoughts about the validity of their viewpoint. Straus, for instance, has counselled that the sociologist who becomes "a good chameleon" can do so "without sacrificing either his integrity or his professional identification."¹⁵ "The fostering of the physician-sociologist relationship," Freeman and Reeder asserted earlier, "requires participant experience in the medical setting."¹⁶ And Freidson candidly admits that "in general, when I test what I have learned about medicine against my experiences with my colleagues teaching in universities, it seems to me that whatever difference exists is in favor of physicians." He further observes that "as a profession medicine is better regulated and provides a more honest product than does university teaching."¹⁷

What may underlie these questions are two different styles of work. The scholar as depicted by Durkheim, Veblen and others has the duty "of submitting his judgment to no authority other than reason."¹⁸ The academic sociologist, as Reader has noted, is accustomed to "little authoritarianism or hierarchical structure and . . . research is done almost entirely as an individual activity."¹⁹ The style of work to which the sociologist and the physician are accustomed differs often by a subtle nuance in respect to the tempo of their activities, how they organize and schedule their responsibilities, in their body idiom, grooming and dress, their relations with other individuals and, not least, in how and how much they are paid and socially rewarded for what they do. The physician for instance uses purposive questions, often intervenes in his patients' affairs that are of a sensitive, personal nature or makes decisions that affect their life chances.

The physician and the sociologist differ not only in who they are but also, even if they are university professors, in the types of social subsystems in which they work within the academy. The medical subsystem is more closed than that to which the scholar is accustomed for the physician's daily routine is circumscribed by ward and grand rounds at which his work is reviewed, if he is a surgeon his effectiveness is monitored by a hospital

tissue committee, and his scientific papers are often subject to review prior to publication by his chairman or by an academic editor. In contrast, the sociologist usually prepares for his lectures by himself, delivers them without peers being present, less frequently collaborates with others in undertaking or writing up his research activities and relies on the judgment of the general scholarly community to establish his competence. He often resents the social fetters imposed, if indeed they are, of detailed group curriculum planning, or peer and student review of his ability as a lecturer. Considered singly, none of these differences is of particular significance. Their collective fusion in different work roles, however, becomes the hallmark of the scholar or the professional.

When a scholar such as a sociologist joins a medical faculty, it is he who is regarded as the outsider, perhaps even a deviant. He in turn "may not accept the rule by which he is being judged and may not regard those who judge him as either competent or legitimately entitled to do so."²⁰ From the comments cited earlier it is apparent that for some individuals this is indeed the case. In his perspective and attitudes the academic sociologist is in some respects not unlike the solo family doctor. Both are accustomed to working by themselves, bristle at bureaucratic or professional control of their work and frequently find genuine collaboration difficult. Although this role may serve to preserve professional autonomy, its dysfunctional facets cannot be discarded merely as role rationalizations. In most sociologic studies few, if any, peer groups checks govern the collection of field data, their statistical analysis or the reliability of their interpretation. Such controls, and the possibility for replication are made even more difficult by a custom that is frequently followed of attributing pseudonyms or anonymity to the settings that have been studied, or the composition of statistical tables that often precludes verification or replication.

Because of his training, which epitomizes individualism, the sociologist working in a medical setting involving a complex technology and a myriad of overlapping social transactions may

have only a limited appreciation of what is actually happening. Indeed, given the explosion of knowledge in most areas and the institutional and technical complexity involved in many issues, the question of the degree of involvement in a given setting is a central dilemma for the scholar. The sociologist has several alternatives in resolving this issue. To understand more fully the issues at stake in complex problems such as pain, stress or death, he may seek additional training in the basic physical or medical sciences, complement his perspective by collaboration with a physician or superimpose his own conceptual framework on those aspects of the situation that his training has taught him to perceive.

Few sociologists or physicians have chosen the first two alternatives. That only a handful of men have had dual training in social science and medicine has been borne out by a study prepared by the United States National Institutes of Health in 1968, which reported that 12 per cent of teachers of medical sociology held both an M.D. and a Ph.D.²¹ Most of the studies that have been done to date in the sociology of medicine have been the products of those working on the sidelines of medicine. Their detachment, while protective of role identity, has often precluded a more sophisticated and penetrating analysis of what they are studying and, on occasion, has resulted in interpretations that may most charitably be regarded as specious, simplistic or nonverifiable. Although their independent stance may reduce one of the role friction points inherent in working in medicine, it may also subtly increase the unreliability of their observations. In sum, the field is too new in Canada, perhaps for the United States and elsewhere to accept or reject at this time Straus' proposition. Only when recently established programs in medicine have matured will it be possible to compare the significance of the contributions of sociologists "in" or "of" medicine with those of scholars who for historical reasons in this country have been members of academic departments.

It still remains for sociologists and physicians, to work together on a basis of genuine collegueship. It is often assumed

that the study of the health professions or working in medicine is synonymous with collaboration. But collaboration between the two disciplines, that is, the joint planning, the execution and the reporting of findings has occurred rarely in Canadian or American studies. Such joint efforts have produced some of the most useful contributions to both sociology and medicine. The attributes of those involved, how their frustrations were reconciled and the settings in which their work was conducted all merit further exploration.

RECRUITMENT AND GROUP PRESSURES

The winnowing process in the recruitment of social scientists working in medicine has been determined by a man's background and philosophical outlook as well as by his reception in a medical faculty. Medicine, like other fields, draws many of its teachers from a few academic islands of excellence and has tended to use its own canons in the process of interdisciplinary recruitment. For example, one-sixth of all full-time teachers and approximately a quarter of all deans of American medical schools received part of their training at Harvard University or one of its affiliated teaching hospitals.²² That the medical and sociologic prestige ratings of universities differ is underscored by the sources of academic training of the social scientists in the health field in Canada, many of whom received their training at McGill, Toronto, Harvard or Yale. Those sociologists who are more rather than less involved in teaching medical students in the United States or elsewhere may also tend to select newcomers from universities perceived as having prestige in medicine.²³

Although little is known about the backgrounds of American medical sociologists, impressionistically, a disproportionate number (relative to the composition of the American population) may be members of various religious, ethnic and racial minority groups. This is not the case in Canada, which is still bound by a more conservative and rigid social structure than is the

United States. Although a medical sociologist's ascribed class background does not appear to have affected his acceptance and it has been on the basis of his achieved academic status that he has been judged, most of the academic pioneers in this field in the English-speaking universities in this country are WASPS (one-third of the population is of non-British or non-French origin) and most have adhered in their dress and personal grooming to a "cleancut" prototype, all attributes that accommodate readily with the traditional, but now gradually changing image with the physician. Also, although the majority of sociologists with Ph.D.'s in Canada are Americans, of those social scientists who have been "ice breakers" in medicine (i.e. representing the initial full-time appointment in this field by a medical faculty), virtually all have been of Canadian or British origin. These selective factors, while still operative, may exert less influence in the process of recruitment in comparable American settings, a country whose society is often suggested as being more open and heterogeneous.²⁴

Posts requiring interdisciplinary collaboration involve several areas of potential role conflict. For example, because of his nonmedical training the sociologist in medicine may be unintentionally dominated or deliberately upstaged, despite his rank, by a physician. Likewise, even first-year medical students who may reject the subject matter in a particular part of a course in behavioral science can effectively "retaliate" by asking questions that require medical knowledge. Perhaps the severest dilemma a social scientist must resolve is how to present his ideas and subject matter to students in another profession. L. J. Henderson's wry observation remains undemonstrated but still an important issue that "skill in managing one's relations with others is probably less common among professional psychologists and sociologists than among the ablest men of affairs or the wisest physicians."²⁵ Perhaps he like others of us was generalizing too broadly from personal experience, for he apparently had a profound influence on Talcott Parsons' formulation of his notion of pattern variables. In any event there is at present no

consensus in Canada about either what should be taught or how instruction should be given. Until recently, although this situation is changing, no established career ladders or tenure positions existed for sociologists in medicine.

The behavioral science in medicine programs in Canada represent different degrees of commitment, the sharing of responsibilities and prerogatives given to these academic newcomers by medical faculties. The involvement of the social scientist ranges from: partial (e.g., where psychiatry may direct this portion of the curriculum); intermediate (e.g., where the program is under the joint aegis of community medicine or psychiatry with active social science representation); to more complete (e.g., divisional status evolving into an autonomous department). The correlates of these institutional arrangements are reflected in the degree of autonomy in fiscal affairs, responsibility for the planning and review of the curriculum and in making staff appointments. Membership on pivotal committees, a tangible measure of acceptance and status, also varies; e.g., admissions, examination, faculty appointment or executive or heads of departments.

A review of Canadian programs also illustrates a range of arrangements that have been made with academic departments of psychology and sociology. In one instance social scientists are virtually full-time members of an academic department of sociology. In contrast, in another university a dual cross-appointment arrangement has been established, on the one hand, drawing in members of the academic department in research and planning activities, and on the other of the sociologists in medicine giving graduate and undergraduate courses and serving on Ph.D. supervisory committees.

The variability of these institutional arrangements is crucial to understanding what the sociologist may or may not do in his new setting, the extent to which he is or is not subordinated to medicine, how and by whom his activities are observed and the nature of his perspective of the field. The quality of his work and how his sociologic imagination is kindled may also vary by

the type of institutional post he holds. From the literature it would appear that where sociologists have been members of a clinical department such as psychiatry they have more often reported frustrations, a sense of subordination and of competition with physicians. It is in such settings where the clinical chief's authority is paramount and recognized, where rapid decisions in patient care have to be made and where spheres of responsibility are relatively sharply delineated. Caught in this type of institutional web the sociologist by definition cannot do his teaching or research work on an equal footing with the practicing physician.

Where institutional safeguards have been introduced by intention or accident or where a vital nucleus of social scientists has been involved together with medical colleagues, as in the case of the Columbia-Cornell and Kansas City studies of medical education, the critical observations of the scholars concerning their own roles have been less prominent in their writings and their insights have made a substantive contribution to the sociology of education or of the professions.²⁶

Seminal conceptual models for the social sciences have also emerged from a second type of involvement by sociologists working in medical settings. In several instances where the social scientist has initially been a full-time participant or collaborator, he has subsequently had an opportunity for a partial or complete withdrawal to formulate his analysis of what he has observed in the presence of academic peers. Talcott Parsons, for instance, acknowledges that his interpretation of the social system was influenced by a field study of medical practice he had carried out some years earlier in Boston and his contacts with L. J. Henderson. Erving Goffman, after a year's intensive participation observation of the social life of the mental patient, had several opportunities for further study and discussion with colleagues as he wrote perceptively about the matrix of the total institution or behavior in public places. Friedson's recent contributions to the sociology of the professions draw heavily

upon his residency at the Montefiore Hospital in New York City.²⁷

These trends suggest not that sociologists should abhor involvement in unfamiliar settings, but that when such ventures are undertaken they, like other workers, need the critical presence or review of colleagues, a relation established either through effective cross appointments to a parent discipline, through the introduction of a group of social scientists on a medical faculty or through a subsequent opportunity for analysis in the company of scholarly peers. What is being suggested here is hardly new and an analogy can be drawn for the sociologist of Hall's distinction between an "individual" and a "colleague" careerline.²⁸ Whether working in a department of sociology or a medical setting the influence of colleagues of a similar discipline is vital to ensuring the quality and relevance of what the scholar does. Too often, it would seem, for both settings this type of catalytic relation may not occur and little systematically collected information exists on the patterns of formal and informal control or supervision among sociologists.

Whether working in a medical context or otherwise, sociologists, whose business it is to understand others, have seldom written frankly and fully about their experiences, their motives or their academic settings. The insights that might be gained from such professional introspection might provide a better understanding of why some programs are thought to be successful and others may be quiet failures. Some of the reasons for these variable outcomes stem from the ascriptive attributes of those who are so involved, whether work is done by individuals or in colleagueship type groups, the structural settings in which this innovation takes place, and the extent to which genuine collaborative links are established between disciplines.

In respect to the prerogatives he enjoys and the frustrations he may endure, the sociologic newcomer of today is no different from his predecessors in other basic science or clinical medical specialists who in some instances served an apprenticeship of

several decades before their academic credentials were fully accepted in medicine. Considering the recent emergence of the field and the fact that the United States National Board of Medical Examiners has now introduced examination questions on behavioral science, this field may well have gained more rapid acceptance in medical education than is the case historically for many other specialties. The microcosm of the sociology of health in Canada is too limited a cross section of the field to assess the broader validity of most of the observations made here on the sociology of medical sociology. Some of these points it is hoped will be further explored in the United States in a study of *The Teaching of the Behavioral Sciences in Schools of Medicine*, which is now being carried out under the auspices of the Medical Sociology Section of the American Sociological Association.

TRENDS IN RESEARCH

The research that has been undertaken in social science and health in Canada has predominantly dealt with the organization of health services, the sociology of mental illness and the social attributes of patients with specific diseases. The volume of literature on the sociology of health in Canada has expanded rapidly during the past decade. Several useful books have been written by university based scholars and their output has been complemented by thorough case reports commissioned by provincial or federal commissions that have scrutinized health services. Sociologists, for instance, prepared reports for the 1964 Royal Commission on Health Services on dental manpower (B. McFarlane), use of dental services (O. Hall) and the role of chiropractors, osteopaths and naturopaths (D. Mills). Several of the reports of the 1970 Ontario Committee on the Healing Arts drew heavily on the findings and conclusions of sociologic studies.

Although many of the studies have been of a descriptive or social epidemiologic nature, they provide a fertile and neces-

sary foundation for the testing of sociologic theories or the formulation of new research ventures. Several relatively "neutral" issues of broad social interest have received little attention, whereas questions sensitive to medicine have been largely ignored. Such areas include: the nature of the transactions between doctors and patients; the impact of the health services on the population; how doctors and other health workers are paid; what changes in status are involved in the transfer of functions from one category of worker to another; the social structure of the medical profession, or its relation to the state. When issues of this type have been considered, almost all of the scholars concerned, for whatever reasons, are no longer working in Canada.

Sociologists have explained their choices of certain topics for inquiry as opposed to others by such factors as the scarcity of qualified investigators and the recent development of the field. These factors by themselves do not provide a sufficient explanation of how and why certain areas have been selected. The decisions made by researchers may have also been influenced by the availability of scarce research funds for particular projects, and by a "stand-pat" orientation that has been adopted toward many vital social issues. But perhaps the most relevant reason why studies in some areas have not been initiated is that sociologists either have not recognized their potential sociologic interest or simply may not have had enough knowledge about the intricate social complexity of the health system to formulate sociologically relevant questions.

Most of the researchers have sought to present their findings from an ideologically neutral perspective, but the problems they have selected, and the conclusions they have reached all reflect their underlying moral notion of society. Often by accepting society as it is, some observers have tacitly injected a conservative interpretation of what men are doing and of existing patterns or social relations. Most studies of medical education for instance, whether Canadian or American, fall into this category. These reports implicitly and unintentionally buttress

the existing system of medical education as justified and necessary without reviewing the development of this institution from either a historical or international perspective. Few social scientists have considered structural alternatives to existing ways of educating doctors or nurses, mechanisms for effecting their geographic redistribution or institutional options that might modify their working conditions. Such an approach is usually rejected as radical, polemic or perhaps unscientific. The rebuttal of this position is less a question of scientific method, although it is often phrased in these terms, as it is of conservative, liberal or radical values underlying the selection and the articulation of what is studied and how it is analyzed.

Most researchers whether medical or sociologic, when they deal with the psychologic and social aspects of the health system appear to adopt a perspective of liberal practicality. C. Wright Mills has asserted: "If there is any one line of orientation historically implicit in American social science, surely it is the bias toward scattered studies, toward factual surveys and the accompanying dogma of a pluralistic confusion of causes."²⁹ He concluded that this approach readily lends itself to the "liberal politics" of "piecemeal reform," of effecting minor modifications in existing social institutions. The ideologic purport of many studies in the sociology of health represent a modest nudge of the *status quo*, a sense of restrained social commitment. Freidson's recent study on PROFESSIONAL DOMINANCE or Duff and Hollingshead's SICKNESS AND SOCIETY are notable exceptions to this trend. That social inequities exist in who receives care or that the receipt of health and welfare services may be fragmented often evokes tacit or explicit conclusions about how health services may more effectively reach disadvantaged groups, how patients with special problems may be more efficiently treated, how students can be more suitably socialized or how the staff of clinics and hospitals can more readily accommodate themselves to patients. These putative reformers seldom consider such issues from a broader context of the total

fabric of the health system that may account for this shaping of human affairs.

For whom does the medical sociologist publish and in which journals are his books reviewed? Not unlike the scholar posed between two cultures, in C. P. Snow's phrase, the scientific and the humanistic, he is never certain at least in Canada to whom he is an insider or an outsider. The Canadian sociologist, unlike his American counterpart, is caught in a most intricate web consisting of several audiences for whom he may write: social scientists in Canada or the United States, the medical profession or the public. He has usually resolved this dilemma by publishing most of his papers either in American social science reviews, a professionally prestigious outlet or in Canadian medical journals. Whether he has sought out or been rejected by several Canadian social science or public health journals is unknown. Such journals either have seldom published book reviews or have ignored acknowledging the publication of several key volumes or federal commissions dealing with the field in this country, thus effectively curtailing the interests of a potential lay and professional audience. If assessment has occurred, it is more often found in the pages of literary weekend newspaper supplements.

The organization of the medical profession has also influenced the types of investigation that have been done or left undone. Many occupations seek to preserve their autonomy and where possible to deal internally with sensitive problems. Many university professors for instance still ardently oppose any attempt to evaluate their abilities as teachers or researchers by their professional peers or students. In a similar fashion the medical profession has often been reluctant, either publicly or in its own councils, to deal with issues about which they are uncertain or that may be internally divisive. Whether the result of a lack of medical sponsorship or sociologic imagination, more studies in Canada and apparently elsewhere have dealt with patients rather than with doctors, medical students

than medical teachers, or disease patterns than the organization and politics of the health service system. Rue Bucher for instance in her analysis of the social organization of a medical school with some trepidation observes that, "To my knowledge one other investigator has extensively interviewed the faculty of a medical school." The conclusions of that study have not been published "because the situation was deemed too delicate."³⁰

The collective impact of these several historical influences has produced a newly minted field of the sociology of health in Canada, which to date has made only a modest contribution to sociologic theory or methodology, and has not always been perceived as particularly relevant by the medical profession. Indications are that this situation may be changing as more sociologists become involved in health-related activities, as increasing numbers are serving on public or professional committees and are being sought out as teachers and researchers by the health professions. For the decade ahead the areas of potential collaboration are unlimited; their realization is dependent not so much on the necessary availability of fiscal resources for research, but on the growth of a sense of mutual professional respect and of the structuring of institutional settings that foster creative scholarship.

CONCLUDING OBSERVATIONS

For several decades social scientists and health workers have been discussing how they might more effectively work together. This exchange of views, on occasion uninformed, always challenging, has gradually led to a better understanding by both disciplines of some of their differences and of the key issues involved. As this dialogue continues in the future it may signify for the sociologist the development of a new role, one involving both more colleagueship with his peers and members of the health professions. Writing in 1945, Henry E. Sigerist, in proposing a program for a new medical school, asserted "that

a department devoted to the social sciences in the medical school has an important function to fill.”³¹ His prediction, now occurring, may represent for the sociologists so involved the gradual transformation from their traditional roles as individualistic scholars to academic professionals. Writing a quarter of a century later New and Bynder have trenchantly observed that if the sociologist cannot achieve his optimal work in such a setting then “we would know clearly we have been living in a dream world.”³² The academic millennium they advocate is of itself not a sufficient cause to generate conceptual insights or to safeguard the sociologist from being hampered by the purposes of others. The emergence of this new scholarly hybrid represented by the sociologist in medicine may provide us with a better opportunity of assessing what influences the sociologist in different work settings in regard to his outlook and research contributions.

It has become axiomatic that reviews of a discipline, particularly if written by those who are involved in it as in this case, should end on an optimistic note, calling for “greater things to come in the future.” Too often such reviews have concentrated on the byproducts of scholarship and have not examined the settings or conditions from which they have emerged, the characteristics of those who have been involved or for whom the state of the field may represent a contribution to knowledge. As social science and medicine evolve in the future, what is called for to complement these appraisals is a more penetrating evaluation than we now have from the perspective of those working in different settings and in different nations of the sociology of medical sociology.

REFERENCES

¹ Flexner, A., *UNIVERSITIES: AMERICAN, ENGLISH, GERMAN*, (revised edition), London, Oxford University Press, 1968, pp. 12, 17.

² Sigerist, H. E., *THE UNIVERSITY AT THE CROSS-ROADS: ADDRESSES AND ESSAYS*, New York, Henry Schuman, 1946, p. 132.

³ Madge, J., Trends in British Sociological Research Since 1950, *Transactions of the Third World Congress of Sociology*, 8, 85-105, 1956; see pp. 99-101 on medical sociology; recent data on the Medical Sociology Group of the British Sociological Association were provided by Derek Gill of the Medical Sociology Research Unit, University of Aberdeen.

⁴ Group for the Advancement of Psychiatry, *The Preclinical Teaching of Psychiatry*, New York, Group for the Advancement of Psychiatry, Inc., 1962, Report number 54.

⁵ Badgley, R. F., Sociology in the Medical Curriculum, *Canadian Medical Association Journal*, 84, 705-709, 1961; ———, Social Sciences and Public Health, *Canadian Journal of Public Health*, 54, 147-153, 1963.

⁶ Flexner, A., MEDICAL EDUCATION IN THE UNITED STATES AND CANADA, Boston, The Merrymount Press, 1910, p. 48.

⁷ Connor, D. M. and Curtis, J. E., SOCIOLOGY AND ANTHROPOLOGY IN CANADA, Montreal, Canadian Sociology and Anthropology Association, 1970, p. 16. Specialty interests indicate only 12 sociologists, or 2.4 per cent, listed medical sociology as their prime interest, in contrast with at least 15 per cent who have or are currently undertaking research in the sociology of health.

⁸ *Medical Sociology Newsletter*, American Sociological Association, 6, 4, Winter, 1970; see also Anderson, O. W. and Seacat, M., *The Behavioral Scientists and Research in the Health Field*, Health Information Foundation Research Series 1, 1957; ———, *An Analysis of Personnel in Medical Sociology*, Health Information Foundation Research Series 21, 1962; National Research Council, *Profiles of Ph.D.'s in the Sciences: Summary Report on Follow-up of Doctorate Cohorts, 1935-1960*, Career Patterns Report No. 1, Washington, National Academy of Sciences, 1965, pp. 47-49; Elbridge, S., THE EDUCATION OF SOCIOLOGISTS IN THE UNITED STATES, New York, Russell Sage Foundation, 1963, pp. 50-51. The observations in this section that pertain to Canada and the United States appear to characterize the development of the field in several other nations.

⁹ Straus, R., The Nature and Status of Medical Sociology, *American Sociological Review*, 22, 200-204, 1957; ———, The Nature and Status of Medical Sociology, A Reappraisal, Chairman's Address to Medical Sociology Section, American Sociological Association, Boston, 1968.

¹⁰ Merton, R. K., SOCIAL THEORY AND SOCIAL STRUCTURE, Glencoe, Illinois, The Free Press, 1957, pp. 387-420.

¹¹ Freeman, H. E., Levine, S. and Reeder, L. G., Present Status of Medicine Sociology, in Freeman, H. E., Levine, S. and Reeder, L. G. (Editors), HANDBOOK OF MEDICAL SOCIOLOGY, Englewood Cliffs, New Jersey, Prentice-Hall, Inc., 1963, pp. 476-479.

¹² *Ibid.*, p. 479.

¹³ Freidson, E., PROFESSIONAL DOMINANCE: THE SOCIAL STRUCTURE OF MEDICAL CARE, New York, Atherton Press, Inc., 1970, pp. 42, 54.

¹⁴ Lest this discussion be misconstrued as a "protective rationalization" of my role, my post in the medical faculty is complemented by a cross appointment in sociology that involves a graduate seminar and the supervision of Ph.D. candidates.

¹⁵ Straus, *op. cit.*, p. 204.

¹⁶ Freeman, H. E. and Reeder, L. G., Medical Sociology: A Review of the Literature, *American Sociological Review*, 22, 73, 1957.

¹⁷ Freidson, E., PROFESSION OF MEDICINE: A STUDY OF THE SOCIOLOGY OF APPLIED KNOWLEDGE, New York, Dodd, Mead & Co., 1970, pp. 380-381.

¹⁸ Durkheim, E. (translated by Brookfield, C.), PROFESSIONAL ETHICS AND CIVIC MORALS, Glencoe, Illinois, The Free Press, 1958, p. 5.

¹⁹ Reader, G. G., Contributions of Sociology to Medicine, in Freeman, Levine and Reeder, *op. cit.*, p. 13.

²⁰ Becker, H. S., OUTSIDERS: STUDIES IN THE SOCIOLOGY OF DEVIANCE, New York, The Free Press, 1963, pp. 1-2.

²¹ Manpower Analysis and Statistics Branch, National Institutes of Health, Bethesda, 1968.

²² McCord, D. (Editor), BIBLIOTHECA MEDICA: PHYSICIAN FOR TOMORROW, Boston, Harvard Medical School, 1966, p. 7.

²³ See *Medical Sociology Newsletter* and Anderson and Seacat, *op. cit.*

²⁴ Lipsett, S. M., THE FIRST NEW NATION: THE UNITED STATES IN HISTORICAL AND COMPARATIVE PERSPECTIVE, New York, Anchor Books, 1967, Chapter 7.

²⁵ Henderson, L. J., The Patient and Physician as a Social System, *New England Journal of Medicine*, 212, 819, 1935.

²⁶ Merton, R. K., Reader, G. G. and Kendall, P. L., THE STUDENT-PHYSICIAN: INTRODUCTORY STUDIES IN THE SOCIOLOGY OF MEDICAL EDUCATION, Cambridge, Harvard University Press, 1957; Becker, H. S., Geer, B., Hughes, E. C. and Strauss, A. L., BOYS IN WHITE: STUDENT CULTURE IN MEDICAL SCHOOL, Chicago, University of Chicago Press, 1961.

²⁷ Parsons, T., THE SOCIAL SYSTEM, Glencoe, Illinois, The Free Press of Glencoe, 1964, pp. vii-xii, 428; ———, THE STRUCTURE OF SOCIAL ACTION, Glencoe, Illinois, The Free Press, 1949, pp. v-viii; Goffman, E., ASYLUMS, Garden City, New York, Anchor Books, 1961, pp. ix-xi; ———, BEHAVIOUR IN PUBLIC PLACES, New York, The Free Press, 1963, p. v; Freidson, E., PATIENTS' VIEWS OF MEDICAL PRACTICE, New York, Russell Sage Foundation, 1961, pp. 7-8; ———, PROFESSIONAL DOMINANCE, *op. cit.*; ———, PROFESSION OF MEDICINE, *op. cit.*

²⁸ Hall, O., Types of Medical Careers, *American Journal of Sociology*, 55, 243-253, 1949.

²⁹ Mills, C. W., THE SOCIOLOGICAL IMAGINATION, New York, Oxford University Press, 1959, p. 85.

³⁰ Bucher, R., Social Process and Power in a Medical School, in Zald, M. N. (Editor), POWER IN ORGANIZATION, Nashville, Vanderbilt University Press, 1970, p. 4.

³¹ Sigerist, *op. cit.*, p. 142.

³² New, P. K.-M. and Bynder, H., Issues and Problems in the Teaching of Social Sciences in Health Professional Schools, *Social Science and Medicine*, 4, 603, 1970.