Organizational Authority and Professional Responsibility in Clinical Sociology

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When, if ever, are clinical sociologists justified in accepting the directives of employers and management sponsors as setting the parameters within which they proceed with their work? In particular, is it ever permissible for clinical sociologists to accept an employer's or a manager-sponsor's definition of a problem to be studied, even though they may not view it as the more fundamental problem needing study in the situation? These questions are important for understanding the professional role and moral responsibilities of practitioners in the still-coalescing profession of clinical sociology. They also have increasing practical importance at a time when job opportunities for sociologists are shifting from academia to industry and government--both within organizations as employees and as external organizational consultants.

My aim is not to attempt a direct response to the questions in the form of providing a set of simple guidelines. Instead, it is the more modest one of arguing against two influential answers to them. Several prominent writers have held that to the extent sociologists study what employers or manager-sponsors tell them to study, they are either (1) not doing clinical sociology at all, or (2) abdicating a large share of their professional responsibilities. I want to challenge these views in, respectively, Part I and II of this essay, and in doing so comment on the legitimate interplay between the organizational authority of management and the professional responsibility of clinical sociologists.

I.

In his insightful and influential essay, "Explorations in Applied Science," Alvin Gouldner (1965) tacitly held that to the degree sociologists follow a client's definition of a problem to be studied, they are not doing clinical

sociology. Gouldner formulated two models for applied sociology: the clinical and the engineering. He cites as an approximate illustration of the clinical type a study at Hacienda Vicos, an Indian community in Peru. The social scientists discovered that much of the strife among various groups of the Indians was due to fights over the ownership of cattle. They suggested a simple program of branding. This idea was immediately verbally agreed to, but it was implemented only after the scientists provided branding irons and initiated further discussions with leaders of the groups. The branding system successfully ended the disputes over the ownership of cattle.

Gouldner's example of the contrasting engineering approach is the familiar case of an industrial firm which hires a consulting social scientist to assess employees' satisfaction with their work. The scientist conducts a survey of employee attitudes and conveys statistical information in a report to the management of the industrial firm. The report usually includes "some recommendations for changes in the company's labor relations policies" (p.11). At management's discretion, the sociologist may discuss the report with management before it "may be quietly interred in that graveyard of creativity, the filing room" (p.11). The attitude survey usually throws little light on any underlying problems which probably were vaguely sensed by management and had led them to request the survey in the first place--problems such as weakened informal communication channels between management and workers. Moreover, the report may be used by management during union negotiations in a way that heightens labor-management tensions.

On the basis of these two examples, Gouldner itemizes a number of differences between the clinical and engineering approaches within sociology and other applied social sciences.

1.   The "consulting 'engineer' has conceived and completed his assignment largely in terms formulated by his client" (p.11), and hence merely studied what he was told to study (p.13). Clinicians, by contrast, study the problem that they identify by their independent judgment. And they attempt to arrange the "relationship with a client so as to secure the latter's consent to examine (i.e., diagnose and treat) the underlying problems" of the group (p.19).

2.   Engineers present their results and proposed solutions to just their client-sponsor, typically management. Clinicians present their results to all groups involved in the study (p.14).

3.   Engineers view themselves as mere bearers of facts and figures, which are generally best conveyed in writing (pp. 17-18). Clinicians emphasize the personal interactions necessary for helping the client to genuinely *"learn something"* (p.20).

4.   Engineers presuppose their client's values as given and settled, and affirm a strictly value-neutral approach. Clinicians establish a relationship where the client's values "may legitimately come up for re-examination in the light of their connection with the client's problems" (p. 14).

5.   Engineers naively assume that their clients will accept as true whatever is discovered through proper scientific investigation. Clinicians expect resistance from the clients and come prepared to deal with it (p.19).

My interest here is with (1), which is logically distinct from the other features. It sets up the valuable guideline that sociologists seek to obtain client consent to get at the fundamental problems. But it also goes beyond this in implying that to the extent sociologists work on problems as identified and assigned by their mangement-client or employer they are not doing *clinical sociology. This seems to me an inadequate way of conceptualizing what con-*stitutes clinical work in organizational development.

To begin with, Gouldner's descriptions of the examples involve both under-description and slanting in ways that are relevant to the issue at hand. Missing from the industrial consulting case is a specification of the recommendations made by the consultant concerning ways to improve the company's labor relations policies. Suppose that the recommendations were based upon or embodied insights that the consultant had gained while conducting the study and while exercising a significant degree of helpful diagnosis of the workers' attitudes. Suppose further that if the recommendations were acted upon by management they would lead to marked improvement in the job satisfaction of the employees, greater openness and trust among employees, lessened anxiety, or healthier attitudes. In that case I would see no reason for refusing to view the sociologist's work as "clinical" in nature.

The description of the consultant case is slanted because of the virtual assumption of an absence of genuine good will in the management. Management is portrayed as likely not to act on the (unspecified) recommendations, to use them primarily in power struggles with unions, or to use the survey to maintain a status quo in strained relations among employees and management. By contrast, in the Peruvian Indian case the clients happen to be responsive to the sociologists' suggestions. Surely, by chance, the opposite could have occurred, or both cases could have involved therapeutic successes. This would make it much less natural to refuse to call the consultant's efforts clinical.

I personally have no hesitation is viewing consultants as doing clinical sociology *where they seek to aid managers whom they perceive as having the good* will to improve the working environment of the organization. The

sociologists may, of course, do such clinical work stupidly, badly, or merely in a limited way, depending in part on the presence of various other features mentioned in 2-5 above. Gouldner assumed, no doubt justifiably, that the sociologist's approach in the Peruvian Indian case is more likely to have positive results than those of the consultant. But it is misleading and question-begging to pack an assumption about the relative likelihood of success into the portrayal of the approaches. And it seems inappropriate to make the criterion for whether sociologists have engaged in clinical work the managements' use or misuse of the sociologists' results.

The criticisms raised so far are based upon the central meaning of the word "clinical," which extends to efforts to improve health and well-being that may go beyond acting always on one's independent diagnosis of a problem. The point of the criticisms was to show that Gouldner's distinction between the two approaches does not turn on health-centered vs. non-health centered sociology. Both types of sociologists may well be dedicated to improving healthy group relationships, and have some success therein. Their main differences reside elsewhere, in the degree of autonomy and scope of independent activities of the two.

We would perhaps have a better image of Gouldner's distinction if he had allowed some of both types of sociology to be called clinical where the focus is on therapy (in some general sense), and instead labeled the two types of sociologists "physicians" vs. "nurses." For his real interest, as is made explicit in the final sentence of his essay, is in the type of clinical sociology "which can aid in mending the rift between the policy maker and the social scientist" (p.21). The clinician he heralds must have the degree of authority and independence of the physician, not the nurse. Yet the complexity of possible interplays between the responsibilities of organizational administrators and the therapeutic interventions of sociologists would seem to welcome a greater variety of roles for clinical sociologists.

My view, then, is that accepting a sponsor's definition of a problem to be studied and working within general directions for goals of a study do not by themselves make applied sociology non-clinical. For there may still be room left for valuable diagnosis and recommendations by a sociologist seeking to make genuinely therapeutic improvements. Such restrictions do, of course, place limitations on the degree of autonomous work of the sociologist. But limited therapy, to continue with the medical language, is therapy nevertheless. In any case, consulting work will virtually always involve some degree of accepting the client-sponsor's view of the problem to be studied since it is the sponsor who initiates and sustains the services of the consultant toward an end the sponsor views as valuable to the organization. Perhaps for this reason

at least one writer has recently made the extreme recommendation to carry Gouldner's insistence on wide autonomy to its logical conclusion by distinguishing clinical sociology from all consulting and bureaucratic roles (Straus, 1979: 22-4).

In their textbook, *Clinical Sociology,* Glassner and Freedman cite with approval Gouldner's account of the consultant and use his 'engineering' model as a major contrast with the clinical approach. They suggest that "from a clinical viewpoint, the engineering procedure . . . is analogous to a physician limiting his or her treatment of a broken limb to writing a prescription for pain killers" (Glassner, 1979: 13). This, however, is a misleading analogy. The reality of the situation is generally not that sociologists absurdly refrain at whim from applying the full range of their skills. They are often, especially in doing organizational development, given guidelines by their sponsors.

A more relevant analogy is with the patient who places restrictions on the physician and nurse. Thus, after weighing the side-effects of various optional therapies, a cancer patient might refuse to allow an M.D. to attempt to remove the cancer--the underlying problem--and instead request treatment for pain during the terminal stage of the illness. When a Jehovah Witness refuses treatment by blood-transfusions, and hence refuses to see the basic problem as the need for a blood transfusion, doctors' options are restricted. But the limited care they provide instead still qualifies as reasonable medical work.

To be sure, even these analogies are limited, Sociologists deal with groups, not just individual patients. Moreover, in organizational consulting they are confronted with both a client who sponsors the work and another client who is the target directly influenced by the work. A slightly closer, though still misleading, analogy would be with an M.D. treating a child or adult in the custody of parent or guardian who contacts the doctor. The guardian stands in a position of authority, akin to that of the employer or manager. In these cases that authority is subject to abuse and has limits, both moral and legal. But within bounds it is permissible for an M.D. or sociologist to accept guidelines of the parent or manager.

II.

The discussion thus far has focused on two emphases in delineating the role of clinic sociologists: (a) according to the degree of independence the applied sociologists have in identifying the problems they will study; and (b) according to the sorts of therapeutic aims and approaches used and attempted.

The current emphasis in the literature seems to be upon (a). I have favored the wider definition obtained by emphasizing (b). It is time to turn to the significant issue of whether applied sociologists are acting irresponsibly when the degree of their autonomy fits Gouldner's engineering model.

Neither Gouldner nor Glassner and Freedman explicitly say that 'engineering' sociologists are acting irresponsibly. But others have suggested this. Donald Warwick (1978: 149), one of the most insightful contemporary writers in the ethics of social science, held that when organizational development practitioners simply go along with management's definition of a problem they are acting irresponsibly in reducing themselves to the status of technicians. Warwick makes this charge in response to a case of organizational development described by Beckhard (1969: 45-6) which bears retelling.

Due to increased competition and costs, an outmoded marketing strategy and a somewhat rigid management style, a large food and catering company had over several years lost its leadership in the market. One of the managers diagnosed the problem as calling for a change away from the current family-management of the company to a professional management which would introduce innovative marketing strategies as well as new organization and promotion patterns for employees. After convincing other members of the management to adopt this major change, he contracted social scientists as consultants to help with implementing the change. The consultants, after examining the situation, basically accepted and worked within the aims set by management. They did so even though they soon learned that most employees were largely satisfied with the current family-managed arrangement and would find the change threatening and even traumatic. The complex and extensive role of the consultant centered on fostering the attitudinal and emotional adjustments among employees necessary for effecting the change with the least harm to individuals. Detailed plans were formulated, surveys conducted, and numerous and varied meetings held with individuals and groups over several moths. These included team-development meetings, confrontations groups, off-site conferences, and individual counseling.

Warwick (1978: 149) raises two ethical objections to the role of the consultants in this case. First, he emphasizes that the ability to define the problem to be studied carries with it a large power advantage, and he hints that it may be unfair for management to have this increase in the power they already marshal. Second, he asserts that when consultants, as in this case, simply go along with the definition of the problem specified by the sponsor they have irresponsibly reduced themselves to the status of "a technician applying the tools of social science to ends specified by others." Such a role definition "implies significant abdication of professional responsibility."

Missing in these charges is a sympathetic account of the legitimate areas of responsibility of management. Managers have the authority and power they do because of their charge to responsibly insure the effective functioning of the organization they serve, an organization directed toward goals selected in large measure by owners and stockholders. Moreover, surely in some areas managers possess not only the authority but the special expertise for directing the organization. Management had every right to decide to shift the organization in the direction they did. I personally cannot fault the consultants for accepting that decision in the case at hand and seeking to engage in clinical work within the general limits set by it.

Warwick's discussion is focused on external consultants, yet his remarks are phrased generally so as to apply to all organizational development practitioners. Now, the internal practitioners of clinical sociology--ones who are employees within organizations--would be in a hopeless position if they were viewed as irresponsible for going along with management's directions. They have special responsibilities for serving the organization, within moral limits, as directed by management. And at least in many cases those moral limits do not prohibit going along with management's definition of the problem to be studied.

At this point I wish to add several caveats to what I have said, while expressing my large areas of agreement with Warwick. First, I have urged that clinical sociologists are not automatically acting irresponsibly when they go along with management's definition of a problem and do not pursue the problem they have independently diagnosed. This, of course, does not mean they are always responsible when they do so. If management's decisions are unethical or violate the sociologists' personal standards of minimal decency the sociologist has a compelling reason for refusing to participate.

Second, the proper exercise of conscience in this area presupposes that sociologists always exercise independent judgment *in the sense* of making an assessment of the management's decisions and, where appropriate, expressing their viewpoints. Here I wholly concur with Gouldner, Glassner and Freedman, and Warwick's sharp objection to blind, thoughtless, and unquestioning obedience. All I have argued against above is the idea that they must always work primarily on the basis of that independent assessment. The objection to blind obedience holds for sociologists working within corporate settings where they may have relatively the same degree of control over the corporate goals as do most engineers. For engineers, in spite of Gouldner's slightly negative use of the word, have similar responsibilities to form and express their views, or so I have argued elsewhere (Martin, 1980).

Third, clinical sociologists must make every effort to define their specific role with respect to each concrete situation of organizational development or social intervention and make that definition clear to all involved. I have suggested that they are not automatically irresponsible when they accept management's definition of a problem to guide their work. They would, however, be irresponsible if they simultaneously encouraged or even allowed their client-targets to perceive them as doing something else--e.g., as acting on their own independent assessment of the situation with an attempt to give all groups a fair and equal hearing alongside that of management as to which problem to pursue.

Fourth, there is a continuum of possible degrees of autonomy of sociological work within organizations. At some point, where there is a virtually complete loss of freedom to diagnose problems and make recommendations, clinical work will become impossible. It is the responsibility of sociologists to seek to secure for their work the necessary degree of autonomy to make a genuine contribution, without always insisting on the full degree of autonomy urged by the writers I have discussed.

REFERENCES

Beckhard, R.
  1969   Organizational Development: Strategies and Models. Reading, MA: Addison-Wesley
          Publishing Co.
Glassner, B., and J.A. Freedman
  1979   Clinical Sociology. New York: Longman.
Gouldner, A.W.
  1965   Explorations in applied social science. In Alvin Gouldner and S.M. Miller (eds.), Applied Sociology. New York: Free Press, pp. 5-22.
Martin, M.W.
  1980   Professional autonomy and employers' authority. In A. Flores (ed.), Ethical Problems
          in Engineering, 2nd ed., Vol. 1. New York: Center for the Study of the Human Dimensions of Science and Technology. pp. 177-81.
Straus, R.A.
  1979   Clinical sociology: An idea whose time has come . . . again. Sociological Practice, 3/1
          (Spring): 21-43.
Warwick, D.P.
  1978   Moral dilemmas in organizational development. In G. Bermant, H.C. Kelman, and
          D.P. Warwick (eds.), The Ethics of Social Intervention. Washington, D.C.:
          Hemisphere Publishing Corp., pp. 147-59.