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The Contributions of Clinical Sociology in Health Care Settings

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ABSTRACT

This paper focuses on the emergence and promise of clinical sociology. Particular attention is paid to certified practitioners' contributions (theoretical analysis, social systems perspective, levels of analysis, methodological sophistication, intervention skills and specialized body of knowledge) in health care settings.

This paper focuses on the emergence and promise of clinical sociology, one of the areas of sociological practice.[1] Particular attention is paid here to the utility of clinical sociology in health care settings.

Clinical sociology has been defined, over the years, in slightly different ways. In 1966 Alfred McClung Lee (1966:330), a past president of the American Sociological Association and a co-founder of the Sociological Practice Association, provided a fairly comprehensive definition when he identified three ways in which social scientists could be "clinical":

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> (1) through critical discussions with practical observers of spontaneous social behavior in problematic situations, (2) through scientific utilization of available clinical data, and (3) through participation directly in clinical situations.

The first and third approaches are emphasized in the contemporary explanation of clinical sociology.

Clinical sociology, as defined here, involves analysis and intervention. Clinical analysis is the critical assessment of beliefs, policies and/or practices with an eye toward understanding and improving the situation. Intervention is based on continuing analysis. Intervention is the creation of new systems as well as the change of existing systems.

Clinical sociologists are humanistic scientists who are multi-disciplinary in approach. They engage in planned social change efforts by focusing on one system level (e.g., individual, interpersonal, small group, organization, community, international), but they integrate levels of focus in their work and do so from a sociological frame of reference.

The Roots of American Clinical Sociology

The origins of the field date back at least five centuries—to the work in North Africa of Arab historian and statesperson Abu Zaid Abdalrahman ibn Muhammad ibn Khaldun Wali-ad-Din al-Hadrami, best known as Ibn Kahldun (1332–1406). He founded "the science of human social organization," the basis for what is now called sociology (Baali, 1988:xi, 107). In his *Muqaddimah*, Ibn Khaldun provided numerous clinical observations based on his work experiences, which included seal bearer, secretary of state, ambassador, negotiator and judge. In the latter role, he was seen as a reformer who practiced with "strict honesty and great integrity" (Baali, 1988:1–3; Fritz, 1989a:73).

Ibn Khaldun was the first to use a scientific approach to the study of social life in combination with intervention. But he and many other individuals now designated as early sociologists, were not called sociologists during their lifetime. Identifying the earliest clinical sociologists is also difficult because many of them did not use that label for themselves. Nonetheless, a review of the work of early scientist-practitioners allows us to identify precursors and clinicians.

Among those in Europe who would be included at the very least as precursors of contemporary clinical sociology were the classical sociologists Auguste Comte, Emile Durkheim and Karl Marx.[2] Among those whose work has been identified directly as clinical sociology is Beatrice Webb (1858–1943). Webb was active in the Fabian Society and helped to establish the London School of

Economics. She identified herself with sociology and social investigation (Webb, 1938:17, 64, 67, 129, 131, 136, 175; Drake and Cole, 1948:16) and had a strong influence on British social policy (Fritz, 1989a:76).

The History of American Clinical Sociology, Part I

The early American sociologists were practitioners and professors, and some—such as Frank Blackmar (Fritz, 1990a) in Kansas and W.E.B. Du Bois (1990b) in Georgia—combined these roles. But chroniclers of the field have said that in the first third of the twentieth century, the male sociologists at the University of Chicago were the most important force in the development of American sociology. Although these sociologists had a variety of interests and perspectives, they frequently were referred to as "The Chicago School." That label was given to them as early as 1930 (Bernard, 1930:133) but apparently was not used by the Chicago sociologists of the 1920s to describe themselves (Cavan, 1983:408).

"The Chicago School" is a label with limitations. If it were replaced by one such as "The Chicago Network" (Fritz, 1985) or "The Chicago Circle" (Thomas, 1983:390),[3] the new label would call attention not only to the men in the sociology department, but to the women sociologists who held a variety of positions at the university (Deegan, 1987, 1988; Fritz, 1989a). Moreover, it would give due recognition to the involvement and impact of Chicago practitioners, including the women of Hull House, a prominent social settlement house. A label such as "The Chicago Network" also would direct researchers to look at the influence of these early sociologists on practitioners and practice settings as well as on sociology professors and university sociology programs.

The work of the early sociologists in Chicago was very much directed, in different ways, at the resolution of pressing social problems. Many of the early members of the University of Chicago's sociology department—such as Charles Henderson and Albion Small—would be included in this group along with Marion Talbot, an administrator and professor at the University of Chicago, and Jane Addams, the head of Hull House (Fritz, 1989a).

There were, of course, differences of opinion on how to get involved in the issues facing the community (Deegan, 1988:37–39). For instance, some at the university saw the settlement houses and the city as a "sociological laboratory" (White, 1929a.24–25; Park, 1929; Burgess, 1929:47)—a place where university professors might test their ideas. There was great utility to this work, but some questioned whether it might be undertaken primarily to meet the scientific interests of the professors and their students.

Others were concerned about referring to the community and settlement houses as "sociological laboratories." To them, even the use of that term seemed

to indicate a lack of respect for the work of the organizations. In their view, settlement houses, for instance, were established to meet community needs; scientific assistance could be useful but it should follow the community interests—not be the driving force for these interests.

This example illustrates the tension that so frequently exists when an individual or program tries to meet both scientific and community needs. While it is possible to meet both objectives, the struggle to do so can overwhelm the community interests or dilute the scientific possibilities. An interventionist has to be aware of the dilemma, respect the community's right to set an agenda and be accountable for proposing particular research and intervention strategies.[4]

University sociologists were very interested in working in "laboratory settings" in the mid–1920s. While some talked of doing this research in the city or neighborhood, sociologist Ernest W. Burgess (1929:47) pointed out that this work was already in progress "on a small scale... with institutes of child research."

Burgess (1886–1966), a graduate of the University of Chicago and a faculty member from 1919–51, is considered one of the second generation of sociologists who taught there. During his career he was president of the American Sociological Association, the National Conference of Family Relations and the Gerontology Society. Burgess was active in civic affairs in Chicago, supervised sociological work in clinics, was on the advisory board of a child guidance center (The South Side Child Guidance Center, 1930) and taught the first courses in clinical sociology.

Burgess' courses in clinical sociology were offered at the University of Chicago from 1928 through 1933 (Fritz, 1991). The courses focused on pathological cases and the analysis of personalities. They also discussed the roles sociologists, psychologists and psychiatrists held in child guidance clinics.[5]

Students enrolled in Burgess' 1928 and 1929 clinical sociology classes were the clinical sociologists at two community child guidance clinics.[6] Among their tasks (Cottrell, 1929:1):

> intensive treatment work, such as attempting treatment of the home situation, placement of the child in foster home, vocational adjustment, adjustment in school, cooperation with settlement in recreational adjustment...

The South Side Child Guidance Center also indicated an interest in being a "sort of training laboratory for students interested in the field of Clinical Sociology." One of the clinical sociologists, Leonard Cottrell (1929:3), indicated in his annual report that 16 students had received assistance in case analysis during the last year. He thought that full student involvement for "carefully

selected students. . . may be thought of as the clinic's most valuable function so far as the Department of Sociology is concerned."

Some of the other students in Burgess' classes were affiliated with the Institute for Juvenile Research.[7] This organization "correlated sociological investigation with the case findings of the clinics" (Stevenson and Smith, 1934:153).

The work in the child guidance clinics fit with Burgess' teaching and research interests at the time. It also went forward because the child guidance centers requested assistance and because the project received financial support. The University of Chicago's Local Community Research Committee provided grant money for this project from 1927–29. This support was matched by local funds from the Chicago Woman's Club, the South Side Child Guidance Center and the Lower North Child Guidance Center (White, 1929b:35–39).

Although the name "child guidance clinic" was not used until 1922, the idea had been put into practice as early as 1909 by William Healy,[8] the founder of the Chicago Juvenile Psychopathic Institute (Stevenson and Smith, 1934:15). In 1934 physician George Stevenson, then director of the Division on Community Clinics for the National Committee for Mental Hygiene, and Geddes Smith (1934:2) identified the functions of child guidance clinics:

> They study and treat patients; they seek to interest other community agencies in the prevention of behavior and personality disorders in children and in promising methods of dealing with them when they occur; and they attempt to reveal to the community, through the first-hand study of individual children, the unmet needs of groups of children. Some clinics also undertake the systematic analysis of case material in the hope of contributing to a more exact knowledge of child behavior, and some provide training for students. . .

Sociologists at Tulane University in Louisiana also were involved in child guidance work. Louis Wirth (1897–1952) was a full-time faculty member there and he was director of the New Orleans Child Guidance Clinic. In the spring of 1930, he was scheduled to teach what was the nation's second course in clinical sociology. Because Wirth accepted a fellowship to work in Europe that year, the course was taught by another faculty member. The course was described in the university catalog (*Tulane University Bulletins*, 1928–29) as a "clinical demonstration of behavior problems and practice in social therapy through staff conferences and field work in a child guidance center."

In 1931 when Wirth returned to the United States, he joined the faculty at the University of Chicago and published "Clinical Sociology," an article about the contributions a sociologist can make in child development clinics. The following year, he taught a course in clinical sociology.

While clinical sociology was part of the Chicago tradition from at least 1928, a discussion of the subfield first surfaced in print in New Haven. Milton C. Winternitz (1885–1959), a physician and dean of the Yale University Medical School from 1920–1935, thought of medicine as a social science. In the earliest known publication discussing clinical sociology (Winternitz, 1930), he wrote of his intention to form a "clinical sociology section." He wanted each medical student to have a chance to analyze cases based on a medical specialty as well as a specialty in clinical sociology.

Winternitz vigorously sought funding for his proposal from the Julius Rosenwald Fund through Michael M. Davis, director of the Fund's medical services. Davis had studied sociology at Columbia University[9] and been the director of the Boston Dispensary as well as the director of New York City's Committee on Dispensary Development before joining the Rosenwald Fund.

While Winternitz (1931a, 1931b) noted the success of a course in the medical school's section on public health that was "modeled directly after the outlined plan for clinical sociology," he couldn't obtain the funds needed to put the department in place (Fritz, 1989b). He never lost interest in the program, and even mentioned it in his final report as dean in 1936.

The History of American Clinical Sociology, Part II

Between World War II and the mid–1970s, sociology was publicly characterized by its empirical approaches, theoretical developments and academic employment. Periodically there was interest in applied sociology but clinical sociology essentially went unnoticed. The histories of sociology didn't include information about clinical sociology and so most sociologists thought it never existed. The development of clinical sociology also was slow during this period because clinical sociologists often were unaware of others with similar interests.

The first formal definition of clinical sociology, written by Alfred McClung Lee, appeared in H.P. Fairchild's *Dictionary of Sociology* in 1944. That same year Edward McDonagh published "An Approach to Clinical Sociology" in *Sociology and Social Research.*

McDonagh thought he independently had come up with the idea of a clinical sociology and may have been influenced by his dissertation work on the group health movement. McDonagh had noticed that "group health associations favored the centralization of physicians and medical equipment in a clinical setting and purported the advantages of pooling ideas and health providers — in opposition to solo practitioners." McDonagh's article stressed the value of working in "clinical" groups and discussed the kinds of community problems that might be tackled by a clinical research group (Fritz, 1986:11–12).

In 1946 George Edmund Haynes' "Clinical Methods in Interracial and Intercultural Relations" was published. Haynes, the first black recipient of a Ph.D. from Columbia University, was a co-founder of the National Urban League (1910) and the first black to hold a sub-cabinet post in the U.S. government. In 1946 Haynes was executive secretary of the Department of Race Relations at the Federal Council of Churches. His article discussed the department's urban clinics which dealt with interracial tension and conflict.

Publications mentioning clinical sociology now were appearing at least every few years (Fritz, 1991). Among them were ones by Alvin Gouldner (1956), Warren Dunham (1964) and Julia Mayo (1966). Gouldner also taught a course entitled "The Foundations of Clinical Sociology" at Antioch College in the mid–1950s. The course was taught at the highest undergraduate level and students were expected to have successfully completed the department's course in social pathology. The course was described in the following way in the *Antioch College Bulletin* (1953:123).

> A sociological counterpart to clinical psychology, with the group as the unit of diagnosis and therapy. Emphasis on developing skills useful in the diagnosis and therapy of group tensions. Principles of functional analysis, group dynamics, and organizational and small group analysis examined and applied to case histories. Representative research in the area assessed.

The Utility of Clinical Sociology

The Sociological Practice Association (SPA) was founded in 1978 as the Clinical Sociology Association. During the last twelve years those who established the SPA have used their collective skills in organizational development and, despite limited resources, have begun to change the landscape of American sociology. Even the most conservative sociology organizations now include information about clinical sociology in their newsletters, although these organizations still have not developed plans to integrate clinicians.

The term "clinical sociology" was first adopted in the United States by well-known university personnel who were receiving or anticipated receiving funding for clinical work.[10] Several of the first sociologists to use the term "clinical sociology" did so in a limited way—to refer only to sociological work within actual clinics. But the term was used in a variety of ways from the late 1930s to the mid–1970s.

In the 1970s and 1980s the most frequent definition of clinical sociology was a broad one. It referred to intervention on various levels (e.g., individual, group,

organization, local community, national, international) and in various settings such as clinics, courts, schools, neighborhoods and board rooms. That usage is accurate historically because some early advocates recognized the broad use of the term,[11] and a review of the variety of intervention activities undertaken by early American sociologists, such as those in The Chicago Network, shows that a broad definition has a basis in fact.

While the field can be defined narrowly or broadly, much of the actual work of clinical sociologists has been and currently is in health care settings. Clinical sociologists work, for instance, conducting alcohol and tobacco control intervention research; supervising oncology units; providing counseling and sociotherapy; consulting on the improvement of health systems and administering health delivery and funding systems.

Their major contributions in those settings differ depending on a practitioner's level of training (B.A., M.A. or Ph.D.), length and type of experience and areas of competence. Skilled practitioners have the possibility to apply for certification.[12]

In general, we might expect the following contributions from certified practitioners:

Theoretical analysis. The clinical sociologist has had extensive training in theory. The result is a working knowledge of a range of major theories in two or more disciplines that affect her or his area of specialization. The clinical sociologist is expected to:

- have the ability to translate theories for practical use
- periodically reflect on her or his own theoretical approach and the possible effects of this theoretical approach on the work undertaken
- provide theoretical perspective, when the situation warrants, for clients, colleagues, employers and interested community members.

Social systems perspective. A sociologist's training emphasizes understanding of (1) the social system—a configuration of positions, roles and norms—as a dynamic force and (2) the effects of membership in overlapping systems. Clinical sociologists are expected to be knowledgeable about systems, to move between theory and practice in working with systems and to assist individuals and groups in assessing and possibly changing systems.

Levels of analysis. The clinical sociologist is expected to concentrate on a level of analysis (e.g., individual, small group, organization, local community, international) when undertaking an intervention project.

But the translation of social theory, concepts and methods into sociological practice requires an ability not only to recognize various levels, but to move between levels for analysis and intervention (Freedman, 1984).

Methodological sophistication. A sociologist receives extensive training in research methods. Clinical sociologists are expected to know the comparative strengths and weaknesses of qualitative and quantitative methods in their practice settings. A clinical sociologist also is expected to recommend appropriate methods by taking into account the objectives of the involved parties, ethical considerations and available resources.

Intervention skills. A clinical sociologist will have interdisciplinary training and substantial intervention experience in her or his specialty area. The certified practitioner would get beyond simply pointing out a few of the difficulties in a situation. The practitioner would provide analysis,[13] suggest alternative ways of dealing with a situation and, when possible, actually initiate or assist in the intervention. In any intervention, the clinical sociologist is bound by a code of ethics and is expected to identify and address ethical issues that may arise.

Specialized body of knowledge. Each clinical sociologist has a frame of reference which emphasizes social factors (e.g., socio-economic conditions, ethnicity, gender) and at least one or two areas of special competence — e.g., health promotion, gerontology, counseling, community organization or social policy. A clinical sociologist is expected to work in areas where she or he has particular expertise, and to advise interested parties before undertaking work that goes beyond the special areas of knowledge or intervention.

The six contributions mentioned here are general ones. The list would be longer if one takes into account an individual practitioner's skills and the requirements of the task at hand. Clients, colleagues and employers also should understand that clinical sociologists are not the only ones with these skills. Practitioners in various fields may be sensitive to these areas, although a certified clinical sociologist's training may have broader emphasis on theory, research methods and systems analysis than some other fields.

Clinical sociologists have made valuable contributions in health care settings for over sixty years. If this trend is to continue, sociological practitioners must take advantage of the ongoing networking possibilities and have more training and employment opportunities.[14] At the same time there must be growing

recognition of the contributions of clinical sociologists and better collaboration among the disciplines involved in health care.[15]

Notes

[1]The practical sociology of the 1890s and early 1900s is now referred to as sociological practice (Fritz and Clark, 1989). This label includes two areas, clinical sociology and applied sociology. Clinical sociology refers primarily to intervention while applied sociology refers to research specifically designed to help in resolving problems faced by organizations such as businesses or government agencies.

[2]Comte believed the scientific study of societies would provide the basis for social action. Durkheim and Marx provided a clinical perspective — a model or framework — for the analysis of social dilemmas (Fritz, 1989a:73).

[3]Deegan (1988:3) plans to write a volume which will describe the " 'female' Chicago School of Sociology." The alternative names — Chicago Network or Chicago Circle — would more adequately cover the practice and academic bases from which the women operated.

[4]Stoecker and Beckwith (1990:4,8–9) have the following to say about the relationship between community projects and applied sociology: "The general 'top-down' bias of applied sociology is reflected in Freeman et al.'s (1983) *Applied Sociology*, which discusses numerous applied projects, none of which have been generated, developed and controlled at the grass roots level... Nowhere in the development of applied sociology as we know it was adequate attention given to the influence of power and ideology on applied sociological research. Applied sociology has merely responded to elite generated definitions of problems, and serves only those who can pick up the tab. Even those who believe they are taking account of the needs for citizen participation and democracy innocently reveal their lack of real attention to power issues... In contrast to 'applied sociology,'... action research is based in community-defined needs rather than elite-defined needs, involves community members in the research process rather than isolates them from it, and employs the research results for the benefit of community action rather than elite domination."

Stoecher and Beckwith make some excellent points but their target shouldn't be all applied sociology. Applied sociology certainly includes "elite-dominated" research but it also includes action research projects.

[5]Louis Wirth was director of the Child Behavior Clinic at Tulane University (Smith and White, 1929:265) and *Tulane Scraps*, 1929) and Harvey Zorbaugh was in charge of a clinic at New York University. They held academic appointments in sociology and educational sociology at their respective universities and, at some point, provided research assistance to the University of Chicago's Local Community Research Committee (Smith and White, 1929:258–65).

[6]Clarence E. Glick (1989) began graduate study at the University of Chicago in the spring of 1927. Burgess arranged for Glick to be the clinical sociologist at the Lower North Side Child Guidance Center. Another class member, Leonard S. Cottrell (1899–1985), was for two years a "Clinical Sociologist for the Institute of Juvenile Research" and acted as such with the South Side Child Guidance Clinic. Cottrell also was a probation officer for the Juvenile Court for two years and a research sociologist for the Institute for Juvenile Research for one year (Cornell University Archives File on Leonard S. Cottrell, biographical statement for promotion, n.d.).

[7]According to a document in the Burgess Collection at the University of Chicago (Laboratory for Criminological Research, n.d.),

[The Institute for Justice] is the oldest center for child study in the United States having been founded in 1909 under the name The Juvenile Psychopathic Institute, with Dr. William Healy as director. Under the administration of Dr. Hermann M. Adler, 1917–29, it was transferred from county to state auspices and has expanded its work in many directions... In Chicago it maintains a branch at the Juvenile Detention Home and has affiliated with it the Lower North Side Child Guidance Center and the South Side Child Guidance Center. Besides maintaining a service program, it conducts a large research program. The case records of children examined is now increasing at the rate of 1,000 a year.

[8]According to Ruth Shonle Cavan (1983:413), a graduate student at the University of Chicago from 1922 through 1926, "In his course on delinquency, Burgess depended on a series of cases of delinquent boys published by a psychiatrist, William Healy."

[9]Davis wrote his dissertation, *Gabriel Tarde, An Essay in Sociological Theory*, in 1906.

[10]Winternitz vigorously sought funding for a department of clinical sociology from the Rosenwald Fund (Fritz, 1989b), and Burgess' work in clinical sociology had funding from a university research group, a local women's organization and child guidance groups. Tulane University sought funding for its child guidance center from the Commonwealth Fund and the Community Chest (*Tulane Scraps*, 1929; Wyckoff, 1925, 1928).

[11]For example, Dean Milton Winternitz (1932:50–51) of the Yale Medical School said the following in his 1930–31 annual report to the president of Yale:

> The field of clinical sociology does not seem by any means to be confined to medicine. Within the year it has become more and more evident that a similar development may well be the means of bringing about aid so sorely needed to change the basis of court action in relation to crime...
>
> Not only in medicine and in law, but probably in many other fields of activity, the broad preparation of the clinical sociologist is essential...

[12]The Sociological Practice Association (SPA) has certified experienced clinical sociologists since 1984. To gain the title "certified clinical sociologist," an individual must submit an acceptable portfolio which includes documentation about training and experience. The applicant must have had training in sociology and in a related discipline, written theoretical and ethical statements and provided specified kinds of references. If the certification committee finds the applicant's portfolio acceptable, the applicant is invited to give a demonstration before peers and a reviewing panel. The applicant takes part in a discussion with the audience and then meets privately with the reviewing panel. The reviewing panel rates the applicant and makes a recommendation regarding certification to the SPA Certification Committee.

[13]Roger Straus (1984:52,54) has said that sociological intervention may be characterized in the following way:

> (1) directed at the operational definition of the situation, in such a way as to (2) take into account the multiple, interacting layers of social participation framing human problems and predicaments and their resolution.

Straus also provides the following taxonomy of sociological intervention:

Level of Participation	*Target of Intervention*
Persons	Conduct
Groups	Role Structure
Organizations	Institutions
Worlds	Culture

[14]Some initiatives — such as state licensure, job classification and third-party payment authority—may set standards for health care, but they also may be exclusionary. Because of the costs involved in tackling current and proposed restrictive policies, professional organizations that are relatively small and have few resources are not able to assure members that they can protect their right to practice.

[15]"Collaboration" should mean that each of the disciplines involved in health care has the possibility of taking the lead in situations requiring research, administration and/or intervention. Too often one field may dominate and this limitation may mean that certain problems are not considered and certain theories or methods are not used.

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The Importance of the Study of Medical Sociology[1]

Charles McIntire

ABSTRACT

This 1894 article by a physician discusses the relationshp between the medical profession and the general field of sociology.

> The science of social phenomena, the science which investigates the laws regulating human society; the science which treats of the general structure of society, the laws of its development, the progress of civilization, and all that relates to society.
>
> *Century Dictionary*

As the *Century Dictionary* is among the latest products of the lexicographer, we may unhesitatingly accept the statement in its entirety, feeling assured that the rush of the current of progress has not yet swept the word beyond this definition into new relations and a changed signification. A question then arises, can there be a particular department of the science of sociology worthy the name

Excerpt (pp. 425–33) from the *Bulletin of American Academy of Medicine*, 1, 1894.

of Medical Sociology? Are there any peculiarities in the phenomena attending the existence of the members of the medical profession distinctive from the phenomena environing the lives of the same set of people apart from their profession? If this is the view taken of the trend of the subject, one need but refer to the codes of ethics which have been deemed to be necessary by the wisest and most progressive of our craft in the years gone by, and which, to-day, are the subject of no little discussion. But there is another view of the relation which medicine may bear to the science of sociology. While the physician as a member of society has a certain relation and duty which relation would not change should the individual cease to be a physician, and become a lawyer, a business man, or what not, there are, in addition to this, other relations to society which are peculiar to the profession and because of the profession.

Medical Sociology then has a two-fold aspect. It is the science of the social phenomena of the physicians themselves, as a class apart and separate; and the science which investigates the laws regulating the relations between the medical profession and human society as a whole: treating of the structure of both, how the present conditions came about, what progress civilization has effected, and indeed everything relating to the subject.

In order to determine the importance, if any, of the study of the subject it will be necessary to examine some of these points a little more in detail. And first, has that variety of the *genus homo* known as the physician any marks by which the strain can be determined? or are the supposed peculiarities merely incidental and in no way either characteristic or distinctive? To formulate a reply, it will be necessary to pass some of these in review.

There is, *e. g.*, the language of the physician, as characteristic or as cabalistic as the Romany, depending upon one's initiation. Our fellow Academician, Dr. F. H. Gerrish, in an introductory address before the Medical Department of Bowdoin College in 1891, on the "Medical Dictionary," makes this fact very clear. I quote two or three paragraphs.

> As medical men, our interest is peculiarly drawn to the special dictionary, which treats of the language of medicine, and to this work I shall devote my attention for the remainder of the hour.
>
> You are supposed to have a reasonable knowledge of your mother tongue already; and, knowing your teachers are of the same nationality as yourselves, those of you who are just entering upon your professional studies may have a belief, firmly held because never jarred by a doubt, that the lectures to which you will listen, and the books which you will read in your medical course are spoken and written in the language which you already know. Fond, delusive hope, so soon to be blasted! I do not mean to imply that the instruction is to be given in a foreign

> tongue; but it will be imparted in what many of you will find to be almost the equivalent of an exotic speech,—the language of medicine.
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> * * * *
>
> The fact is that the study of medical language is like that of French, German, or whatever language you please.
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> * * * *
>
> Medical language once learned is so well adapted to the needs of medical men that it is difficult for them to express themselves, on professional topics, in ordinary English, even when they try to do so. Its employment is so habitual as to be automatic, like almost every movement of the body or in the body, which is well done. I had a striking illustration of this while still a student. My preceptor came into his office one morning, fresh from a case which was so curious as to excite his interest in an unusual degree, and told me of its remarkable features. For a few minutes we had an animated conversation about it, and then he started again on his round of visits. Hardly had he closed the door, when the office-boy, a very alert, intelligent little fellow, who had listened intently to all that was said, spoke up and asked, "what language was that which you and the doctor were talking in?" He had failed to catch a word of our discourse; if we had spoken in Sanskrit, he would have gathered no less from what he had heard. And yet we had not consciously obscured our remarks by the introduction of ultra-technical expressions, but had simply framed our thoughts in words which conveyed them with the greatest precision and conciseness.

Having this testimony from one of our craft, permit me to summon another witness that by the mouth of two the fact may be established. A friend and a chum of my medical student days was the son of a physician; and his mother would, at times, endeavor to report to me some of the interesting topics for conversation between father and son at the breakfast table. It was before the days of antiseptic surgery please remember. She told me that she would become quite interested as they were absorbed in the discussion of some very entertaining topic; and as they spoke of its being of a "creamy consistence," of a "healthy yellow" and "laudable in every way," whose praiseworthy function seemed to be to "bathe healthy granulations," her curiosity was not only excited but she was filled with a desire to become more intimately acquainted with so useful a substance, when the single word "pus" escaped from the lips of one of the pair and she was disillusioned.

Then there are customs *sui generis*. These may vary in different parts of the world depending upon environment, but as the claim is for a variety, and not a distinct species, this lack of uniformity does not invalidate the claim. For a number of years the physicians of Pennsylvania had been endeavoring to secure a bill creating a Board of Medical Examiners for Licensure to Practise; and a committee of the State Medical Society was untiring in its zeal and inexhaustible in its resources. One of its plans was to ascertain the opinion of the aspirant for legislative honors before his nomination, and to use the influence of the profession for those candidates who would be in favor of the bill; for this purpose the candidates for nomination were interviewed in each county. In one of the counties there was a man, a graduate in medicine, who had afterward studied law and was in the active practice of both professions. Being quite prominent in the counsels of the dominant political party of his county he was requested by this Committee of the State Society to interview the candidates for the nomination for the purposes named. He replied that he would be very glad to act for the committee upon the receipt of a retainer: whether he followed the customs of the law or of medicine, I will leave you to decide; and as well the other question, whether this incident illustrates a fact of customs peculiar to the physician.

But the thought has a broader meaning, and I am reminded, in this connection, of the words of President Eliot, of Harvard, at the last Annual Dinner of the Harvard Medical Alumni Association.[2]

> "I believe," he says, "that all this [the lower salaries of the teachers in the Medical School] hangs on our English inheritances on this subject. I need not tell you, gentlemen, that in England the profession of medicine, the profession of surgery, does not now to-day stand on a level with the other learned professions. This is not the case on the Continent: it is conspicuously the case in England at this moment. They have the inheritance of the barber and the barber-surgeon still in their minds in England, and we have inherited two things from England, a lower standard of general education in the medical profession, the lower standard of requirement for admission to that profession or admission to the studies of the profession, and we have inherited this lower rate of compensation."

Clearly this indicates a special condition having a legitimate development from a definite cause. The condition of the profession in London was very pleasantly presented by a close observer in an anonymous paper read at the "Re-union Session" last year.

Some one has defined a "crank" as a specialist in a subject in which you have little or no interest. A characteristic of the present generation of physicians is the development of crankism, for specialities multiply and very little interest is manifested outside of the one line of practice. Then another distinguishing mark is a combination of the blind following of custom as marked as the Arab fellaheen who plough with a crooked stick because their grandfathers many times removed did the same, and an eager acceptance of every new fancy that is wafted on the breeze of the medical journal or diffused by the itinerant agent of the manufacturing pharmacist.

It would seem then that there are common conditions peculiar to the physician, the study of which for the purpose of improving the race (the developing those characteristics to be desired and getting rid of those marks not to be wished for) is not unworthy the serious effort of the mightiest intellects of our profession.

Were Medical Sociology thus confined to the study of the physician himself, it would include many fields of interesting study. But there is a still broader field; the physician is because there are those who are not physicians, who in their individual and collective experience need the help of just such a variety of the *genus homo* for their comfort. In this busy, many-sided civilization of ours, the physician is brought into contact with almost every side and angle. Reference is not made in this connection to the individual intercourse of a professional nature with all classes and conditions of mankind so much as the professional factor of the social problems themselves. Does the "lower side," the "under half," the "darkest spot" loom up with suffering and disease superabounding? There is no class of men more faithful or self-denying in their efforts to ameliorate than the physician. The story, simply told, of the labors of the physicians of America for the people so characterized, in the hospitals alone, would furnish a history abounding in scenes of greater self-sacrifice and permeated with more unassuming bravery than the recital of all our wars would afford. Do you touch the municipal question in our body politic? What could be done in these days were it not for the solution of the questions pertaining to the public health by the sanitarians of the land; physicians largely. In like manner the influence of the medical profession is manifested in the marching of our armies, in the sailing of our navy; in the mansion of the wealthy, and the improved tenements for the poor; while the condition of the criminal and the unfortunate classes in prisons, asylums, and poorhouses is made much more endurable through the labors, often unrewarded, of our guild. In courts of justice, while often much abused, he is necessary for the securing (or aborting) of justice.

Turn we to the children of the land and investigate the processes necessary to educate them to be useful citizens and we find many problems for the medical

profession alone. There must be for the good of the State a mind that is active in a body that is sound. Physical education, under the pioneering of the elder Edward Hitchcock, of Amherst, sustained in his plans by the board of trustees under the direction of one of our fellows, the late Nathan Allen, of Lowell, and nobly forwarded by a score and then by hundreds of others, among them Sargent, of Harvard, and the younger Hitchcock, of Cornell, likewise Academicians, has become an important factor of the educational problem of to-day. Even in so brief a reference it would not do while in Milwaukee to overlook the tremendous help given by the Turner Bund to these efforts were one so inclined; but the idea did not get a firm, scientific position in our American educational system until the American physican entered upon the study of this sociological problem.

These illustrations are enough to illustrate, and probably to demonstrate, the proposition, that there is a close relation between the medical profession and the problems of general sociology; or, better perhaps, that general sociology has problems which can only be solved from a medical standpoint: and these two divisions together form what is designated in this paper as Medical Sociology.

It might be well to inquire what components constitute this comprehensive subject. A very satisfactory working classification is given by Mr. Melville Dewey, librarian of the State Library at Albany, N.Y., in his "Classification and Subject-Index for a Library," which is now the standard for classification in many of our public libraries. His classification is a decimal one, and sociology is made the third of the nine grand classes. The chief of sub-divisions are:

1. Statistics. 2. Political Science. 3. Political Economy. 4. Law. 5. Administration. 6. Associations and Institutions. 7. Education. 8. Commerce and Communication. 9. Customs and Costumes. And wherever medicine or the physician comes in touch with either of these divisions there are to be found problems of medical sociology.

The Academy has, in reality, been devoting its energy to a branch of this subject, included under the division of education. Happily its life has been in a time when the need for a more extended education for the physician became apparent, and its growth has been contemporaneous with the opening of opportunities for this improvement. While the goal has not yet been reached and there is still need for labor and an opinion expressed in no uncertain words on this subject, still so much preliminary work has been accomplished that all the energy of the organization is not now needed in this direction; and as there lies open this extensive and interesting field of study at the present unoccupied by any medical society (the wilderness indeed in which an occasional excursion is made but inhabited by none), it behoves the Academy to pre-empt the land and secure for itself a field so full of natural wealth, which will be sure to yield to

us, if we enter upon it with the proper spirit, harvests of value in the marts of thought and of scientific literature.

Having, it is hoped, demonstrated the existence of medical sociology, and shown to some degree its extent and its limitations; there remains a plea for the study of this subject on the ground of its importance. Possibly this can be done in no better way than by mentioning concrete examples. On June 28, 1883, Dr. Balthazar Foster delivered the presidential address before the Birmingham and Midland Counties Branch of the British Medical Association, selecting for his theme the striking caption: "The Political Powerlessness of the Medical Profession." It is not proposed to review the address nor to restate its propositions, but to appeal to the experience of you all for the truth of the proposition suggested by the title of this address. And yet the medical profession very rarely asks for political aid for self-advancement; its efforts uniformly are for the welfare of the commonwealth. Surely the benefit resulting to the country at large and to the increase of the true dignity of the profession itself from the discovery of the cause of this asthenia, and of a true remedy for the same can be fairly classed among the important questions of the hour.

Or again, the prevention of pauperism is a question of the greatest importance. How to give to the worthy poor and enable them to retain their self-respect; how to prevent the unworthy or the miserly from being recipients of the bounty of the charitable, are questions attracting attention on every hand. The free dispensaries of our land have in them possibilities of starting more people on the road to pauperism than any other agency on the one hand; and the ability to accomplish more real good in the alleviation of suffering on the other. If the philosophical study of the question can reduce the possibility to the minimum and elevate the ability to the maximum, who can compute the importance of the results of such a study to the medical practitioner or to the country at large. The educational problem is one of far reaching influence for good or ill. The increase of scientific knowledge causes a greater demand to be made on the student; the general advance in the literary culture of the people necessitates a general higher training than formerly; the changes in the manner of living have weakened, possibly, the physical stamina. The proper adjustment of hours and subjects to enable the pupil to properly develop his mind without a prodigal expenditure of his vital energy, whereby his body is made to suffer; the use of manual training schools, and of physical education, and other problems of the educator involve questions that can only be solved by physicians; and should be discussed from a purely medical standpoint before they are rendered more complex by the other factors which the teacher must take into consideration. And on the proper solution of these questions much of the future welfare of the nation depends.

There are other questions, some of more, others of less importance, but the specific instances given already, open important fields of study wide enough to keep us employed for some time to come, hence they will suffice for the present purpose.

There may be a possible criticism in the thoughts of some that should be noticed before closing. "The themes are all right in their way," you may be thinking, "and interesting enough, doubtless, possibly even important; but they are not practical and, therefore, not worthy the attention of serious men in this serious life of ours." This criticism is a just one if, and please mark the "if," if you put the definition of practical on low enough a plane. If you think the time given to the study of pathology wasted and had better be devoted to committing to memory "favorite prescriptions;" if, when any new remedy is mentioned, you do not waste your practical mind on its composition, properties or mode of action, but simply ask: "What is it good for?" and, "What is the dose?" if you savor at all of what our friend, the talented editor of the *American Lancet* has so fitly characterized as the G. T. R. — Get There Regardless — Doctor; I grant you that these themes have little of such practicability in them. But if you are built after a different pattern and give to the word its true significance: to achieve rather than to accomplish. If you understand in medicine that is practical which tends to produce the best, the noblest physician; the most accurate knowledge of cause and condition of the sick and the precise action of the remedy to cure; the greatest ability to prevent the ills of flesh; the development of the highest type of manhood, and the fruit this type should bear; then, while the study of these problems, their presentation and publication may not bring you a single consultation nor add a single dollar to your not too large bank account, you will find in them topics intensely practical. . . .

Notes

[1]A paper read before the academy at its meeting in Milwaukee, June 5, 1893.

[2]*Boston Medical and Surgical Journal*, July 12, 1892.

Toward a Sociology of Medicine

Bernhard J. Stern

ABSTRACT

This paper, first presented in 1951, promotes the emergence of a sociology of medicine.

Criticisms of sociology have been of two general varieties. There have been those who have been scornful of its abstract theory spinning, its formulation of categories without content and of generalizations without purpose other than seemingly to afford their makers with intellectual exercise in semantic subtlety. Others have been critical of the banality of its illustrative matter, the inconsequentiality of the problems it tackles concretely. It has been felt that sociology has dealt with problems too large to handle with its present skills or those too trivial to bother with, out of a larger context. These antithetical criticisms have had one basic premise in common. They have assumed that if sociology is to justify its designation as a science, it must contribute insights, principles, theories, and methods which will permit more effective prediction of human behavior and of cultural change and facilitate manipulation and control of social situations.

Address delivered at the annual meeting of the Eastern Sociological Society held at Yale University, March 31, 1951.

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The field of sociology of medicine offers a stimulating area of research for sociologists who accept this definition of the function of their discipline. Its problems are vital ones and its data are sufficiently capable of controlled observation to enable the sociologists to test the validity of current concepts and to permit the formulation of new principles. Its range of problems are amply diverse to engage the attention of sociologists interested in historical, anthropological, institutional approaches; in studies of acculturation and cultural change; in research on the behavior of small or large groups involving leadership, bureaucracy, cooperation, competition, and other social processes, in community studies; in social classes and social structures; in demography and ecology; in mass communication; in attitude studies; in culture and personality; in social control and sanctions, in fact, in the entire gamut of conventional topics under which sociologists are prone to classify their major interests. The sociology of medicine permits the fruitful marriage of theory and practice; it is both speculative and practical, analytical and constructive.

In projecting the recognition in college curricula of the sociology of medicine it is not proposed that it be confined within the conceptual frame of the tradition of what has come to be called social medicine. It is worth noting in passing as sociologically significant that the idea of medicine as a social science arose during the struggles of the middle class for political and social rights in Germany during the 1840's, which had repercussions in a medical reform movement. It was at that time that the German physician, Salomon Neumann, formulated its basic premise that "medical science is intrinsically and essentially a *social* science, and as long as this is not recognized in practice we shall not be able to enjoy its benefits, and shall have to be satisfied with an empty shell and a sham."[1] After a short period in Germany during which this sentiment captured the interest of a group of notable physicians and suffused their work with heightened social sensitivities and social responsibility, it almost passed out of currency when the middle class attained its objectives. It was revived in England and the United States as a by-product of the pressures of the working class for social security legislation and for wider recognition of their democratic right to share more fully in the vast economic and cultural advances of the period. In both cases social medicine was associated with progressive movements that brought larger groups of people into the orbit of medical services, as they widened the conception of social participation and responsibility and put greater demands upon those who possessed political, social and financial power.

Social medicine is no longer a bold idea. There is now an Institute of Social Medicine at Oxford and a chair of social medicine at Edinburgh, and a *British Journal of Social Medicine*. In 1947 a short Institute on Social Medicine was held by the New York Academy of Medicine. There are various lecturers in

social medicine at American medical schools. In 1950 Leonard A. Scheele, Surgeon General of the U.S. Public Health Service could declare that "all public health workers, worthy of the name, recognize a social component in the health problems that confront them."[2]

Yet the concept of social medicine remains vague and ill-defined. In its most developed form it remains largely a groping effort on the part of the medical profession and other health workers to deal with the fact that a patient is a personality, has a family and is a member of society, when considering his health and diseases. It does not seem too audacious to assume that since this is already taken for granted by sociologists who have not been obliged to work their way tortuously from an absorption with specific diseases of special organs to an understanding of the patient as a whole and to the social context of health and disease, we may demand more mature formulations of principles and more concrete guidance from a sociology of medicine. The historic interest of sociologists in comparable fields involving the relation of humans to their environment provides special funded knowledge that should facilitate progress in this area.

The time is opportune for the emergence of a sociology of medicine. Recent social developments and prodigious advances in medical science and public health have led to the transformation of medical practice, with consequences that make the help of the sociologist imperative. Issues requiring the help of the sociologist arise because medicine functions in a changing social context resulting from concentration of economic power; technological developments that involve urbanization with its housing, educational and recreational problems and changing levels of living; mechanization with its effects on working conditions and industrial and occupational hazards; the passing of the closely knit neighborhood and of the integrated community that influences standards of social responsibility, and the authority and competence of local handling of social services. Among the important developments in medicine and public health are: (1) broadening of the concepts and skills of medical science; (2) growth of medical specialization; (3) rise of the modern hospital and health center; (4) aging of the population; (5) movements for more effective distribution of medical services; (6) possibility of the realization of a functioning program of preventive medicine. The relevance of each of these developments to a sociology of medicine will be considered briefly.

1. Medical science in going beyond exclusive concern with communicable diseases involving external agents of infection to devote increased interest in deficiency and degenerative diseases has focused attention more decisively upon the patient as a person, as a member of a family, of a status group, and of a social class. This requires fuller understanding on the part of the physician of the impact of culture upon the patient in such matters as the significance

of economic and psychological strains, of poverty and its sequelae, of class and other social coercions, of irrational sanctions and dreads, of cultural prides and prejudice, of the influence of war tensions upon disease incidence, of the disparity between social myths and cultural realities, and of the consequences of the struggle for survival and status in a competitive, class-structured society, the acquisitive values of which pervade and influence directly or indirectly all phases of the American cultural pattern and the life cycle of the patient.

2. Medical specialization consequent upon advances in medical knowledge, has posed important sociological problems involving professional status and role, interprofessional relationships, the relation between the specialist and the general practitioner, and the development of group practice, the effectiveness of the patient-doctor relationships, medical ethics, and the place of the cultist in the contemporary medical scene.

3. The rise of the modern hospital and health center as the primary agency of medical practice, research and teaching has raised a host of sociological problems that have theoretical as well as practical interest. These include where a hospital should be located and what its size should be to be most effective, and what its tie-up to the community should be. There are also the problems of authority relations between the staff and the lay boards of directors, between the professional and administrative staff, between physicians and nurses and technicians and medical social workers, and between physicians in the practice of group medicine within the hospital. The relation of the hospital to voluntary health associations and to prepayment plans invites the aid of the sociologist as do the problems of hospital *esprit de corps* and the formulation of codes of hospital ethics.

4. The aging of the population has wide consequences. Here it will be noted only that it increases the rate of chronic diseases and thus changes the physician-patient relationship, which varies greatly depending upon the age and nature of the illness of the patient.

5. There are many sociological problems in the quest for more effective distribution of medical services to bridge the gap between medical knowledge and medical practice for all persons in society whether they belong to low or high income groups or are on relief, whether they reside in rural or urban areas, whether they are white or Negro. The ensuing controversies over proposals for the solution of this problem involve inquiries into the relation of the medical profession to the State; the relation of medical services to public welfare; the relation of curtailment of social services to war preparations; the relation of the local to state and federal governments; the dynamics of social movements; the function of pressure groups; the techniques of propaganda; the measurement of public sentiments; the tenacity and the vested interests of established groups and practices;

the power relationships within such professional organizations as the American Medical Association and devices of control which such organizations utilize.

6. Programs of preventive medicine are in transition from potential to actual realization. The focus of medicine is changing from the control of disease to the maintenance of health. Health education which would facilitate this achievement has therefore become more important as a factor in health services. Sociologists can be helpful in this field which has long been plagued with irrational myths, rituals and cults. Sociological histories of these cults that analyze the insecurities to which they appeal and the interests that utilize them make excellent studies. Moreover, problems of changing food habits, of methods of preventing contagion, of determining the occasions to consult a physician, and of alerting against industrial and home hazards, involve skill in the manipulation of tenacious attitudes and behavior patterns. Controls over communicable diseases, of the water supplies, waste disposal, and smoke and smog are sociological community problems. Social engineering and planning are implicit in any basic program for the prevention of industrial accidents and occupational disease and for assuring healthful working conditions in mines, mills, and factories. Moreover effective promotion of legislation in this field requires a knowledge of social structure and social classes and of all phases of political sociology.

Studies have been made by sociologists for at least the last 25 years which impinge and throw light on all the fields suggested in this attenuated and by no means definitive listing. Some extend beyond these categories into the area of the sociology of knowledge such as historical studies of the impact of diverse social economies and culture patterns upon medical science and the role and status of the physician, and of medical change upon other sciences and upon cultural change; and research in the cultural and scientific backgrounds of medical innovations and factors which impede or accelerate receptivity in professional circles and among the general public.

The time has come to systematize these studies into a body of knowledge and a definite academic discipline. Lecture courses and seminars should be introduced into university curricula that will stimulate wider interest and further research studies. A demand is beginning to develop for trained personnel in this field. It is the task of sociology departments to stimulate and satisfy such a demand.

Notes

[1]Cited by George Rosen, "Approaches to a Concept of Social Medicine. A Historical Survey," in Milbank Memorial Fund, *Backgrounds of Social Medicine* (New York, 1949), p. 9.

[2]Leonard A. Scheele, "Cooperation Between Health and Welfare Agencies. A Health Officer's View," *Public Health Report*, Vol. 66, February 9, 1951, p. 163.