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EMPLOYMENT, THEORY AND PRACTICE IN QUALITATIVE MEDICAL SOCIOLOGY*

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Abstract

Applied qualitative medical sociology is almost an unheard of phenomenon. When it is done, however, it is usually accomplished by sociologists employed in academic institutions. Here we discuss the possibility of such a specialty, building upon the established literature and resources, as a potential area of employment and expanded sociology practice. Three "types" of approaches: symbolic interaction, phenomenology and Marxism are used to suggest the diversity and resources available in qualitative sociology.

Few sociologists are comfortable with the concept of "applied medical sociology." There is a paucity of textbooks and monographs on the subject, little formal training is available, and a kind of "poor relations" stigma is attached to an approach which incorporates value statements in its process. Yet, strong incentives provided by government funding for the development of applied medical sociology, at a time of increasing scarcity of job openings in academia, have made it a significant field of interest to professional sociologists. We find, therefore, that this gap in existing knowledge is presently being rapidly filled by positivistic policy evaluation studies and programs. This is a logical step for a discipline which is positivistically oriented, whose statistical findings lend themselves to the type of schedule expectations and demands made by contracting agencies. This rather rational partnership, though, has serious consequences for the field of applied sociology. Other theoretical paradigms and critical, political critiques remain abstract, receiving little implementation and development. At this juncture, we see a relatively new area developing whose dominant perspective tends to ignore symbolic interactionism, phenomenological and critical Marxist theory. There are other perspectives which could be listed, for example, exchange theory, ethnomethodology, or reflexive sociology, but due to limitations here, we shall concentrate on the potential for former theoretical frameworks and their practice in health institutions.

* An earlier draft of the paper was presented at the American Sociological Association Meetings, Sept.4-9, 1978, San Francisco, California.

In the following discussion we shall briefly introduce the theories and then discuss some problems encountered in training, obtaining professional experience, and being employed. Next, we take a gigantic leap over these dilemmas and show that despite difficulties in these areas some promising work is being done, primarily by sociologists employed in academic or academically affiliated settings. And finally, we will suggest some ways to handle the problems of employment for applied medical sociologists using qualitative research methods.

A BRIEF OVERVIEW OF THE THEORIES & PRACTICES SUGGESTED

No attempt is made here to claim that symbolic interaction, phenomenology, or Marxism share paradigm assumptions (Kuhn, 1970). These approaches were selected because of the author's familiarity with them, and because they exhibit some of the major problems encountered in non-positivistic applied medical sociology. They also show very strong evidence of potential benefits to be gained from their application. Only the barest sketch of each will be given here so that we can move on to a discussion of their application in health institutions.

Symbolic interaction, a loosely associated body of theory, assumes that man is a product of social interaction. The world gains meaning that is derived from human action, and sustains it through interaction. The development of the self, the ability to take the role of others (Mead 1962), to define a situation and act on this definition (Thomas, 1923; Thomas and Thomas, 1928), and to communicate with others on all facets of human behavior, are each crucial components in this framework (see Manis and Meltzer, 1972; Stone and Farberman, 1970).

Phenomenology assumes that human experience is the primary data for the sociologist. The social construction of everyday life defines and categorizes these experiences with "recipes" or customary ways of looking at the world around us. The words we use, our explanations of life and behavior, and our place in reference to others (or identity) are clues to the social meaning and actions found in everyday life (Schutz, 1967; Berger and Luckman, 1966).

Marxism is based on a model of social conflict between classes which differ in their control over capital: one group, the bourgeoisie, obtain excess capital through the exploitation of labor of the other group, the proletariat. An ideal society would be based on economic equality (Marx, 1906).

Although each of the above models has varying theoretical assumptions. It illustrates some problems that applied medical sociologists have

In common. These shared hurdles are discussed in our next section.

INSTITUTIONAL PROBLEMS

There are five major hurdles for the applied sociologist here: training, access to institutions for data collection, publication of the findings, and getting a job. Each of these obstacles is examined below.

The Student

The first difficulty arises from the fact that teaching qualitative methods and theoretical expertise is in many ways an art and not a science. (Bogdan and Taylor, 1975). The mentor must have a combination of skills in theory and methods as well as experience in health institutions which have their own language, sets of rules and expectations. (Becker et al, 1961). Since the mentor has had little chance of being trained in applied medical sociology, it is a new situation for him or her, and a little like the untrained leading the untrained. Nonetheless, there is an outstanding tradition of symbolic interaction studies in medical settings providing a secure base for training. Phenomenology and Marxism, however, do not have this base, and the problems of training is more acute here. In the United States, sociologists trained in these paradigms are relatively scarce (as are symbolic interactionists when compared to the total number of sociologists) and fewer still are engaged in medical research. Nevertheless, since it is often difficult for a graduate student in any field to find dissertation committees in precisely his or her area of specialization, this need not be an impossible barrier. It is a problem, though, and cuts down the number of students willing to enter this field.

A more crucial problem is entry into the health institutions themselves. Again, symbolic interactionism has the edge: the rich literature available in this field, comparable studies and approaches, participant observation in medical institutions, and a mentor's support and sponsorship, provide models for negotiation and procedures for entry into health settings. But with phenomenology we see more potential problems. Not only is there a scarcity of experts but the theory questions the intrinsic logic or value of our present medical model and advocates examination of how the institutions create and the practitioners experience their world. With an evident potential for criticism and skepticism of the existing structures and practices, phenomenologists are liable to be seen as unwanted critics. Thus is it more difficult to justify entry into the medical setting. Problems of access are most severe, however, for the Marxists. With specific and articulate criticisms of our present capitalist system, with its corrupt emphasis on making a financial profit

from others' pain and suffering, American Marxists have faint hope of institutional access to our dominant forms of health care delivery.

The Professional

In addition to difficulties encountered in training, the crux of the problem lies in professional status. Understandably, institutions will not allow researchers to enter their settings without specific goals, timetables, and a concrete plan, even though something akin to a Carte Blanche situation is available to a few academics attached to university-affiliated institutions. /Glazer and Strauss (1965, 1967, 1971), for example, appear to have relatively open access to medical settings./ But what we are discussing here is something very different: a full-time job allowing a person to use qualitative methods while advancing theoretical issues.

If this seems too much to ask, it is only because we lack the vision and "chutzpah" of the natural scientists to expect and demand what they have had for decades: practical support for the advancement of science. In order to attain professional stature we need full-time jobs granting us explicit professional rights and obligations and mechanisms to integrate qualitative sociology into the theory and practice of health care delivery. Steps to achieve this professional status are listed now.

First, we need medical centers that hire and support professional qualitative sociologists in full-time positions. This is being done in a few places which are affiliated with academic institutions or medical centers. Research grants give some support, but offer few fully recognized and prestigious career options. This does, however, provide us with some models and professional experiences. Unfortunately, knowledge of this work is obtained primarily by word of mouth or by reading research publications, resources that rarely provide information on professional socialization and function.

Until sociologists are allowed the freedom to explore their theories and methods, within the bounds of ethical constraints on human research, a rift will continue to exist between academic and non-academic sociology. The academic sociologist has vital job benefits such as academic freedom and tenure, that compare very favorably with the freedom of sociologists in medical institutions. Therefore, it is absolutely mandatory that medical sociologists in non-academic institutions be given professional controls and status comparable to those in academic institutions.

Second, institutional roles need to be dispersed throughout non-academic settings to provide viable alternatives to sociology graduates. This would be the crucial step making applied medical sociology possible in a qualitative and critical sense. Mechanisms to integrate sociology with non-academic institutions would ideally include action at legislative levels. If centers and health planning regions were legally required to employ qualitative social scientists, including sociologists and anthropologists, then job openings would appear rapidly. Although chaotic at first, this would eventually provide for systematic inclusion of qualitative sociology in medicine.

Symbolic interactionists and phenomenologists would then fit into a competitive job market, but Marxists would still be unlikely candidates. This latter group would be more likely to find a home with an adversary group outside the present institutional arrangements. Health consumers, political and community organizations and privately financed groups would be the only possible employers for Marxists at this time in the United States. Training in other countries may be a desirable and revitalizing experience for them since application of anti-capitalist thought in America is in stark contrast to the currently advocated and dominant direction of medicine and political economy. Nonetheless, institutional Marxist medical sociology needs institutional foundations, and academic sociologists could provide a more visible base and support than now exists.

Third, we need mechanisms to help structure qualitative research; for example, what should be the optimal time for open-ended interviews, participant observation, and reading? Since academics have no time-restrictions, and graduate students are notorious for lengthy incubation periods, there are few concrete guidelines for scheduling these events and for accountability to institutions.

Finally, we need specific models for applied, qualitative medical sociologists; that is, articulated paradigms for theory and practice. The process of putting theory into practice is relatively unknown. We are familiar with the skills and art necessary to interpret data, but lack knowledge to link such interpretations to action. Sociologists burned by social reform activities at the turn of the century have left us a legacy which shuns active involvement and clear-cut recommendations for a "better" way to do things. Nonetheless, involvement in concrete steps to change medical services are vital for an applied sociologist. Examples of studies involving both the theory and practice of symbolic interaction, phenomenology and Marxism are presented in our next section.

APPLIED SYMBOLIC INTERACTION

Medical sociology has a rich heritage of ethnographic studies. Three

promising areas for their application are dramaturgy, the teaching and dispersion of labelling theory to users of health services, and clinical symbolic interactionism.

Dramaturgy is an excellent theoretical resource for the dramatic events occurring in medicine: birth, death, pain, and stigma. Goffman's brilliant studies of mental illness (1961) and stigma (1963) are themselves powerful, political statements on medical concerns. But training others to do studies similar to Goffman's who are employed in a non-academic setting and publishing their findings has not been done. Goffman's remarkable career in sociology, his marginality to the profession, and his controversial preeminence, illustrate precisely the problems of acceptance discussed earlier in the paper.

Critical dramaturgy is a more specific perspective than dramaturgy, examining the political implications of the roles we play in everyday life. Emanating from a base established by Erving Goffman, critical dramaturgy has been most thoroughly elaborated by T.R. Young. In a series of papers (1972, 1975, 1976, 1977, 1978), Young examines the political drama in the mass media, sociology and society, providing us with a base for political analyses of medical delivery.

Other proponents of the study of the dramatic reality of daily life could be used, although sociologists tend to emphasize Goffman's work. Overington's study of policy making as a highly ritualized and dramatic act draws upon the work of Hugh Duncan. Lyman's analysis of The Seven Deadly Sins (1978) could be employed to define the "deadly sins" in medicine, one of them being the greed of physicians. Dramaturgy could also be used in combination with the role-playing approach which is an established therapeutic model lacking a sophisticated understanding of the similarity between play and our everyday world (Deegan, 1977a).

Another branch of scholarship in symbolic interactionism, labelling theory (Becker, 1963; Lemert, 1972) could be brought into medical practice through its dissemination to the public, especially to health consumers. Labelling theory taught to cancer patients, the mentally ill, and people with chronic diseases, would be most helpful in explaining their status as it appears to a variety of "others". Such teaching would move the powerful critiques of labelling theorists into the world of the patient or consumer. In addition, teaching labelling theory to the families of the mentally ill would be a challenge to the theory as well as to the families.

In addition to these applied uses of symbolic interaction, one of the most vital and innovative areas open to qualitative medical sociologists is clinical sociology. This is not a new idea. For example, Louis Wirth

wrote an excellent article on the topic in 1931, and many sociologists since then have called for the development of clinical sociological practice. Many of the requirements for clinical sociology are outlined by Glass (1977) and could be met through applied symbolic interactionism.

The founders of symbolic interaction, C. H. Cooley, G. H. Mead, and W. I. Thomas, were concerned with the application of their ideas to problems in everyday life (Deegan and Burger, 1978, 1979). Their intrinsic concerns with the resolution of crises have languished in academic sociology ever since. Fortunately, though, their ideas were applied by many of their non-academic students, and a rich body of literature using symbolic interaction in the clinical setting already exists in social work, counseling, and social psychological literature. For example, Jessie Taft adapted Meadian thought to Rankian psychology (see her bibliography in Robinson, 1962), and an examination of her writings is sorely needed. Other clinicians, such as Alfred Adler (see Morris, 1965 for a discussion of this proposition) and Sigmund Freud (Lyman and Scott, 1975; Swanson, 1961) have occasionally been mentioned in conjunction with Meadian thought, and a very exciting merging of clinical thought and experience with symbolic interaction is clearly possible. Moreover, with our knowledge of therapeutic personnel as control agents (Szasz, 1966; Scheff, 1966) we could attempt to eliminate the present weaknesses of clinical work while preserving its many strengths.

APPLIED PHENOMENOLOGY

The phenomenological study of behavior demands a return to human experience. The starting point for any analysis, then, always probes a person's world and his interpretation of it. In medical sociology, a fruitful area seldom explored is the patient's experience of pain, illness, hospital treatment and bureaucratic organization. Moreover, the work that has been done (for example, Zborowski, 1969) rarely takes the additional step of trying to improve the service, environment, or social construction of reality which exacerbate the painful experience.

This final application step does not mean that the phenomenological analysis itself is biased. As Weber (1949) has already stated, a scientist is subjective in the selection of the topic, and we are suggesting here that values enter into the application of findings which have been gathered and analyzed in the most objective way possible. The problem of values in applied sociology is intrinsic, whether the paradigms used are positivistic or phenomenological.² Despite these potential problems some excellent work in applied medical phenomenology has been initiated. Friedson's analysis of the social construction of medicine, (1975) for instance, is an excellent example of a phenomemo-

logical study of medicine, and his attempt to combine theory and practice must be lauded, even if one does not agree with the applications suggested. Furthermore, a potential for clinical phenomenology is already firmly established in psychology, especially by R. D. Laing. (1965,1971) Links between sociological phenomenology and psychology could result in an innovative critique of the social construction of mental illness (especially combining Scheff (1941) and Laing (1965,1971)).

Further clinical uses for phenomenology are clear in physical rehabilitation, where the utilitarian, pragmatic thrust of physical rehabilitation has been relatively unexamined.

Current physical rehabilitation practices, drawing upon the experience of the patients as a guide for recommended changes have been examined and critiqued in Deegan's analyses of the social construction of depression in physical rehabilitation settings (1977a); in the labelling of the real experience of a limb after amputation as a phantom (1978); and in the emphasis of functional change in physical health as the most important criterion of rehabilitation needs, rather than personal and social changes in appearance or self-presentation (1977b).

Psathas' study of blindness (1977) provides an excellent summation of needed proposals for changes in rehabilitation: for example, an examination of disability classifications made for non-medical purposes, such as organizational or legal demands; an examination of the extent to which these classifications orient studies and findings irrelevant to the actual problems of the disabled; and the use of qualitative methodology to determine types of disabilities encountered by individuals with physical limitations.

What these studies by Deegan and Psathas establish is a need to change the structure of rehabilitation services, to redefine the meaning of disability, to re-examine the amount of control the disabled should have over their own re-training, and the social process of creating limitations. Applied phenomenology, then, has the potential to alter the type of rehabilitation services offered, the client's relationship to the practitioner, and the role of the disabled in everyday life.

As radical as these suggested uses of phenomenology are, the application of explicit critiques of the political economy of medicine is even more threatening to medical practitioners.

MARXIST MEDICAL THEORY

The professional role and production of knowledge of Marxism is the most tenuous of our three paradigms. "Red scares" are more subtly exercised now than they were in the McCarthy era. Today, it is merely "difficult" to find a job, publisher, or institution willing to provide support for work in and access to medical institutions. In other words, imprisonment and social ostracism are not likely to occur, but effective, even if invidious, destruction of a person's career still exists.

Waltzken and Waterman's "The Exploitation of Illness in Capitalist Society" (1974) is by far the best American Marxist analysis of our present system. Critiquing the major medical sociologists (i.e., Parsons, Freidson, and Mechanic) from a Marxist perspective, the authors discuss the benefits of National Health Insurance and Health Maintenance Organizations for medical schools and teaching hospitals, insurance carriers and professional associations. The goals of a non-exploitive health system would include abolishing profit from illness, removing bureaucratic obstacles to care, and exercise of national instead of local control. Waltzken and Waterman favor at least some compulsory redistribution of services and the elimination of hierarchical authority which evolves from and is concerned with status and prestige rather than care of the sick. Navaro's analyses similarly critique "medicine under capitalism" (1976, 1977), although his writings are primarily theoretical rather than praxis-oriented.

Another potential model is the Frankfurt School's critique of modern medicine, of its dehumanizing properties and its alliance with bureaucratic structures. Moreover, the use of "scientific" equipment to control human behavior could be analyzed devastatingly as a function of scientific ideology, dehumanization, and alienation. Dreitzel's introduction to the Sociology of Health (1971) is a brief example of the possibilities here. (See also the Frankfurt Institute, 1972 and Habermas, 1970).

Marxist analysis of medicine is maximally threatening to administrators and gatekeepers. Like symbolic interactionism and phenomenology, it does not lend itself to fixed time schedules or narrow problem definitions. The ambiguity in answers to key questions--why a sociologist is there or when he/she will be finished--can be fatal for the continued employment of the non-academic sociologist.

Therefore these issues are briefly examined next.

RECOMMENDATIONS FOR THE APPLIED QUALITATIVE MEDICAL SOCIOLOGIST

Some concrete measures implementing the theory and practice of these paradigms in medical settings enumerated here to provide a skeletal frame for action.

1. A period of internship in the educational process is vital. This traineeship can easily be integrated into present doctoral programs with their emphasis on research and data collection. Since all qualitative sociologists must spend time collecting their data, this process could be formalized with the development of expected timetables, training in sociological theory, and doctoral supervision while the observations are being made and data is collected.

2. A professional model for each type of practice needs to be developed, giving a great deal of study and emphasis to the structuring of accountability to the employing institution, the need for professional rights of control over data and freedom of speech, and the protection of human rights while conducting the research and disseminating the results.

3. Many sociologists do not have the experience or training to prepare others; therefore we need to generate professional panels, publications and training courses to give a base for such a professional option to academic employment.

4. An understanding is sorely needed of the demands of inter-disciplinary, multi-methodology research in a setting demanding accountability. Barriers to such interactions and collegial relations abound even within the profession of academic sociology. The expansion of a sociologist's network as a member of a non-academic multi-methodology team is an approach with few professional antecedents.

5. We need thorough reviews of medical sociology in light of its contributions to medical practice. One of the problems of writing this paper was to determine which limits, if any, exist between this topic of theory and practice and the general topic of medical sociology. Such differences do exist, but we need to crystallize what these boundaries between academic research and applied research may be. For example, one criterion for applied sociology is the explicit intent to change present practice. Also, the great wealth of research that has already been done needs to be communicated to the general public, the users of health care services, and medical practitioners. What we need, then, is a clearinghouse to organize and translate the implications of medical sociology theory to sociologists as well as to people in everyday life.

CONCLUSION

This paper has been only an introduction to a significant problem for qualitative medical sociologists. We have attempted to discuss the key obstacles: training and employment. Although the suggested changes are not dramatic reforms, it is hoped that this analysis will initiate an exchange of information and ideas.

Those of us in academic positions can continue to make inroads into the development of this area. Simultaneously, we have an obligation to those we train, to consumers of medical services, and to ourselves to institutionalize qualitative medical sociology studies. At this stage, our understanding about the relation between theory and practice is muddled, communication about our experiences as professionals in health institutions is faulty, and institutional mechanisms to provide employment outside academia exceedingly weak. Therefore, we have not suggested implementation of a grand program, but only a call to action and organization at what is a promising stage in the development of applied medical sociology.

FOOTNOTES

¹Positivist Marxism is, of course, another alternative. For our purposes, though, we are limiting our discussion to qualitative methodology and Marxism. For a discussion of the problems encountered in combining Marxism and positivism see Adorno, 1976.

²Moreover, the phenomenologist as a scientist has some acute theoretical problems in becoming a practitioner. Since the paradigm demands a presuppositionless stance, the applied sociologist has strong incentives to justify his position, potentially violating this major assumption of the paradigm.

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