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Sociology, medicine and the construction of health-related sociology

ABSTRACT

Starting from a paper about closing the gap between sociology and medicine in Brazil and the United Kingdom that was published in 1971, a historical update was made with the aim of reflecting on the new shapes of health-related teaching and research within the social and human sciences, in these two countries. The methodology was qualitative and the study was developed using secondary data. The reflections were developed through the authors' immersion in Brazilian and British realities. It was concluded that the interface between sociology and health has expanded, although persistent old difficulties exist in relation to the structure and focus of the healthcare system, medical school power and medical student culture

DESCRIPTORS: History of Medicine. Social Medicine. Sociology, Medical. Sociology. Schools, Medical. Qualitative Research.

INTRODUCTION

In 1971, Candeias[4] published an article with the title "Sociology and Medicine" in the *Revista de Saúde Pública*, written after her visit to educational institutions in the United Kingdom, with the aim of clarifying sociological teaching and research in the field of healthcare. In her words,

"The most recent discussions have led to a willingness to train, on the one hand, physicians with sociological knowledge and, on the other hand, sociologists with medical knowledge, so that (...) through one complementing the other, they are together able to solve problems of individual and social pathology." (p.111)[4]

Today, the presence of social sciences in the field of healthcare is essential for several different reasons: to corroborate the understanding of changes in mortality patterns and their relationship with habits and behavioral patterns; to enable understanding of the dynamics of chronic conditions, thereby promoting multidisciplinary and intersectoral work; to clarify the multicultural and multiethnic composition of societies and assist in constructing abilities within the fields of communication, negotiation and motivation; to help in identifying stress factors and in developing action strategies regarding physical, psychological, cultural and environmental factors; and to promote humanization in patient care and work relationships.[2,5,6,7,8,12,13]

Based on the changes that have occurred since the publication of Candeias's paper, the aim of the present paper was to update the discussion and reflect on the new shapes between sociology and medicine in the United Kingdom and Brazil.

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DATA ANALYSIS

Secondary data, in the form of papers available in indexed journals in Brazil and the United Kingdom, along with material available on the internet, were analyzed.

Current state of sociology *of* and *in* healthcare in the United Kingdom

Since Candeias's paper was published, changes in terminology have taken place: until the end of the 1980s, the possibilities of bringing sociology and medicine together were emphasized, from the perspectives of sociology within medicine, developed in medical schools, and medical sociology, produced in departments of sociology.[15] In the 1990s, other types of sociology appeared, such that medical sociology gave rise to the sociology of nursing, health/disease, healthcare, health services and alternative and complementary practices.

Another significant change related to the number of institutions and projects. In the 1970s, Candeias visited all four of the educational institutions that had developed courses on sociology and health: Department of Sociology of Bedford College, University of London; Department of Preventive and Social Medicine, University of Manchester; Department of Mental Health, University of Bristol; and Department of Sociology, University of Aberdeen. She also identified 63 research projects on behavior towards disease, organization of medical care, use and underuse of services, health-related professionals, health education, mental diseases, drug use, old age and death.[4]

The coverage that Candeias achieved would be impracticable today, since there has been significant growth in health-related sociology in the United Kingdom, to produce responses that are immediately applicable to healthcare.[9] To grasp the size of the expanded frontiers, some data on the teaching of social sciences in medical schools and of health topics in departments of sociology is presented below.

Sociology *in* medicine

On the Guardian newspaper's list of the best medical schools in the United Kingdom in 2008, the following appeared: Oxford, Edinburgh, Dundee, Cambridge, Manchester, University College London, Imperial College, Aberdeen, Leeds and Leicester.[a] From internet consultations, it can be seen that all of them have social science teaching activities. However, the type of information made available on each school's website is not uniform. The data analyzed here were based on the results from the study by Russell[13] (2004). This study had two phases: a questionnaire sent to medical schools and a national meeting of professionals who teach social sciences in medical schools. The study was motivated by the change in status of health-related social sciences that had taken place through the paper "Tomorrow's Doctors", published by the General Medical Council in 1993. This had recommended that social components should be inserted into the training of medical professionals.[13]

The main results related to the reasons for social science teaching in undergraduate medical courses and the topics recommended for inclusion in the medical curriculum. The justifications for such teaching were grounded in: comprehension of personified individuals and the nature of social processes; the social dimension in the health-disease process; development of holistic thinking; promotion of team-working; respect for differences and diversity among patients and colleagues; and development of social investigation and critical thinking. On the other hand, the topics recommended for inclusion in the courses were: health-related social inequality; social categories (gender, ethnicity, social class, incapacity, stereotypes, stigma and prejudice, among others); healthcare models, different types of knowledge and the social construction of common sense; popular medical culture and the evidence-based medicine project; the doctor-patient relationship; communication, social structure and power; and different types of intelligence.[13]

Furthermore, the difficulties in standardizing experiences were taken into consideration. Nevertheless, using the facilities of the internet, a network of professionals who teach social and behavioral sciences to undergraduate health-related students was created. Although this network is still at an initial stage, investigations have already be conducted on, for example, comparisons between what social and behavioral science specialists and non-specialists in medical schools consider to be the fundamental concepts for training medical students.[12]

This comparative approach was novel in the United Kingdom. The method used was to mail a questionnaire to the schools, containing a panel of 93 concepts within the social and behavioral sciences; 214 questionnaires were sent out and 140 were returned. Only 91 of these were used in the analysis, representing 29 of the 31 British medical schools. Of these responses, 63 were from specialists in the social and behavioral sciences (31 psychologists, 22 sociologists and 10 anthropologists) and 28 were from non-specialists (13 general clinical physicians, five psychiatrists, two public health specialists, one obstetrician, two nurses, one pharmacist, two educationalists, one economist and one epidemiologist). Most of these professionals (60) worked in departments within medical schools and the remainder in departments or schools of psychology and sociology (23), nursing schools (seven) and in practice within the British National Health Service (one).

[a] The Guardian. University Guide 2008. Manchester; 2008 [cited 2008, Aug 1]. Available from: http://browse.guardian.co.uk/education/2008

On the one hand, although it was found that the specialists and non-specialists agreed regarding the importance of teaching social and behavioral sciences to medical students; on the other hand, the following were also evident: divergence regarding the perspectives of work in this discipline; the centrality of the theory among the specialists; and lack of knowledge of the topics among the non-specialists.

The authors considered that these differences would partially explain why social science specialists had been abandoning medical schools and transferring to departments of sociology. This was leading to an increase in sociology *of* medicine, to the detriment of sociology *in* medicine.

Sociology of medicine

According to the Guardian, the best sociology schools in 2008 were: Cambridge, Oxford, Warwick, London School of Economics, Birmingham, Edinburgh, St Martin's College, Brunel, Leeds and Durham.[a] Again, from the internet, it can be seen that comparative analysis using the material available on the respective websites is not possible. Nonetheless, it can be seen that these institutions run health-related undergraduate courses, on topics such as: origins and status of medical sociology; challenges and perspectives of the biomedical model; disease and social deviation; lay and professional representations of health, risk and the body; professional-patient relationships; children, health and social order; aging and health; experience of chronic diseases; death; social class, gender and ethnicity in relation to health; medicine, gender and division of work; health professions; health promotion and the new public health; alternative and complementary therapies; and medical pluralism; among others.

According to the results from the project "Social and Organizational Mediation of University Learning" (SOMUL),[b] which had the aim of expanding the understanding of social and organizational mediations on the British university-level educational system and its consequences for students, there are 2110 different courses with sociological content in the United Kingdom, in 125 higher education institutions, of which 76 are departments of sociology.

It was also seen from this project that, over recent decades, the sociology curriculum has become more flexible and fragmented as a result of organizational and pedagogical changes that have made it possible to introduce courses on particular topics, such as: crime, deviation and society; gender and sexuality; identity, cycle of life and autobiography; media and mass culture; body and emotions; health and disease; social division and inequity; race and ethnicity; social stratification; industrial and organizational sociology; sociology of education; sociology of religion; comparative and historical sociology; and others.

Lastly, from the SOMUL report, it can be seen that around 20,000 undergraduate university students are taking sociology as a central theme in their studies and that 67.2% of recent graduates are employed in the United Kingdom, of whom 8% have connections with the health sector in different manners.

Current state of sociology of healthcare in Brazil

When Candeias's paper was published in 1971,[4] an investigation on the teaching of social sciences in medical, nursing, dentistry and public health schools in Brazil was underway, which was published in 1976.[3] The authors of that study concluded that "the teaching of social sciences in professional health schools in Brazil (...) can be characterized as being at an incipient stage". They also concluded that specific social science courses were little represented in the curriculums of the schools investigated; that the personnel trained in the field of social sciences only accounted for one sixth of the lecturers responsible for the courses; and that the teaching of social sciences was associated with prevention, psychology, sociology, education, demographics and the environment.[3]

At the same time, another investigation was conducted on the theoretical framework of social science courses. Four theoretical-conceptual models were identified, of which three had emphasis within the medical model (natural history of diseases, comprehensive care and patients' ways of life) and one on social orientation (structural history). It was concluded that in the first three models, the social aspects were a coating from the biological model, appearing more as a descriptive element than as an explanatory one. In other words: the models did not attain the "capacity to univocally describe a synthesis of the concrete conditions under which social phenomena are produced and explain them in the light of the variables that operate through such conditions".[10]

One example of the teaching of health-related social sciences is the experience developed in the Department of Preventive and Social Medicine of the School of Medical Sciences of Unicamp, which is still ongoing today. The first experience was developed in 1965,[11] for third-year medical students. It was strictly theoretical and conceptual, with little content applied to healthcare, and was composed of distinct courses on anthropology, sociology and social psychology. For the next year, modifications were made: for example, social scientists

[a] The Guardian. University Guide 2008. Manchester; 2008 [cited 2008, Aug 1]. Available from: http://browse.guardian.co.uk/education/2008
[b] Jones R, Jary D, Rosie A. SOMUL Report for Sociology. Birmingham: Centre for Learning and Teaching Sociology, Anthropology and Politics; 2004 [cited 2007, Jul 1]. Available from: http://www.c-sap.bham.ac.uk/resources/publications/samples/SOMUL.pdf

were hired and two students undertook a monitoring project on a family in a district on the urban periphery. These signified that the course underwent adaptation to conform to the model of "comprehensive care associated with the natural history of the disease". In 1967, the course became compulsory within the medical curriculum, with 120 timetabled hours per year. In 1968, four major units were developed: social sciences and medicine; the role of social sciences in understanding health and disease; the medical system: organization and structure; and the relationships of the medical system with the overall social system. Over the 1970s, efforts were made to ensure the "construction of a health-related social project", with emphasis on updating the bibliographic material and transmitting the basic concepts of the social sciences. Several proposals were drawn up, covering: sociological knowledge versus common sense; social values; ideology; social system; social institutions; structure; social stratification; social classes; and development and underdevelopment.[11]

In the 1980s, the health-related social project was consolidated and the courses continued to be based on the four units described above. There was a practical research component developed in collaboration with lecturers without training in social sciences.

It was observed that, at the start of the 1990s, the lecturers were sure that, despite the persistent difficulties in teaching social sciences in health-related undergraduate schools, there was no longer a need to discuss the validity of these courses. However, differences in language and approach were present throughout this period. One factor that helped during those years was that specific bibliography on health-related sociology was available. However, the number of professionals with specialization in the social sciences decreased. On the other hand, there was intense collaboration from postgraduate students, through a lecturer capacitation program created by the university. Basically, this decade can be considered to have been one of continuity, although in the last few years, a transition has been identified, marked by the construction of a new curriculum for the medical course and the need to train professionals oriented towards working in the public sector.

The consequences of this curricular reform for the social science course have been: a return to the 120 classroom hours per year; planning and development of the Health and Society module for the second year; planning of programs oriented towards development in the community; practical activities in primary care services within the municipal public healthcare network; adoption of the research-action methodology; relative loss of theoretical-conceptual content; and a need to expand the teaching staff.

In summary, two trends can be indicated with regard to course development: working with the perspective of application to the social sciences, with the aim of answering pragmatic questions regarding the training of physicians to work in the public sector; and bringing the course closer to what has been called the "new public health" [1] (Table).

One final set of information on the teaching of social sciences within the Brazilian healthcare field relates to the characteristics of the professionals connected with these teaching experiences. Both in the British and in the Brazilian case, it has not been easy to produce empirical data. The most recent figures, albeit preliminary, come from a survey conducted among 68 professionals, with the aim of outlining their profile and their thematic fields within the teaching of health-related social sciences.[a]

The data from this survey indicate that male teachers predominate (67.6%), with concentration in the age group between 40 and 59 years (65%). The subjects in which they had graduated were: social sciences (36.7%); medicine (27.9%); psychology (7.4%); social services (5.9%); others (22.1%), including economics, law, health education, nursing, pharmacy, philosophy, history, nutrition, dentistry and pedagogy. Among 62 interviewees with a master's degree, 24.2% obtained it from a course on collective health; 22.6% public health; 11.3% social sciences; 9.7% anthropology; and 6.5% sociology. Among the 54 respondents with a doctorate: 28.3% had a title in public health; 20.0% collective health; 10.0% sociology; and 8.3% anthropology. It was observed that 48.3% of the interviewees had obtained their master's titles between 1990 and 1999 and 40.7% had obtained their doctorates in 2000 or more recently.

COMMENTS

The present paper has the limitation that it was produced using secondary data from publications available in indexed periodicals in Brazil and the United Kingdom, along with material available on the internet. A discussion from this type of material will certainly have the possibility of bias in its analysis. Nonetheless, we believe that the reflections presented here have achieved a historical update of the debate on the teaching of the social sciences to health professionals, in addition to making comparisons between Brazilian and British realities.

In a general manner, there has been growth in the health-related social and human sciences in both countries, with great similarities in how their experiences have developed. However, few new questions have arisen over these three-and-a-half decades.

[a] Nunes ED, Barros NF, Nascimento JL, Montagner MI. Os profissionais em ciências sociais e humanas em saúde. Campinas, 2005. [Relatório de Pesquisa].

Table. Contrasts and similarities between the "old" and the "new" public health.

Old public health (Up to the 1980s)	New public health (Since the 1980s)
Focus on the development of physical infrastructure, especially for providing housing, water and sewage systems.	Focus on the development of physical infrastructure, but also on developing social support, behavioral patterns and healthy lifestyles.
Development of legislation and key policy mechanisms, especially in the 19th century.	Legislation and policy rediscovered as crucial tools for public health.
The medical professional had a central role.	Recognition of intersectoral action as crucial, with medicine as just one among the many professional contributions.
In the 19th century, public health was another social movement that worked to improve living conditions. Initially, it was directed by specialists and had a certain legitimacy from community movements; subsequently, it became more dominated by professionals.	The philosophy of social participation gained relevance but, despite some positive experiences, it was not achieved in practice.
The research methodology was legitimized through epidemiology.	Several methodologies are recognized as legitimate.
Focus on disease prevention, and health was regarded as the absence of disease.	Focus on disease prevention, health promotion and positive definition of health.
Fundamentally concerned with the prevention and treatment of infectious and contagious diseases.	Concerned with disease treatment, including chronic and mental diseases, but with growing interest in environmental sustainability questions.

Source: Baume[1]

Back in the 1960s, the following difficulties regarding the development of health-related social sciences were indicated: the structure and focus of the healthcare system; the power structure within medical schools; the medical student culture; and the influence of social scientists.[10]

The structure and focus of the healthcare system add extra difficulty for social scientists working in the healthcare field, especially in relation to: requests for work within a short space of time in order to supply rapid responses for immediate application; large quantities of course planning, preparation and administration work; large numbers of students, thereby making social approaches to health problems difficult; thematic diversity; difficulty in developing a minimum curriculum for courses; and assessment methods.

With regard to the power structure within medical schools, it can be seen that one of the persistent difficulties within both of the situations investigated is the shortage of human resources with training in social sciences. In the 1970s, Candeias observed that this shortage created unfavorable working conditions, in that it did not allow the formation of a balanced team of specialists. In 2004, in the United Kingdom, the same conclusion was reached through the following reflection:

"*while some problems highlighted are common to higher education in general – for example, balancing the demands of teaching with those of research and administration, increased student numbers, and lack of resources – (…) social and behavioral scientists based in medical departments [have] their contact with departments [of] sociology often limited, (…) this cause some to feel both isolated from disciplinary support and or departments and marginalized within medical schools.*" (Benbassat et al[2])

With regard to difficulties with the medical student culture, some of the resistance among these students reproduces what is expressed by the leaders and opinion-formers within the medical school, while another part of it comes from the fact that:

"*some overwhelmed students were more anxious about learning the basic and clinical sciences and resented having to invest time in the social and behavioral sciences, which they perceived as mere "common sense"; others thought a much greater emphasis on anatomy and less on social and behavioral sciences would serve them better in clinical practice; still others thought the qualitatively different social and behavioral sciences content in some lectures was better suited for small-group discussions.*"(Satterfield et al[14])

In relation to the barriers placed by social scientists, there have been important changes. According to Candeias,[4] in the 1970s, "[it was] not rare to find literate lay people and even social scientists with specializations in other subjects openly opposing affirmations for which the evidence came from very rigorous sociological investigations". However, it is seen today that there is now a generation of social scientists lecturing in health-related schools, with full training in postgraduate programs of medical and public health schools, under the supervision of social scientists. It is also observed that social and human scientists have taken positions in

non-academic institutions, such as in the management of the Brazilian health system (SUS) and in relation to production of specific policies for humanization, social control and social inclusion.

Both in Brazil and in Great Britain, it can be seen that the *habitus* of social and human science agents within the healthcare field is formed by idiosyncrasies such as: the relative youth of this teaching in undergraduate courses, since five decades is not a long time compared with the thousands of years of medical tradition; continual criticism within and between the theories, which is different from the doubts put forward as the principle of scientific experimentation, since there are many hypotheses without theoretical reflection; the relationship with the written word, which gives rise to the use of long and detailed texts to express the complexity of multicausal analyses.

Because of these characteristics, it is seen that different approaches are developed. One result from this is, for example, that words like reality and truth are used transitionally, given the recognition of the historical perspective in constructing "normality". Thus, it is observed that different socialization processes generate different values and symbols and that exercising social and human science techniques consists of analysis and synthesis in slow and deep slices of theoretical-conceptual knowledge. On the other hand, although the healthcare field is also analyzed through the written word, its most important technique requirement is of a pragmatic and immediate nature, almost within the dimension of positivist thinking. Thus, the technical capital elaborated from these two approaches is recognizably different but may be complementary. However, in a field in which concrete images that "are worth a thousand words" have been taken to be part of the foundation, those who produce abstract images achieve lower yield through their actions.

Nevertheless, within the healthcare field, there has been recognition of the need for differences in the training for professionals, in order to reflect greater support from the point of view of legality, even though from the point of view of legitimacy, the difficulties are still notable. The statements of British professors certainly find an echo within the Brazilian field, since they affirm that the orientation of the course is almost exclusively biomedical, thereby creating a hierarchy of knowledge and making room for doubts such as: "*when critical social science clashes with biomedical sciences, is this controversy going to assist deep-reflexive learning or simply going to create more confusions*?"[2]

Finally, although social and human science professionals have achieved entry socially into the healthcare field, differences and difficulties still persist. It is possible that these differences will never be resolved and, to a certain extent, it is not expected that they will be, since it is fundamental to recognize the differentness in healthcare work. This makes it possible to have an expanded perspective of a paradigm of healthcare in which professionals and patients interact with their biological, social, psychological and spiritual knowledge.

From the updates presented in this study, it can be stated that there has been expansion between the social and human sciences and healthcare. Furthermore, the interaction between these two fields of knowledge has created zones of contact and intersection, thus resulting in important scientific production and additions within the spheres of teaching and services over the last few decades.

Candeias[4] stated in 1971 that the training of social science specialists in healthcare had already gone beyond the field of improvisation and amateurism. Today, there is certainly even greater positivity regarding the training of these specialists. There are now sufficient elements to constitute this profession as a form of sociology, with its professionalization process.

As shown by British researchers, there is certainly still a notion of "us and them" in the healthcare field. However, the space available for treating the social and human sciences as anti-medicine disciplines has become smaller; or the space for stating, as the head of a clinical department in the United States did, in 1981, "*it is dangerous to let sociologists into medical schools… they cause divisiveness by emphasizing differences in care rather than commonalities*".[2]

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