Low profile, high impact: the role of the sociologist in quality in health care

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It was claimed over 50 years ago that medicine cannot do without sociology,¹ but what impact have sociologists had on quality of health care? Most clinicians and managers would not be able to identify sociology's contribution even though it forms part of the educational preparation of healthcare professionals, including medical practitioners. Why does sociology seem invisible when it is so relevant to health care in a rapidly changing society? The declining social importance of hospital clinicians in the 1990s, for example, shows how important all the social structure of medicine is for all disciplines. In this article I have evaluated the unique role of sociology in determining quality and main methods of investigating aspects of health and illness. Reasons for sociology's low profile are discussed and future opportunities delineated.

Sociology: its definition and concerns, with reference to health and illness

Sociology investigates how society is organised and examines the processes by which it is maintained or changed. Sociology is about how society works at the levels of institutions and organisations and what beliefs and attitudes (ideologies) support or challenge this.² The subject is based on critical analysis whereby nothing is taken for granted,³ not even the existence of sociology. The distinguishing features of sociology are (a) the systematic and objective study of human society, and (b) the sociological imagination,⁴ with which it can be seen that "personal troubles of milieu" are connected with "public issues of social structure".⁵ A keystone for sociology is exploring the links between behaviour and social structure (social institutions such as government). Nowhere is this better illustrated than in the area of health and illness.

Sociological autonomy

During the 1950s, both in Britain and the United States, medical sociology established itself as an academic discipline based on the methods and theories of mainstream sociology applied to medicine. Initially sociologists worked largely in a subservient role on problems identified by doctors,⁶ but this changed rapidly. The medical profession itself became the subject of investigation and American sociologists in particular examined critically the power of doctors,⁷ and pointed to the "medicalisation" of social life.⁸ In Britain, sociologists promoted a social model of illness and doctors, the proponents of the medical model, were regarded as failing to solve the

social causes of disease. Subjective experience of illness was highlighted as crucial to understanding behaviour during illness (box 1).⁹ In less than two decades sociologists developed their own research agenda published in new journals, which helped to establish their autonomy. In Britain the Medical Research Council established a Sociology Unit. Incorporation within medicine, as a paramedical profession, never occurred.

This autonomy has had important implications for health care. Sociologists, situated outside of the system and educated apart, brought a new vision. Cherished assumptions were challenged and different questions were asked from those of professionals trained within the confines of a medical curriculum. From the subject's earliest days medical sociologists opened up new and fruitful areas for investigation and discussion. For example, research in the early 1950s¹⁰ showed that people seemed to experience symptoms much more often than they consulted their doctors. Early sociological surveys helped to

INITIAL STAGE: *sociology in medicine*
Sociology acts as tool for medicine, clinicians set agenda.

Key issues: social role of medicine; social factors in illness prevalence; consultation rates especially in general practice.

TRANSITIONAL STAGE: *sociology of medicine*

Sociology develops own focus of interest. Medicine itself subject to sociological scrutiny. Emphasis on theory and application of concepts.

Key issues: Medical power and control; patient experience of illness and medical organisation.

CONSOLIDATION STAGE: *sociology of health and illness*

Increasing areas of health care examined by sociologists; medical boundaries challenged, feminist perspectives incorporated.

Key issues: definitions of health and illness and patients' perspectives.

COLLABORATIVE STAGE? *Sociology of health*
Sociologists seek partnerships with clinicians in investigation of problems. Doctors incorporate sociological perspectives especially for rehabilitation, care in the community, and health promotion.

Key issues: health; lifestyle; health beliefs; social support; alternative treatments, outcomes.

Box 1 Main trends in sociological perspectives on health care

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Accepted for publication 8 July 1996

establish the importance of patients' views of treatment and care.

In contrast with medical or managerial investigations, sociological studies have shown the unintended consequences of health care. Certain practices within mental institutions helped to create a "total institution", counterproductive to treatment.¹¹ This highly influential concept illustrates two major elements of the sociologist's role in quality in health care — namely, the development of theories and concepts resulting in a better understanding of health, illness, and health care, and methods for describing and evaluating health care.

Theoretical and conceptual development

New ways of thinking about illness and health care resulted from publications in the 1950s with health and illness as key factors in the maintenance of social stability (equilibrium).¹² These key factors thus needed to be controlled.¹³ Illness and behaviour during illness were seen to follow prescribed forms (as formulated in the sick role), with the patient, physician, and any other person involved having the shared goal of recovery. Illness was seen at best as disfunctional and at worst deviant. More radically, medical ideology was fundamentally challenged: "the medical establishment has become a threat to health. The disabling impact of professional control over medicine has reached the proportions of an epidemic".¹⁴ This concept of iatrogenesis has now become embedded in sociology, alongside such concepts as stigma, applied to illness and defined as "the situation of the individual who is disqualified from full social acceptance".¹⁵ Over the years this concept has been widely used to describe feelings associated with disease and disability, both by researchers and patients. The stigmatising effects of both physical¹⁶ and mental illness¹⁷ have been explored — for example, in research on AIDS¹⁸ and epilepsy.¹⁹ Stigma was found to be very strong indeed in people with epilepsy; only 5% of patients included in one study told employers of their disorder and only 33% informed their fiancées. Clearly healthcare professionals have to acknowledge and consider such issues.

The book *The meaning of disability*²⁰ has had a major influence on disability research and subsequent work has confirmed that services need to be well coordinated²¹ and that continuity in care is crucial.²² With care in the community, a common fear is that the quality of care will be compromised.²³ Sociological research which showed that long stay care was dehumanising for patients through such practices as "identity stripping"²⁴ and "batching"²⁵ has tended to be forgotten. High quality care, however, may be provided by family members in the community, who offer comfort, companionship, and respect dignity.²⁶ Although early studies highlighted the strain on carers²⁷ and the extent to which women were relied on,²⁸ more recent research has shown that caring can provide satisfaction²⁹ and give purpose to life.²⁶ Sociological theories and studies on the family and community —

important foundations for the discipline — are vital in providing a framework for understanding and planning community care. Ultimately the feasibility of care in the community may depend on the quality of care provided by informal carers, and health professionals' ability to assess and harness that care. The *Black report*³⁰ which stressed social factors in health recommended long ago that statutory services should be seen to supplement rather than substitute family care.³¹ If health is to be promoted health services may need in some situations to perform functions, such as support, previously provided by family members.^{32 33} In the future quality of health care is likely to become inextricably linked to research on interpersonal relations, the family, and neighbourhood networks.

Sociological theories and studies on stratification encompassing class, age, sex, and race have stimulated and contributed to research on social inequality in health and health care. Conceptual underpinning has been provided for understanding why women have higher rates of mental illness.³⁴ how different social classes respond to symptoms¹⁰ and participate in medical consultations,³⁵ and why there is differential access to good medical care.³⁶ Sociological surveys of deprivation and poverty contributed to the *Black report*,³⁰ the formulation of the *Jarman index*,³⁷ and the recommendations of the *Acheson report* on public health.³⁸ Jarman's system of compensatory payments, related to levels of social deprivation in the community, was an important attempt to improve quality of care in the community through encouraging the purchase of additional staff by general practitioners.

Assessing quality of health care

Research into health care has relied largely on quantitative methods,³⁹ and sociologists helped to establish the survey in health services research through their established reputation in surveying and questionnaire design.⁴⁰ Specific contributions have also been important in the development and evaluation of health measurement.⁴¹ New approaches have been advocated, however, as awareness has grown of the limitations of quantitative methods. Although randomised clinical trials have been regarded as the gold standard for effectiveness research, there is increasing recognition of their fallibility. Problems of blinding and exclusions have been reported recently by medical practitioners,⁴² extending criticisms put forward earlier by sociologists.⁴³

Dissatisfaction with validated measures such as the short form 36 (SF-36),⁴⁴ and increasing emphasis on patient defined outcome⁴⁵ has created a need to develop new tools. Yet questionnaires are not easy to design.⁴⁶ Objectives will not then be met,⁴⁷ as "poor questionnaires act as a form of censorship".⁴⁸ High levels of research competence are required, as qualitative studies have shown.

Qualitative methods have been described as having an "enormous potential to illuminate the impact of care on patients".⁴⁹ Doctors today may find qualitative methods more

acceptable given that they have been exhorted to discover patients' existing knowledge, "rather than treat them as empty vessels into which "appropriate" knowledge can be poured".⁵⁰ Qualitative methods in medical and health publications are now being promoted 30 years after they were advocated in sociological journals. Two of the studies highlighted in recent articles,^{49, 51} on patients presenting headaches to a neurological clinic,⁴⁷ and on surgical decision making processes,⁵² were carried out over 10 and 20 years ago respectively. Although different rates of tonsillectomy in adjacent small areas in Scotland were found⁵² only recently have qualitative methods been suggested as a means to examine variation in clinical practice.⁵³

Qualitative approaches could be used to discover why research findings are not applied to clinical practice⁵⁴ and to better understand medical practice so that clinical behaviour might be changed.⁵⁵ Indeed, a qualitative study based on four district hospitals has shown recently that although some obstacles to audit could be overcome by simple practical measures others would require a change in doctors' knowledge, beliefs, and attitudes.⁵⁶

Sociology in professional education

Sociology is included in the education and training of a wide range of healthcare professionals. Sociology is incorporated in both the medical undergraduate and postgraduate curriculums — for example, it forms part of the membership of the Royal Colleges of Psychiatry and General Practice, and the Faculty of Public Health Medicine. Medical educationalists have long seen the need for practitioners to understand the relation between health care and the structure of society. The role of sociology in helping to understand behaviour of patients has become increasingly important: "Demographic change and medical advances mean that the main challenge now confronting doctors is managing chronic conditions in such a way as to maximise the social functioning of patients. In many instances long term drug treatment will have to be combined with dietary or some other form of intervention, with obvious implications for enlisting and maintaining patients' cooperation. If this is to be achieved doctors must understand better the lives in which they are intervening."⁵⁰

A specific recommendation of *Tomorrow's doctors* is that courses on human development and aspects of psychology and sociology relevant to medicine should feature on all curriculums.⁵⁷

Impact of sociologists

Despite the wide ranging nature and long lasting effects of the sociologist's contribution to health care as shown by work in psychiatry (box 2),⁵⁸ a common perception is that it has not had a major impact on quality of care.

There are several reasons why this may be so.

LOW PROFILE OF SOCIOLOGISTS

Sociology is a small profession, current membership of the British Sociological Association is about 3500. Few sociologists are employed in the National Health Service (NHS). Few work in NHS trusts (more are employed in departments of public health) and they rarely act as facilitators or serve as members of audit committees. Their voice has not been heard in quality debates. Sociologists usually publish in sociology journals (*Social Science in Medicine; Sociology of Health and Illness*) rather than in clinically oriented publications. Even when they write for more general journals, their language and emphasis on theory discourages readers. Often there is a long time lag between initial publication and health professionals' awareness of sociological research.

NATURE OF SOCIOLOGY

Clinical work is case bound, concrete, and always is situationally specific.⁵⁹ By contrast with the practical and pragmatic nature of medicine, sociology is an analytical science and can, at best, prescribe.⁶⁰ Medical students may find sociology frustrating because it accentuates pre-existing worries about medicine, without offering practical solutions.⁶¹

LACK OF JOINT WORKING BETWEEN CLINICIANS AND SOCIOLOGISTS

Close collaboration seldom occurs between sociologists, healthcare professionals, and managers.

Sociologists fear loss of independence, and prefer generally to work in university departments of sociology — which are regarded as having lower status and often lack

Box 2 Case illustration: research on social origins of depression

Surgeon's problem

In certain routine types of surgical operations (particularly ulcer surgery) the long term outcome for some patients did not seem to bear any direct or obvious relation to the technical success of the operation.

Sociologist's problem

Coping with surgery for ulcerative colitis and good long term adjustment to ileostomy, had no clear relation either to presurgical experiences with the disease, or to postoperative medical or surgical complications, or their absence.

Box 3 Interdisciplinary research: identification of common problems (modified from Kelly et al⁶⁴)

tenure — rather than in clinical settings. Doctors have stereotyped sociologists in the past as scruffy and left wing. Sociological work is often critical of medicine — for example, that on the “medicalisation” of maternity care is a case in point.⁶²

LACK OF INTEREST IN HEALTH SERVICE RESEARCH
In former years most healthcare professionals have not needed to become involved in research, particularly that relating to delivering health care. Despite social and behavioural obstacles to outcome measurement in clinical practice being identified in 1972,⁶³ clinicians showed little interest in determining precisely what these were, or how they might be overcome. When sociological research on clinical effectiveness was encountered by medical practitioners it was often seen as lacking in scientific rigour.

The future

Recognition of the value of qualitative research and emphasis on patients' perspectives in care indicate that health care may have a greater need of sociologists than ever before. The necessity to understand better the processes by which research evidence affects clinical practice, and how high quality health care can be sustained in the community, means that considerable opportunities exist for sociologists to help to improve quality in health care. This may be achieved best by collaborative work — for example, a joint research project between a surgeon and a sociologist.⁶⁴ Although a similar problem was identified from different starting points (box 3) both the surgeon and the sociologist were unaware of this until, through luck, a colleague brought the two together. Too often sociologists and healthcare professionals are not aware that they share common concerns; brokers may be required.

Increased opportunities for contact are needed, and joint initiatives by professional associations may be useful. Multidisciplinary journals too have an important part to play; *Quality in Health Care* has sociologists and healthcare professionals as contributors and readers. At local levels closer links could be forged between sociologists in universities and healthcare professionals and staff in quality departments in trusts and health authorities or boards. Through such strategies a closer involvement of sociologists and the sociological perspective in assessment of quality in health care and health services research may be achieved to the benefit of both patients and clinicians.

I thank Drs Ann Bisset and Cleo Hart for their comments on an earlier version of this paper, as well as Dr Richard Thomson for his valuable editorial advice.

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