New Perspectives in Clinical Medicine: the Sociologist

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Sociologists look upon medicine as a social institution. They see western scientific medicine in general and clinical medicine in particular as one way among many in which women and men the world over have come to deal with the sufferings and misfortunes of life. They note that clinical medicine deals only with a small fraction of these sufferings and misfortunes: that it has a limited and specific brief located in notions of disease, its diagnosis and cure. Sociologists, therefore, can read with interest and understanding of the cosmology of the Manus of the South Pacific (Schwartz, 1969) who accept the efficacy of western medicine but see it as a very low level empirical activity capable of dealing with or explaining only a fraction of human suffering.

The Manus, like many other peoples, do not distinguish sharply between somatic illness and other suffering: all are part of a general misfortune. They are clear that there are some illnesses western medicine cannot touch which must, therefore, go to native healers. And they are clear that western medicine is limited in its power and applicability. It is not that they send terminal cases to western doctors and retain the self-limiting diseases to themselves, for their healers deal with a category of ailments, referred to generically as nam, which are known to be incurable.

Comparative perspectives such as these can help the sociologist to stand back from a system of knowledge in which the sociologist as much as the medical practitioner believes, for as individuals, most sociologists just like other westerners rely upon scientific medicine in times of illness. The comparative perspective, however, makes it more possible to ask, 'Well, what is it that clinical medicine is doing? How does its contribution rate in the problems that there are to solve?'

Reference to scientific medicine as a matter of belief is not intended to be derogatory or offensive in any way. Sociologists must look at scientific medicine in that and other ways. Medical knowledge and medical practice are social forms that may be examined critically. Cosmologies, including western science, are human attempts to make sense of the regularities in the world around us, be they the regular rising and setting of the sun or the regular course of a disease. As Horton has shown (1967), western scientific theory shares this characteristic with the cosmologies of many other peoples. The important difference between western scientific thought and African thought, in his view, is that the former is open and the latter is closed. While African cosmologies cannot envisage alternative explanations, it is central to western scientific thought that scientists seek to disprove their findings and that they are able to envisage the possibility of totally different explanations and the possibility of revolutions in scientific thought.

In reading this article, clinicians are invited to exercise that facet of their learning as scientists to open their minds to the possibility of other explanations and thought systems than those they acquired in medical school. The sociological approach to clinical ways and means is undoubtedly based upon a different set of scientific presuppositions from those that inspire day-to-day medical practice and guide the education and training in our medical schools. Some effort of scientific imagination may well be needed for readers to accept the arguments that follow as plausible and as forming the basis for discussion.

At the same time, sociological analysis would suggest that the social processes associated with the practice of medicine have the effect of reducing the willingness of scientists and practitioners to adopt the open approach that characterises the scientific mode. This point can be readily appreciated when one thinks of the difficulties innovators like Pasteur had in seeking to get their views accepted. Particular practices, modes of thought and analysis become embedded in institutional arrangements and associated with career structures. In these circumstances certain paths of development become easier to follow than others.

This article, therefore, relies upon scientific imagination and must do so because it is not easy for clinicians to think sociologically. Some expansion of the relationship between sociology and medicine may aid this process. In order to understand society, sociologists study the entire array of social organisations and social institutions of which medicine and all the varied facets of health care are a part. The ways in which matters of health, illness and suffering are handled in a society may be particularly important for social relations in that society, because they touch on critical matters of mutual respect and support; on how dependence is handled; on power relationships; on resource allocation and upon caring; on issues associated with individualistic or collective approaches to dealing with human suffering.

In addition, there is a strong tradition in sociology, and
one to which I subscribe, that sociology should not be an esoteric discipline, or only interested in theoretical explanations or ideas, but that the social understandings it has to offer should be of use. What then is the relevance of sociology for clinical medicine?

The Relevance of Sociology to Clinical Medicine

There are two ways in which sociology can be relevant to clinical medicine and one is perhaps more comfortable than the other. First, and the less comfortable one, it can set the detail of clinical practice in the wider framework of the health and welfare of society, seeing clinical medicine, with its concern with disease, as only one facet of our concerns with health and illness and, indeed, only one way of conceiving of them.

The second contribution of sociology is in helping to understand aetiology in cases where the methods of traditional clinical medicine seem to have difficulties, and in helping to understand the social relations that surround therapy and may have an impact upon it. This is probably what those clinicians who have thought about the sociological contribution want and expect. Nevertheless, the first is, in my view, at least as important, and may be even more important for society as a whole. At the same time, the first approach is also likely to present problems and make sociologists unpopular in clinical circles. This is because it would measure clinical methods against other methods of maintaining and restoring health, an analysis which in principle might work to the disadvantage of clinical medicine. The first approach is also uncomfortable because it involves the critical analysis of long-established and hallowed institutions such as the Royal Colleges, the medical schools and the professional associations.

In addition to these potential difficulties, there is a further initial problem in the relationships between sociology and medicine. This problem derives from the type of abstract conceptualisation involved in sociology, which is so different from clinical medicine. The process of theory-making involves selecting observations and coming to conceive of the observed world in ways that transcend commonsense. Thus, Foucault (1973), in that work on The Birth of the Clinic which he describes as an archaeology of medical knowledge, has shown what a radical change there was around the end of the eighteenth century and the turn of the nineteenth century in the ways in which doctors perceived disease. From sixteenth century origins, doctors developed new ways of seeing beneath the surface of life, and with this new vision, this 'gaze', as Foucault describes it, modern clinical medicine was born. Disease was no longer seen as something descending from the outside, but as within the organism. Similarly, death was no longer seen as entering the body from without, but life in the body was seen as subject to myriad deaths. From these beginnings, the gaze deepened until we come to the present day when the vision is focused on cells, and microbiology and the laboratory have come to take a dominant place.

Thus clinicians, as scientists, rarely think of living relationships on a larger scale than the human body. Perhaps more often their gaze is focused on only a small part of the body and on the chemical and microbiological processes that are occurring in limited clusters of cells within it. They will, of course, recognise some of the human implications of these processes. But they have not studied these scientifically. They think about them commonsensically.

Sociologists, on the other hand, abstract from commonsense understandings in quite a different way. Sociological units of analysis, as Nesbit (1966) discusses, are concepts like community, authority and power, status and class, the sacred and the secular, alienation and, I would add, relationships of equality, domination, and subordination. Thus, neither clinician nor sociologist focuses on people, but where the clinician focuses within the body to cells, the sociologist's abstractions are outside and away from human bodies, to the social interactions between people and the established social relationships that constrain their actions. Clinicians and sociologists share a common concern about the implications of their subject matter when it is applied to human beings: how the social arrangements and the cell behaviour result in a comfortable life or an early death. This is our common focal point.

The divergence in our starting points means that, when trying to communicate, clinicians and sociologists have to be mutually aware of their totally different modes of abstraction. How then do sociologists see medical knowledge and clinical practice as having developed? Where do they see it going? What are the problems facing clinical medicine? What has sociology to offer to them?

The greatest danger for clinical medicine today is that it is locked into a method of looking at health and ill health which, while successful on some fronts, is quite unsuccessful on others. Furthermore, clinical medicine is institutionalised in such a way that it may be difficult for it to change to deal with new problems.

History of Clinical Medicine

The history of the rise of clinical medicine is well known. It culminated in the achievement of power, influence and wealth for its leading practitioners in the nineteenth century. Its basis was in the rise of the hospitals where the poor were treated to provide clinical material on which to train the students, while their teachers lived on the fees they charged to the students and to their wealthy patients (see, for example, Abel-Smith, 1964).

These were the social circumstances in which the possibility was created for the development of modern clinical medicine. It did not grow in a social or economic vacuum. It required the rich to provide the money, through fees and subscriptions, and the poor to provide the clinical material. The development could only have taken place in a society of the type that emerged in the nineteenth century (Johnson, 1972).

It is clear that the relationship between the doctor and his patient (doctors were, of course, at that time all men) differed according to whether the patient was wealthy or poor. Jewson (1974, 1976) has described the disappearance of 'the sick-man' and the relationship that the
patronage of the rich had with the restriction of medical development up to the eighteenth century.

So long as medical practitioners were dependent on the fees of wealthy clients, the patients could define their own terms of treatment and were viewed as whole persons and treated as such. The rise of the hospital made it possible for doctors to emerge from this bondage and gave them the freedom to develop medical knowledge as they, rather than their patients, saw fit.

Jewson develops these arguments, showing how there is a relationship between the kind of medical knowledge, the technology it uses, the way health care is organised and the nature of the doctor-patient relationship. He characterises three types of medicine that developed from the eighteenth century onwards: bedside, hospital and laboratory. Bedside medicine he associates with the patient as the patron paying private fees. The sick person is seen as a person, the occupational task of the medical investigator is prognosis and therapy, and illness is conceptualised as total psychosomatic disturbance. With the development of the hospital, the state and the hospital replace the patient as patrons, and the practitioner becomes a clinician involved in a professional career structure. The sick person is perceived now as a case, the medical task is to diagnose and classify, and illness is conceptualised in terms of organic lesion. In the third phase, laboratory medicine, the state and the academy are in the patron role, the clinician becomes a scientist in a scientific career structure and now perceives the sick person as a cell complex. The clinician’s occupational task becomes analysis and explanation. Illness is now conceived as a biochemical process. Thus, the nature of the medical knowledge that it is possible to develop is related to the source of patronage and to the relative power of patient and doctor in consultation and treatment. At the same time, the development of medical knowledge and associated changes in practice themselves modify the relationship between doctor and patient.

The nineteenth century saw the consolidation of the developments of the new clinical methods. During that century, of course, the health of the people improved remarkably if one is to judge by the rapidly rising population and the increased longevity, the rise in the population continuing well after the birth rate began to fall. It seems likely that these improvements came not from curative medicine, but from a rising standard of life, particularly from improved nutrition, and from public health measures, sanitation, clean water, and clean food. In Professor McKeown’s view, only the smallpox vaccine was a really competent preventive agent in those early days. And we know the early hospitals to have been fairly lethal places. Few specific therapies were effective and many, like digitalis, had been known to the wise women of old (McLachlan and McKeown, 1971; McKeown, 1977). Dollery has recently come strongly to the defence of clinical medicine, arguing that McKeown may have exaggerated his case. Nevertheless, Dollery himself concludes: ‘The fall in mortality over the past 150 years must have occurred mainly because of better sanitation, agriculture, and social organization’ (Dollery, 1978).

There were, therefore, two major models of health in the eighteenth and nineteenth centuries: the disease-cure model that used an ‘engineering approach’ (McLachlan and McKeown, 1971) and dealt with patients on an individual basis, and the public health model, derived from sanitary science and focused on collective preventive measures. It seems that the prestige and the money went to the former although the less prestigious public health movement may well have saved more lives. Figure 1 illustrates the dichotomy that has developed.

**Modern Clinical Medicine**

All that, it may be argued, is now in the past; recent advances have made modern clinical medicine more effective, particularly in the last 40 years. And indeed McKeown, the critic of the great emphasis placed upon clinical medicine, is himself prepared to take a more generous view of late twentieth century than of mid-nineteenth century medicine (McKeown, 1977). He acknowledges the contribution of biomedical science, through extending hygienic measures and through immunisation, but particularly by providing an understanding of the body and its diseases and making surer curative measures possible.

Dollery echoes these views: while admitting that the role of scientific medicine, judged against the backcloth of history, has been modest, Dollery argues with some cogency that its role is ‘real and growing’. As examples of the process of therapeutic discoveries, Dollery traces the history of allopurinol in the treatment of gout and of cimetidine for peptic ulcer. He looks also at the drug treatment of hypertension, although there is a noticeable absence of outcome data in this section, as in the section where he discusses the revolutions that have taken place in the management of chronic respiratory failure by the
application of the Venturi mask. In the latter case he does, later, raise the question, saying, 'How much difference does any treatment make to life expectancy and comfort of these patients (with chronic lung disease) once they have reached the stage of requiring hospital admission?'. When speaking of technology, Dollery stresses the increased diagnostic accuracy made possible by endoscopy, ultrasound, scanners, and computerised axial tomography. He is rightly critical of present methods of their purchase and use. He does not, however, address the question of the relationships between diagnosis, therapy and cure.

Dollery is appropriately critical of some clinical developments where outcomes have not justified the resources expended, as in the coronary care units. In his final section on future hopes and problems, he correctly draws attention to the relief that clinical medicine, in association with the pharmaceutical industry, has brought to many sufferers: L-dopa for Parkinson's disease, propranolol for angina and hypertension, and cimetidine for peptic ulcer, all of which he considers 'brilliant successes'.

In Dollery's view, both laboratory science and clinical science are worthy of more support. When discussing angina and hypertension, he does not refer to continuing high rates of premature death from heart diseases and cancer. Later he looks to better methods of dealing with them in perhaps 10 or perhaps 100 years.

He is afraid that the cry for 'relevance to man' is beginning to undermine the position of preclinical science departments in undergraduate medical schools and that clinical scientists are being distracted by current policies in the National Health Service and universities and by the requirements for higher medical training. In discussing how resources can best be used and research organised to ensure continued progress, Dollery, despite his many cogent criticisms of clinical medicine, concentrates entirely on ameliorating or curing diseases that have already developed. In this, despite his often radical approach, he remains firmly within the long-established tradition of clinical medicine that focuses on cure rather than prevention.

Although McKeown (1977) accepts that contemporary clinical medicine is now making a measurable contribution to improved health, he nevertheless argues that greater attention still has to be paid to the prevention of disease by personal and non-personal measures and to the care of the sick who are not thought to require active medical intervention. While Dollery is correct to argue that cure and care overlap in the treatment of the acute sick, for many handicapped and chronic patients for whom medicine can do no more, care is paramount. At present these two areas of prevention and long-term care are neglected, and disproportionate amounts of resources are spent on the sick while they are providing scope for investigation and treatment.

The clinical mode of investigation and treatment has developed divorced from the preventive and purely caring services. Its development has been associated with powerful and self-perpetuating institutions. These arrangements, and the disease-cure model with which they are associated, have led inexorably to expensive developments, not always well tested scientifically as Dollery shows, and sometimes to major social changes without an awareness of their implications.

Let us take the case of heart disease. Early deaths in men from such diseases have not diminished since the nineteenth century, and indeed may have increased proportionately (Cochrane, 1972; Powles, 1973). Two careful studies have now thrown great doubt on the curative efficacy of the coronary care unit compared with more conservative domestic treatment in certain coronary cases (Mather et al., 1971; Hill et al., 1978). Yet health authorities, at the urgent request of clinicians, backed by a public that has more faith than knowledge, continue to vote large sums for the maintenance and extension of such units, which can only overcome an acute episode: they cannot cure the underlying disease. Such expensive procedures divert money and attention from the underlying causes of the disease, which remain largely unknown and which may have major environmental or social factors in their aetiology.

Developments in obstetric practice have also followed the same inexorable trends. Obstetricians have experienced a good deal of public criticism in consequence. This has happened because childbirth is a social event of major importance as well as being a physiological event that may need medical intervention. As Cochrane (1972) has pointed out, the evidence used to justify the transfer of childbirth from home to hospital was slender indeed: it was based on the covariance of a decline in mortality and an increase in hospital confinements. Any first-year student of elementary statistics knows that no causal connection may be assumed just because two attributes vary together. In looking for a possible intervening variable, improved nutrition comes to mind. The possible major importance of early nutrition for successful delivery has been demonstrated by Dugald Baird (1975). Nutrition undoubtedly improved in the period referred to in the arguments of the Cranbrook (1959) and Peel (1970) Reports.

The continuing social class differential in neonatal and perinatal mortality rates suggests that nutrition and allied socio-economic factors may well be causal. Yet the dominance of the clinical approach leads the obstetrician to seek procedures which at the time of birth will override these socially-caused disadvantages. And she or he is right to try to do this once the trouble has occurred and the risks are present. Yet why should all the effort go this way? One does not hear obstetricians arguing loudly for resources to be spent on reducing the social and economic disadvantages of social class V women. Obstetricians' clinical focus encourages them to spend resources on repairing damage rather than preventing it. That, it may be argued, is their task. They are not concerned with social or economic reform. That is, of course, the case and is part of the argument presented here: the way in which clinical medicine has developed, divorcing prevention from cure, has made it difficult to come to grips with many of the causes of illness and death.

Along with the removal of childbirth to the hospital went the development of the active management of
labour, following technological possibilities and biochemical and pharmaceutical advances. It is greatly to Professor Turnbull's (1977) credit that he has publicly accepted that subsequent research has shown that certain active interventions are less valuable than he had thought (Chalmers et al., 1976a).

My anxieties as a sociologist in this issue are that clinicians made decisions which had effects in areas outside their competence to understand. No attention was paid to the psychological and sociological consequences of the removal of births to the hospital, of its possible effects upon social relationships, on the authority structure of the society, on the social relations in the family. Had account been taken of these matters, the decision might have been the same. That is not the point: the anxiety is that these factors were not even weighed in the balance. Thus, not only does the concentration on cure divert attention from wider aetologies, but the power that has been accorded to clinicians is profoundly altering important facets of our social structure. It is doubtful whether clinicians are aware that this is so.

In childbirth, the social implications are obvious. In other cases they may be less clear. But I think McKeown is right to suggest that the relative deprivation of the caring compared with the curing services is connected with this clinical dominance. The relative lack of attention to mental and physical handicap and to chronic illness are examples of this, as is the low status accorded to the care of the elderly. The entire blame should not be laid on the clinical model. Those sufferers who are accorded low prestige are all people who are unlikely to have a major or even any contribution to make to industrial production. In advanced industrial societies the non-productive appear to be devalued: attention is focused on returning the worker to work. This is socially and economically more rewarding. The clinical concentration on acute illness fits well with this hierarchy of values. Indeed, clinical medicine could be said to be the victim rather than the author of these tendencies.

At the same time, one would expect that industrial societies would wish to maintain health, for this is after all a rather more efficient way of going about things and of achieving maximum production. Do we have our present emphasis because of the close connection in the early days of medicine between clinicians and wealthy patrons which made the development of modern medicine possible? Is it a sort of vestigial remain? Why does the pattern continue? Why do we have this isolation of clinical medicine from other ways of health maintenance?

Sociology's Contribution to Medicine

These questions draw attention to a connection between the two contributions that sociology can make to medicine. Sociology may perhaps be able to help in understanding aetiology where the methods of traditional clinical medicine seem to have difficulties. It may also help in understanding the social relations that surround therapy and may have an impact upon it. Indeed, it may be able to show what sort of therapy is necessary.

A main recommendation that emerged from a multi-disciplinary study of the effects of hospital on children was that therapy should be redefined to include sociological and psychological aspects. This recommendation arose from observations in several hospitals which showed that suffering of psychological or social origins went unrecognised and untreated, while pain believed to be caused by disease or by operative procedures received prompt and routine attention. Indeed, we observed that the hospital regimes were, themselves, a cause of unintended suffering (Hall and Stacey, 1979).

Recent research (Cash and Stacey, 1978) has shown that parents of handicapped children often have difficulty in co-operating and communicating with professionals because they are interested in different things. The parents may have quite different goals from the professionals: one obvious example is parents who seek a cure where there is none, while professionals are looking for the best way of helping a child with irreversible damage. The persistent questions 'why me?', 'why my child?' are ones that crop up in the minds of many suffering from irreversible conditions or who have children or other relatives who are thus affected. Moreover, medicine does not seek to answer this question. Indeed, medicine's beginnings can be traced to the period when it turned its back on that question. Modern medicine is interested much more in 'how has this come about?' Professionals and parents therefore may talk at cross-purposes.

By taking population samples rather than patients, George Brown and his colleagues (1976, 1978) have been able to reveal much about the social causes of depression in women, showing the relevance of stressful life events, and also of the structure and processes within the family. One important finding is that those most prone to depression or other psychiatric disturbance, because they have no intimate available to support them in their social situation, are also less likely to seek skilled attention.

But what of somatic illness? There has been much too little work done on the social causes of disease. We are aware of a causal connection between smoking and lung cancer. We cannot yet explain why some smokers do not develop carcinoma. We speak of immunological agents and invest much in immunology. The medical gaze is inward and downward to the cells. But why do some develop immunity or are apparently immune, despite other predisposing circumstances, to cancers or to viral infections? We know that certain social events can lead to increased vulnerability. The bereaved, for example, show raised rates of morbidity and mortality. And as Brown has argued, whether or not a physical agent can be shown to exist in such cases, the social aetiology is still present (Brown, 1976).

In the same paper, Brown reports a study, albeit rather rudimentary, which suggests that not all those acquiring streptococcal infection developed streptococcal illness, and that streptococcal illness was more likely to occur in families that had recent experience of stressful life events (Meyer and Haggerty, 1962). In Brown's own work the need for sound theory and careful and complex
methodology are both demonstrated. His evidence of the relevance of stressful life events for disease onset is impressive. Too little research has been done and much of it is too speculative. What has been shown clearly is that there are other ways of exploring aetiology than having recourse to the laboratory, although these other ways may in the end set new problems for the laboratory scientists to solve.

These thoughts are summed up in Fig. 2. This suggests that there may be social as well as biological processes at work in the aetiology of disease. Suffering, ill-health and illness are added to disease in the central box, for ill-health and illness cover what patients experience and present with, but they are not always linked to a clearly defined disease process recognised and understood by medical science. The complexity of the biochemical processes are well understood by clinicians. The social processes involved in aetiology are at least as complex and difficult to conceptualise and unravel. They certainly cannot be understood at a commonsensical level derived from individual life experience, as is all too often assumed to be the case. The social processes require systematic scientific study. The dotted line suggests Brown’s point that the social processes may well work through triggering biochemical processes. In this way new problems may be set for laboratory scientists. The importance of studying the social causes remains. If we can isolate the social triggers, we may be in a better position to prevent the disease developing in the first place. If research, education, and practice followed this model, the divisions demonstrated in Fig. 1 would dissolve. Biochemical process and social processes are linked because we already know that pathology can disrupt social processes, although it has been social scientists rather than clinicians who have studied this interrelationship.

It is my view (Stacey, 1978), that at this stage it is necessary to seek possible social factors in the aetiology of a number of different disease categories because it may be that social factors work differently in different diseases. One starting point is obviously clinical diagnostic categories. There may well be others. There were major and interesting differences in the classification of 50 cases of handicapped children made by a sociologist who interviewed parents and the physician who was carrying out research alongside. His categories were disease categories. Hers were socially relevant and related to the process of seeking for diagnosis and help, and depended on such variables as ‘known at birth’ or ‘soon after’, ‘learned about later’. These cut across the disease categories and could form the basis of a quite different investigatory trail (Cash and Stacey, 1978).

The new perspective on clinical ways and means I wish to propose is that those involved in clinical medicine should let their scientific imaginations roam more widely. This means they should back not only research based on cells, but also research based upon social relationships, seeking alternative models for health maintenance and disease onset. This involves a recognition that as soon as psychological or sociological factors are expected to be relevant (as in heart disease, for example) the skilled attention of psychologists or sociologists is called for. Vague and woolly notions about ‘stress’, for example, are totally inadequate. What stress is, how it arises, how it im pingest, must all be investigated in terms of social structural factors as well as individual mental processes.

In addition, it appears important to bridge the gap between preventive and clinical medicine and to put more resources into the former. To build that bridge soundly would require some radical reorganisation of medical institutions and educational procedures. A loosening of the present tight boundaries would be a good start.

In this latter regard, it is encouraging to learn that in their discussions of the new guidelines for basic medical education they are currently preparing, the Education Committee of the General Medical Council has recognised not only a need to spell out what sort of basic social science teaching is relevant to undergraduates in their foundation years, but also has drawn attention to the need to integrate topics studied in social and preventive (community) medicine into the teaching of other clinical subjects. The new perspective I have been arguing for is at least beginning to find a place on the agenda of those responsible for medical education.

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