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Social medicine and sociology: the productiveness of antagonisms arising from maintaining disciplinary boundaries

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Abstract This essay considers the boundaries between the sociology of medicine and social medicine and the reasons distinctions are maintained between the two disciplines. To investigate, the essay asks what constitutes the distinction between social sciences and social medicine, and goes on to question historical distinctions of how foundational sociology is to social medicine; how much autonomy the sociology of medicine should have; contemporary challenges to the relation between sociology and social medicine; and the status of ethics, both traditionally and contemporarily, between sociology and social medicine. In the face of increasing emphases on interdisciplinarity, this essay offers a note of caution by demonstrating how the antagonism between sociology and social medicine is important as a site that produces a necessary polemic. Ultimately, I argue that the social sciences and social medicine are linked in a productive relationship that instates and reinstates their respective functions and values in a process that validates the practice of modern medicine.
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Introduction

Social medicine and the sociology of medicine share a common antecedent; to conceptualise the social. Despite this, throughout the 20th century, two distinct traditions have emerged and been maintained through differing career paths

and titles, funding streams, distinguished pedagogic spaces, departments and publication houses. This essay asks why we have traditionally made distinctions between the two disciplines, and the productivity of these distinctions.

The essay begins by questioning the status of the sociology of medicine in contrast to social medicine, and asks in light of the similarities, why sociology is so often contrasted against social medicine rather than seen as integral? The distinction between the two is framed in the first part of the essay, by contrasting the similar historical origins of social medicine and sociology in the 19th century, with the important disciplinary distinctions that began to emerge by the mid-20th century. Around the 1950s, across Europe and America political will began to recognise sociology as important in the medical curriculum and the sociology of medicine emerged and began to question its own disciplinary position. Foundational work of social medicine from the 1950s questioned whether sociology could exist as a third branch to medicine. However, this thinking of the 1950s never managed to defend itself against the establishment of discourses arguing for disciplinary distinctions, which was typified in 1957 when Strauss (1957) formulated a much recanted distinction between sociology *in* medicine and sociology *of* medicine. Strauss argued that the social sciences need to uphold independence from medicine to maintain an alternative perspective of society aside from the aims of medicine. Since the 1950s, concurrent waves of social sciences have prioritised reflexivity over closer integration with medicine. Increasingly, however, these disciplinary distinctions are the cause of contemporary concerns. These concerns are covered in the second part of this essay. For example, contemporary STS discussions revisit some old questions around interdisciplinary thinking, the malleability of boundaries and the need for disciplinary autonomy. In this climate, some like Rose (2013) and Fitzgerald and Callard (2014) question how arbitrary the stringent maintenance of disciplinary boundaries (such as between the social sciences and social medicine) is. In the final section of this essay, I counter some contemporary trends by positing alternative directions of contemporary theory that attempt to consolidate developments in theory with traditional work in the sociology of medicine aimed at defining its boundaries. I argue that interdisciplinarity in the social sciences should not disregard the maintenance of disciplinary autonomy and ethical contrast. To demonstrate, I point to the ways in which antagonisms between the practice of social medicine and sociology are productive of innovations in each discipline.

Disciplinary Distinctions

The opening speech for the 2013 conference of the Association for the Social Sciences and Humanities in HIV (ASSHH) was delivered by Nobel winning

chemist Françoise Barré-Sinoussi. As head of the International AIDS Society (IAS), she had been invited to talk to ASSHH about the place of the social sciences in the work of the IAS and in their campaign: *Working Towards a Cure* (Deeks *et al*, 2012). Her speech was structured to inform the audience of 'medical advancements' that had taken place over the last 30 years of HIV medicine and the 'social research' that had supplemented these 'achievements', and the continued need for this research. The underlying message of the presentation was:

> Since the very early days of the epidemic, social sciences have been key to understand the social, cultural, political drivers or barriers and consequently adapt biomedical interventions.[1]

Discussion about the role and position of the social sciences is trite to biomedical/social science collaborations and even date right back to the first meeting of the British Sociological Association (BSA) conference in 1953 (Reid, 1976). HIV medicine constitutes one of the latest parts of this long tradition but is a good example to use here as a gauge of where the debate has come as the HIV epidemic is younger than debates between social medicine and the sociology of medicine, and the social sciences have been at the forefront throughout the span of the epidemic but with no clear consensus on its weight or usage. Therefore, I do not wish to challenge this statement head on (or pose it as an empirical universalism); I seek to understand it better. Specifically, which social sciences are being conceptualised and alluded to? My confusion is that here, the social, cultural and political are conceived as clearly delineated as a distinct sphere. The statement implies that biomedical interventions occur separately from the social, cultural and political 'drivers or barriers'. However, isolating the social, cultural or political into separate spheres or domains is difficult to place and locate so convincingly (Rosengarten, 2009). According to modern developments in social thinking, exactly which conception of the 'social', of the many utilised in medicine, is being alluded to (Rojas, 2015). Some difficulties of defining 'the social' are already accounted for in the IAS. The IAS already has a working group for social and political research and the group's own description acknowledges the difficulty of delineating social research[2]. Barre-Sinoussi provokes a thinking point as to the need for the social sciences as distinct from already well-integrated branches of social medicine. The establishment of distinctions between the social sciences and social medicine is not innate and has been continually reinstated and maintained throughout their history. In 1952 when 'medical sociology' was emerging as a specific field of study, renowned historian René Sand (1952) argued that there is no great difference between social medicine and medical sociology. Consequent scholarship has defied this observation by

developing two contrasting 'social' positions to medicine, one dependent in social medicine and the other independent in the sociology of medicine.

These two contrasting positions are no exception in HIV medicine. The principles behind the foundation of ASSHH (aside and independent from the IAS) as a specialist social sciences forum and its scope, size and eminence reflect the persuasiveness of the argument that the medical treatment of HIV cannot function without engaging with enquiries central to the social sciences and humanities. Engrained in the ethos of the organisation is an acknowledgment of not just the need for social medicine, but also contrasting social scientific positions such as those subscribing to the sociology of medicine. The activities and positioning of most ASSHH members are not isolated easily between disciplines but span broadly across the philosophical, scientific, classificatory and practical formulations of medicine[3]. Therefore, if activities like HIV treatment require a broad conception of the boundaries between medicine, society, culture and politics, what determines the imposition of distinctions in research between social medicine and the sociology of medicine?

Historical Distinctions

Social medicine and medicalisation

Social medicine and sociology share a common link. The foundation of sociology coincides with the emergence of social medicine in the 18th and 19th centuries (Porter, 1997; Porter and Porter, 1988). Over the last two centuries, sociology, to a greater or lesser extent, has strove to distinguish its place as a distinct discipline alongside the many activities of contemporary social medicine which have adapted and used conceptualisations and models of society.

A classic debate put on the agenda by Foucault (2002) charts the emergence of 'social medicine' in Europe as radicalising medicine from pre-modern era medicine through its focus on inherently social concepts, and in turn, profoundly revolutionising the ways in which medicine was conceptualised and practiced. 'Social medicine' antiquated pre-modern understandings of medicine by emphasising the concept that medicine is applicable to and a concern over the entire collective of every individual of a given society. Foucault points to the role that medical categories have played in how we have come to understand ourselves as particular kinds of subjects:

> Medicalization – that is, the fact that starting in the eighteenth century human existence, human behaviour, and the human body were brought

> into an increasingly dense and important network of medicalization that allowed fewer and fewer things to escape (Foucault, 2002, p. 135).

The drive allowing for an expansion of a network of medicalisation is the compulsion to make medical principles applicable to the whole population and to standardise medicine to every individual. This process relies heavily upon a conceptualisation of society amongst those practising, planning – and as much as possible – receiving medicine in order to standardise, enrol and perpetuate medicine as universally as possible. These emergent understandings of aggregations of collective population salient in the 19th century can be linked to the impetus for a new body of knowledge to define, explore and conceive of society (Mazlish, 1999; 1993). Therefore, the social sciences and social medicine emerged through processes geared towards ordering and disciplining individual subjects (also see Armstrong, 2002)[4]. Studies in medicine encompassing themes common to the social sciences and sociology can be traced back to the 19th century across Europe and America, and by the late 19th century medical sociology had emerged as a terminology in American publications. However, the distinction between the use of this term and social medicine was not well developed and would lack cohesion until the process of defining and differentiating the two disciplines was started in earnest in the 1950s (Bloom, 2002).

Modern developments of this debate contend that there exists a singular solid 'medical rationalisation' specific to all of the medical sciences. Neither medicine nor society exists in an abstracted domain but must be brought into being and continually enacted (Mol, 2002; Mol and Law, 2004). This means that medicine does not exist as a fully formed unaltered domain but is adapted through the way it is enacted in practice. So in this sense, medicalisation is a process without one coherent aim but one that must be adapted in practice. This has sparked a plethora of directions in the sociology of medicine some seeking to affirm, others to dispute or nuance understandings of medical dominance (such as Mol, 2008; Latimer, 2015). I wish to argue that consequently, the antagonism between social medicine and the sociology of medicine can be seen as co-productive[5] of a range of related and opposing positions.

Viewing social medicine and the sociology of medicine as co-produced is a shift in the ways disciplines have traditionally been viewed and experienced by users and initiates the question as to their necessity. Boundaries between the two disciplines are often maintained as if solid and totally ulterior to each other. If conceptions of society are really so integral to both sociology and social medicine how did each discipline come to make such distinguished boundaries?

Value and foundation

Throughout the 20th century, the social sciences have continued to question the position of the boundaries between the two disciplines and the potential of social medicine. A good example of this can be seen in the political will in the UK from the mid-20th century that made sociology important to the medical curriculum. Several significant policy reforms presented the link between medicine and the study of society as being integrally valuable to each other as well as raising the question of how society should be integrated and represented. In 1944, the first recommendation of The Goodenough Report suggested that social medicine should gain a higher prominence in the syllabus for training medical students:

> The committee recommends: (1) Drastic overhaul of undergraduate training; more attention to be paid to social medicine, the promotion of health and the prevention, as well as the cure, of disease, to children's health, and to mental health (The Goodenough Committee, 1944, p. 121).

In the sense given in this report, social medicine is a commitment to the idea that there are social determinants to illness and medicine (although the full extent of the conception of 'the social' implied is contestable). In this report, there is an ethos salient of the times that coincides with the instigation of the UK's National Health Service (NHS) and the post-world war 2 optimism that questioned afresh the foundation and value of the concept of 'society' as Europe was under reconstruction. It would initiate further questions around the relation of medicine to the societies it serves. Following the Goodenough report, the recommendations of other reports such as the Todd Report (1965) have had a similar emphasis on social medicine. Therefore, if social medicine was conceived and put to use during the 19th century, by mid the 20th social medicine had become a salient question within the medical establishment and the need for its formalisation was further contemplated. Around the same period, changing policy and increasing awareness around 'social medicine' had also led to corresponding sociological discussions around how to position the study of social issues in medicine. One of the most evident can be seen at the first annual BSA conference of 1953, where one discussion suggested that sociology should become the third basis of medicine alongside the traditional pillars of art and science (Marshall, 1953, p. 208).

These developments can be highlighted as historical because they not only place sociology as an integrally valuable companion to medicine but speculate on integrating social science as a foundational knowledge basis of medicine. This was also a common sentiment of the middle of the 20th century spread across Europe and America, for example in 1947 Lord Horder declared to the

New York Academy of Medicine that through social medicine, 'medicine is now of concern to the sociologist' (Anon, 1947) and similar debates from that time can be found in Anon (1943), Sand (1952), Platt (1965), and Terris (1964). These claims may have seemed significant, but few in contemporary sociology or the medical sciences would consider sociology as crucial or foundational to medicine today. Contemporary scholars such as Bloom (2002) are left instead to question why 'medical sociology' does not occupy the same place as, for example, social epidemiology. Bloom's contemporary question affirms the position of the social sciences in medicine but is a major revision of the size and scale of the conceptualisations of sociology in the first BSA conference. Speculations of sociology as foundational to medicine are now rhetorical peculiarities. Throughout the 20th century, it seems that as social medicine has asserted its prominence and importance, sociology has recurrently taken up a contrasting role. Biomedicine has asserted its dominance through the use of conceptualisations of sociality but finds no need to prioritise sociology as a medical science. The first BSA conference's dream of creating a medical science fully responsive to its own use and service to society through sociology has never been fully realised.

Disciplinary autonomy

Since the 1950s, sociology and social medicine have only seemed to grow into greater disaccord. Instrumentally, from the 1950s, medical sociology has asserted its independence in contrast to social medicine. The question of sociology's applicability to social medicine has complexified through the development of reflexive methodologies that seek to problematise the relationship between the researcher and the 'society' they represent (May, 1999). Conversely, the scope of biomedical advancements attempt to offer evermore 'complete' explanations. Two clear examples are contemporary accounts of neuroscience and genetics, which claim ever more explanatory power over questions of humanity and the definition of what it is to be human (Keating, 2006). The result is that sociologists have sought to distinguish social enquiries from the scope of medicine and bring into question the cohesion between social medicine and contemporary sociology. In effect, not only are the methodologies of sociology and social medicine different, but they also hold different understandings of society. In the face of fears of biomedicine becoming more totalising, some sociologists have intensified distinctions about what constitutes the boarders (Levinson, 2005). Traditional social medicine now forms its own spheres of study with distinct branches such as social epistemology and psychosocial studies apart from sociology.

These questions can be related to much earlier insights on the role of the social sciences in medicine. One now classic distinction is posed by Straus (1957) between the sociology *of* medicine and sociology *in* medicine:

> We suggest that the sociology *of* medicine is concerned with studying such factors as the organizational structure, role relationships, value systems, rituals, and functions of medicine as a system of behaviour and that this type of activity can best be carried out by persons operating from independent positions outside the formal medical setting. Sociology *in* medicine consists of collaborative research or teaching often involving the integration of concepts, techniques and personnel from many disciplines. (Straus, 1957, p. 204).

This has become one of the most significant foundational statements of the field. Rather than assuming the preoccupations of the first BSA conference 3 years earlier to unify the social sciences with medicine, Straus acknowledges a distinction between sociology which must be maintained as independent from social medicine in order to achieve an independent perspective. A contemporary reading of Straus's idea of disciplinary 'Independence' may contest the difficulty of defining or attaining such a pure split between the two. One discipline will always reference another, but it is this process of demarcating parameters and defining distinctions that gives each discipline its relevance amongst others. Therefore, a modern interpretation of Straus could understand independence instead as the maintenance of a disciplinary autonomy continuously defined and redefined by users in relation to counter-claims. In this sense, users are disciplined and disciplining in their interpretations of knowledge.

Barré-Sinoussi's role for the social sciences is confusing as to if it alludes to sociology *in* medicine or *of* medicine. Straus's work can be directly contrasted against the reports of the 1950s detailed above, and gives some insight into why sociology has imposed such distinctions on the use of the social sciences in medicine. Back in 1957, Straus's fear was that sociologists who attempt to adjust their enquiry to the aims readily expected by medicine risk losing their focus on society and the alternative perspectives it can have on medicine. As the social sciences have developed and adapted themselves, Straus's insight has been taken forwards as a central concern of the field and made more acute. It is a constraint and fear that has been recited prominently over the years, for example, Reid (1976), Gold (1977) and Timmermans (2013). The rift between sociology and social medicine can be traced back to these discussions on the level of autonomy and pragmatism between sociology of medicine and sociology in medicine. Straus's distinction is not specifically addressed towards social medicine, but it opens the way for concerns about how

individuals professing to work on society conceptualise and utilise understandings of society, and encompasses perspectives now more closely aligned to social medicine.

What is at stake for sociology is the ability to conduct enquiries that are beyond the scope of, or not immediately applicable to social medicine. Some like Rosenfield (1992) point to the functions that sociology geared towards making medical recommendations fail to make:

> very useful for short-term problem solving, less so for longer-term programmatic changes, especially beyond the health sector, and even more limited in impact on theory building for coping with the changing human condition.

The point confirms why sociology is at a disposition to defend its boundaries. If, as argued, medicine has drawn upon concepts of society since the 18th and 19th centuries, as part of the same process, sociology, once emerging as distinct from the same revolutionising gambit of the human sciences, would have to strive from being subsumed by the same processes that instate and maintain medicine as important, thus initiating a co-productive relationship. In so doing, the approach to ontology, epistemology and methodology in the social sciences has developed autonomously and is not always compatible with social medicine. By maintaining their autonomy, sociology has fostered a sustained disciplinary practice able to raise the awareness of the effects of epistemes and resulting practice beyond their immediate application[6]. In the case of the sociology of medicine this means garnering reflexive perspectives able to conceptualise and question medical processes (good examples of this tradition are Timmermans and Berg, 1997; Timmermans and Epstein, 2010).

To maintain this awareness, sociology and social medicine should not be merged seamlessly, their distinctiveness and identity needs to be maintained, and users should have the freedom to contest the notion of 'objectivity' or the practicality of 'reflexive' methodologies. It can also be argued that sociologists ultimately gain much of their identity from defending and defining themselves against social medicine whilst offering their own contestations. Therefore, it stands to reason that the traditional approach to collaborations between medicine and the social sciences, such as the one suggested by Barré-Sinoussi, is not concerned with fully resolving the contestations between the disciplines. Instead, I argue that rather than resolving contestations, sociology has maintained disciplinary autonomy and distinctiveness through exploring contestations to generate contrasting insights on society. However, no single defined boundary can ever be fully achieved.

Contemporary Resolutions and Concerns

Contemporary challenges

However, these traditional distinctions between sociology and social medicine are under increasing challenge by contemporary theory. Some 21st century currents of methodology in Science and Technology Studies (STS) surround the productive effect of forming specific epistemes and methodologies. Latour's (1987) modern classic, *science in action,* argues that authoritative knowledge within disciplines is formed through a deliberated process of assembling the most convincing 'human and non-human allies' to distinguish one account over others. This has led leading figures in STS to question the extent to which disciplinary distinctions are malleable. Most evident is a collected volume by Barry and Born (2013), featuring the works of Jansanoff, Pickering and Schaffer amongst others united in the commendation of STS as allied to forgoing arbitrary disciplinary boundaries. Regarding social inquiry as an assemblage of allies suggests that disciplinary boundaries must be maintained and that the boundaries between disciplines are negotiable. What is implied is that disciplines are not inherently fixed around central (a priori) questions or methods, but are open and aggregated around the point where enactions within a discipline reach consensus as to what they wish to achieve and what is within their scope (in accordance with the principle of radical symmetry as referred to in STS terminology). It suggests that knowledge does not have one coherent rationale that can unite all knowledge or fix them together in one system, but instead suggests that knowledge must be produced and has the potential to be conflicting and contradictory depending upon the task it is produced to fulfil. From an STS standpoint, knowledge is heterogeneous and cannot be separated purely into one disciplinary assemblage or another, for example, social assemblages will always rely on technical assemblages for definition and vice versa.

Traditionally, the social sciences have maintained their distinctiveness through fostering contrasting insights on society and medicine. Therefore, any collaboratory work between the two disciplines that aspires to be sociology *of* medicine rather than sociology *in* medicine struggles with the question of autonomy. Rather than continuing to see autonomy as problematic, STS logic aims to make research decisions based on what is to be achieved and intended outcomes. Within the logic of STS methodology there is no core independence to sociology that must be maintained, rather both disciplines must have their relevance to each other, and dominance over each other continually tested and re-evaluated[7]. For the benefit of both disciplines each one must be able to contend with and counter the demands of the other. Forging antagonistic

collaborations is a key site where each discipline is aligned and challenged. Viewed in this way, the preconceptions of Barré-Sinoussi become an invitation to overlook disciplinary distinctions and affirm exactly what the social sciences have to offer the areas identified by Barré-Sinoussi (or challenge why they are incorrect), and find common solutions.

However, the implication is concerning. It conceals another inherent totalising motive parallel to the motives (such as medicalisation) the social sciences are supposedly in charge of policing[8]. Conceiving disciplinary logic as an assemblage constructs a vantage point that continues to imagine the existence of a logic charged with organising all things placed before it into one system. Paradoxically, however flexible the system imagined, this malleable logic is even a motive that allows us to forgo the absence of universal truth as a universal truth. It may even be impossible to avoid totalisations; some modern theorists like Sloterdijk (2013) even advocate that philosophy should aim to be narrative and totalising, the point is that being aware of totalisations, however much this is possible, gives some indication as to the totalities limits. Therefore, I am not refuting STS's insight on disciplinarity, I am refuting the conclusion that this should advocate non-disciplinarity. Rather I would see STS as a useful tool to understand how sociology and social medicine are co-produced, without eroding why disciplines have traditionally found it important to maintain a boundary or distinction. As social medicine claims ongoing explanatory 'advancements' it opens contrasting space to counter these claims. Therefore, I throw caution on the use of STS as inviting sociology to forgo contradictions and seek solutions, as it obscures reflections on the underlying totalising motives certain conceptions of society may have.

Antagonistic relations

One interpretation of STS methodologies such as Latour's approach advocates bringing sociology more in line with the natural sciences[9]. However, I wish to reconsider what STS's stance on the inseparability of disciplines might imply for social medicine and the sociology of medicine. Rather than using STS to rethink disciplinary compatibilities (not to say it is not important), I want to highlight ways that the antagonisms between social medicine and the sociology of medicine can be considered as productive of important ontological and epistemological contrasts. To do this I will consider in what ways this antagonism has been manifested in contemporary debates.

Professor Nicholas Rose (2013) was invited to talk at an event hosted by the Centre of the Body about collaborations between the social sciences and the 'life sciences', and what the social sciences can offer to the life sciences[10]. The central questions of the event were:

> How should or might we respond as scholars of the humanities to the rising prominence of the neurosciences? Does this open up the opportunity for collaboration and if so, what kinds of collaboration might be possible?

As was suggested by Rose, the social sciences and humanities are often treated as the 'handmaidens' of the life sciences. What was meant by this was that the contributions of the social sciences and humanities are often reduced by the life sciences to contributions on "social and ethical implications and public engagement" (Rose n.d., 47.51 m). During the talk, Rose made the controversial recommendation that the social sciences "need to take seriously the 'truths' the life-sciences are generating about the human body and the human brain" in order to improve the disciplines standing in relation to the life sciences (Rose n.d., 17.20). Rose (2001) even questions the social sciences position to give poignant ethical deliberations:

> I do not think that, today, the most far-reaching ethical innovations concerning our relations to ourselves are being made in the deliberations of the bioethicists and moral philosophers – they are being made within medical and biomedical thought and technique itself. (2001, p. 20).

For Rose, what is at stake is how sociological accounts of the human are to proceed when so much of what we understand ourselves as human subjects comes from e.g. the neurobiological or genomic sciences. He questions whether the formation of contemporary large-scale scientific projects, in which 'ethical legal or social implications' are rigorously separated out from scientific questions, and handed to a technical staff of moral philosophers, actually serve either science or ethics well – and whether, more broadly, such an apparatus represents an especially bright future for the social sciences.

According to Rose, many of the traditional approaches of the social sciences that serve to counterpoise the life sciences through reflexivity (the bodies of knowledge Foucault has inspired was specifically singled out during the talk) have historically caused antagonistic relations between the social sciences and the life sciences, and that if these arbitrary distinctions were overlooked, the social sciences could be aligned with the aims of the life sciences and help foster more equal collaborations (also see Rose and Abi-Rached, 2013; Fitzgerald and Callard, 2014). Rose's claims are important because it provokes a re-evaluation of the traditional relationships sociology has had with social medicine. Although the exact place where Rose's work sits alongside STS can be debated, his re-evaluation is in line with STS's attempts to align the social sciences and natural science more closely. Rose asks for a careful deliberation as to the usefulness of the enforcement of distinctions between the disciplines.

In this deliberation, I would like to add that the sociology of medicine has emerged through the same processes as social medicine and evolved with social medicine to act as a retort to the ongoing claims and highlight contradictions in understandings of society, or in implications to society arising from perceived 'objective' scientific 'developments' or 'advancements'. Sociology will necessarily be contentious (as well as necessarily ethical and political) when reacting to ongoing scientific 'advancements'. In this sense, I do not wish to negate the STS principle that disciplines do not have a stable a priori 'core' or 'centre' but instead consider how the principle can be interpreted differently. Rather than asserting that the boundary should be obscured, I would like to argue that to focus on sociology's contrast to social medicine serves a purpose to obtain alternative scholarly dialogues that are especially pertinent to ethics (or 'bioethics'). My contention is that both disciplines should have awareness in collaboratory work that dispels any ambiguity of the importance of the social sciences pursuing alternative epistemologies. In accordance to the longstanding debates drawn on in the opening sections, the social sciences need to maintain their antagonism to safeguard the production of heterogenic perspectives. An important assurance that both epistemes will reflect on totalisms comes from them having some kind of opposition to the other. Therefore, downgrading the importance of sociology's focus on ethics or politics, especially as applied to medicine, is a miscalculation of the subject that sociology has unavoidably been charged with attempting to understand and study.

Other Theoretical Directions

Methodological Contradictions: Ethics

A contemporary reading of Peter Winch (Winch, 1972, 1958) still raises some important enquiries about the difficulty of assessing ethics separately to society. However, much of Winch's legacy has given way to scrutiny since publication (or distortion through association with social constructionism and the resulting fallout from the 'science wars'), for example, STS criticism centres on Winch's over-emphasis on language before practical or technological activities in social life (Bloor, 1983), or the conservatism of Winch's main thesis around the importance of philosophy over science within the social sciences (see Hutchinson *et al*, 2008; Lerner, 2013 for a full discussion). Instead, I want to review the principle:

> I argue […] that any such conception of a world to be understood is intelligible only against the back-ground of a way (or ways) in which

> men live together and understand each other […] Moral ideas can only be understood in a context of social life. p. 3.

The implication of this statement is that ethics and morals cannot exist independent of the processes that make them intelligible. That to interpret society one cannot step outside of the ethical bounds which interpret and understand them. I do not wish to reanimate Winch at the expense of STS, rather I have chosen to highlight Winch to demonstrate that similar concerns around meanings or ethics not having an a priori existence outside of their enaction have been on the sociological agenda since the 1950s (and is contemporary with the emergence of the sociology of medicine in the 1950s) and have been used to support disciplinary distinctions rather than interdisciplinarity. References to or usages of the concept of society imply some sort of ethical structure, and vice versa, references to or usages of ethics derive from their relation to society or societal ideals. Ethics are the unassailable product and effect of endeavouring to accurately study, evaluate or describe society. Longstanding trends in the social sciences have called to transcend ethics. From inception to current trends, the social sciences have a long history of attempting to organise or situate ethics in terms of positivistic science with varying success[11]. Any attempt to circumnavigate ethical deliberations or decouple ethics, risks obscuring a long lineage within the short history of the social sciences (Haimes and Williams, 2007; Turner, 2013). Therefore, can collaborations or disciplinary boundaries be assembled that offer a contrast to social medicine which avoid epistemological antagonisms?

In the opening section, Barré-Sinoussi places ethics within the realm of the social sciences, as argued, the social sciences may never be fully disentangled from social medicine, but the invitation to study epistemological and ethical contrasts should be appreciated by sociologists[12]. The IAS positions ethics in the organisation as integral to all research activities and has set up a dedicated multi-disciplinary working group (The IAS Ethics Working Group *et al*, 2013). Although this may mean that the social sciences risk gaining their definition through social medicine, antagonisms between the two are productive in forming contrasting epistemologies.

At their most applied, both sociology and social medicine work towards ordering all aspects of (that which is understood as) human existence into totalising contrasting systems. Traditionally, sociologists have produced their disciplinary boundaries as a contrast to social medicine. After at least 50 years of debate these standpoints may now be questioned as non-complicit or antagonistic, but in the sense detailed in this essay, these standpoints have been necessary. Sociology has a co-productive relationship to contrast social medicine, and as a result has made possible an insight into the scope and

impact of medicine beyond enquiries immediately applicable to medicine, allowing social medicine to proceed with practice. The antagonism whereby sociology recurrently contests the 'objectivity' of social medicine and where social medicine scrutinises critical sociology's relevance to medical practice is co-productive. If each position seeks some countenance to the other each discipline losses much of their ability to totalise.

Barré-Sinoussi's address to ASSHH posed at the beginning of this essay prescribes a curious role for the social sciences. The role she prescribes to the social sciences and the antagonism it causes is responsible for producing a border between the disciplines as it forces sociologists engaging with the field to consider their relation to biomedicine, and how their contribution may or may not be sociological and distinguished from social medicine. Enacting the boundary in this way may often seem antagonistic or counter-intuitive, but it is an important productive mechanism – sociology should not fit neatly into all research agendas. Sociology should be cautious about the type of 'science' that it pursues, the nature of collaborations it builds and the place of ethics in the discipline. In the words of Law and Urry (2004), the social sciences "do not simply describe the world as it is, but also enact it", and that "if social investigation makes worlds, then it can, in some measure, think about the worlds it wants to help to make" (also see Law, 2007). Therefore, what should not be obscured are lessons learnt and deemed important since the social sciences were put on the medical syllabus in the 1950s, namely the importance of maintaining boundaries in sociology when the question of the social sciences being an integral branch of medicine were fresh.

Conclusion

This essay has discussed the reasons behind the maintenance of disciplinary boundaries between sociology and social medicine. It has detailed some of the key historical momentums behind why boundaries have been maintained and the compatibility between current interdisciplinary agendas and the traditional aims of the sociology of medicine. Much of which hinging upon and stemming from the development of the medical curriculum across America and Europe and the importance placed on the sociology of medicine's independence since the 1950s.

The boundary between the sociology of medicine and social medicine is significant because of the intricate implications it holds for ethics and the limits to the explanatory power of each discipline. One result of this essay is that it questions the amount of intelligent oversight possible over the boundaries between disciplines. Is the boundary a by-product of individuals working

towards the goals of their disciplines, and to what extent can individuals mould the boundary lines as they understand them? The answer lies concealed over the entire range of possible positions. Nevertheless, the line is organised, but the significance of the argument remains; many ways of practicing knowledge exist under the positions of both sociology and social medicine[13], and their contrasting co-existence is testament to their being many approaches to the human experience and human knowledge. The loss of epistemological contradictions would risk limiting the range of possible ethical oppositions.

The boundary is especially important because it touches on several tropes between social medicine and sociology, which question how do we value the work carried out in each discipline. In the UK, this question has come under the guise of 'impact', which specifically exerts pressure on all social sciences to prove their value[14].

Instead of engaging head on with questions around 'impact' I have attempted to answer the question why have disciplines developed and been maintained as distinct, but there is an obvious white elephant in the room; the problem is that disciplines are not equal; they are not equally funded; each disciplines status is often not equally regarded; their extent and scope is not the same; individual's eminence and pay grades are not the same. This means that the boundaries are not as open and malleable as could be ideally imagined, and these inequalities may also offer answers on why boundaries are enacted in certain ways. This essay however, appeals to the choices that are available when enacting boundaries however slim. The main point of the essay remains unaffected: interdisciplinarity should not obscure contrasting ethical accounts, and strong disciplinary oppositions that are routed in the production of opposing disciplinary focuses should not be discouraged.

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Notes

1 Taken from the 2013 ASSHH Paris Conference Guidebook. Barre-Sinoussi's main social science goals related to reducing stigma and barriers to treatment.
2 http://www.iasociety.org/Default.aspx?PageId = 572.
3 The work of Sue Kippax serves as a compelling example (Race, 2008).
4 Related to medicalisation, as demonstrated here and presented in 1974, is a much more popular series of lectures from 1976 on biopolitics (Foucault, 2004). I have purposefully chosen to highlight medicalisation over biopolitics as it more readily highlights totalism and the relations on social sciences and medicine and totalism. Foucault's notion of biopolitics offers more development of the far-reaching effect of humanism on society but my aim is not to further or counter these perspectives. That is done better elsewhere see (Rose, 2001; Latimer, 2015). Instead, I wish to highlight the debates on historical importance in the development of the sociology of medicine.
5 I have in mind Jansenoff's idea of co-production: "Briefly stated, co-production is shorthand for the proposition that the ways in which we know and represent the world are inseparable from the ways in which we choose to live in it" (Jansenoff p. 2)
6 Stengers (2000), gives a warning to the social sciences attempting to define sciences as cultural as being in danger of being a super science that explains all other sciences.

7 This exploration is inspired by the work of Stengers (1997, 2000, 2003) whose work traces the ongoing 'invention' of the sciences and explains that the process of inventing science necessitates a productive tension between 'objectivity' and 'belief'.
8 Both Radder (1992) and Fraser (2006) raise cautions about the ethical overtones of Latour's approach to knowledge production.
9 Such is the aim of Latour (2005) and is discussed in Barry and Born (2013).
10 http://magiclantern.gold.ac.uk/podcasts/centreofthebody/centreforthebody1.mp3.
11 Consider the founding fathers of Compte and Durkheim's vision for sociology and the Religion of Humanity. Contradictorily, as classically stated, society must add up to more than its constituent parts.
12 This is not to suggest that the social sciences do not already engage with ethics as the rapidly rising discipline of 'bioethics' with its own paradigms and problematics is testament, but to highlight the continued importance of doing so (Vries *et al*, 2007).
13 Karl Popper (1974) famously demonstrates that the term 'science' traditionally has a broader etymology than simply the empirical sciences.
14 Consider Research Councils UK's extensive impact requirements: http://www.rcuk.ac.uk/ke/impacts/.

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