

Bodies and Tales. Grounds for an Interdisciplinary Exchange between Medical and Social Sciences

Mario Cardano

Department of Cultures, Politics and Society
University of Turin
Italy

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Abstract

Health is a field of study of a large set of disciplines. Biomedical disciplines, obviously, have an important role, but alongside them also social sciences, particularly sociology and anthropology play an important part in the study of care relations, and in the reconstruction of the subjective experiences of health and illness. The cohabitation of these two scientific communities in the same field, that of health, meets some difficulties, due to the differences in the epistemic styles and in the way each community defines the proper way to produce evidence. This implies troubles in the reciprocal recognition, and some difficulties of communication. This essay analyzes two independent and parallel movements who characterize these disciplinary contexts, which offer an important occasion for an interdisciplinary exchange: namely the emergence in the field of social science of the body, and that of narration in the biomedical field. In both cases, attention will be directed to the most recent transformations, that have their roots in the last century, and that – at least in this writer's eyes – have had a decisive impact in shaping both the outlook (the epistemic dimension) of each discipline, and the forms of collaboration between them (the political dimension)¹.

Keywords: Body; Body in sociological thought; Narration; Narrative medicine; Relation between medical and social sciences; Method as a collection of principles



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Corresponding Author: Dr. Mario Cardano, Professor, Director of the PhD School on Sociology and Methodology of Social Research - Universities of Turin and Milan, Italy

Affiliation: Department of Cultures, Politics and Society, University of Turin, Italy

Address: Campus Luigi Einaudi - Lungo Dora Siena 62 Torino - terzo piano, settore D4, stanza 21; tel. 011-6702694; 011/6702606

e-mail: mario.cardano@unito.it

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1. Sociology and the Body

Sociology's attention to health care is of recent origin. Talcott Parson's *The Social System*, published in 1951, and is commonly seen as the first systematic discussion of this distinctive social relation [1]. The Parsonian analysis of health care emphasizes the normative dimensions of the physician-patient relationship, shying away from the theme of power, of its asymmetry, and that – which is central here – of corporality².

It was not until thirty years later that the theme of the body entered sociological thought. In the 1980s, Chris Shilling thus offered the first methodical thematization of the body, seen no longer as merely a vehicle for cultural and social processes, but as the very basis of self-identity and social identity [3]. Sociology has taken different routes to metabolizing, as it were, this conceptual category, depending on the prominence assigned to the biological and social factors that make it up. The various perspectives on the theme of the body can be said to lie along a continuum whose polar ends are the positions that Chris Shilling has cogently labeled “natural essentialism” and “discursive essentialism” [3]. In the former perspective, which sociobiology expresses almost to the point of caricature, the body is formed and shaped exclusively by biological factors – or rather, genetic factors – that in the final analysis define the profile of society. At the opposite extreme of this virtual continuum, the body is emptied of its biological, material characteristics, becoming an exclusively cultural construct molded by the different discursive regimes that crisscross society. Shilling sets out the metes and bounds of these two extreme positions, justifiably proposing an image of the body and of the processes of embodiment that considers the biological and cultural factors jointly.

The newfound ability to recognize the body as a salient locus for sociological reflection opens up an important channel for communication and exchange with the biomedical disciplines. Regaining its centrality, the body becomes a prime vantage point for observing the relationships between nature and culture, acknowledging that each has its own role. In this connection, mention should be made of an area of research that has provided opportunities for useful interchanges between the biomedical and social disciplines, viz., the study of social inequalities in health³. In this line of investigation, the body is layered with the accumulated deposits and signs of the social relationships of which individuals are the protagonists, whose weight can be seen from the bruises and scars they leave.

In recognizing the body's specific ontological independence, which cannot be reduced to any discursive regime, sociology has been able to draw nearer to the biomedical disciplines without the epistemological encumbrances expressed by the more extreme forms of social constructivism. As Bryan Turner argues, the body with its materiality documents the stubborn harshness of life (what Turner memorably calls the “stuffness of existence”), forcefully countering the extreme constructivist penchant for thinking of the body as a docile product of the dominant discursive practices, as a “project” to be worked at [6, 3]. Turner's argument and, in particular, the words in which it is couched call to mind Herbert Blumer's

2 This crucial aspect, that of asymmetry of the relation between physician and patient, was dressed later by Eliot Freidson, who focused on what he termed “medical dominance” [2].

3 Internationally, the theme of social inequalities in health was put on the scientific and political agenda in 1982, with the publication of the Black Report [4]. One of the most significant instances of collaboration between the biomedical and social disciplines is afforded by Michael Marmot's Status Syndrome [5]. In his discussion of social inequalities in health, Marmot, a social epidemiologist, draws a picture of how power relationships play out in everyday life that brings the work of Erving Goffman and Ralph Dahrendorf to mind.

methodological reflections on the “obdurate” character of the empirical world which, with its materiality, imposes itself on the observer, setting – I might add with a certain philological license – a limit to his interpretative project [7]. The body, with its irreducible materiality, stands as a healthy barrier to the unchecked proliferation of theory, to the “anything goes” of Feyerabendian memory, bringing our discipline more in tune with the empiricism that distinguishes the biomedical disciplines⁴.

2. Medicine and Narrative

In the same years in which the themes of the body and corporality began to gain ground in sociology, the biomedical disciplines turned their attention to narration. This was a process that resulted in a specific branch of medicine, narrative medicine, and was fueled by the rise of a new literary genre, illness narrative, in the final years of the last century.

More social than scientific, this process has been ably described by the literary critic Ann Jurecic, whose husband’s bouts with cancer made the topic one of personal concern [9]. Jurecic’s fine book opens by noting that one of the most momentous epidemiological and demographic events of the last century, the 1918 Spanish flu pandemic, is virtually absent from British and American literature of the era, though it is estimated to have killed fifty to one hundred million people, or as much as 5% of the population. Jurecic contrasts this remarkable absence with the flood of illness narratives that appeared in the United States in the Eighties, following the emergence of HIV/AIDS.

To account for this surprising fact, Jurecic engages in an interesting abductive exercise that sees the observed change as stemming from the transformations that swept through North American society, and health care practices in particular. With a noteworthy sociological sensitivity, Jurecic cites the profound changes in clinical practice, with the increasing professionalization and specialization of medicine that resulted in a loss of intimacy in the patient-doctor relationship [9]. This loss – Jurecic continues – was made all the more distressing by the changes in the need for care brought about by the epidemiological transition as the world entered the age of chronic diseases. The impoverishment of the patient-doctor relationship was a driver of the protest movements, the women’s health movement chief among them, which heralded the later and more widespread emergence of the “politicized patient”. With the publication of a number of seminal texts, this malaise found its first expression in “high” literature: Jurecic mentions *Medical Nemesis* by Ivan Illich, which came out in 1976, Susan Sontag’s *Illness as Metaphor* in 1978, and *Anatomy of an Illness* by Norman Cousins, published in 1979. These canonical texts were quickly followed by a flurry of illness narratives produced by people with AIDS and those dear to them, narratives that were not so much an expression of literary inspiration, as they were acts of resistance to the widespread moral prejudice against AIDS sufferers, who had contracted the disease – it was said – because of their wanton lifestyles⁵. With its beginnings in the AIDS pandemic, this genre of illness memoirs expanded to cover the vast territory of chronic diseases and disability, and even the stories of those who, in Arthur Frank’s words, are members of the “remission society” by people who are effectively well but could never be considered cured [11].

Severe illness, as Michael Bury notes, causes a “biographical disruption” in the life of the sufferer [12], that catapults him into an alien and hostile world, a condition where the present is not what the

4 The empiricism to which I refer in the text is not that of the dawning of science or that celebrated by Positivism, but the critical empiricism espoused by Bruno Latour in his more mature work [8].

5 For a discussion of these prejudices, see Kinsmann [10].

sufferer thought it would have been in the past, and the future is scarcely thinkable [11]. The self, as well as the body, is shattered, and narrative is the only tool that can be used to build a new link between present and future, the only tool that can make sense of the experience of illness. What these narratives describe is first and foremost the subjective experience of illness as opposed to the disease which is the representation created by health practitioners on the basis of taxonomic and potentially impersonal knowledge⁶. A further aspect of these discursive productions that merits more attention is that they are constitutive, as well as representative, in nature. Personal narratives, as Kleinman remarks, do not merely reflect the illness experience, but also contribute to the experience of symptoms and suffering [13]. Hence they are important, not only for the literary critic, but even more so for the clinician⁷.

More or less at the same time this new genre of popular narrative made its appearance, the clinical environment began to take an interest in literature and, more generally, in narrative as a means of providing the clinician with better tools for diagnosis, and at the same time, a way of restoring the human and relational dimension to health care that has disappeared under the weight of medical technology⁸. Thus, we have a further point of contact between the biomedical disciplines and the social sciences in the progressive – though slow – rise of the so-called narrative medicine, a medicine practiced, as Rita Charon has put it, “with the competence to recognize, absorb, interpret and be moved by the stories of illness” [15]. With health care in an age of specialization and fragmentation of knowledge, and an increasingly overwhelming technology that crowds out the human relationship, the narrative competence emphasized by narrative medicine can bring physician and patient back together, reestablishing their bond. Narrative competence, as Charon observes, has a value that goes beyond the ethical plane, as it also provides health professionals with greater diagnostic accuracy and therapeutic direction.

With narrative medicine, two forms of knowledge, employing Jerome Bruner’s two divergent modes of thought – “paradigmatic thought”, which seeks regularity and general laws, and “narrative thought”, which concentrates on the particular – are merged, returning health care to its rightful epistemic value and ethical profile [16].

3. The Conditions for Fruitful Interdisciplinary Exchange

If attention to the body and narrative have brought two traditionally separate fields of inquiry closer together, holding out hope for interdisciplinary collaboration, we must ask – in conclusion – what conditions can make the alliance between the biomedical and social sciences less shaky. In his reflection on the patterns of relationship between the human sciences and the natural sciences, Luciano Gallino pinpoints the first – at least chronologically – difficulty that stands in the way of an effective exchange between the two disciplinary areas we are also dealing with here [17]. More often than not, the “cognitive incidents” that make the alliance between the human and natural sciences so uncertain arise from the mistaken assumption that “other people’s cognitive map (...) is pretty much identical to our own”. Not infrequently,

6 The distinction between illness and disease is discussed at length by Arthur Kleinman [13].

7 It should be pointed out that this new genre of writing was (and still is) far from being well received. Specifically, it has been claimed that these memoirs fail both to meet the standards of testimony – particularly in terms of being verifiable – and the critical expectations and standards of judgment applying to works of literature [9].

8 In 1972, the first medical faculty appointment in literature was made at the Pennsylvania State University College of Medicine in Hershey [14].

this cognitive presupposition translates into a normative disposition to believe that one science, normally the softer by comparison and hence in our case sociology, must adapt to the ontological models, the epistemology and, wherever possible, to the methods of the harder sciences, which in the area of health are the biomedical disciplines. That this is neither possible nor desirable is – in my own view – abundantly clear, though there is no lack – even within sociology – of pressure in the opposite direction. Here, I am thinking in particular of the evidence-based research movement, which maintains that the biomedical research model, based on randomized trials, should also be adopted in the social sciences [18].

I believe that fruitful dialog between the social sciences and the biomedical sciences can take place only if the legitimacy of each area's specific research methods is fully and freely acknowledged, with no claim to dominance or, worse, attempts at colonization. This need is particularly pressing in view of the amount – sizable by now – of social research on health, illness and care conducted with qualitative methods⁹. Using these research strategies, based on observation carried out with small numbers and carefully tailoring data collection techniques to the characteristics of the setting and the object of study, demands a thorough rethinking of the notions of rigor and of what it means to be scientific, notions that are more extensive than the procedural models typical of the biomedical sciences would imply.

More generally, what is needed is a thorough rethinking of the notion of method, not as a collection of rules that act as *orders*, but as a set of *principles* whose interpretation differs according to the context in which they are applied. These are principles that, as Gary Brent Madison contends, are more like the ethical or juridical norms of jurisprudence than the laws of physics; the principles for which there is no single correct application, but more than one, and this depends on context; principles whose application, not unlike a sentence handed down in court, must be defended with appropriate arguments [20]. For the social sciences, taking such a stance does not mean forgoing the rigor that solid ethical and pragmatic reasons, even more than epistemic reasons, demand of the biomedical disciplines. Rather, we must accept that the biomedical and social disciplines should have a different application of the *principle* of rigor. We must accept, for example, that rigor in a large-population epidemiological study must be defended with the tools provided by probability theory, but also that the same goal of rigor in a qualitative investigation of illness narratives involving a handful of cases can legitimately be defended with tools borrowed, not from probability theory, but – for example – from argumentation theory or from informal logic, seeking in these forms of reasoning the most appropriate ways of defining the degree of uncertainty affecting the conclusions that have been reached. We must recognize the equivalence between the formal models of the biomedical disciplines, and the metaphorical devices commonly used in the social sciences, whose value also stems from their openness to invention, to creativity [21, 22]. By fully acknowledging each other's legitimacy, the biomedical sciences and the social sciences can contribute more effectively to reconstructing the causal mechanisms that are responsible for health and illness, centering on the body, but also going beyond its borders to give an account of the social – as well as biological – determinants of health and illness.

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9 The use of qualitative methods in health research achieved mainstream status with the publication of a series of papers dedicated to these techniques in the authoritative British Medical Journal, which were then collected in a single volume under the BMJ Books imprint [19].

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