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From sociology in medicine to the sociology of collective health: contributions toward a necessary reflexivity

De la sociología en la medicina a la sociología de la salud colectiva: apuntes para un necesario ejercicio de reflexividad

Roberto Castro[1]

[1]*PhD in Medical Sociology. Principal Researcher, Centro Regional de Investigaciones Multidisciplinarias (CRIM), Universidad Nacional Autónoma de México (UNAM), Cuernavaca, Mexico.* ✉

ABSTRACT This text looks at the difference between sociology *in* medicine (collaborator of health institutions) and the sociology *of* medicine (independent of health institutions). If consistent, sociology *in* medicine should become a sociology *of* medicine. As an example, it is shown how the study of the social determinants of health and illness begins by assuming non-problematically the ontological reality of health and illness, but ends up problematizing the very concept of health-disease, demonstrating that the study of health determinants also requires the study of the determinants of the social construction of disease. The urgent necessity of objectifying collective health itself is argued. By applying sociological tools we can examine the so-called objective factors in the determination of health and disease, the socially constructed nature of these categories of knowledge, and the struggles and power relations that determine whether or not such categories are viable

KEY WORDS Medical Sociology; Social Theory; Medicalization; Health Inequalities.

RESUMEN En este texto se aborda la distinción entre la sociología en la medicina (colaboradora de las instituciones de salud) y la sociología de la medicina (independiente de las instituciones de salud). Se argumenta que, si es consecuente, la sociología en la medicina deviene sociología de la medicina. Como ejemplo, se discute el caso de los determinantes sociales de la salud que, inicialmente, asumen como no problemática la realidad ontológica de la salud-enfermedad y luego problematizan el concepto de salud-enfermedad y muestran que estudiar los determinantes exige estudiar también los determinantes de los procesos de construcción social de la enfermedad. Se muestra la ineludible necesidad de objetivar la propia salud colectiva, es decir, de aplicar las herramientas de la sociología de manera que podamos poner bajo examen los llamados factores objetivos de la determinación de la salud-enfermedad, el carácter socialmente construido de las categorías de conocimiento, y las luchas y relaciones de poder que determinan la viabilidad o no de tales categorías.

PALABRAS CLAVES Sociología Médica; Teoría Social; Medicalización; Desigualdades en la Salud.

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INTRODUCTION

In a study dated around 60 years ago, which has become a classic,[1] Straus proposed to differentiate between the concepts of sociology *in* medicine and sociology *of* medicine. The former was defined as the "collaborative" research conducted from and side by side with medicine, seeking to develop the health agenda. In contrast, the latter refers to the study conducted "from independent positions outside the formal medical setting,"[1 p.203] and whose purpose is to integrate medicine, health institutions, medical knowledge and practices into its object of study.

In this article, such difference is shown to be useful only to a certain extent, since the so-called sociology *in* medicine, if consistent, should become sociology *of* medicine, resulting from the demands of the reflexivity that the discipline requires. A good example to illustrate this argument is the study of the social determinants of health and illness. The research tasks for the construction of this object of study are initially performed in the form of sociology *in* medicine, that is, a collaborative work with public health/collective health, which considers things from the perspective of the expert whose interest focuses on the concept of health-disease. Nevertheless, the evolution from sociology *in* medicine into sociology *of* medicine is inevitable once the sociological inquiry has started. In this case, the focus is on the performative nature of the professional actions with respect to what is known as disease and, particularly, on the struggles underlying the medical field or field of health. It is evident that the sociology of medicine aims at an unavoidable task: to necessarily transcend the proclamations that give social sciences a central place in collective health, giving way specifically to the *sociology of collective health*. For the purpose of this article, Nunes' description of collective health[2] was adopted as a school of thought, theoretical practice, and social movement. This characterization is the product of the evolution of Latin American social thinking regarding health and it is the consequence of the integration of its more questioning currents.

On the epistemological level, the struggle between positivism and social sciences may have been settled (this is not so on other levels, such as the academic administration or the public funding for scientific research level). Since the booming of the interpretive approaches in the 1980s (which claim that the construction of the object of social sciences is based on the sense of actions and their meanings), the scientific method of social sciences has been hardly required to resemble the method of the exact, physical and natural sciences.[3] In any case, those are demands made on social sciences from other fields of knowledge, such as biomedicine or public health, or from the academic bureaucracies; however, they are requirements external to the discipline and describe the struggles within the scientific field.

Despite the fact that the relation subject-object of these disciplines is completely different to that of natural sciences, social sciences are still considered *sciences*.[4] Therefore, it is not possible to minimize the importance of developing and using theoretical frameworks and specialized methods of analysis, which have to be applied rigorously to the construction of the object of study and through procedures that have to be subject to the evaluation and appreciation of peer experts. Popper's postulate[5] asserting that the fundamental attribute of the scientific method is its *public* character applies unreservedly to the social sciences. For sociology not to be reduced to mere *spontaneous sociology*, and consequently indistinguishable from common sense, the method of social sciences applied to health is required to have public character. That means that the method should allow the concepts, steps, techniques, and evidences to undergo peer evaluation; unlike mere table talk-like opinions, which are not subject to any type of *controlled* verification.[6] At the same time, it should allow specialists to apply on themselves the research tools that are applied on the diverse objects of study that these experts construct. This is so not only

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because this exercise is indispensable as a *breakthrough*, but also because the overcoming of the obstacles hindering the full development of collective health is impossible without the scientific objectification of the latter. Therefore, it is not irrelevant to demand a regulation – this is especially promoted from universities – on the access of applicants that will be certified as social sciences experts, basically through the imposed obligation to demonstrate they know well the fundamental rules of the game, those of the scientific method of social sciences. Thus, the new flexibility of this criterion is not inconsequential either.

The convergence between social sciences and health in Latin America has been given different names that reflect the struggles, ideologies and political positions which are specific to this field. In this way, at different times and particularly in the academic field, this convergence has been referred to as behavioral sciences in medicine, medical sociology and anthropology, social medicine, and collective health. Moreover, under the promotion efforts by the World Health Organization (WHO), it has been called the "new public health," which distinguished a coincidence between the "population factor" and social sciences in the analysis levels and sought to differentiate from the traditional branch of public health.[7]

It is not difficult to realize the variability in the scientific quality and the critical scope (in fact, both aspects go hand in hand) of the publications in the area of social sciences and health in Latin America. This disparity not only results from the lack of academic rigor of some research studies, but also responds to the structural situation, which, in turn, is sociologically discernible.[8,9]

On the one hand, the development of a sort of medical sociology with relative autonomy (and, obviously, subject to its own internal struggles) has indeed taken place. However, if developed in several relatively autonomous universities and research institutes, this discipline tends to remain unconnected from the health sector by which it also tends to be *ignored* in both senses, both as a lack of knowledge and as omission.[10] Hence, this is a practice that occasionally can reach a high level of theoretical, methodological and critical development, but with little impact on the field of health policies and programs.

On the other hand, the official public health institutions encourage the development of a domesticated social science, subordinate, for merely instrumental purposes, without further critical potential. This practice has a bigger impact on the health sector, but it always functions within the narrow limits defined by the medical establishment itself.

This dichotomy, which has material bases that reproduce it (each approach develops within specific public institutions or universities, or particular epistemic communities), is at the root of the difficulties observed until now to apply the principle of *reflexivity*[11] in the world of medical sociology or sociology of health studies. If the agenda of social sciences in health is set by the medical establishment, the construction of the object will be prevented from critically including the medical field itself.[a] In those cases, it is confirmed that the contributions of social sciences are limited to certain descriptions of the context or the implementation of a specific type of qualitative studies that cannot always be differentiated from spontaneous sociology.

As shown below, a good example to illustrate the continuity that exists between the sociology *in* medicine and the sociology *of* medicine is the study of social determinants of health and illness, which may initially be framed within the field of sociology *in*, in other words, at the service of the public health policies agenda, but which might omit very important aspects in the construction of the object, unless it rightly objectifies the objectifying subjects themselves. The field of collective health has got the conditions to undertake its own objectification and, consequently, to gain access to better professional knowledge of (and, eventually transform) the conditions of possibility that shape the kind of knowledge produced.

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SWITCHING EMPIRICALLY FROM SOCIOLOGY IN HEALTH TO SOCIOLOGY OF HEALTH

In another research study, it has been already shown how the study of social determinants of health and illness can take three approaches.[14] The first approach, referring to *sociology in* medicine, differentiates social determinants according to levels: from those of a wider scope (such as globalization and climatic change), going through the structural levels (such as mode of production, class inequality and gender determinations), those of intermediate level (work process and social support) and, finally, to the so-called "lifestyles" at the individual level. Regarding this matter, to identify the main struggles with respect to the object, it is necessary to highlight the existing dispute between the analytical proposal of the WHO[15] and the proposal made by the Latin American Social Medicine Association (ALAMES) [*Asociación Latinoamericana de Medicina Social*][16] and others.[17,18] The proposal made by ALAMES and others, which is generated primarily in academic circles, is much more precise than the former in identifying the social origin – therefore, political, economic, of social justice – of the determinants. On the other hand, the proposal of the WHO is clearly subject to the decisions imposed by the possible negotiation between the member states of this international agency. Although the critical studies undoubtedly represent an excellent approach to the issue of determinants, given that they insist on the indispensable inclusion of the dimensions of power explaining the existence of the determinants recognized by the WHO, we agree with the remarks of other authors which indicate that under this approach, the principal determinants were well-identified long time ago, and, thus, there is very little knowledge that is genuinely new in this subject.[19] Nevertheless, it is particularly important to highlight the positivist presumption underlying this classification, as it assumes that the concepts of health and disease are relatively *non-problematic* for medicine and social sciences. In other words, it assumes that the concept of disease is basically defined by the *objective* criteria of biomedical science and assumes that this field of science is, actually, the most competent perspective to draw the boundaries between what is normal and what is pathological. This hierarchy of determinants by levels of aggregation, from macro to micro level, cannot be explained if not properly considered within the context of global capitalism; and already being a contribution to social sciences (given that it introduces an order and imposes an obligation of finding its interconnections beyond biology), this hierarchy cannot be the conclusion at which the social study of health-disease arrives. The reason for this is that once the sociological inquiry on "determinants" begins, it is unavoidable to study how biomedical sciences and occidental clinical practice construct their own objects of study. Failure to do so might imply complicity with the positivist approach which argues that diseases, like the other objects in which the scientific research has an interest, are "out there" and they can be studied through simply coming into contact with them.

The second approach to health and illness determinants provides, as its fundamental contribution, a problematization of the concept of health-disease, thus making way for the study of the socially constructed nature of this phenomenon. Examples of this were the studies carried out from the perspective of the labeling theory,[20,21,22,23] which showed, from different perspectives, that illness (and deviation) is far from being a stable concept and that its presumption (therefore, its existence) fundamentally responds to interactional dynamics clearly determined by power dynamics. It was demonstrated from this approach that what is called "illness" is the result of intense struggles and negotiations between diverse social groups rather than the corollary of an objective and faultless biomedical research process.[24] The medical profession, as Freidson highlights,[25] is actively engaged in the *medicalization* of reality, which results in a constant expansion of the medical horizon:

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there is a growing number of behaviors, signs and symptoms which medicine claims to be objects within its competence. From this derives a devastating consequence for the classic biomedical paradigm: the *determinants* of illness are also of political nature, as they have to be found basically in the classifying activity performed by medicine professionals, particularly, by those with more power.[26]

Certainly it is important to consider the role played by the large pharmaceutical companies in the invention – also known as disease mongering[27] – of new illnesses, motivated by their desire to expand their markets and increase their profits. It is surprising to notice how relatively silent the social sciences have been on this matter. Although from a sociological point of view, it might not be sophisticated enough to expect the whole issue to be reduced to a matter of markets and profits, thus overlooking all the social processes associated to the social construction of illness, it is inescapable to approach this matter as a central issue.

Along with disease mongering, it is necessary to include as object of study what might be called the "new medicalization" fostered by certain pseudoscientific new age philosophies that promote (and, particularly, sell) supposedly critical views of the conventional allopathic medicine. These philosophies spread esoteric notions about the body and health in terms such as "energy fields," "magnetism and health," "tonal focus," which in turn are translated into alleged new "pathologies" that need to be battled.[b] Eventually, social research on the determinants of health-disease will have to turn its attention to these parallel phenomena, without sidestepping the strategies of institutional legitimization to which these phenomena are gaining access.[c]

Therefore, the second approach, far from arguing that illnesses are mere inventions or that the categories of medical knowledge lack a material correlation, problematizes the apparent stability of medical categories. At the same time, this approach demonstrates that the categories of knowledge, which serve to identify illness and its determinants, are themselves objects of struggle and that this struggle is only discernible by using the tools of social sciences.[d]

Nevertheless, it is necessary to go beyond this point. The social constructivist approach destabilizes the medical categories of knowledge and explains their historical and socially-negotiated nature. However, at the same time, social constructivism implicitly and erroneously presupposes that social sciences specialists hold a privileged position to study the functioning mechanisms of social machinery, as if these mechanisms, which such specialists identify in others, did not work on themselves. Just as it is possible to study the determinants of health-disease as well as the categories of health and illness, it should also be possible to study the social determinants of the sociological practices on health that may or may not allow for the development of those two approaches.

TOWARDS A SOCIOLOGY OF COLLECTIVE HEALTH

Collective Health has progressed in its efforts to objectify itself, but this task has not been completed yet. There is a remarkable amount of reflective work that has been collected – for example, numerous books and academic articles – about the origins and nature of collective health, its current challenges and the role social science has in it, and also about the difficulties that collective health is facing in order to leave its subordinate place within the medical field or health field, and to gain a more favorable position with respect to other disciplines.[2,32] It is also notable that this reflexivity usually stays halfway in the process of objectification to which it is necessary to submit the analytic perspective which is intended to defend. As Bourdieu explained, "an objectification process is only scientifically controlled in relation to the objectification, which has been previously submitted as the subject of the objectification" [11 p.160] [own translation].

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In order to initiate this reflexive analysis, we can take as a datum the content of the articles that consider the relation between social sciences and collective health, in other words, as an expression of several actors of the health field who are in charge of objectifying the health-related objects but who have not objectified themselves, and whose articles reveal their position in the field and their point of view consequently determined. For example, many articles describe the relation of *subordination* that social sciences have kept with respect to biomedical sciences, especially in the area (of political action) of collective health/public health and, considerably, in the (academic) area of medical sociology and anthropology.[32] However, it is essential to sociologically build the field of health and to locate collective health in it (in other words, to establish the relation of force it has with respect to the other members of that field). The fact that this task has not been completed explains the difficulty that can be noticed in many authors who cannot go beyond the descriptions made until now about the status of collective health, or the role social sciences have in it.

In the development of this reflexive analysis, it is essential to recall two of the social characteristics of the social sciences that are important for this article: a) the products of social sciences can be confused with those of common sense, because they deal with issues everyone is, in a way, "an expert." Social sciences do not have, therefore, much autonomy, as it occurred with astronomy and evolutionary biology in the past; and b) medical sociology has grown within various trends which are more autonomous at times, and more heteronomous other times, primarily according to the type of institution (university or governmental) where it is developed. The most heteronomous trends of social sciences in health generate specialists that are more regarded or accepted by the medical establishment or the establishment of public health, or even more useful to it, which contributes to reinforce the position of *misrecognition* of sociology: "scientific truth is not to be imposed by itself, that is, by the mere strength of demonstrative reason (not even within scientific field). Sociology is socially weak, and even more so, the more scientific it proves to be"[11 p.154] [own translation].

Within the medical field or the field of health, social sciences occupy a subordinate place, they are invited to "collaborate"; and within the field of social sciences, health has one of the last places in the hierarchy of the legitimate objects of study. It must be understood that, within the medical field, social scientists have not much *autonomy* but they are more regarded, while within the academic field, medical anthropologist and health sociologists have relatively more autonomy but little *impact* on the field of health (that is, their discoveries and analysis are not easily translated into health-related actions and programs). The most heteronomous – i.e. those which basically carry out the biomedical establishment agenda of research – contribute to perpetuating the conventional view of health-related problems and of the nature and potential (duly domesticated) of social sciences.

The logic of fields[33,34] allows us to identify one of the main tensions to which social scientists are submitted. Marsiglia[35] describes appropriately that, as social sciences are invited to "cooperate" with health sciences, they are usually in the awkward position of having to produce something "to solve problems;" they are usually submitted to the command of being "practical," of providing solutions, thus, abandoning any theoretical or methodological pretention that could be interpreted as superfluous under the dominant *logic of practice* dominant in the field of health. The subordination of social sciences inside the field of health makes it really difficult to consider another characteristic of them, which Weber expressed clearly in *Science as a vocation*, where he establishes that neither sciences nor social sciences can give us the answer to our question on what we shall do, but they provide us basically with methods of thinking and investigating, the discipline to do so, and the clarity to formulate better questions.[36] And, simultaneously, the lack of a theory of the fields to objectify collective health as part

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of the medical field or the field of health (and also as part of the field where it is disputed the definition of the model of health care of populations – the field of population health – in which public health appears in various modalities) explains many of the failures that exist in the answers and alternatives given by many authors when trying to explain and transform the subordinate status of the social sciences in their relation with the subjects of health. For example, after having asked himself whether it was possible to produce social knowledge that were not subordinated to natural sciences, Marsiglia just manages to answer: "yes, if we succeed in looking jointly to the real object."[35 p.39]

Another characteristic of the medical field or the field of health – and the field of collective health inside it – which is closely related to what has just been said, is related to the changes that can be noticed in the postgraduates studies of social sciences and health, and the role that the state agencies that finance the investigation have. Amélia Cohn[37] describes another tension to which social scientists in health are subject: the urgency to solve problems, contrary to the slower process typical of sociologic investigations. This situation results in a poor sociological work and "quanti-quali" studies commanded as such by the medical establishment. The final product proves the irrelevancy of social sciences and the "good reasons" biomedics have not to recognize them with a better status. Amélia Cohn notices that most of the studies on social sciences in health are made by professionals who have no original training in social sciences. In addition, as in the previous case, the lack of an appropriate objectification of the field of health explains the limited solution offered by Cohn to the systematic production of the subordination of social sciences in health, and the demand for quickness and efficiency imposed: "the search for dialogue between different strategies of scientific appropriation of reality may only occur if their respective characteristic and requirements are respected"[37 p.17] [own translation]. We sustain that the problem here, similarly to the example given previously, is not only to call for respect to the varying characteristics of the different health sciences, or for equal treatment for divergent disciplines, but also, and most important, to explain why such respect or equal treatment in not applied. We need to ask ourselves, in order to achieve a complete objectivation why it is produced and reproduced that failed form of social sciences and its consequent effects that reproduce subordination.

In the efforts for the construction of the medical field or the field of health, it would be a necessary step to sociologically objectify collective health itself – as one of the many approaches that conform that field – in order to *disenchant* that perspective and to identify the social nature of its strengthen as well as its weaknesses. It can be noticed, for example, the large number of articles published, especially in Brazil (where the approach is more vigorous), that defend the critical and emancipating nature of collective health, and that identify different "adversaries" against which they are fighting: conventional epidemiology, quantitative methods, ideology and practice of scientific production, dominant and non-critical collective health, among others. All these arguments are held from a subordinate position, with the need to fight against the model that imposes the rules that organizes the field of health, and the field of population health within. And from there, many significant contributions have been made that focus exactly on a sociology of collective health by illustrating several material transformations (for example, the lowering of academic standards in postgraduate studies, or the imposition of certain rules of academic production and evaluation) that relate to internal disputes within the field of collective health and the field of population health.[38,39]

However, a significant part of the difficulties faced so far derives from the vagueness used to apply the term "field," which has been motivated by several authors' passion for, and commitment to their own convictions. There are numerous statements originated within collective health that defend such as a "scientific field."[40] But it is a wrong characterization,

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because the dimension of *conflict* distinctive of any field is missing: what is at stake? What are the resources under dispute within collective health? The authors not only ignore the *agonistic* nature that has to be identified in a field, but they also offer a "hagiographic" description of it: they talk about "the constitution of collective health, considering its productive dialogues with public health and social medicine."[40 p.309] In fact, the relation between these three perspectives has been much more about conflict than deep dialogue. The definition of collective health as a "field" may be accepted if it is thought of as a synonym for "disciplinary perspective." But not in the same terms as understood by the genetic structuralism of Bourdieu. From this last point of view, collective health should be formed by a group of agents, both individuals and institutions, that makes up a larger field – that of population health – that at the same time, forms another field even larger: the medical field or field of health in general. In the field of population health, there is also another group of agents – the representatives of the public health approach, the World Health Organization, the Pan-American Health Organization, several universities and so on – and what is disputed is the capacity to dictate or impose the rules that will provide the framework to approach a number of health issues arising in populations and the relevant policies needed, in addition to the study approach required and the ways of assessing the scientific quality of the research studies involved (rules of academic survival) and of course, the name that will be given to the field.[41] It would be a field where, clearly, the dominant position (though not necessarily hegemonic) is occupied by the traditional public health and its view of the world, and against which the criticism and counter-proposals formulated within collective health are articulated.

This characterization is described better in the research study done by Bertol Leal and Camargo Junior,[42] where they question the pertinence of characterizing collective health as a scientific field (given that practice is differently involved in collective health than in the scientific field) and suggest the necessity of applying to a broader concept of field.[e] These authors point out that the field of health is formed:

> ...by different institutions that produce knowledge (associations, universities, training and research centers), different health professionals (doctors, nurses, among others), leaders from government, administrators and techno-bureaucrats, users (patients, sick people) and several institutions, such as hospitals, health posts or basic health units, state and municipal secretariat of health, associations of professionals (such as labor unions, associations of professionals or specializations), associations of institutions providers of services (for hospitals and laboratories, for example), associations and groups of governmental representation (such as the association of state or municipal secretaries of health), associations of users (for example, the AIDS NGO or different associations of patients who have the same pathologies), and institutionalized boards of participation of different agents (municipal and state boards of health, boards of agent of services).[42] [Own translation]

These authors recommend not to confuse collective health in Brazil with the health reform in that country. Similarly, in the effort to objectify collective health, as part of the field of health in Latin America, it is necessary not to confuse collective health with the case in Brazil, even when such country is its main reference, undoubtedly. Although we consider that there is certain ambiguity in the localization of collective health (sometimes it is cited as part of the field of health, and other times as a field of collective health itself), many authors detect a central element of the field which, however, they cannot objectify completely: the *illusio*, that is, the belief (even a passionate belief) that what is at stake is important and it is worth investing in it. They highlight that one of the characteristics of the field is "its activist nature in the dispute of the approval over the Truths

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that apply most to social necessities; it is a movement of tension that generates energies of renovation"[42 p.62] [own translation]. But they do not manage to separate themselves from what they are most passionate about: instead of objectifying such activist nature, they demonstrate being completely taken by the field by vindicating as a value its agonistic nature. We sustain that the objectification of the field should also expose to sociologic examination what the most committed agents might consider their most precious values: their conviction, their activism. The major obstacle to objectify a field which an actor belongs to is the fact that the same actor is taken by such field:

> ...the point of view that objectify the points of view and made them as such [...] involves the substitution of the polemical, partial and arbitrary view of the same agents [...] for a comprehensive and indulgent view according to the expression of 'to understand is to forgive' of the different positions and positioning [which] under no circumstances means the elimination of the differences in the points of view. In addition, far from lead, as it might be thought, to a relativism which concedes the reason to none of the competitors for the truth, the construction of the field permits to establish the truth of the different positions.[44 p.99] [Own translation]

Other research studies have identified not only the subordinate nature of collective health, but also a kind of crisis of identity "that is evident in its fragmentation and dilution as scientific field."[45] It is indicated that, through its theoretical developments and sophisticated use of sociologic concepts, collective health maintains its subordinate position and, in several ways, an instrumental functionality to a biologicist conception that is dominant, pragmatic, positivist and "Anglo-Saxon's kind." Therefore, along with the research studies that defend its position, there are also agents that notice signs of disenchantment, in the sense that the promise of collective health has not been fulfilled, and that there are not many signs that this situation will change.

Thus, in order to objectify collective health, it would be necessary to build the field of disputes where it would be possible to understand its movements, recognitions... and also its silences. What is also at stake in the field of health is the monopoly of the legitimate approach taken to study the *determinants* of health and the place and role of social sciences in it. The medical field or the field of health is, at the same time, a subfield of the field of power, and maintains a clear link with the academic field and the publishing field.[46] To consider this fact would facilitate the progress in objectifying collective health, as we would be able to identify its position within the different structures of power hierarchies where it is immersed, and distinguish between the several agents involved. In this way, in professional terms, the dominant group of this dominated subfield seems to be constituted by health specialists with certain education in social sciences, whereas social sciences specialists interested in health occupy a secondary position[37,47]; and, in regional terms, the dominant group of this subfield is placed specifically in Brazil, whereas the rest of the countries of this region hold a peripheral position.[10,48]

Once collective health is placed within the medical field or the field of health and the main logics of action that organize the disputes within collective health itself are identified, it should be possible to progress towards a sociology of collective health that includes an analysis of the conditions of possibility of the transformation of the objects in dispute: for example, academic productivism, the active lack of interest of the establishment in the study of social issues in its most critical aspects (and the promotion of social sciences without further questioning potential), or the limited impact on public policy, among others. The objectification of these aspects, thus, would put us in an uncomfortable position, but whose exploration is essential.

For example, from collective health, it has objected to the academic productivism

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to which its representatives are submitted, as a consequence of the imposition of a type of academic evaluation that is established by the biomedical and sanitarian dominant approach, which is supported by the State to the benefit of the publishing industry. It is also discussed – a long-standing dispute among those of us who dedicate ourselves to medical sociology – the necessity of arguing in defense of the book over the articles, as the first is a more appropriate tool to present the discoveries of social sciences. However, the criticisms to the established system (overly pertinent) are still silent with respect to an essential aspect: by what indicators and through what system of institutional evaluation we could differentiate high quality research studies and its products from the mediocre or clearly wrong research studies.[49] It is correct the criticism of the fact that the productivist system confuses quality with quantity: as it lacks capacity to evaluate quality, this system chose to concentrate in quantity (or either favor the productivism based on different interests).[38,46] What we have to ask now is why the criticism of this system has not offered a viable alternative, and how this repeated "criticism-without-alternatives" position contributes to reproduce its subordinate position, as it remains in a "loss of prestige" position within the field.[49] In the description of a high quality investigation, it is acknowledged, of course, the supremacy of the traditional sanitarian group over the group of specialists in social sciences. Whereas the first group is inclined to demand that the research studies "serve" to solve specific problems, the second group, who has no need of providing solutions to such specific problems, is inclined to defend the especially clarifying nature of its research studies. But other important issues are also discussed, such as the justification for getting public funding for social research work in health issues (if such research work is of good quality) or not (if it is not). An adequate objectification of collective health will most likely provide new elements of sociology of knowledge, which might allow us to discover what prevents us from modifying such order and proposing alternatives, as we overcome these obstacles.

On the other hand, a sociology of collective health should make us question the social origin of the so-called "movement" for a qualitative investigation and its persistent criticism of quantitative research work, as if this last was always bad science, or the qualitative guaranteed by itself a science of quality.[50,51,52] The qualitative research work that is published in the region mentioned before is often devoid of solid theoretical anchors and sometimes also lacks basic concepts that distance itself from spontaneous sociology and mere common sense interpretations.[53] A modification in power relations inside the field of health should be subject to empirical demonstration, based on appropriate evidence, of the fact that the defended science is superior to the dominant science. But far from favoring the discussion and refutation, what predominate are declarations of principles and self-congratulatory proclamations that actually have little effect on the field. What motivates the defenders of this "movement"? Their "dispute," in fact, doesn't perpetuate the subordinate position? For the purpose of this research study, this issue is fundamental because what is at stake, let us keep it in mind, is the possibility of development of a social science applied to health that provides true clarification and that, therefore, can discover the determinants of the knowledge that is produced, and omitted. This example that we have already analyzed illustrates it with clarity: to progress substantively in the sociological study of the determinants of health-disease requires to examine the so-called objective factors (first approach), the socially-constructed nature of these categories of knowledge (second approach), and the struggles and power relations that determine whether or not such categories are viable (third approach).

CONCLUSION

Collective health is in a good position so as to seek its own objectification. The discipline knows the critical potential of social sciences and is also aware of the consequences of

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applying these sciences without a horizon that gives them autonomy. Nevertheless, in order to develop a sociology of collective health from the perspective of collective health, it is necessary to face a significant epistemological obstacle: the *habitus* of its members that predisposes them to criticize the established powers and, along with this, their tendency to disregard the observation and criticism of themselves. The set of relevant reflections made on collective health, which mark the cooptation of collective health or the debilitation of the perspective, can only be completed as long as the full reflexive objectification of the approach is made. Bourdieu's field theory may be truly useful to clarify this point; however, it will be particularly useful to subject to empirically test all evidences and the "findings" that are discovered. In this article, we simply identify some aspects to be considered in an attempt of objectification, but the project itself has not been carried out yet.

ENDNOTES

a. In another research study, this fact was shown in relation to the abuse that women suffer in health services during labor: as long as the object of study is defined under the hegemony of the medical field, the matter remains as a problem of "quality of care" or as a problem of "dehumanization" of medicine, which term demonstrates the absence of social sciences in the conceptualization. Conversely, if the medical field itself is objectified in sociological terms for its study, the deeper factors that structure this field can be explained.[12,13]

b. A subject of study which is fascinating is the huge popularity that these "new types of medicine" are gaining as well as the epistemic and practical struggles that exist between them and allopathic medicine.[28] In the construction of this object, it is necessary to avoid the accusations hurled from both fronts. In addition, it is important to notice that not all alternative medicine is "pseudoscience" and, simultaneously, that in allopathic medicine several non-scientific beliefs and practices are observed as well.

c. A team of researchers and professors of UNAM have created a Facebook page called "No to pseudoscience at UNAM" (NoPseudoscience) to actively work against new forms of medicalization, among other aims. The Center for Inquiry, located in the US, is also waging war on "complementary alternative medicine." In the construction of the field of health, these new agents should be included.

d. In order to study the epistemological controversies raised by the approach of social constructivism, the debate about this subject between Bury, Nicolson, and McLaughlin should be examined.[29,30,31]

e. The definition coincides quite well with that which was offered in other research study on the medical field in Mexico: "The medical field comprises a group of organizations, institutions and health actors that, from different positions, maintain power relations that seek to preserve, acquire, or transform that kind of specific capital which implies the aptitude to impose the dominant schemes of definition, perception and evaluation of the subjects pertaining to the health agenda, as well as the schemes of the actions (political, commercial, scientific, professional) that derives from that. From this perspective, along with health institutions themselves, other components of the medical field are the pharmaceutical and the medical equipment industry, insurance companies, and subordinate forms of medicine, such as homeopathy, chiropractic medicine, and so on. Moreover, in a very relevant way for this research, the medical field includes those institutions, which train the new teams of professionals that in due course will be part of this field, the managers of these institutions, as well as the professors and students of all these medical specialties"[43 p.342] [own translation].

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