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A French paradox according to epidemiologists
On the development of the sociology of health in
France

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Abstract

The article discusses a paradox pointed out by epidemiologists and consisting in the quasi-absence of French sociologists in research on social determinants of health whereas references to Durkheim and Bourdieu are central in that field. It considers the handbooks of medical sociology and sociology of health published since the 1970s and gives an overview of the theoretical frameworks in use in French sociology of health. It examines the formation of this orientation in three periods to which correspond three layers of research topics and approaches: the foundation in the 1960s in which American medical sociology compensates partly the limitations of French sociology, the institutionalization in the 1970s marked by a firm orientation towards qualitative sociology, and the consolidation during the Aids years. These orientations are replaced in their institutional context and related to strategic choices made by researchers.

Key-words : France, sociology of health, qualitative research

A review of 20 years of research on social determinants of health in France made by epidemiologists concludes on a paradoxical situation:

Faced with the impressive international mobilization of human and social sciences and epidemiology to study social determinants and social inequalities in

health, in which many researchers are referring high and clear to Durkheim and Bourdieu, how to understand the virtual absence of French scientists, including social scientists in an eminently sociological research field? (Goldberg et al., 2002, p. 114).

The authors note that «social sciences have almost completely deserted [the study of social determinants of health] yet traditional to them whereas social inequalities in health are more important in our country than in most of those with a similar economic level» (Goldberg et al., 2002, p. 112). Their critical address applies to social sciences in general, but it challenges more directly a French sociology claiming the legacy of Durkheim, and having promoted various analyses of social structure and social change.

Exploring this so-called French paradox is a way of analyzing the formation of sociology of health in France since the 1960s and of questioning its theoretical and thematic choices, and the conditions in which they were made. The designation of sociology of health has been established in the 1980s over a previous qualification as medical sociology. This change marks a clarification between a contribution to medical sciences and an autonomous analysis of health issues, that is strategic in the formation of this segment of sociology.

The article does not aim to give an exhaustive account of the diversity of sociology of health in France. It draws significant lines in an institutional field in which two research centres are specialised in health¹, some laboratories have a component focusing on health issues², and in which sociologists of health, more or less isolated, work in university laboratories hosting a variety of approaches and topics. It focuses exclusively on the formation of sociology of health in its relations with the social demand and the medical world.

Three periods to which correspond three layers of research topics and approaches are considered: a time of foundation in the 1960s that sees the emergence of research on hospital and on representations of health; a time

¹ CERMES 3 (Research Center on Medicine, Science, Health, Mental Health, Society), previously CERMES founded in 1986 [<http://www.cermes3.fr/>]
SE4S (Economic and Social Sciences, Health Systems, Societies), in Marseilles [<http://www.se4s-orspaca.org/>]

² CLERSE, Lille Centre for Economic and Sociological Research and Studies [<http://clerse.univ-lille1.fr/>], CSI, Centre for the Sociology of Innovation at the Ecole des Mines Paris [<http://www.csi.ensmp.fr/>]; IRIS Institute for Interdisciplinary Research on social issues (Social Sciences, Politics, Health) at the EHESS and Paris13-University [<http://iris.ehess.fr/>]; LISST- Interdisciplinary Laboratory on Solidarity, Territories and Society-at Toulouse University [<http://w3.lisst.univ-tlse2.fr/>].

of institutionalization that goes from a special issue of the *Revue française de sociologie* in 1973 to the creation of the CERMES, a research centre dedicated to health issues, in 1986; a third period of consolidation corresponding partly, but not exclusively, to the years of social research on Aids.

Before presenting these periods, the relevance of the idea of French paradox is discussed by examining the handbooks of sociology of health available since the 1970s. Then, the developments of sociology of health during the past decades are presented. This analysis owes much to Herzlich and Pierret (2010) who have analyzed the constitution of the sociology of health in France since the 1950s until 1985, when research on Aids develops.

The handbooks of sociology of health and the French paradox

The critical address of French epidemiologists to sociologists refers to the discovery by American social epidemiologists of the interest of Durkheim's analysis of suicide (1897) to explain variations in health status and to analyze the social structure of health and disease.

Durkheim's contribution to the study of the relationship between society and health is immeasurable [...]. In light of recent attention to 'upstream' determinants of health, [his] work reemerges with great relevance today. Durkheim's theories not only related to the patterning of suicide intended but easily extend to other major outcomes ranging from homicides to violence and cardiovascular disease (Berkman *et al.*, 2000, p. 845).

This use of Durkheim found little interest among health sociologists in France. Cockerham (2007), who refers many times to Durkheim, explains it by the sociological orientations of research on health :

Theories of causal structures in health matters have languished. [...] Acknowledgment of the causal role of social factors and conditions in sickness and mortality has been slowed down not only because of the priority given to the individual in social sciences but also as a result from methodological difficulties in determining the direct effects of macro-level variables on the health of individuals (p. 185).

In France, Durkheim is popular among social epidemiologists and neglected by sociologists of health that have mainly developed their approaches in reference to American sociology.

The same applies to Bourdieu's analyses, that have occupied a central place in French sociology from the 1970. Cockerham (2007) notes that Bourdieu «is recently attracting the attention of medical sociologists, largely through his book *Distinction* (Bourdieu, 1984) and his discussion of lifestyles, habits and fields». In France, Bourdieu's analyses are not mobilized to study the social stratification of health status. As an example, in his analysis of the social production of health, Drulhe (1996) refers to Bourdieu among many other contributions in a chapter on lifestyles and their health implications, but he does not discuss the relevance of his analytical framework. In the first comprehensive book on social inequalities in health that brings together contributions from epidemiology and sociology, there is a unique reference to Bourdieu, among many other references, in a chapter devoted to qualitative approaches (Leclerc *et al*, 2000).

This absence of French major sociologists can be found in the handbooks of sociology of health. A look at these books and at the context of their writing give an overview of the theoretical frameworks in which sociology of health has developed in France.

Medical sociology in the 1970s handbooks

The first two handbooks have been published in the 1970s when this segment of sociology is forming and gaining visibility. About her textbook published in 1970, Claudine Herzlich explains:

When I have begun writing my thesis about 1965 [on social representations of health], the fieldwork being finished, I have tried to extend my initial bibliography which was very skinny. The French studies [...] were very rare [...] ; their subjects were very far from mine. So I explored the Anglo-Saxon literature. It was not a very common approach among French sociologists: they relied on the rich tradition of French sociology and they often read little English. However, social psychology was born in the United States. For me, it was obvious I had to look in that direction. The revelation was a special issue of *Current Sociology* (1961-1962) edited by Eliot Freidson with a review of issues on the theme : *Sociology of Medicine*. It has shown me that there was in the United States a structured and lively research domain, and it has provided all the necessary references for my thesis. In fact this literature was so interesting that soon after, in 1970, I published

a book of American texts that has long served as the introductory handbook for this domain (Herzlich, 2000).

In her book, she defines medical sociology as «the study of the social definition of illness, practices which relate to it, institutions which intervene on it, social status and behaviours of the patient» (Herzlich, 1970, p. 7). The book is organized into two parts: health and society, medicine and society. The final index, divided into seven themes (hospital, sick person, sickness, doctor, medicine, medical practice, medical care), reflects an approach focused on hospital, medicine and doctor-patient relationship.

In 1972, François Steudler publishes a handbook of medical sociology in which he explains the development of medical sociology as a result of the convergence between medicine and humanities through the technical development and transformation of organizations and through the awareness of the role of social factors in the development of diseases. He defines the object of medical sociology as: «the study of the more specific socio-economic aspects of health, of the place of the health sector in societal orientations, and of the relationships between health and other policies» (Steudler, 1972, p. 15). Each part of the book is organized in four themes: health, culture and society; therapeutic relationship (defined as values, beliefs and attitudes involved in the therapeutic relationship considered as a social relationship); the hospital and medical professions; health policies and economics.

One of the current interests of these two books is to illustrate the origins of the sociology of health in France. On the one hand, they are based on concerns about the medical profession and the hospital which are subject to major changes in the context of technical innovation and institutional transformations. On the other hand, research interests about the values mobilized by patients and their representation of health and disease develop in a changing context of the therapeutic relationship. If the theoretical options of French sociology provide analytical frameworks to address some of these questions, such as the analysis of the social implications of technological and organisational changes of the hospital, they offer little resources to analyse other topics. Similarly, the analysis of the medical profession does not find sufficient resources in a sociology of work mainly concerned by working classes.

Medical sociology in the United States of America provides the missing sociological resources to analyse the production of standards and professional practices that become important issues or, in conjunction with Moscovici (1961), to study popular representations of health. These

resources allow a sociology of health in development to define its own objects. Autonomy is claimed explicitly by Herzlich who writes about the relationship of sociology with the epidemiology :

Epidemiological studies address directly the issue of the relationship between illness and social factors. It is about them that the term 'medical sociology' has been used for the first time. However the contribution of the sociologist was often, rightly or wrongly, only auxiliary [...]. Epidemiology remains a branch of social medicine, rather than it has become a field of sociology. The contribution of the sociologist has to be located, in fact, on other plans, which include firstly the study of illness behaviours (Herzlich. 1970, p. 14).

Steadler has a different perspective. Following the distinction made by R. Strauss, he sees medical sociology rather as a balance between

The sociology of medicine, whose objective is to study medicine and to find confirmation of global hypotheses about the whole social system and the sociology in medicine [...] which participates in the prevention and treatment of disease, helps the patient to solve medical problems and contributes to the development of health policy (Steadler, 1972, p. 10).

Such different orientations can be reported to the positions occupied by these scholars in the 1970s. While Steadler has a university tenure and works in the research group directed by Alain Touraine, Herzlich is a researcher at a CNRS (National Centre of Scientific Research) laboratory in social psychology. She decides to move closer to sociology where she tries to develop a specific research space by working with research organizations (CNRS, INSERM –National Institute of Health and Medical Research) and the EHESS (School of Advanced Studies in Social Sciences), i-e institutions dedicated to postgraduation and scientific research. These two paths lead to different definitions of medical sociology. In one case, a position in academic sociology gives legitimacy to work in close association with professionals and to contribute to their activity, whereas in the second case, differentiation with medical institutions and medical research is a condition to establish an autonomous place for social sciences.

Sociology of health in the recent handbooks

The thematic and theoretical orientations taken in the 1970s can be observed in the three more recent books published by sociologists

conducting research on health issues. As in the previous handbooks, references to Durkheim are almost absent. It is true that the interpretation of *Suicide* (Durkheim, 1897) by French sociologists is largely biased by its association with the debates on the foundations of the discipline in the courses of sociology. However, its recent use by social epidemiologists to analyse social determinants of health is not either discussed. The intellectual and institutional separation between social epidemiology and sociology of health finds here an illustration.

The short handbook (128 pages) of Adam and Herzlich (1994) refers to Herzlich's previous textbook (1970) and to studies conducted over this period by researchers who came to join her in her research group. A chapter is devoted to the analysis of representations of health and illness in a historical and sociological perspective, following one of her major studies (Herzlich and Pierret, 1984). Another chapter which analyses medicine in its historical dimension and in the doctor-patient relationships, is partly fed by research on careers and practices of the French doctors (Herzlich *et al.*, 1993). The hospital is also the topic of one chapter, as well as the analysis of the experience of chronic illness which has become a central theme in the research group. The chapter on the social determinants of health relies on statistical data and develops an analysis of relations between characteristics of individuals and their health by using psychosocial models (stress, coping behaviours, social support). The authors stay within the limits of health studies and do not refer to sociological research on lifestyles. In their bibliographic guidance, they note that « the majority of studies and articles which relate to the sociology of illness and medicine are Anglo-Saxon ». According to them, the seminal book is *Profession of medicine* (Freidson, 1970) which « besides its own interest theoretical interest, is a real treaty of sociology of illness and medicine » (Adam and Herzlich, 1994, p. 24). *Suicide* and *On the normal and the pathological* (Canguilhem, 1943-1966) are presented as basic texts, but their influence on research presented in the handbook is difficult to find.

In 2004, Carricaburu and Ménoret publish the first exhaustive handbook of sociology of health in French, in which they claim the heritage of the American sociology of health. These two researchers, who did their doctoral research at CERMES, explain:

One will find hardly hexagonal [i.e French] sociological tradition in this book. One can probably make many hypotheses to try and explain why French sociology have developed little interest in illness before the 1980s but there is one which is obvious in terms of intellectual heritage or academic reproduction. Durkheimian

inheritance has probably a substantial responsibility in this state of the art. Considering that illness is a matter of contingency or accident [Durkheim, 1895] comes down to stick to a apparently biological evidence [and to] professional definitions [of diseases]. Efforts of several generations of French sociologists to establish their discipline as a science have deprived their students up to the 1980s, of substantial sociological knowledge [of health issues] and have given way to an individualizing, when not psychologizing approach to health and illness, without venturing to discuss a hegemonic medical model (Carricaburu and Menoret, 2004, pp 5-6).

Sociology of health is presented in four parts following its chronological development from the 1950s in the United States and the 1960s in France: the analysis of institutions (in this case the hospital), an approach of occupations and professions (with a central attention paid to doctors and to medical activity), an analysis of the experience of illness (with a particular attention to chronic illness and, more recently, to AIDS) and current issues shaping the world of health (inequalities, social movements and the dynamics of medical innovation). They put great emphasis on American interactionist sociology (mainly Freidson and A. Strauss), and do not pay attention to debates among epidemiologists, in particular as regards health inequalities.

Drulhe and Sicot (2011) present their book as an introduction to sociology of health and of living together, with the ambition to become a reference for students and for researchers in sociology, but also for health professionals. It relies on research conducted in the Institute of social sciences at the university of Toulouse. The laboratory has developed cooperation with research groups in public health and with health institutions, hence the importance given to the affirmation of an autonomous and critical sociological point of view on health issues in order to clarify their contribution to sociology.

This research field that developed before the second world war in the United States, emerged only gradually in France in the 1960s. Besides, the autonomy vis-à-vis the medical perspective is never acquired definitely, as the latter benefits from a legitimacy a priori to say the healthy and the unhealthy, the normal and the pathological (Drulhe and Sicot, 2011, p.11).

They assert the need for a perspective on health and illness firmly grounded in sociology, and not in a medical approach. According to them, the object of sociology of health is «to describe precisely the realities, to establish multiple observations on ways in which societies and their

members take over health issues, engage in practices that shape configurations that may or may not be institutionalized and last over time» (p.14). Their book, comprised of eleven contributions, introduces to different facets of issues relating to health and to illness: the formation of bodily norms in childhood and youth, pathologies and their implications for social relationships, old age and death. Between these stances of the life cycle, they develop an analysis of health inequalities, of risks, but also of cure and care in the hospital. Following Norbert Elias, the objective of the different contributions is «to be attentive to various configurations of 'porosity' between health and social life through phenomenon of de-medicalization and sanitisation of social life» (p.14). If the authors acknowledge the necessity to know and to mobilize the theoretical and conceptual heritage of sociology of health, they also claim the right to participate in the current debates of general sociology. This option can explain why they do not discuss the use of sociological frameworks by social epidemiologists whereas in referring to Durkheim's dualistic analysis of conscience or to Bourdieu's concept of habitus, this discussion on health issues could contribute to the structure-agency debate.

The presentation of these different handbooks of sociology of health shows the limited place given to French sociological analyses of health after a first period in which the concepts of social representation or social organisation promoted in France in the 1960s have been largely used. If there is a paradox, it can be formulated in the following way: if sociological analyses have a claim to universality, they are also a product of a political and cultural context which nourishes them and which makes them more relevant to understand the society in which they are developed. French sociologists of health have borrowed their models from American sociology and, for chronic illness, from British sociology. These models have led them to select some issues and to blur some others, including the problem of social inequalities that they were not in capacity to address. Therefore, the question is to discuss the conditions of these orientations of French sociology of health.

The stages of formation of sociology of health in France

The state of French sociology at the end of the Second World War explains some aspects of its further developments. Different authors agree to recognize the declining state of sociology at the university, compared with previous periods: four faculty chairs of sociology, aged durkheimians

and low academic recognition of the discipline. «Sociology had declined in France after 1918 in terms of research as well as in its institutionalization: in 1945, there was no sociological training, no more sociological tradition, no research» (Chapoulie, 1991, p. 325). The intellectual context, dominated by existentialism, is not in favour of social sciences and specially sociology seen as a deterministic and reductionist approach. The challenge is to build a sociology out of the Durkheimian legacy. For example, Stoetzel, a young sociologist who had written his thesis under the direction of Halbwachs, writes in 1946: «[Durkheim] has invented a sterile and paralyzing sociological logic. It is questionable if it is not better to put the younger generations of future researchers away from his influence» (quoted by Mendras, 1995, p. 33)³.

The creation of the Centre of Sociological Studies of the CNRS in 1946 provides an institutional space in which a sociology based on field studies can develop. This empirical orientation results from a hierarchical division:

The essential restriction was implicit: it was necessary to respect the division of work according to which 'big' questions, theoretical and others, were reserved for professors. This division, very marked in reciprocal attitudes and expectations, reinforced differentiation between 'theoretical ' and 'empirical' work, which had characterized the immediate post-war sociology. In fact, researchers were accepted only as much as they fulfilled a work which the academics considered unworthy of them (Heilbron, 1991, p. 371).

For reasons linked to their biographies, as well as to the dominant role of Marxism in post-war France, most of these young sociologists specialize in industrial sociology or sociology of work. Other research areas include urban sociology, particularly housing and working classes conditions of living, and religions. In a context in which the questions of work and conditions of living prevail, health issues are not central. In addition, the very notion of medical work is not familiar to most of these researchers, doctors do not constitute a category of sociological interest like industrial workers.

The travel to America made by some of these young researchers at the beginning of the 1950s reinforces them in their orientations towards empirical sociology (Dechamp-Leroux, 2010). They also discover and introduce American sociologists in France. Mendras, who studies peasant societies, translates Merton in 1953, some years before his study on medical students (Merton *et al.*, 1957). Parsons is translated in 1955 by

³ Stoetzel will be the director of Herzlich's doctoral thesis at the Sorbonne

Bourricaud, who works on relations between monetary income and social status. His analysis of modern medical practice do not deserve specific attention until an article of Stoetzel in 1960 who gives lectures of social psychology in the Sorbonne devoted to the «problem of the sick person in society». He concludes his article by a call to research on the doctors and their relations with the patients.

The foundation in the 1960s

The 1960s mark a turning point in the development of sociology in France. The creation of a BA in sociology (*Licence de sociologie*) attracts a large number of students who are trained in the theoretical frameworks of the discipline and in its research practices. From 1965, the number of academic positions, opened to face up the growth of students, offers opportunities to consolidate fieldwork-based sociology. Meanwhile, research moneys allocated by the CNRS being limited, researchers turn to public administrations to get funding and become their interlocutors. It is in this context in favour of the development of sociology that sociological research on health develop.

The first sociological research on health and illness result from an extension of research in sociology of work. In a context where issues regarding medical training arises from the reforms of hospital and medical faculties (1958) and where French social security system is generalizing, the interest of researchers for health issues grows. Research is conducted over these years on the relationships of the medical profession to social security (1963), on the reform of hospital and of medical studies (Jamous, 1967), on the hospital organization (Chauvenet, 1973; Steudler, 1974).

In Bourdieu's research network, Boltanski studies the effects of medical standards on childcare (Boltanski, 1969) and on the fabrication of body (Boltanski, 1971). In Moscovici's laboratory of social psychology, Herzlich conducts a doctoral research on lay representations of health and illness. Her book, published in 1969, is the first one to explore health (and not the institutions) from a sociological point of view (Herzlich, 1969).

A special issue of *Revue française de sociologie* in 1973 provides a first state of research in a field qualified as medical sociology. Jacques Maître who is the special guest editor of the issue, and who directs a programme on health at the CNRS, highlights the close relationship between sociology and medicine, and justifies the qualification of medical sociology:

The theoretical and practical successes which have characterised biology in the recent years have not only had the effect of blurring social sciences in the eyes of professors of medicine. They have also reinforced the effects of the academic division of work associating sociology with Faculties of arts and humanities, so that the interface between sociology and medicine has become increasingly limited. [...] The impact of research undertaken abroad, notably in the Anglo-Saxon countries, has been needed, to restart an research effort in this field in France. Yet [there is] little interaction between the health system and sociological research groups, in any case lower than the interaction of the health system with psychology, and economics. Even among researchers in medical sociology, coordination is almost nonexistent, as the French have too little contact with their colleagues abroad (Maître, 1973, p. 4).

Research articles focus on hospital medicine after the major reforms of 1958, and of 1970 with the creation of hospital public service and the policies of rationalisation, which hold the interest of sociologists. The bibliography at the end of the issue includes publications on health and medicine coming from various disciplinary and professional orientations with no identification of a specific contribution of sociology. A retrospective look at the issue shows the weakness of this medical sociology. This weakness results unquestionably from the consideration of medical sociology as an auxiliary discipline of medicine whereas research directions, for instance on social representations, give a very different picture of a sociology of health and illness at work.

During that period, research in sociology of health takes support on innovative theoretical perspectives, and uses extensively empirical studies. However, these orientations are fragile since they depend on the choices made by researchers and not promoted yet by institutions capable of ensuring the continuity of research directions. From that point of view, the future of studies on health developed in Bourdieu's research centre is interesting to consider. In the 1970s, Boltanski reorientates his research activities on the managerial professions. His previous studies which opened new research perspectives on health are not extended by others members of the centre. Later, *Distinction* (Bourdieu, 1979) does not give rise to significant extensions on health issues, even though the analysis of the styles of life and consumption can be an intermediary stage to tackle the social formation of health. *The Weight of the world* (Bourdieu, 1993) which analyses the conditions of production of social misery and suffering through field studies based on interviews does not either consider health and illness issues. In that case, the French paradox can be explained by the relations of affiliation and/or domination that have crystallized around

Bourdieu and his research group, resulting in sociological priorities among which health and illness do not appear.

The institutionalisation in 1970s

Sociology of health knows a development in the 1970s. It takes support on the critique of medical power and medicalization of society which is carried out by professionals and by activists claiming the emancipation of the body and the empowerment of patients. It develops in a cultural context marked by a great intellectual interest in the work of Michel Foucault and by a critic of institutions of social control. This context promotes health issues as legitimate objects for a critical sociological approach.

During this period, research demands emanating from the public administrations result, as in many other areas of sociology, in the development of contractual research. Between 1970 and 1976, research programmes concern particularly the health system, its management and the control of expenses in a context of rationalization. The effect of this public demand, not exclusive of other fundings, is to allow the training of young researchers numerous enough to constitute a sociological research milieu on health, provided that they are capable of formulating an autonomous approach allowing them to work together. As pointed out by Herzlich:

It seemed to me that we had not to be swallowed up by the social demand that wanted applied studies. I did not think we should refuse, but that to meet these perfectly legitimate demands, efforts should be made to keep the possibility of constructing a scientific object. I also thought that the denunciation of medical power was insufficient to establish a scientific approach. It was necessary to strengthen the purely academic research (Herzlich, 2000).

Different opportunities allow this milieu in formation to get organized according to a sociological perspective of its own. It is particularly the case of a research seminar at the EHESS in 1974, and the organization of a conference of medical sociology in Paris in 1976 with support from the CNRS. They make it possible for French and foreign researchers to come together around health issues. They also contribute to give visibility to sociology of health in research institutions.

Following these initiatives, the creation of a quarterly peer-reviewed journal *Sciences sociales et santé* in 1982 contributes to this

institutionalization by providing researchers with a publication which give them a visibility in social sciences. The editorial of the first issue establishes the framework within which the creation of this review takes place. It develops a critique of the assertion of an autonomy of health issues compared to other areas of human activity (production, consumption). It also highlights the lack of general social science theories to account for the specificity of health events. It refuses the disciplinary specialization of health topics, considering that research areas overlap and that the same object can lead to complementary disciplinary approaches, hence the commentary from another disciplinary approach following each research article. Finally, it emphasizes the necessity for researchers involved in contractual research to discuss the theoretical implications of their studies. The journal aims to develop interdisciplinary approaches that focus on the social construction of health and disease. Since 1982, it has been the major publishing medium for sociology of health in France.

In 1986, after having directed a CNRS research programme «Health, illness and society», Herzlich creates the CERMES as a joint unit between CNRS, INSERM and EHESS. The centre brings together a group of researchers that had the opportunity to collaborate on various research programs on health during the previous decade.

At first, CERMES included three disciplinary groups : sociology, economics and anthropology, devoted to the analysis of ‘the social construction of health and disease’. Health and illness do not consist merely of biological realities, but can also be analyzed through all the practices and discourses which a society works out in their respect and that manufacture their reality. Following my first research, anthropologists became attached to the analysis of interpretations and representations of illness in traditional and modern societies. Sociologists and economists worked on medical profession and on medical responses to illness (Herzlich, 2000).

At the same time, INSERM recognizes the specialization of one of its research units into psychoanalytic and sociological research in public health, including a sociology of medicine and of medical doctors in a historical perspective. Pinell, who takes the direction of the unit in 1987 explains this sociological orientation as follows: «My idea was to introduce a hard sociology in INSERM, i.e. a sociology inspired by the works of Pierre Bourdieu and Norbert Elias. I have defended the idea that sociology, anthropology, history were disciplines which developed fundamental research taking health and medicine as case studies» (Pinell, 2002). The unit does not know an important development and is closed in 1999. Pinell

joins then the Centre of European sociology of Bourdieu with whom he has been working since the 1970s.

The creation of these two research units illustrates two different strategies of institutionalization of sociology of health. Pinell, trained as a medical doctor specialized in biology, develops a strategy of distinction with the medical world and of recognition inside French critical sociology. In the opposite, Herzlich, coming from social psychology, is concerned by the development of sociology of health. She finds supports in the research institutions and forges alliances in the medical world to promote the interest of sociological research. Whereas Pinell remains dependent from a single institution (Inserm) in which social sciences have a limited place, Herzlich creates a unit which depends on several institutions and gets the advantage of a membership in multiple networks dedicated to social sciences. CERMES participates in postgraduate courses at the EHESS and can receive doctoral students. This strategy contributes to enlarge its activity and to favour the formation of a new generation of sociologists.

Research directions taken in this period allow explaining aspects of the French paradox. The vast majority of studies are based on qualitative inquiries designated to analyse the social construction of illness in its different facets. Quantitative surveys are conducted by specialized institutes, the research units having neither competences nor sufficient resources to carry out these surveys. The result is a division of work in which sociologists develop qualitative research and find theoretical resources in the Anglo-American sociology of health. This orientation allows more easily an articulation between responses to public demands and the construction of an autonomous approach whereas dominant French sociology, by its reference to the epistemological rupture between common sense and scientific facts, requires mediations between research and intervention to meet the expectations of public demand of research on health issues.

The consolidation in the Aids years

When Aids becomes a public problem, between 1985 and 1987, sociology of health is established with its objects and publications. It has reached a sufficient size to respond to the research challenges Aids poses in terms of public policies of prevention and care of patients in a context in which medical answers are limited.

Important resources (research moneys, doctoral grants) favour a development of research and the emergence of a new generation of researchers that will later find professional positions in universities or in research institutions. Compared with the 1970s, when contractual research was also important, Aids years introduce new actors, patients and associations, with whom sociologists of health are called to work. These collaborations, confronting two modes of knowing, one founded in experience and identity and the other in scientific expertise, lead gradually to the development of new scientific practices converging with research on other diseases such as muscular dystrophy (Rabeharisoa and Callon, 1999). Interactions between patients' associations and sociologists of health become then an important element in sociological research on health.

This period is also characterized by a strengthening of the orientation towards qualitative research, resulting from the division of work implemented by ANRS. On the one hand, the quantitative surveys of sexual behaviour and of opinions and attitudes to AIDS in general population are considered as strategic components of public policies. They require an important logistics which a sociological research unit is not capable of providing, contrary to public health units. On the other hand, qualitative research is considered capable of producing knowledge where quantitative surveys are difficult to carry out (e.g. substance abuse) or need additional research (e.g. sexuality, risk perception and prevention strategies). If sociologists manage to establish research on Aids as a legitimate object for sociological research (Pollak *et al.*, 1992), they also reinforce their theoretical orientations (e.g. studies on chronic diseases) and promote issues poorly developed in France (e.g. on the perceptions and representations of risks). As these questions are centred on the individual, they tend to minimize structural dimensions of the Aids epidemic, but this is not specific to French sociology of Aids.

Sociological research on Aids illustrates how sociology succeeds in acquiring a central place to address the issues of prevention and care of patients until 1996, when new therapeutic combinations become efficient (Calvez, 2004). One of the consequences of research on Aids is to extend sociology of health beyond medical domain towards social practices and to promote collaborations with other areas of sociology (sexuality, family, risks, and network analysis). The success of new therapeutic combinations in 1996 redirects research priorities towards a greater articulation with clinical and epidemiological research and collaboration with Aids associations. It allows new developments of medical sociology as a component of public health, mobilizing research methods by questionnaire

closer to epidemiology than to qualitative research. These orientations can be found particularly in SE4S which has made the choice to develop research in public health to which sociology contributes. The perspective of application drives also mainstream research groups with a preoccupation of intervention to be interested in Aids and to find resources for doctoral students. Young researchers from these groups being now in academic positions tend to promote health issues as legitimate questions in mainstream sociology.

Conclusion

The article has characterized three key moments in the development of sociology of health in France. The research directions taken at each period and the theoretical frameworks used have resulted in a variety of objects and approaches within sociology of health. Bourdieu's analysis of lifestyles has not been taken into consideration for reasons that need to be considered from within this research centre and its limited interest for health issues in promoting of its theoretical frameworks. Nevertheless, the idea of a French paradox does not give a fair picture of the process of institutionalization which has led a field of little importance in the sociological revival of 1950s to develop. This institutionalization results from the capacity of the actors to meet public demands on health issues and from their strategic choices. Two different strategies have been shortly described. One comes from mainstream sociology and tries by institutional relations and collaborations to find common grounds with medical world and, more recently, with patients' associations. The other comes from medical institutions and tries by distinction to constitute research objects which are legitimate in mainstream sociology. In retrospect, the first strategy has been more efficient because it has led social scientists to work together, and to take part in institutional dynamics while the second, in considering health issues as a domain to test general sociological hypotheses, has diluted the specific dimensions of health. Recent years have been characterized by significant academic appointments in which the specialization in sociology of health was noticeable, in relation to mutations in university health courses for doctors and nurses, as well as in the development of public demands of research on health issues. The newly recruited generation will be confronted to strategic choices in defining its research object, at the time when the generation which created the sociology of health in France leaves the academic scene.

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