in this country. To take two examples, however, the thematic schools system at Macquarie University seems to the outsider to have had negligible interdisciplinary impact, while it could be argued that it has created new divisions. And the 20 specialised centres and units at the A.N.U. (the "third dimension", as the university recently called them) appear to have no analogues for basic teaching purposes within the School of General Studies there.[11]

In summary, I think we have a long way to go in recognising the problem and doing something about it. My conclusion—unpalatable as it will be to some—is that many Australian social science departments are still turning out limited monocultural "specialists" who are generally content to make a "career" within the local system. This is fundamentally wrong: an abdication of real intellectual responsibility. For a small but rich country steadily becoming involved in the massive complexities of Asia, the implications of perpetuating this are alarming.

NOTES

[1] Quoted by R. C. Bannister, Jnr., "William Graham Sumner's 'Social Darwinism': A Reconsideration", History of Political Economy, V, 1, 1973, p. 67.

[2] J. F. Szwed (ed.), *Black Americans*, Forum Lectures, U.S.I.A., Washington, D.C., 1969, p. v.

[3] For an excellent locally published example of wide-ranging cross-cultural scholarship see the recent book by the Professor of Malay Studies at the University of Singapore: Syed Hussein Alatas, *Modernization and Social Change—Studies in Social Change in South-East Asia*, Sydney, 1972. He includes a salutary warning against mere dilettantism as a reaction to over-specialisation.

[4] The main target, of course, has long been the astonishing Arnold Toynbee. For his reasoned reply see the new Oxford, 1972 one-volume edition of his *Study of History*, esp. pp. 46-8. On the other side the Oxford historian H. R. Trevor-Roper, a dedicated Europeanist, a few years ago wrote some truly remarkable things about China, after a three-week visit. It was also Trevor-Roper who made the egregious claim that pre-European Africa had no history: to which Roland Oliver, Professor of African History at London University, made the apt reply that according to all the evidence both the Trevors and the Ropers originated in Africa.

[5] Allan Healy, "The Intercultural Problem: New Guinea", *Meanjin Quarterly*, XXIX, 4, 1970, p. 463.

[6] A. Schlesinger, Jnr., *The Bitter Heritage—Vietnam and American Democracy 1941-66*, New York, 1967. The French sociologist Paul Mus illuminated the key problems, after many years work in the country: much of this work is carried over into English in Frances FitzGerald's *Fire in the Lake*, Boston, 1972.

[7] N. Chomsky, "The Responsibility of Intellectuals", *New York Review of Books*, 23 February, 1967.

[8] R. Engler, "Social Science and Social Consciousness—The Shame of the Universities", in T. Roszak (ed.), *The Dissenting Academy*, Penguin paperback, 1969, p. 168.

[9] F. M. Voltaire, *Philosophical Dictionary*, trans. and ed. P. Gay, New York, 1962, I, p. 265.

[10] This is from Montaigne's *Journal du Voyage*, written in 1581 but not first published until 1774. Of course today the social scientist would regard mere *travel* as either worthless or dangerous, serving only to confirm established preconceptions. Sustained and perceptive residence by a trained person in a different society is an entirely different matter.

[11] *The A.N.U. News*, VIII, 3, November 1973, is devoted to these Centres and Units. This writer was associated with the first of them in its early stages. Generally, on the theme of this article, see J. Hajnal, *The Student Trap—A Critique of University and Sixth Form Curricula*, Penguin Books, 1972.

MEDICAL SOCIOLOGY—A BOUNDARY BETWEEN THE SOCIAL, BEHAVIOURAL AND MEDICAL SCIENCES

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Introduction

FOR the past four years the author has conducted an interdisciplinary course in Medical Sociology. The course is "interdisciplinary" in two distinct senses: the course content is drawn on and nourished by many disciplines, and the students—never more than 30 in number[1]—bring to the course a variety of disciplinary perspectives. A conscious attempt is made to ensure that in any one year there is a careful balance between "students" and "practitioners". In practical terms this means that in any one year the class may be comprised of, say, third-year sociology students, fifth-year medical students,[2] advanced students/practitioners of nursing, together with a sprinkling of hospital matrons, resident medical officers, family planning centre personnel, and other practitioners within the health professions.

In this contribution I will provide readers with a description of the course of studies,[3] and these data will then be used to generate some brief discussion of two questions: First, what is the importance of interdisciplinary teaching in the medical and allied health sciences?; and, second, how can such studies best be fostered?

A Course in Medical Sociology

Any course of studies can be considered in terms of *process* and *content*—and "interdisciplinary" elements can relate to both of these dimensions. Over the past four years the *process* used in teaching the course has remained relatively constant—that is, a successful recipe was devised, and has only required minor subsequent revision; the *content* has varied considerably from year to year, and this is generally decided jointly by the students and myself.

Process: All of the topics that comprise the course content are discussed by way of seminars. In each three-hour session—and they seldom finish on time—two seminar topics are discussed. Generally

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[1] The need to restrict the number of participants to 30 is largely dictated by the teaching methods which are used, and not by the number of persons wishing to enrol in the course.

[2] No medical student is permitted to enrol until he/she has had a minimum of one year's "clinical experience".

[3] Further details of course content and other information are available on request from the author.

an attempt is made to ensure that the two topics presented on any one evening are related to one another—e.g., "Changes in the Role of the Nurse" and "Changes in the Role of the Primary Physician", or "Illness Behaviour and Lay Referral-systems" and, "Illness Behaviour and Professional Referral-systems". All students are required to precirculate a synopsis, generally of two or three pages, of their contribution a week in advance of the seminar presentation. Experience has shown that students do read these documents and do prepare for each week's seminar. Each student's presentation is generally restricted to about 20 minutes, and this is then followed by a wide-ranging discussion of the issues which have been raised by the presentation. Students are evaluated in terms of their seminar paper (s), and through the preparation and presentation of a research design on a problem of their own choice.[4] Further details of this course, and of the way in which it relates to the broader issue of developing relevant courses in the social and behavioural sciences for medicine have been elaborated elsewhere (cf. Blizard, 1973a; in press).

Content: As has already been noted, the specific content of each year's course is variable, and is jointly negotiated between all of those participating in the course. The skeletal outline which is shown below,[5] and which can be seen within the framework suggested by McKinlay (1971), illustrates some of the broad areas which would be included in any course, and some of the more specific strands—strands which may vary from year to year.

A close reading of the content of Diagram I shows that the data draw on many different academic disciplines, and suggest that with such a course of studies the framework could hardly be other than interdisciplinary. Without going into any detail, and merely as a prelude to a statement as to the value of interdisciplinary courses, I could itemise the aims of this course in medical sociology. The course has three broad objectives. These are:

(i) To stimulate students to think about the various factors and processes by which a "person" becomes a "patient";

(ii) to develop an awareness of the principles, concepts and methods of study relevant to an understanding of man, his social environment and his responses to illness: and

(iii) to assist students to understand the social processes that they

[4] A number of the students are not content with *planning* a research design, they also proceed with its implementation. Some brief illustrative examples are shown at the end of the References in Appendix I.

[5] It must be emphasised that the sub-topics shown in Diagram I are only examples, they by no means exhaust the possibilities which are available—they merely scratch the surface.

as doctors, nurses, medical social workers (etc.) become involved in, in their interaction with patients.

DIAGRAM I

Some General and Specific Areas for a Course in Medical Sociology

Conception, definition and distribution of health and illness, e.g.:	Demography of illness in migrants, Aborigines; conceptions of illness within/between societies on the bases of age, sex, social class.
Illness behaviour and processes of referral and health service use; e.g.:	Models of illness behaviour, the role of the family, self-medication, factors which affect referral to professional help-sources.

Patient-healer relationships, e.g.:
Different perceptions of patients and healers; level of medical knowledge and self-referral, etc.

Adoption of the "sick role" and "being a patient" e.g.:
Formulations of the sick role and critiques of them; effects of sickness on thinking and perceiving.

Patient-healing agency relationships; e.g.:
Admission procedures to medical institutions; communication with patients; ward prestige systems, etc.

Healers; e.g.:
Socialisation of doctors, nurses, etc.; relationships between medical and allied professions, and also with "natural health" practitioners; birth and death of professions.

Healing Agencies; e.g.:
Ideology and structure of hospitals and other agencies; the hospital in the community; responses of different socio-economic groups to different types of health care institution; delivery of health care.

Rehabilitation; e.g.:
Leaving the sick role, the importance of family dynamics, social acceptance of different types of illness, etc.

Death; e.g.:
Death and the hospital, social values, the family and ethics; the roles of various personnel.

Why Are Interdisciplinary Studies of Value?

Several different answers can be provided to this self-imposed question: some answers arise out of present deficiencies in medical and allied health curricula (cf. Blizard, 1972; 1973 ab), and other answers arise from some of the inherent value of an interdisciplinary framework. There are, I believe, three cardinal values: the first emerges from the nature of medicine, *per se;* the second is a practical consequence of this; and the third is essentially an

educational question. I would identify the values of interdisciplinary studies in the following terms:

First: the practice of medicine is an eclectic activity; any one perspective is incomplete and partial. The very notion of "illness" itself, as has been pointed out (cf. Blizard 1971; 1973b; Osmond and Siegler, 1966; Siegler, Osmond and Newell, 1968) is multidisciplinary, and a variety of models exist which help us to clarify and hence understand man's behaviour when it is modified by illness, how one intervenes when illness occurs, and how people respond to different kinds of intervention. Thus, the first rationale for interdisciplinary studies springs from the nature of medicine:[6] it is eclectic, and much of its content needs to be taught eclectically.

Second: and arising as a practical consequence of the eclectic nature of medicine, we are presently experiencing a shift away from doctor-centred medical care, and a shift towards the notion of a "health-team" (cf. Andrew, 1971; McCreary, 1968; Sax, 1972). Deeply embedded within the notion of a health team is the idea that our society can and ought to train a wide variety of persons each possessing different but important sets of skills; a further implication is that we can no longer rely on an all-purpose person (the general practitioner?) to fulfil a wide range of tasks for which he is presently untrained. It seems to me that the translation of the concept of the "health-team" from the "drawing board" to the "reality" will at least require that all members of the health-team are aware of the skills which doctors, nurses, medical social workers and clinical psychologists possess, will be aware of the limitations of their own professional skills, and will thus know when to call in additional professional resources. The present course in medical sociology is, I believe, one way of breaking down some of the barriers of professional isolation (cf. Owen, 1973); it is, of course, not the only possible approach (cf. Cox, 1972).[7]

Third: the development of interdisciplinary courses *can* also bring about a number of significant educational changes; I should perhaps add that the comments made in this context flow largely from my experience as a participant in this course in Medical Sociology. Much university level teaching places a very heavy emphasis on the expertise of the teacher, and while this is often unavoidable, I believe that it carries with it a rather heavy philosophical price. Put bluntly, "expert" teachers teaching "inexpert" students can often lead to the teacher conceiving of the educational process largely in terms of "filling students up with useful (?) knowledge"; or, to shift the analogy, "education" can become a process of creating "intellectual pate de fois gras"—you pump in the knowledge (fatten the liver), wait until the student is full to bursting point (liver engorgement), then you stamp on the official seal of approval (degree granting and certification). This conception of the educational process, though over-painted, is not at all unfamiliar in the context of medical education in Australia. It leads to intellectual passivity among students and lack of enthusiasm among the teaching staff. I am not asserting that interdisciplinary courses necessarily avoid this problem, but they can provide a context in which teachers are simultaneously "teachers" and "learners", can provide a situation which is intellectually and emotionally creative—a place where it is exciting to be. That, at any rate, is my experience where you have a wide range of persons, with considerable and different professional experience all in the same classroom.

[6] The term "medicine" is not used as synonymous with what doctors do and are, it is used in a much wider sense and embraces all forms of health personnel and all forms of the delivery of health care.

[7] Other approaches are very briefly discussed in the concluding section.

Let me now briefly tie together a few of the threads of this brief presentation. I will briefly suggest a number of ways in which interdisciplinary studies can be fostered in universities. Though I relate the examples to medical education, they harbour possibilities in the wider context.

How Can Interdisciplinary Studies Be Fostered?

There are two basic approaches to the development of a genuinely interdisciplinary course of studies, and both of them provide for thorny difficulties. A first approach, which is exemplified by the course in Medical Sociology described in this paper, is to "create an interdisciplinary situation"—say, by gathering together groups of students/practitioners from a variety of disciplines to discuss problems common to all of them—and then throw the teacher into the middle of the situation. Teachers and students have to learn to cope with the situation together. In other parts of this paper I hope that I have conveyed the strengths inherent in such an approach. It also has its dangers. Many academics, trained as they are in one (or at most two) basic disciplines feel rather uncomfortable when confronted by a multidisciplinary situation. This can be a source for growth as a teacher however.

A second approach, and one which may be more comfortable for a number of persons—and with large groups of students may be a more practicable proposition—is a variant of the notion of team teaching. It is currently being used at the University of Sydney in "Social and Preventive Medicine", at St. George Hospital

with fourth year medical students, and is being used in "Introductory Clinical Studies" in 1974 at the University of New South Wales. Students come from one basic discipline; in the instances cited above all are from Medicine. The teachers/resource persons, however, come from a variety of disciplines: some are medical—both specialists and general practitioners—while others are nurses, social workers, medical sociologists and clinical psychologists. Students are, over a period of a year, exposed to a wide variety of disciplinary perspectives. The weaknesses of this approach seem to me to be twofold: first, it is rather demanding in terms of the number of staff required; second, in terms of the discussion which is generated, it does not provide for the ebb and flow across disciplines because of student-homogeneity.

Conclusion

All I have tried to do in this short contribution is to suggest one approach to the teaching of an interdisciplinary course, convey a sense of the excitement that I have felt as a result of being a part of the venture over the last four years, and suggest some of the benefits that can accrue. Interdisciplinary teaching is not a panacea for all of the difficulties besetting university teaching: there is no panacea.

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APPENDIX I

Some Illustrative Research Projects Self-selected by Students

The following six examples show the range of topics which is selected by students; they, of course, give no indication of the depth and sophistication of each of the projects—in this context it may be sufficient to note that many students spend quite a few months on their project, and submit work which, at the upper level, is worthy of an Honours or Master's thesis.

1. *"A Study of the Characteristics and Attitudes among Student Nurses who are Receiving Training at Different Types of Nursing Institutions"*. This study was designed and carried out by a senior nurse educator. Its principal aim was to assist in the design of nursing education curricula.
2. *"A Study of the Dissatisfactions among Junior and Senior Nursing Students"*. This study was designed and carried through by a student engaged in the Bachelor of Arts-Nursing (conjoint) programme. The student reviewed the relevant literature and then carried through the study to the "pilot" stage.
3. *"A Study of the Effects on Patients of Tensions in the Hospital Ward"*. This study was carried out by a third year Arts (Sociology) student. She commenced from a theoretical understanding of organisation theory, reviewed the relevant literature, and then applied this combined understanding to the planning, design and preliminary implementation of the above topic.
4. *"A Survey of the Applications of Research Conducted on the Hospitalisation of the Child"*. Strictly speaking this (and the next topic) is not research *per se*, but an extended essay and analysis on the implications and applications of already existing research data. It was carried out by a medical student.
5. *"A Review of the Ways in which the Social and Behavioural Sciences Can be Successfully Incorporated into Undergraduate Medical Education"*. This, also, is an evaluation and review of existing data. It does, however, go one stage further in (a) suggesting hypotheses concerning the successful introduction of the social and behavioural sciences; and, (b) proposing a design by which these hypotheses might be tested.
6. *"An Investigation of Children's Accidents in New South Wales"*. The author, a teacher in social and preventive medicine, presented an international review (in statistical terms) of children's accidents, and then developed comparative Australian and New South Wales data. He then developed a research project which would shed light on the complex of forces that result in accidents of childhood.

BEHAVIOURAL SCIENCE FOR STUDENTS IN HEALTH ADMINISTRATION

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