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The School Form of the Hospital: How Does Social Class Affect Post-Stroke Patients in Rehabilitation Units?

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Abstract
This paper wishes to explain, using qualitative sociology, an epidemiological finding: that the extent of recovery following stroke is class-based and that patients from the working classes and lower socioeconomic groups are more vulnerable to functional impairments following stroke than those from higher socioeconomic groups. Based on a 15-month ethnographic study of neurology and rehabilitation units, the paper shows that hospital rehabilitation after stroke is shaped by a "school form," and that it therefore proves far more efficient with patients who have scholastic dispositions, more frequently associated with people from the middle and upper classes with considerable cultural capital. "What is lost" during a stroke and "what is regained" after is not only a question of location in the brain and how serious the neurological incident was, but also correlates with class-based dispositions and attitudes towards practice, as well as language and learning situations. The notion of "school form" can be useful outside the school context per se when it comes to understanding social inequalities, since it can, in this case, explain the class-based processes through which health inequalities arise.

Keywords Health · Stroke · Rehabilitation · Social class · Habitus · Social inequalities

Stroke is today the most common cause of adult physical impairment. Following stroke, patients can lose the ability to walk, count, swallow, read, remember, seize an object, feel touch, or plan things. These abilities can, however, be partially or totally regained. Stroke therefore raises the question not only of adapting to disabilities but also of recovering lost skills.

Medical advances today mean that survival after a stroke is increasingly likely. Rehabilitative therapy has therefore taken on major importance. It involves a vast range of therapists: physicians and nurses, but also physical therapists, occupational therapists, speech therapists,

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psychologists and neuropsychologists, adapted physical education teachers, and social workers. Patients, but also their relatives, are supposed to participate in the collective work of rehabilitation. My research aims to reach beyond the biological and neurological reasoning at play and decipher the social logics that may govern both the assessment of deficits and their potential recovery.

Bringing sociology into the study of stroke itself—and not only its narratives or its representations (Faircloth et al. 2004; Pound et al. 1998)—is not such a big leap. More specifically here, the sociology of social class seems highly relevant to analyzing stroke since epidemiology currently shows the importance of social class in stroke recovery. It is usually said that one-third of patients having suffered a stroke will die from it, one-third will recover without any heavy sequelae, and one-third will become dependent in everyday life due to disabilities. However, social inequalities inform these three outcomes, which do not only depend on the location of the lesion and its seriousness. People with low socioeconomic statuses (SES) tend to make poorer recoveries from stroke than their counterparts with higher SES. For example, they experience more disabilities up to three years after the stroke and more handicaps up to five years after (van den Bos et al. 2002). This poorer recovery in the lower quadrant of the social space is verified even when the type and severity of stroke are controlled for, and even when people with lower SES do receive rehabilitative care. It is therefore not, or not only, a question of unequal *access* to care.[1]

Social class therefore affects post-stroke patients' careers. But *how* does it produce these effects? How can we explain class inequalities in rehabilitation outcomes? The epidemiological studies allude to something that may happen during hospital care itself, and statistics can give some answers. But I would like to suggest that, to explain what happens in rehabilitative care and therefore what can account for these inequalities, ethnography is a very good method and can provide robust answers to this question. It is indeed useful to enter hospital units and try to understand what can account for such social inequalities in recovery, and *when* and *where* this happens. Such an approach makes it possible to go beyond the statistical influence of "socioeconomic status" as an "individualized and reductive measure" and to sociologically analyze the effect and the workings of "class" as a "social relation of power" (Shim 2014).

Based on an ethnography of what happens during rehabilitation for stroke patients, I would like to show two things. First, that hospital rehabilitation after stroke is shaped by a "school form," and that it therefore proves far more efficient with patients who have scholastic dispositions, more frequently associated with people from the middle and upper classes with considerable cultural capital. Second, that hospital rehabilitation involuntarily and unknowingly aims, like school, to transmit a body of knowledge that is not universal but class specific (Bourdieu and Passeron [1977] 1990). Rehabilitation is therefore a form of *reeducation*, educating people in class-specific content and practice, and is also a kind of *reformation*, aimed at transforming working-class behaviors into middle-class ones. The success or failure of such a class conversion may therefore play a role in the success or failure of rehabilitation itself for stroke patients, and can therefore account for social inequalities in recovery.

[1] For reviews of the current evidence of the association between socioeconomic status and stroke outcomes, but also the fact that the mechanisms through which socioeconomic status affects stroke outcomes remain unclear, see, for example, Cox et al. 2006, and its update in Marshall et al. 2015, both published in *Lancet Neurology*.

Institutional Socialization and Class Dispositions in Hospitals

A first possible way to conceive a sociological approach of class inequalities in rehabilitation could have been to investigate differences in quality of care, depending on patients' social class, and to observe them in practice through ethnographic study. Various qualitative approaches to the "social value" or "social worth" of patients in hospital units have stressed over the years the influence of social class, among other factors, on the type and quality of care patients receive. Julius Roth's study of ER units in the 1960s (Roth 1972) showed that the quality of medical service provided to the clientele depended on moral categorizations, on social status, and on patients' "social worth"—far from the "universalistic moral neutrality" assigned to medical practice by the Parsonian definition. The "social loss of dying," studied by Barney Glaser and Anselm Strauss (Glaser and Strauss 1964, 1965), is higher for hospital teams when patients are young or middle aged, white, educated, and have a professional job and family responsibilities. David Sudnow's *Passing on* (1967) also showed that medical investments in patients and type and quality of care—resuscitation attempts and interpretation of signs of clinical death, for example—depended on socioeconomic status. Stefan Timmermans (1998) revisited Sudnow's fieldwork and findings 30 years later, and showed the prevailing influence of the "social value" of patients and its combination of moral and social components in resuscitation attempts following cardiac arrest.

These studies point to a first line of explanation for the influence of social class on patients' trajectories. However, by focusing on the effect of social worth on quality of care, they tend to leave out a wide array of other factors. They identify the staff's categories of perception as the major factor, paradoxically (for an activity-oriented sociological approach) leaving actual practices out of the analysis. By doing so, they are also always at risk of implying that members of staff are, in fact, responsible for the unequal treatment patients are receiving (through their moral and classist categories), as though quality of care were something one could choose to deliver or not.

Finally, by focusing on health care professionals, these studies perpetuate the tendency for analysis of "patient cultures" (Zussman 1993) to disappear from hospital ethnographies; analysis which I, conversely, aim to put front and center. Patients' differentiated social value is not the only way social class may influence post-stroke recovery, and I would like to suggest another way of approaching the issue. In this article, I show that the processes of institutional socialization that are constitutive of rehabilitation are in fact more attuned to certain class dispositions. To be efficient, they require certain social conditions of possibility that are more likely to be found in certain class dispositions or cultures than in others. My focus here will therefore be on the ways in which institutional socialization and class dispositions interact, combine, or clash.

The School Form of the Hospital

Hospitals, and more specifically rehabilitation units, can be viewed as "forcing houses for changing persons" (Goffman 1961, 12), "organizations whose explicit mandate is to change [people]" (Wheeler 1966, 53), "apparatus[es] for transforming individuals" (Foucault 1995, 233) or "people changing institutions" (Hasenfeld 1972). They are places where processes of institutional socialization are at work, that is to say, where individual dispositions are potentially destroyed, modified, or created through socialization processes. But they are not all powerful: it is in fact necessary to take into account how pre-existing individual dispositions

make it more or less likely that institutional socialization will occur and create new dispositions within the individual (Darmon [2006] 2016). Institutional socialization operates within a social space of class (Bourdieu [1984] 2010) that can account for how its action differs depending on the social class position of the individuals forming the institution's clientele (Darmon 2012).

To better analyze the kind of institutional socialization that occurs in rehabilitation units, and its close links with specific class dispositions, I advocate using the notion of "school form" (Lahire 2008a, b; Vincent 1980; Vincent et al. 1994). The concept of "school form" aims to describe the slow rise, beginning in the seventeenth century, of the school-as-institution in Europe: a space separated from all others, based on a clear division of duties between teachers and pupils, with timetables and a disciplined space. The use of this concept enables us to understand failure at school as the "product of the contradiction between the cultural forms of school and of the working classes" (Lahire 2008a, 231–232). In the school form, knowledge is formal, systematized, and written (Lahire 2008a, 233; Vincent et al. 1994). The main form of work attached to the school form is the "exercise": the learning technique of completing an exercise repetitively and having it corrected, aims at enabling an explicit and reflexive reenactment of what has been taught. Learning processes are therefore broken down into small units, and organized along a progressive scale. The school form replaces objectivated knowledge with incorporated knowledge, explicit rules with practical regularities of incorporated schemes, and school-based learning with *mimesis*—learning by doing and imitating (Lahire 2008b).

Such a model is said to have pervaded institutions and organizations far from its original scholastic domain (Lahire 2008a). As institutions for re-education, rehabilitation units may well, therefore, be "captives of the school form" (Vincent et al. 1994). It is imperative to verify this hypothesis when it comes to studying the influence of social class on rehabilitation units, since patients from different social and academic backgrounds will necessarily be differently equipped to deal with the demands, everyday rules, and "exercises" of a hospital that functions like a school.

What Dispositions for the School Form?

The sociology of practice and cultural sociology can provide useful tools for analyzing the interaction between an institutional socialization shaped by the school form and patients' classed dispositions. Bourdieu and Passeron, in *Reproduction*, posit that the working classes' material conditions of existence "subject them to the imperatives of practice, tending thereby to prevent the formation and development of the aptitude for symbolic mastery of practice" (Bourdieu and Passeron [1977] 1990, 48). Relationships to language and relationships to practice are therefore class-based: "Some [children] are socialized in forms of social life that give priority to verbal explicitation of utterances and awareness of language in and of itself (the objectivation of cultural schemes). Others are socialized in forms of social life where cultural schemes are immanent in practice, where language is closely linked to acts, actions, and situations, and is more rarely subject to reflexive thinking" (Lahire 2008b, 123).

As a result, dominant versus dominated relationships to language and practice can be described as, respectively: scholastic reason versus practical reason; symbolic mastery versus practical mastery; pre-reflexivity versus reflexivity; aesthetic or theoretical dispositions versus practical dispositions; written-scholastic reason versus oral-practical reason; reflexive relationship to language versus pragmatic relationship to language; written-scholastic relationship to language versus oral-practical relationship to language (Lahire 2008b).

These different relationships have been described and studied *at school*, or within families where young children attend school. They are therefore analyzed primarily in terms of the explanations they can offer about success or failure at school. More generally, the school form has almost never been studied outside of school, despite being framed a concept with relevance beyond simply the school as an institution. Running counter to this tendency, in this article I will apply these sociological concepts to the understanding of health, illness, and health care. I will use these analytical tools—drawn from the sociologies of practice, of socialization, and of social classes—to look closely at rehabilitation as institutional socialization, asking whether it is class neutral or whether it requires class-based dispositions, and whether it entails contradictions between the cultural forms that prevail in the hospital and among the working classes.

Finally, looking at the relationships between class based dispositions and the school form in a hospital setting is a way of developing the study of "cultural health capital," which, "following Bourdieu's notion of habitus, is mobilized in largely unconscious, habitual schemes of perception, thought and action that are embodied through experience and socialization and deeply stratified" (Shim 2010, 11). I will also try to give emphasis to the effects of the presence or lack of a classed cultural capital: not only, as in Shim's article, on "health care interaction" and the type of interaction between patients and health care providers, but also on the nature and success or failure of the patient's rehabilitation itself.

Methods and Settings: A Close-Up on Rehabilitation Units

As I said at the beginning of this article, the mechanisms through which socioeconomic status affects stroke outcomes remain unclear in epidemiological studies, while they point at something happening during rehabilitation itself. This is why I chose to use ethnography as a way of entering medical units and understanding how social class becomes part and parcel of illness and recovery. Such an approach affords the possibility of going "beyond examinations of inequality in access to well-resourced institutions" and examining "the seemingly minute microadvantages (…) which may be missed in the larger aggregate studies more commonly used to document health inequalities" (Gengler 2014, 357). In order to broach such processes empirically, I focus on two different kinds of actors: the various "professionals of rehabilitation" (the medical and nursing team and the wide array of therapists involved in rehabilitation) and the patient himself or herself, whose work (and motivation) are said to be paramount to a successful stay in rehabilitation—according to current norms regarding patient participation in treatment but also due to the specificity of rehabilitative treatment itself.

Typically, a surviving stroke patient will go from the ER to a neurology unit (first in intensive care, then on general neurological wards), before returning home or going to an outpatient clinic or a rehabilitation unit, and then returning home or entering a retirement home. I chose to approach this trajectory through ethnographic studies of its two main hospital moments: the neurology unit and the rehabilitation unit. I conducted direct observation for two to three full days a week and in situ interviews (with the patients, their relatives, and all the professionals involved) in: (1) a Neurology Unit of a University Hospital over a period of three months; (2) the Rehabilitation Unit (called "cerebrovascular injury rehabilitation unit") of the same University Hospital for nine months; and (3) the Neurological Rehabilitation Unit of a private clinic (called "Center for Rehabilitation") close to the University Hospital for a further three months.

Compared to neurology units, where patients typically spent a few days or at most weeks before being discharged, stays in rehabilitation units are measured in months (from two to three months to more than a year, in some cases). To answer the question of when and how social class might influence a patient's recovery, I chose to concentrate on what happens in rehabilitation units in order to understand more precisely the process of institutional socialization.

The rehabilitation units I observed were both structured in the same way. On the second and third floors, there are medical wards, quite similar to any general hospital units with rooms for patients, doctors (senior, junior, interns, residents) making rounds, nurses, and nurse's aides. On the first floor, there is a large "technical platform," the size of the hospital building itself, where every domain of rehabilitation has its own space and its own devices: there are several physical therapy rooms, each equipped with massage tables or barres for standing or walking; occupational therapy has a real-size reconstituted house (kitchen, laundry room, closets, etc.) and a driving simulator; the space also comprises speech therapy offices (although speech therapists often also visit patients in the upper floors, for example, to assess their ability to gulp and swallow their food); neuropsychologists have consultation rooms and computers in the space; the platform also includes steppers and other machines for adapted physical education.

After certification by an ethics committee and negotiation with the heads of department, I was given a white coat and access to the whole unit: patient rounds, rooms, and the technical platform. I was supposed to ask permission from both therapists and patients before observing any consultations or sessions, which I did. In the vast majority of cases, I obtained their assent. I chose to follow "young" patients (under the age of 60) to homogenize my cases and so that the question of "returning to work" and "returning home" (rather than to a retirement home, for example) would be an issue for most of them.

Like everyone in the medical team, and almost every professional on the technical platform, I carried a little notebook in the pocket of my coat where I could write down on the spot conversations in which I was involved or observed, the categories used by doctors to speak about patients or by patients between themselves, and any striking interactions I observed. I wrote up my fieldnotes every day in a field journal. Interviews were sometimes recorded, but mostly began as informal in situ conversations that then evolved into a more formal interview during which I took notes. Finally, I conducted 14 interviews with staff, and 12 with patients and their relatives, which make up a small, albeit important, proportion of the data when compared with the data obtained through observation, informal conversations, or observation of conversations. Interviews were in almost all cases conducted with patients who were not suffering from much speech impairment following stroke. For example, although I did sometimes have some very short discussions with Mr. L. about his experiences, this patient at first had major difficulties speaking and, for a long time in rehabilitation, only used "speech automatisms," adverbs, "yes" or "no" and the like, so I did not request a formal interview with him. Some of the interviewed patients did, however, pause to find their words and often reflected on the difficulty of the interview compared to how easy they would have found this "before." For all patients, finding a moment for the interview meant "finding a slot" in a more or less busy schedule with lots of fatigue attached to the intensity of rehabilitation—with the notable exception of patients who were close to being discharged and felt, on the contrary, quite energetic and welcomed the opportunity for "something to do."

My observations were widespread for the first weeks, but after a while I reduced my focus to a small number of patients (some of whom I had been following since their arrival in the Neurology Unit of the University Hospital). Between the University Hospital rehabilitations units and the Center for Rehabilitation, I followed 14 "cases" as closely as I could over periods

of time ranging from two weeks to nine months—in one of these cases, I also conducted interviews with the patient, Mrs. H., several months after her discharge from the hospital and observed her medical appointments.

The social background of my study subjects resembles, on the whole, the statistics described in the introduction: they mostly came from the lower-middle classes and working classes (11 cases), with only three patients from the upper-middle classes, based on occupation and level of qualification. Although this can have no probative value per se—especially since I do not take into account the serisousness of the stroke, contrary to epidemiological approaches—I can say that for professionals, patients, and families alike, rehabilitation was seen as going or having gone much better for the three patients from upper-middle-class backgrounds, which is congruent with epidemiological findings. For quite a long time during my nine-month observation of his stay in hospital, I thought that Mr. L. was an exception to this trend. A home care employee with no qualifications, he was doing quite well following what was described as a very serious stroke with major impairment. However, when I met his mother and attended her meetings with the team, I discovered that Mr. L. in fact came from an upper-class family. All his brothers and sisters occupied high-level professional positions and his job and lack of qualification were not representative of his social position as a whole and not in line with his primary socialization. All in all, this correspondance between my fieldwork and epidemiological statistics enables me to address the epidemiological question of social inequality in recovery on the basis of my numerically limited but deep data, and to try to understand the processes through which these inequalities are reproduced.

Along with this influence of social class on patients' outcomes, what struck me again and again as I observed the units, was their resemblance with a school setting. First, I had a nagging feeling of odd family resemblance when I attended rounds—which include one representative from every profession (there was often 10 of us in a patient's room, or sometimes five inside and five outside the room when it was not big enough) and are led by the doctor and head of medicine. Each professional was invited to speak and to assess the patient's motivation, behavior, work, and progress during the past week, in school terms (participation, department, progress, etc.) and in a manner very reminiscent of school meetings aimed at discussing each student's progress:

> "[Doctor:] OK, how has Mr. B. been doing this week? In physical therapy? [The physical therapist:] Mr. B. has worked really hard this week, he is still very motivated, today he stood for 20 seconds, and even 22 seconds without holding anything (…) [Doctor:] OK, now, what progress has there been in speech therapy? [Speech therapist:] Mr. B. is also very motivated in my department! His participation is very satisfactory; we've worked on written [language], oral [language]…(…) [Doctor:] And in your department, Martine? [Neuropsychologist:] Well, unfortunately Mr. B. scored very low in time-sensitive tests because of his right hand, and he lost some points on memory, but other than that, he's been really motivated and has clearly improved on other exercises (…) [Doctor, at the end] OK, so we're good, [to the patient] don't change anything and keep working, you're working well, making progress, this is good!" [Fieldwork notes]

My previous research had been on elite schooling, and at the time of the research I was also serving as a representative for the PTA in my son's middle school, where I was attending "class councils" and listening to the subject teachers discussing the progress of each student in the class. The likeness of the situations, but also the very similarity of the terms used in both

settings, led me to think that the concept of "school form" of the hospital could be more than an observer's feeling or a metaphor and to try and apply this concept to the setting I was observing. From this moment onward, what I was observing made more and more sense as an institution shaped by the school form.

Rehabilitation and the School Form

Space and time are indeed shaped by the school form in rehabilitation hospitals. The "technical platform" is spatially structured like a school, with its dedicated rooms and devices and its patients going from one "class" to another (from the gym to the speech therapy session, etc.), with its secluded rooms for the different professionals where they are filling out patients' files, discussing and assessing their progress.

In every patient's room, there is a white paper or blackboard timetable, just like a school one, filled with his or her weekly activities, which changes weekly. For example, in the University Hospital, a patient could typically have one session of physical therapy daily; occupational therapy once or twice a week; speech therapy on Monday, Wednesday, and Friday; neuropsychology sessions once or twice a week, etc.

Each session with a different professional can be compared to a private lesson: the therapist sits behind a desk, the patient facing him or her, and begins by reminding the patient "where we're at," what s/he has done, how well s/he did in the previous session, and what the work plan is for the current session. The patient's abilities are regularly formally assessed, whether in physical therapy or neuropsychology sessions—where the therapist often says, "I can't help you with this [exercise] because it's graded." The therapist constantly uses the written form, as does the patient when he or she is able, and papers, pencils, or a computer are present in each setting and never far from any exercise, even the more physical ones.

The "good patient" has to be a good student. For example, he or she has to "understand" the logic of rehabilitation. For the professionals, for rehabilitation to work the patient has to be reflexive about it:

> "Frankly I don't know what to do with him. He's not the first one not to work and not to fight, but the thing is [insisting on the expression] *he doesn't understand anything about his rehabilitation*" [a senior doctor, about a patient].

> "Florence is a good patient because she keeps a critical eye on her rehabilitation (...). With children, you have to take them with you on a journey, they have to forget that they are working, they must have fun. For adults, on the contrary, they have to understand the way the lungs or the diaphragm work. Florence is very attentive, she wants to understand how her voice works. She understood the necessity of voice stabilization" [a speech-language pathologist, about a patient].

Finally, the abstract form of the "exercise," and the way it disconnects hospital activity from the practical reality of the outside world, while claiming to prepare for it, is also typical of the school form. For example, I observed for a whole day a "driving assessment," in which the patient had numerous exercises to complete before accessing the driving simulator. All these exercises were done on a sheet of paper or on a computer and each exercise—for example, the d2 test, a timed exercise circling specific signs on a sheet of paper filled with letters and signs—was interpreted as a direct evaluation of her attention, while driving, to other cars and

other people on the road: "This d2 test, you see, it *is* the car traffic on the ring-road," explained to me a neuropsychologist one day.

The school form in the hospital is also made explicit by the patients themselves in their frequent use of the term "class" instead of "session":

- I'm waiting in the hallway in front of the office of one of the speech therapists. I hear two patients chatting: K: "What's your next class?" M: [pointing at the door, gloomily] "The same as you…" K: "And do you have Physio today?" M: "No, only tomorrow. I like Physio, it's cool, but I've never liked the others…"
- [One patient to the neuropsychologist] "I'd like to leave [for the weekend] on Thursday but I can't because I've got class, uh, I mean Physio, on Friday" [Fieldnotes].

The fact that the hospital looks and functions like a school is not only a striking descriptive fact. It also means that patients who are well adjusted to the school form, for example, who have been schooled for longer and who were better students, may benefit more easily and more immediately from it. The two patients, Mr. K. and Mr. M., referred to above, were both immigrant factory workers from North Africa, who had not attended school for long there. They met in the hospital and had been bonding ever since over their strong dislike of speech therapy and occupational therapy. Their therapists in these domains regularly mentioned their difficulties and the fact that rehabilitation was "not going well with these two [patients]." They were also not prescribed neuropsychology sessions because they were "not ready," "not there yet"—and in fact never would be, since they both went on to leave the hospital without having been sent to see a neuropsychologist. Conversely, at the same time in the same unit, a young student from the nearby university, Mr. C., was said to be a model patient and was dealt with as such—"He gets what rehabilitation is about" and was seen as "taking part" in the various sessions and during rounds in apt and appropriate ways, with these moments resembling a discussion more than a top-down assessment. Another patient was a high school math teacher with a graduate degree in Mathematics—and his degree was often referred to within the unit. He was the subject of continuous banter about the fact that rehabilitation was "going too well" with him, that he was going too fast, etc. The school form may therefore be better understood by, but also prove more efficient with, patients who are predisposed to it, provided that their scholastic dispositions and cultural capital have survived the stroke to some degree.

Hospital Work: The "Cultural Arbitrary" in Rehabilitation

Now that we have established the pervasive school form of the hospital, we can look more precisely at the way social class may influence rehabilitation therapeutic interactions and even outcomes by looking closely at what actually happens during rehabilitation. I will first show that the way abilities are assessed and trained is deeply engrained in a cultural arbitrary, which will explain why some patients may have social and not only neurological difficulties in understanding and benefiting from rehabilitation.

To do this, I will take a few examples from logic exercises done in occupational or neuropsychological therapy, both from assessment exercises, and from exercises intended to train and enable patients to recover deficits. Assessment exercises are conducted when each professional meets a patient, at his/her arrival in the hospital, or when s/he begins a new "subject." They often come in batches, are closely monitored, often timed, and their results are interpreted in the several-page long

"patient assessment" that takes up the first weeks of rehabilitation. Once they have been completed, the same kinds of exercises can then be used to train the patient, to build new habits, and to measure progress through comparison with the results of the initial exercises. The institutional ideology behind these training exercises is that "practice makes perfect," or at least that repeated practice may enable patients to recover lost skills—in other words, that they recreate old habits of doing or thinking, or create new habits of doing or thinking, not that far away from the influence confered upon repeated practice by the sociology of socialization (Darmon [2006] 2016; Lahire 2011). However, as we will see, when compared to the sociological theory of socialization, this institutional ideology is lacking a crucial dimension: the fact that the repetition has to find specific and welcoming dispositions within the individual in order to "get through" to him/her and function as training.

Mr. K. and His Exercises in Absurdity

Let us first return to the case of Mr. K., a factory worker born in Morocco. During my fieldwork, I observed one of his occupational therapy sessions. Since he had not been prescribed any neuropsychological sessions, occupational therapy was where he was supposed to "work on his reasoning." The therapist explained to him that she was going to read a set of sentences aloud and that, each time, he had to say "what was absurd in them" or "what was 'off' or wrong" about them.

As the therapist would later confirm to me at the end of the session, Mr. K. did not do well in this exercise. However, what she failed to perceive was the social logic at work in his errors. Closer analysis of some of his answers is enlightening in this regard:

> [Therapist reads] "My wife has ordered roast beef for our Sunday lunch from our baker." So, what is absurd here?
>
> Mr. K.: er… Merguez [a traditional spicy sausage from North Africa]? "My wife has ordered merguez for our lunch on Sunday?"
>
> T: …But from "my baker?"
>
> Mr. K.: Ah, OK, no, butcher…
>
> (…)
>
> T: "Every winter, he goes skiing in the Sahara…"
>
> Mr. K.: In ["Coldsea," a popular working-class vacation spot on the coast nearby]? I'm going to go skiing in [Coldsea]?
>
> T: But of course you don't go to [Coldsea] to ski! You go to the mountains!
>
> (…)
>
> T: "Mr. and Mrs. Martin have the surprise of announcing the marriage of their daughter Patricia…"
>
> Mr. K.: I don't know, I don't know…
>
> T: Well, it's an expression, you know, when you make an announcement, well, you're not "surprised," you're "pleased" to announce it… [Mr. K. just looks at her, blankly]
>
> (…)

T: "The child was not able to go to work today because she had the flu"

Mr. K.: [Silence] The flu? The flu's what's not right?

T: No, you know, she's a child, so she doesn't go to work, where does she go?

Mr. K.: Ah, of course, she goes to school, but some children, they do go to work, right?

These few examples of the patient's mistakes all relate to social worlds that are extremely distanced from his actual day-to-day life: roast beef for traditional Sunday lunch, winter breaks in ski resorts, wedding announcements in newspapers, or even a world in which no child ever goes to work. It may well be that Mr. K.'s illness is responsible for his difficulties here, and I'm not denying the neurological aspect of his errors. However, it seems to me that their social nature is also undeniable and both the assessment of his neurological activity and how he was being trained to recover it could be said to be strongly enmeshed in a middle-class world view. At the very least, this aspect to the exercises did not contribute to him doing well (as far as the assessment was concerned) or doing better (as far as progress was concerned).

Let us turn now, instead, to the answers he got right, in this exercise or a slightly different one where he had to say whether statements were true or false. These occurrences were few in number, but quite significant:

T: "He made the Guinness book of records for having caught a huge trout, weighing 0.30 pounds…"

Mr. K., very quickly: … "Weighing 2.5 pounds…"

T: Yes, or even 330 pounds! [He just looks at her, puzzled]

(…)

T: "My mother's sister can be my uncle's wife," true or false? (…) "My uncle's son is my cousin," true or false? [He answers very quickly and correctly each time].

Mr. K. clearly did better on subjects related to traditional working-class knowledge, such as fishing or family ties. This is not the same as asserting, once again, that his neurological problems did not exist or were "socially constructed." However, they were identified, evaluated, and worked on from a vantage point defined by a class arbitrary. The very same exercises would undoubtedly have been more effective, in terms of both diagnosis and treatment, had they been referring to a social world with which he were more familiar.

One might imagine that more neutral exercises in neuropsychology or occupational therapy—such as purely logical exercises about geometric shapes, or rows of numbers to remember, or little bells to circle on a sheet of paper overflowing with different drawings—would not operate according to class-based complicity. However, as I will show below, assessments of and exercises in "logic" can also be class based. Moreover, the very situation in question takes us back to the school form of the hospital as they bring into play social and scholastic abilities: they are performed within a limited and precisely measured time frame, following instructions given once, and under the watchful eye of an assessor for whom all hesitations and errors are highly visible, etc. Put differently, they take place in a situation that more closely resembles a school exam than anything else.

Together with the school form shaping the rehabilitation process, as shown above, these initial examples make it easier to understand why Mr. K. might benefit less from the same rehabilitation process than his middle- and upper-class counterparts, independently from any

issues relating to quality of care. It is important to note that such exercises are not assessment exercises: they are aimed at "training" Mr. K. to "reason" again, to become aware of his difficulties, to improve if possible, or to adapt to his difficulties where improvement is not possible. So the problem is not only that he will be seen as failing the exercises; the problem is also that the processes aimed at training him to improve and recover his reasoning ability are not *reaching* him, no matter how often he goes through them, and can therefore have no retransformative power.

The Medical Reforming of Dispositions: From a Practical to a Reflexive Relationship to Practice

I have shown so far that hospital rehabilitation after stroke is shaped by a "school form," and that it therefore may prove more efficient with patients who have scholastic dispositions and who share the world view and cultural arbitrary of middle and upper classes. I will now proceed to show that hospital rehabilitation involuntarily and unknowingly aims, like school, to transmit a body of knowledge that is itself not universal but class specific.

As well as being assessed and trained in ways that are determined by the lens of social class, the post-stroke patient in rehabilitation is also directly "worked upon" by the institution along class lines. Rehabilitation can be seen as class-oriented insofar as it aims to replace the practical relationship to practice that prevails among the working classes with a scholarly and written reflexive relationship to practice that is typical of the middle and upper classes.

Mr. B. and How to Run Errands

Let us focus first on a classic assessment exercise in neuropsychology: the errands exercise. This is a written exercise in which the patient is provided with a list of errands to run (from taking pants to a dry-cleaner, to buying and carrying a six-pound toner cartridge), a map of the city in which these errands are supposed to be done, a set of constraints (e.g., the closing time of the city hall building s/he has to go to, the opening hours of the shops) and a set of principles: the patient has to minimize the length of his or her virtual travel from one point to another, he or she must not have to wait too long—for example, in front of a closed shop—not carry too heavy a load, etc. The whole exercise is therefore two pages long, with substantial written instructions to consider. The patient is supposed to devise appropriate strategies and, first of all, use the written form to take the various components into account and come up with a logical plan for the optimal order in which to run the errands. Every working-class patient I saw taking this test demonstrated the same bewilderment, verging sometimes on total disbelief. As one patient put it: "You really want me to do that on paper? When I run errands, I take my car and I run errands…". The implicit "I don't think about it" in this sentence is typical of a practical relationship to practice. As we saw above, and contrary to what this test presupposes, the "idea of a practice oriented rationally, intentionally and voluntarily towards explicit ends," and "reflexivity as a consciousness that [is] conscious, systematic and calculating" (Lahire 2011, 144–145) are not universal.

Mr. B. was a young man, with a vocational training certificate but no high school diploma, and the son of a factory worker. The neuropsychologist presented him with the errand exercise: "a planning exercise" she told him. She explained the exercise to him and he stopped her immediately with disbelief in his voice: "I've got to read it all? The two pages?" She answered

that it was a difficult test but that he had plenty of time, he had 15 minutes in which to do it all. She told him he could take as many notes as he wanted and gave him a pencil and extra sheets of paper, which he did not use at all during the test. Without reading all the instructions, he looked at the map and began jotting down the order solely based on the location of the places he had to go—"Well, the dry-cleaner is third, and the shoemaker is close to the dry-cleaner so it's four, right?" At one point, just one errand away from the end, he stopped, looked at the first of the instructions, and said, "Oh, that won't work, what I've done, I should change it all, but too bad, let's keep it that way." She tried to convince him not to give up by suggesting a way of dealing with his errors ("You know, you can think about it a bit more, cross out the numbers, and write down different ones on the side, that would be fine"), but he shook his head, did not continue, and gave her back the paper with visible relief well before the 15 minutes had come to an end.

What is striking here is the fact that Mr. B. had demonstrated—and continued to demonstrate after this—a great deal of motivation and eagerness to do well in his exercises, asking for more, even after a one-hour session, proving happy to remember long sequences of numbers, or to enunciate lots of words beginning with the letter "p." He referred back to the errands test several times during this session and the following one as "the one he did not like at all," which "did his head in." We can draw two conclusions from this. First, the abilities presupposed by this test are clearly class-based due to the kind of relationship to practice that they require. Second, it is not only cognitive functions (planning, for example) that are tested here, but also how the patient perceives the exercise, how he relates to it, the ways in which it is (or is not) meaningful to him. Mr. B.'s emotional reaction to this particular test, his discouragement and his "hatred" of it, themselves class-based, explain his final results just as much as his purely cognitive and neurological abilities.

I asked all the neuropsychologists I observed and had conversations with "what they did" about social class as far as cognitive assessment was concerned. They always answered dismissively that class and qualifications "were taken into account in standardized interpretation of the tests." This is indeed true for some of the tests but, as sociologists, I do not think we can simply leave things at that. Verbal scores, for example, are said to "reflect the parents' social class as well as academic achievement" (Lezak et al. 2004, 103), but here social class is, at best, defined by patients' occupations and qualifications. "School-related skills" are thought to be limited to "arithmetic and spelling" (Lezak et al. 2004, 133), whereas a sociologist would argue that they include far more abilities than that. And while education can be said to have an influence "on just about every other kind of test involving cognitive abilities, including some that would seem to be relatively unaffected by schooling" (Lezak et al. 2004, 315). I nevertheless saw many cognitive tests being interpreted without any information about the patient's SES or level of schooling (whereas age, and secondarily sex, seemed much more systematically taken into account). Neuropsychologiss tend to conceive of (and work upon) "logic" and "memory" as largely independent from such social properties and therefore not in need of ajustments regarding social class. Furthermore, even if it could be proven that the abilities measured in such tests are not class related, we have seen above that the very form of the test—once again, its school form—can strongly affect accurate measurement of these abilities, for example when Mr. B. completely, and almost deliberately, failed the test because it "did his head in."

Mr. P. and How to Build a Bird House

To show that such processes are not isolated or limited to neuropsychology, let us turn now to another example from an occupational therapy session, this time devoted to building a bird house. Mr. P. was a former plumber and security guard. During his first session, his therapist discussed with him what he wanted to make in the hardware workshop, which is one of the rooms on the occupational therapy ward. They agreed on a bird house—Mr. P. had already made some in the past. At that moment, Mr. P. was already half standing and about to head to the workshop to get "a saw and some wood." The therapist stopped him kindly: "We'll need five sessions for this, so please sit down. For the moment, the only tools you'll need will be paper and a pencil." She made him write down a schedule for the five sessions, determining the different stages of "how to make a bird house" before then writing them down. She made him guess that he would need "an action plan" and a "drawing" of the bird house. Then, as he stared down at the two stages he had written down, she urged him to continue: "You have to have at least five stages on your sheet of paper!" He kept repeating "I've already made one, you know" but seemed hesitant sometimes about what he was supposed to make—once, he referred to a doghouse before correcting himself.

For the therapist, determining stages, writing, and drawing were all tools that she was teaching him in order to compensate for his "memory problems." However, the stakes here in fact extend far further. Her aim was also to teach him a new relationship to practice: mediated by the written word, composed of scheduling and planning dispositions, and including a reflexive way of thinking about action rather than acting without thinking, of getting rid of any "improvisation." As she told him at the beginning: "Maybe you like improvising, but here we don't do that, we don't improvise." And this is what she went on to try and teach him throughout all five sessions— over three weeks—using the bird house as a way to work directly on his dispositions towards action. All the dispositions she tried to instill in him can be located in the social space of social class and do not form part of the working-class habitus, which is, on the contrary, defined, as we have seen above, by a practical relationship to knowledge.

This case was not a rare occurrence in my fieldwork and similar situations arose with other patients from a working-class background, as evidenced by the following description of an "occupational therapy session" given by a patient to another therapist:

> I have to make a box, OK, and so then she asks me to make a plan, a drawing… But I don't need a plan to make a box, you know! I've made loads of them, and I had no plan, I know how to make a box! With her, you have to take a ruler, as though you're at school… that's not how I work. I think it's just a waste of time, you know, it's a little job, it's just a tiny box, 12 by 7, you see, I've got the measurements in my head, I don't need a plan. I'm not saying I could make one in 30 minutes, but five sessions? But OK, they do have the right tools here, for my arm, it's a jigsaw, so it's good, occupational therapy is good.

It is worth underlining again that these observations do not equate to claiming that such tests fail to assess anything, that the patients in fact have no neurological problems whatsoever, or that therapists are providing low quality care to working-class patients. Nor does it equate to claiming that therapists are guilty of classism. However, it is clear that they are dispositionally and institutionally prone to class ethnocentrism and are not in fact assessing and working on the things they think they are.

Mrs. E. and How to Walk, Mr. G. and How to Swallow

Until now, the examples have been taken from neuropsychology or occupational therapy and from quite "intellectual" exercises. To avoid giving the impression that the logics uncovered here are restricted to these areas, it is worth looking also at a much more physical area of rehabilitation, such as physical therapy or applied physical education. As seen above, in the discussion between Mr. K. and Mr. M., working-class patients sometimes express their preference for physical therapy, perhaps in the same way as school students might prefer Physical Education (PE) as the least academic of school disciplines. Nevertheless, I wish to demonstrate that the same class–based relationship to practice and education is also at play in these settings.

First, this is because language plays a crucial role in these sessions. Physical therapy or even PE are far from silent physical activities: the therapists or PE instructors talk a lot to explain the movements, describe what they see, explain what they would want to see, suggest what it should feel like, etc. Bodily movements are sometimes demonstrated, but most of the time they are broken down, explained, closely monitored, and criticized. For example, I observed Mrs. E. She is a woman in her 30s, who quit school at 16 and worked for some time in a hair saloon. I observed a session with her physical therapist where she worked on her lower limbs, and my fieldnotes are as full of sentences uttered by the physical therapist as in any other session: "Do you manage to get back up in that position, without it starting like that? That's better, that's good (...) Try to lift your thigh without stretching your leg (...) it's normal that it's harder there because you have gravity, and your toes, they're heavier if you want." The physical therapist explains the role of gravity with a quick drawing on a sheet of paper. Then she makes Mrs. E. do an exercise on the healthy side before making her train the other side: "Go on, go on, go on, there's a beginning of something... there you go! There! There! Did you see that? Did you feel that?"

The way the foot unfolds during walking or the exact position of a paralyzed hand are the subject of extremely detailed discussions, sometimes with graphs or metaphors, such as in dance (Faure 2000). This is all the more the case when the patient has suffered from sensory loss and the physical therapist is also "teaching the brain to feel again," as one of them put it to a patient, trying to make him connect a certain movement with a certain sensation he should feel. Patients' files in physical therapy are filled with assessments, numbers, drawings of the patient's positions, and records of his or her pain and progress. The number of meters walked or seconds suffered standing, or the angle between the forearm and the arm, are discussed with the patient and carefully noted. The correct movement is explained to the patient in minute detail, with therapists often taking several minutes of the session to do so, and this is seen as particularly important for recovery. This kind of relationship to the body can be totally new for some patients and quite familiar to others; it is again likely that this greatly enhances the beneficial character of rehabilitation for those who fall into the latter category. Once again, this reflexive relationship to the body is much more in sync with middle- and upper-class uses of the body (Boltanski 1971).

The same goes for the endless and seemingly pointless nature of certain exercises—for example, artificially moving a paralyzed hand with a ball-bearing device—"to mislead" the brain, the therapists explain—or grasping small pieces of wood and moving them around. In Adapted Physical Education, each patient is given a booklet with a personalized regimen of exercises, as in higher-end gyms. In physical therapy also, the school form is manifest in exercises that seem to be done for their own sake, that are closely evaluated and discussed, and

that presuppose a certain kind of asceticism and a belief in their future efficiency—both of which, according to Bourdieu ([1984] 2010), are typical of the middle classes.

Outside physical therapy, some very basic and apparently purely physiological reflexes are also worked on along the same scholastic lines. This is the case when a speech therapist is working on a patient's deglutition, as in the following example with Mr. G., a middle-class patient with cultural capital. The session begins when the speech therapist asks him: "So, what are the referred swallowing exercises?" He smiles, and begins the first exercise by doing it by himself, blowing hard while holding his hand in front of his Adam's apple. Then, since he can't remember the second exercise, she gives him clues with a drawing and he guesses it's "making the siren of a fireman to exercize breathing" (…) At some point, she asks him to make the sound "Ah," which he does, and then she asks him at once, "But why am I asking you to do this?" He answers tentatively, "To warm up the voice?" She corrects him, using technical terms, but making sure that her speech is clear: "Yes," says the patient, "I understand now, it's to check that I didn't use the wrong pipe!" At some point, she tells him: "What we are working on is called 'Subglottic deglutition,' isn't this name just magnificent?"

More generally, in rehabilitation the patient's body is then fundamentally treated as a project, something that has to be worked upon in a very scholastic and reflexive way, once again typical of middle- and upper-class conceptions (Darmon 2017). For the working classes, promoting or imposing the body as a "project" therefore leads either to a failure to incorporate this new relationship to the body or to the "normalization of corporal hexis" and difficulties in practically combining their previous relationship to their body with the new principles they have internalized (Faure and Garcia 2005).

The Dynamic of Patients' Outcomes: A Class-Based Motivation?

Finally, I would like to touch upon the fact that the class-based dispositions at stake here may play again another part in the dynamic of patients' careers, within the hospital and even once they've left it, via the class-based dispositions that constitute "motivation."

Mr. P. and How to be Motivated

I witnessed numerous instances of rehabilitation that did not "go well," that seemed to never get off the ground, with patients from working-class backgrounds. Mr. P., for example, often missed sessions because he stayed in bed, he "forgot" sessions even when he was reminded to go, or said he was "not feeling well" when an orderly wanted to take him "downstairs" to the technical platform. His files were quite empty and in no way resembled those of his hospital bedfellows. The fact that, whenever he was in his room, he would lie on his bed rather than sit on the armchair, was often discussed as highly significant. On one occasion, I was with a physical therapist who told me that she thought the hospital had given up on this patient and decided to go and fetch him in his room to "shake him up a bit." When we arrived, he was lying on his bed, in pajamas, not sleeping but not doing anything. She cheerfully confronted his body language: "So Mr. P., are you OK, there, in that position?! You could at least sit up! The only things missing are a parasol, a cocktail, and a little umbrella, right?" He then mumbled that he had no session at that time and that he needed to rest to get better. She contradicted him by saying that he needed to work to get better. Once again, Mr. P.'s take on rehabilitation can be traced back to a working-class culture both in terms of relationships to

leisure and to illness. In the working-class culture of leisure time, "doing nothing" and "resting" are considered ways of coping with the difficulties and fatigue of daily life, as is napping (Verret [1988] 1996). This is also a healing strategy congruent with a fatalistic ethos towards illness. The activity culture of rehabilitation therefore struggles to find welcoming dispositions within this patient.

Some patients would speak from a very early stage about leaving the hospital, insisting on its hardships: they wanted to go home and often raised the issue with medical staff. Others, on the contrary, wanted to stay as long as they could: "the longer the better," "I don't want to go home until I have regained everything," and tried to avoid any allusions from the medical team to leaving. Both attitudes were criticized by the medical staff, since only doctors are supposed to be able to assess the right moment to leave the hospital. However, the attitudes were correlated to differences in social class: the first was much more frequent among working-class patients and the second among middle- and upper-class patients. The latter tend therefore to see the unending patient work as work aimed at continuous improvement, whereas working-class patients tend instead to want to go home and believe they will get better by being with their family in their usual setting and/or don't care as much about "making progress."

Mrs. H. and How to Keep Working

Finally, patients are supposed to continue working by themselves after they have left the hospital (I observed sessions aimed at "therapeutic patient education" and encouraging "self-rehabilitation"). Although this is a different topic that cannot properly be addressed in this article, I would nevertheless like to suggest that the same social conditions of possibility may apply here. I followed the case of Mrs. H., a 45-year-old factory worker who had just lost her job prior to her stroke, throughout her stay in the hospital. I also remained in contact with her afterwards and conducted two formal interviews with her following her return home. Her hospital rehabilitation went very well: she worked extremely hard and was viewed as highly motivated and eager to benefit from rehabilitation, which she clearly did according to her own perspective, as well as those of the staff and her husband. However, once she got back home, she told me she found it very difficult to keep "working" without the help of the hospital. First, she had trouble finding therapists to pursue her treatment in the small village where she lived; then, when she did find them, her husband took her, as prescribed, "only a couple of times a week," which she found was not enough compared to her hospital life. The rest of the time, she "did nothing" and felt tired and idle. One month after, and then three months after her hospital stay, she had appointments with her doctor and I observed the three-month consultation. The doctor seemed quite worried because, in his eyes, "she had clearly deteriorated" in the way she walked and held herself. He was quite puzzled by this, given that the tests he had prescribed were inconclusive regarding any biological or neurological factors. However, the interviews I conducted with her were quite telling about the fact that, once out of the hospital, she had trouble continuing to "work" by herself. It could therefore be suggested that while she had followed institutional guidelines well, and had been "worked on" by the institution due to its "total" character, she had nevertheless failed to develop the dispositions and ethos—attitudes towards activity, the body, practice, healing, etc.…— necessary to sustain rehabilitation work alone, outside the total institution, and to complete her rehabilitation through self-rehabilitation.

Another post-stroke patient I interviewed, Mr. M., a university professor, described at length the work he had done after leaving the hospital:

> I kept on observing myself, watching myself closely, really, I kept on doing that (…) You spend lots of time watching yourself and observing yourself. There's a point when a good deal of your time is spent asking yourself: "Is there something else I could improve?" And there's this idea that you can do it yourself (…) Once [after having left the hospital], I saw a speech therapist, and he told me: "That's great because you're such an observer, it's rare to have somebody like you to talk to, because you manage to spot lots of details people usually don't see" (…) And I was very curious about my MRIs, my scans, everything that was in my file. I asked the doctors to explain them to me (…) I began reading things about the brain and everything (…) Rehabilitation becomes omnipresent, because your life is about rehabilitation. This is what your life is made up of, what is better today than it was yesterday?

Indeed, in a corpus of books written by stroke survivors I studied and analyzed, the personal rehabilitation plans and minutely-detailed work programs established when home is an important focus in middle- and upper-class narratives. Post-hospital work itself therefore also depends on several social-class dispositions. It may even do so more than hospital work itself since, as the case of Mrs. H. suggests, the "total" nature of the hospital institution may compensate for absent dispositions during hospitalization.

Conclusion

This article has simultaneously shown three things. First, that hospital rehabilitation after stroke can be interpreted as a process of socialization shaped by a school form. Since this process is highly dependent on existing or persisting class-based dispositions among its patients, it can help explain inequalities in the efficiency and outcomes of rehabilitation. Second, on a more theoretical level, this article shows that the concept of school form can actually be useful to understand illness, health care, and rehabilitation, and that relationships to practice and to language and learning situations, but also "motivation," are class-based dispositions. Third, it explains the class-based processes through which inequalities in stroke outcomes arise.

Envisaging social health inequalities as deriving from "quality of care" always presents the disadvantage of explicitly or implicitly placing blame on staff, as though they were voluntarily neglecting working-class patients and providing better standards of care to their middle- and upper-class counterparts. In this article, I have tried to show how an approach in terms of institutional socialization and the way it interacts with patients' class dispositions can account for the processes in play without ascribing blame to socially prejudiced or "classist" staff—while, of course, also avoiding blaming unmotivated, lazy, or disturbed patients. It is therefore not the conscious or unconscious "prejudices" of the members of medical teams that constitute the object of this article, but rather the potential clash, in a given institution, of rehabilitation processes shaped by the school form with the class-based dispositions of some patients. We must thus refrain from the easy denunciation of "good" or "bad" professional wills, which is missing the point when it does not take into account the fact that professional skills operate on a human material, to use Goffman's provocative expression, unequally disposed to welcome them and to give them an opportunity to work.

Guided by such a sociology of socialization, it would not be impossible to imagine modes of "re-education" or rehabilitation that would be more attuned to working-class dispositions

and cultures, primarily their practical relationship to practice and their specific modes of transmission of knowledge, such as "non-learning," "learning by doing together," "transmission of work" or "transmission of experiences" (Delbos and Jorion 1984). Taking into account the diversity of relationships to practice, as well as working-class relationship to practice as the most prominent one among stroke victims—since stroke affects them more—could lead to therapeutic protocols that would not be primarily adjusted to the dispositions of members of the middle and upper classes.

Finally, if sociology can be useful in explaining stroke recovery, it is because "what is regained" after stroke is not only a question of location in the brain and seriousness of the neurological incident. It also correlates with class-based dispositions and attitudes towards practice, as well as language and learning situations, and forms of motivation.

This article therefore questions the biological and neurological monopoly over understanding "what happens" following a stroke and during rehabilitation. In a famous article, Timmermans and Haas' call to refrain from "ignoring disease" and move "towards a sociology of disease" by including in sociological analysis clinical endpoints or the normative orientation of practice (Timmermans and Haas 2008). This is partly what I have tried to do here by looking at the way deficiencies and progress were assessed, some of the goals of treatment and the manner in which they were pursued, and the influence of the patients' class dispositions on the potential efficiency of treatment. To express their vision of a "sociology of disease," Timmermans and Haas suggest reversing Parson's motto of "sociology first and health second." To my mind, it is neither necessary nor desirable to do so and it remains possible to "sociologize" the biological or even the neurological while still putting sociology first. Putting sociology first is our trade, but it is also our duty, since no one other than sociologists is likely today to look for this particular kind of truth.

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