

**The Impossible Clinic. A critical sociology of EvidenceBased Medicine.**

Jones, Lorelei

Sociology of Health and Illness

DOI:

<https://doi.org/10.1111/1467-9566.13158>

Published: 01/05/2021

Peer reviewed version

[Cyswllt i'r cyhoeddiad / Link to publication](#)*Dyfyniad o'r fersiwn a gyhoeddwyd / Citation for published version (APA):*Jones, L. (2021). The Impossible Clinic. A critical sociology of EvidenceBased Medicine. *Sociology of Health and Illness*, 43(4), 1073-1074. <https://doi.org/10.1111/1467-9566.13158>**Hawliau Cyffredinol / General rights**

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal ?

Take down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

The Impossible Clinic. A critical sociology of Evidence-Based Medicine. By Hanemaayer, A.. Vancouver: UBC Press. 2019, 198pp £60 ISBN-10:0774862076 (hbk)

Lorelei Jones

Evidence-based medicine has failed. It was meant to produce doctors who could critically appraise medical research and then apply the findings to their practice, instead it has turned doctors into rule-followers. This is the central argument of *The Impossible Clinic*. Hanemaayer provides a detailed genealogy of this apparent tension in contemporary medical practice, tracing it back through force relations to the problematisation of clinical judgement after the Second World War. It is at this moment in history that Hanemaayer begins her task, showing how clinical judgement came to be seen as subjective and thus problematic. In the chapters that follow she explores the emergence of clinical epidemiology, the development of a new curriculum at McMaster Medical School, the proliferation of clinical guidelines, and the incorporation of these into professional regulation. Hanemaayer argues that while evidence-based medicine has failed, in terms of its own objectives, it is a success for some in the way it makes the clinical judgements of doctors the focus of attention and intervention, distracting from other influences on the quality of healthcare, such as government funding and infrastructure.

Hanemaayer's genealogy is not for the faint-hearted. I am interested in 'boring things' but even I balked at 38 pages on problem-based learning. And I remain unconvinced by the central thesis. Hanemaayer argues that the key mechanism by which responsibility for appraising medical research became externalised to clinical guidelines was their incorporation into the deliberations of professional disciplinary committees. However, the examples that she has painstakingly assembled, such as the doctor who found himself before a disciplinary committee for prescribing narcotics to his girlfriend, and stimulants to her underage son, did not suggest to me that 'the problem' was that practice was not based on the evidence. And I was left unconvinced that the use of guidelines by disciplinary committees was generally constitutive of contemporary medical practice.

The power of Foucault's genealogies is in showing how what has come to be taken for granted, seen as natural even, is historically and socially contingent. Such revelations have the potential to inspire a radical praxis. That Hanemaayer's rich and detailed scholarship does not have the same impact is down to the fact that, when it comes to clinical practice, the discourse of evidence-based medicine has only ever attained partial closure. Alternative guides for action, such as 'narrative medicine' (Greenhalgh 2011), are readily available, and mainstream medical journals regularly publish critical perspectives. Empirical research shows that clinicians are selective and strategic in their use of clinical guidelines, and attentive to individual preferences, needs and capacities (Timmermans and Epstein 2010). It also suggests that the clinical encounter continues to be a negotiated order with patients adept at enacting their own influence, to the point of playing different professionals off against each other (Waring and Latif 2018).

The Impossible Clinic concludes by asking what kind of medicine we want. While Hanemaayer returns our attention to clinical practice, what struck me about her archival materials was the frequent coupling of clinical and health services research. Hanemaayer's genealogy reminds us that evidence-based medicine was always as much about healthcare policy and planning as clinical practice. For example, she tells us that the role of Clinical Epidemiology Units were to 'promote rational decision-making and the application of quantitative measurement

principles...in the development of clinical *and health care policy*' (p 82), while the objectives of the McMaster Department of Clinical Epidemiology and Biostatistics were to 'improve methodological design, measurement, and evaluation in medical research *and health services evaluation*' (p84). That Hanemaayer finds this elision unremarkable is testament to the extent of discursive closure in health services research. Yet it is in the technicalisation of political decisions that the discourse is at its most effective. This is power hiding in plain sight. It is in health services research, rather than clinical practice, where evidence-based medicine is taken for granted, and where medical sociologists continue to be implicated.

At a time when most university research involving fieldwork has been suspended, *The Impossible Clinic* is a reminder of what can be accomplished with archival materials, and the ones that Hanemaayer uses in her analysis – textbooks, departmental memos, policy documents, and personal correspondence - have an nostalgic old-school materiality. Those interested in sociological studies of healthcare architecture (Martin et al 2015) will delight in the floor plans of McMaster Health Sciences Centre, showing, for the first time, the Department of Clinical Epidemiology and Biostatistics located alongside the medical school and inpatient care. Reading *The Impossible Clinic* during lockdown was evocative, not just of a time when academic life involved *things*, besides a laptop, but a more recent past where academic life happened in *places*, beyond the bedroom.

Lorelei Jones
Bangor University

References:

Greenhalgh, T., 2011. Narrative based medicine in an evidence based world. *BMJ* 318, 323–325. <https://doi.org/10.1136/bmj.318.7179.323>

Martin, D., Nettleton, S., Buse, C., Prior, L., & Twigg, J. (2015). Architecture and health care: a place for sociology. *Sociology of health & illness*, 37(7), 1007-1022

Timmermans, S., Epstein, S., 2010. A World of Standards but not a Standard World: Toward a Sociology of Standards and Standardization. *Annual Review of Sociology* 36, 69–89. <https://doi.org/10.1146/annurev.soc.012809.102629>

Waring, J., and Latif, A. 2018. Of shepherds, sheep and sheepdogs? Governing the adherent self through complementary and competing 'pastorates'. *Sociology*, 52(5), 1069-1086.