Sociological Research online

Problems, Crises, Events and Social Change: Theory and Illustrations

by Constance A. Nathanson
Columbia University

Sociological Research Online 14(5)11
<http://www.socresonline.org.uk/14/5/11.html>
doi:10.5153/sro.1974

Received: 23 Apr 2009 Accepted: 21 Nov 2009 Published: 30 Nov 2009

Abstract

This paper proposes a theory-based approach to the understanding of social change and illustrates that theory with examples from the history and politics of public health. Based in large part on the work of anthropologist Marshall Sahlins (see in particular his Islands of History published in (1985) William Sewell Jr. has proposed an 'eventful sociology.' In this work 'event' is a term of art meaning occurrences in human affairs that result in social change. Sewell's approach and that of Charles Tilly are in many respects complementary, a major difference being Sewell's far greater emphasis on meaning and interpretation by engaged actors as essential to understanding of how historical processes unfold. In this paper I further elaborate Sahlins' and Sewell's ideas, first by showing their connection with concepts that may be more familiar to sociologists and, second, by examining the contingent character of social change. Drawing on my own research on the history of public health, I argue that the transformation of 'happenings' into events and of events into meaningful social change are highly contingent on the social and political context within which these events occur. More generally, I hope to show that 'eventful' sociology is an exciting and productive approach to sociological analysis.

Keywords: Social Change, History, Events, Public Health, Marshall Sahlins

Introduction

1.1 Among the 'pernicious postulates' Charles Tilly enunciates in his magnificent little book, *Big Structures, Large Proceses, Huge Comparison*, is that 'mental events cause social behavior' (Tilly 1984:26). Yet Tilly clearly finds it difficult to do without 'mental' processes altogether. In discussing the inadequacy of rational actor models to account for social movement participation, he allows that 'real social movements always involve a symbolically constrained conversation among multiple actors, in which the ability to deploy symbols and idioms significantly affects the outcome of the interaction. *Existing theories and models do not provide useful accounts of that interaction*' (Tilly 1984:31, emphasis mine).

1.2 Tilly's book was published in 1984. Based in large part on the work of anthropologist Marshall Sahlins (in particular his *Islands of History* published in 1985, one year after *Big Structures*... [Sahlins 1985]) William Sewell Jr. has proposed an 'eventful sociology' (Sewell 2005:81) that incorporates structure, agency, and interpretive (i.e. 'mental') processes to account for social change and, I believe, goes far toward filling the theoretical gap Tilly describes. The purpose of this paper is to further elaborate Sahlins' and Sewell's ideas, first by showing their connection with concepts that may be more familiar to sociologists and, second, by examining the contingent character of social change. Drawing on my research on the history of public health (Nathanson 2007), I argue that the transformations of 'happenings' into events and of events into meaningful social change are highly contingent on the social and political context within which these events occur. More generally, I hope to show that 'eventful' sociology is an exciting and productive approach to sociological analysis.

Different Disciplines: Parallel Concepts

2.1 There are powerful intellectual affinities between Sahlins' concept of the significant (i.e., socially transformative) event, Thomas Kuhn's idea of the crisis-driven paradigm shift that makes a scientific revolution, and the symbolic interactionist conception of a social problem (see e.g., Blumer 1971, Gusfield 1981). The most obvious parallel is in the role played by some form of interpretive process—the attribution of meaning to what Sahlins labels 'happenings': occurrences in the world. Sahlins' wonderful example is Captain Cook's landing in the Hawaiian Islands, an event whose interpretation by Hawaiian natives led not

only to Cook's death but also ultimately to profound transformations in the islands' social structure. Meanings, Sahlins argues, are generated within specific cultural settings: events are distinguishable from mere happenings 'only within the terms provided by a cultural structure....Moreover, what consequences events will have depends on how they are interpreted, and that interpretation can only be made within the terms of the cultural structure in place'(Sewell 2005:199). 'The event is a happening interpreted—and interpretations vary' (Sahlins 1985:153).

2.2 In Kuhn's analysis of revolutions in science—happenings that clearly qualify as 'events' in Sahlins' terms—the position of a 'cultural structure in place' is occupied by an existing scientific paradigm—a coherent tradition of scientific research that includes 'law, theory, application, and instrumentation' and on which practitioners rely to interpret their results (Kuhn 1970:10). Crises—the sparks that ignite a scientific revolution—occur when attributions of meaning based on the established and familiar paradigm are no longer perceived as reliable. As the revolution takes its course, these meanings change, and '...the scientist with a new paradigm sees differently from the way he had seen before'(Kuhn 1970:115). In his exegesis of Sahlins, Sewell observes that 'events can be distinguished from uneventful happenings only to the extent that they violate the expectations generated by cultural structures' (Sewell 1995:199). Substitute 'crises' for 'events' and 'scientific paradigms' for 'cultural structures' and this observation applies equally well to Kuhn.

2.3 Attributions of meaning are central to contemporary sociological analyses of social problems: 'human problems do not spring up, full-blown and announced, into the consciousness of bystanders. Even to recognize a situation as painful requires a system [Sahlins' 'cultural structures'] for categorizing and defining events' (Gusfield 1981:3).[1] This formulation adds an additional—evaluative—step to the process described by Sahlins. Social problems are happenings (usually a sequence of happenings) that are perceived in the terms of a given cultural framework as both significant—they have the potential to become 'events'—and painful. An event in Sahlins' sense is a morally neutral term for a culturally significant occurrence, one that may or may not qualify as a 'social problem.' What Gusfield (along with other students of social problems in the symbolic interactionist tradition) and Sahlins share is their insistence that the categories with which we make sense of happenings in the world are social, cultural (or—to bring in Kuhn as well—scientific) creations. They do not inhere in the happenings themselves.

2.4 A second parallel across these three perspectives is in the role of agency—'interests' in Sahlins' parlance—in the construction of categories. Meanings are created out of the categories available within a specific cultural context but 'in action' they are 'determined also as an 'interest,' which is the instrumental value to the acting subject' (Sahlins 1985:150). 'Undertaking an action always subjects a sign or cultural category to the plans or intentions of the person who acts...actors bend categories to their own ends in the course of action' (Sewell 1995:203-04). The idea of interest is implicit in Kuhn's comments about who are the actors most likely to launch a scientific revolution:

> Almost always the men who achieve these fundamental inventions of a new paradigm have been either very young or very new to the field whose paradigm they change....these are the men who, being little committed by prior practice to the traditional rules of normal science, are particularly likely to see that those rules no longer define a playable game and to conceive another set that can replace them. (Kuhn 1970:90)

In other words, the best candidate for scientific revolutionary is a young turk who has little investment in existing paradigms and is ambitious to make her way in the scientific world.

2.5 Interested actors 'who foresee material gains by elevating a given condition to a problem' (Blumer 1971:302) play an especially large part in social problem construction. Human problems—from smoking and HIV to breast cancer and learning disabilities—compete with each other for attention on the public stage, and entrepreneurial groups and individuals 'promote different problems or different ways of seeing the 'same' problem (Hilgartner and Bosk 1988:56) in an effort to dominate the current social problem discourse and appropriate to themselves what limited resources (of manpower, time, money, media space) may be available.

2.6 Despite the strong conceptual resemblance between problems, crises, and events, there are nevertheless some important differences. Although Gusfield emphasizes that problems have histories—'the social construction of public problems implies an historical dimension....The same "objective" condition may be defined as a problem in one time period, not in another'(Gusfield 1981:8)— history has not been central to research on social problems. Problems have been conceived in terms of stages (e.g., Blumer, 1971)—they appear, occupy the public for a time, and then vanish—but those stages have for the most part been abstracted from their location in historical time (leading such theories to be included among Tilly's 'pernicious postulates' [Tilly, 1984:41]). Kuhn's crises and Sahlins' events are, by contrast, inextricably linked to their historical settings: indeed, the crisis that revolutionized astronomy in the sixteenth century (for example) and the events that revolutionized Hawaiian social structure in the late eighteenth and early nineteenth centuries are inexplicable without reference to history. They are history, but they are history theorized, and this brings me to the second important distinction between most work on social problems and the ideas of Kuhn and Sahlins. Both of the latter advance theories of social change —Sahlins calls his a 'possible theory of history'(Sahlins 1985:138). Work on social problems for the most part does not.

2.7 Essential to both Kuhn and Sahlins is the notion of an 'intractable' world. Preconceived ideas of how the world works (based on existing paradigms or cultural structures) are challenged by happenings on the ground: 'Having its own properties, the world may...prove intractable. It can well defy the concepts that are indexed to it. Man's symbolic hubris becomes a great gamble played with empirical reality'(Sahlins 1985:149). When they have lost too often, scientific or cultural gamblers will begin to question those concepts and, perhaps, to transform them. Crises and 'events' are (in these formulations) precursors of

social change essentially by definition. Crisis is the necessary precondition for paradigm shift. Historical events 'are happenings that transform structures' (Sewell 2005:218). What does and does not constitute an 'event' is, for that reason, a matter of judgment.

> Such decisions [whether structures have, indeed, been transformed] must be made post hoc: with some confidence when dealing with an event that occurred two hundred years ago and whose consequences have generally been fixed for some time [Sewell's example is the taking of the Bastille], more tentatively when the consequences of a rupture have only recently begun to appear and when additional, perhaps surprising, consequences may yet emerge. (Sewell 2005:261)

2.8 Implicit in the forgoing observations—and explicit in other essays in the book from which this passage was taken—is an approach to sociological theory that departs significantly from received ideas of theory as the source of testable hypotheses. 'An eventful sociology,' Sewell argues, will recognize that 'social processes...are inherently contingent, discontinuous, and open-ended' (Sewell 2005:110). Adopting this approach—as I do in this paper—does not mean that theory is abandoned. On the contrary, concepts grounded in sociological and political theory are central to my analysis. My interpretations and explanations are nonetheless post hoc—'theorizing causal narratives through looping contexts of discovery' (Sewell 2005.:112).

Stories of Public Health

3.1 I have titled this section, 'Stories of Public Health,' for two reasons: first, to indicate my adherence to Tilly's emphasis on the importance of time, place, and sequence in the description and analysis of historical processes, and, second, to signal the importance of the authorial voice. These accounts are not fiction but neither are they pure narratives of happenings 'out there.' They are narratives selected and interpreted in the light of a larger 'theory of events.' 'Story' and 'narrative' are used interchangeably in the text.

3.2 The narratives on which I draw for this theoretical exercise are from my book, *Disease Prevention as Social Change: The State, Society, and Public Health in the United States, France, Great Britain, and Canada* (Nathanson 2007). In that book I tell the stories of four public health issues as they unfolded in each of the four countries named in the book's title, 16 narratives in all. My approach to this material is comparative. Methodologically, it is grounded in Charles Tilly's call for 'genuinely historical work' in the social sciences: 'studies assuming that the time and place in which a structure or process appears make a difference to its character, that the sequence in which similar events occur has a substantial impact on their outcomes, and that the existing record of past structures and processes is problematic, requiring systematic investigation in its own right instead of lending itself immediately to social-scientific synthesis' (Tilly 1984:79).

3.3 The four issues around which I organize my narratives are, in the late nineteenth and early twentieth centuries, infant mortality and tuberculosis, and in the late twentieth century, smoking and HIV/AIDS in injection drug users. I describe in the narratives why and how each issue emerged into the public domain, the identity and roles of interested actors, and the social, political, and ideological conflicts attending each of the four issues. Here I propose to reexamine my earlier description and analysis from the angle suggested by the work of Sahlins and Sewell. Synthesizing Sahlins' approach, Sewell defines the 'event' as: '(1) a ramified series of occurrences that (2) is recognized as notable by contemporaries, and that (3) results in a durable transformation of structures' (228). My goals are to identify the circumstances leading each of these four public health issues to be 'occurrences recognized as notable by contemporaries' and to specify under what conditions the turmoil surrounding these issues resulted in 'a durable transformations of structures.'

3.4 Infant mortality and tuberculosis. From the perspective adopted in this paper, infant mortality and tuberculosis have much in common. For at least the first half of the nineteenth century (and before, of course) both conditions were viewed by these four countries' elites—politicians and public officials, economic entrepreneurs, even physicians—as ordinary and predictable occurrences, in no sense 'events' with the power to disrupt or change existing social and cultural routines. Despite consistently high rates throughout the nineteenth century (hovering above 150/1000 and spiking in individual years) infant mortality remained until the late 1850s a family but not a public tragedy.[2] Tuberculosis was in the same period the leading cause of death: 'at the turn of the nineteenth century, one in every five people developed TB during their lifetime' (Braden et al.1996:85). Nevertheless, despite its prominence as a cause of death, tuberculosis commanded little in the way of public attention in Europe or America until late in the nineteenth century. What happened to change infant mortality and tuberculosis from routine happenings to public problems 'recognized as notable by contemporaries'?

3.5 Tuberculosis and infant mortality were not, in themselves, transformative events. Change in their meanings and in their importance to a wide range of interested actors were among the many consequences of earlier events: first, a series of perceived crises in state structure and national identity that affected European and American states in the late nineteenth century; second, the revolution in conceptions of the nature of disease and modes of treatment that resulted from the discoveries of Louis Pasteur; and third, an event about which I will have less to say but that was of incalculable importance, the invention of the telegraph in the latter part of the nineteenth century that allowed this new knowledge to spread rapidly across continents.[3]

3.6 War and immigration. In a context of growing economic and military competition among European states (and in the economic sphere with the United States as well), both France and Britain in the late nineteenth century were visited by disastrous wars (respectively, the Franco-Prussian and Boer Wars) with outcomes profoundly humiliating to national pride. These crises in each country's history fueled fears of

political, economic, and military decline. Among their manifold consequences were explosions of patriotic anxiety about the quantity and quality of each nation's population: '...it seemed that nations needed fit work-forces, fit armies and fit mothers to rear them if they were to compete effectively in an increasingly internationalized market, for imperial domination and in war' (Bock and Thane 1994:11).

3.7 America's crises were more protracted but with comparable results: the transformation of infant mortality and tuberculosis from private afflictions to vehicles for public intervention and control—control, in particular, of 'the hordes of newcomers [from southern and eastern Europe], with their strange customs, foreign languages, and alien religions, [who] lacked a proper reverence for American values, symbols, and heroes '(Hays 1995:138). Between 1890 and 1914 more immigrants arrived in the United States —approximately fifteen million—than in any period before or since. The overwhelming majority of these newcomers were from southern and eastern Europe, strange and unfamiliar places to Anglo-Saxon Protestant Americans. Social crises in the 1890s—labor militancy and the country's first serious economic depression—were interpreted by many Americans through a 'racial' lens, leading some to call for immigration restrictions and others—the reformers—to develop programs for the transformation of immigrants into good Americans. Prominent among the targets of those programs were high rates of infant mortality and tuberculosis among the poor and foreign-born.

3.8 Relative to its population, Canada grew even more rapidly than the United States. In the decade 1901-11 the nation's population increased by 34 percent, due primarily to immigration. Canadian perceptions of immigrants as a threat to social order were not dissimilar from in the United States, (see e.g. Comacchio 1993), but the initial response was highly localized and relatively tepid. Only in the aftermath of World War I, when a 'fit' population became identified with the national interest, did the federal government in Ottawa became seriously interested in the prevention of disease.

3.9 The germ theory of disease. In *Pasteur et la Révolution Pastorienne*, Claire Salomon-Bayet addresses directly the question of whether Pasteur's discovery of the germ theory does or does not qualify as a 'kuhnian' paradigm shift (Salomon-Bayet 1986). Her answer is a qualified yes. There was no single 'crisis,' she argues, but a half-century of competing theories, experiments, and ideas. Nevertheless, by the end of the nineteenth century—more specifically by 1894, when the discovery of a vaccine for diphtheria was announced in Budapest to the astonishment and acclaim of the scientific and medical worlds—a revolution in biology and medicine had been accomplished. Salomon-Bayet's criteria for identification of a 'crisis' are, perhaps, too strict. A 'half-century of competing theories, experiments, and ideas' capped by clear—and carefully orchestrated—demonstrations of the superiority of the germ theory describes a pattern not that dissimilar from Kuhn's account of scientific revolutions in astronomy, chemistry, and physics.

3.10 Due in large part to the actions of Pasteur himself along with his equally media-savvy scientific colleagues, 'the discovery of the causes of cholera, tuberculosis, typhoid, and diphtheria were not esoteric events isolated in the pages of technical journals, but front-page news' (Rosenberg 1988:20). The transformative impact of these discoveries on medicine and public health over the long term was profound; their immediate impact was to discredit environmental theories of disease. If each disease was caused by a germ, prevention might not require expensive intervention in the larger environment but only modifications of individual behaviour to interrupt the germ's transmission.

3.11 Yet, the 'discovery' of infant mortality and tuberculosis as public problems about which 'something must be done' was driven less by the germ theory of disease than by crises of national identity peculiar to the late-nineteenth century: European (and francophone Canadian) fears of national decline and North American fears of subversion by alien presences within. The modes of intervention in these problems, on the other hand (e.g., notification of tuberculosis cases to public health authorities and pasteurization of milk, education of mothers in 'hygienic' baby care and of consumptives to avoid 'promiscuous' spitting), were shaped by the germ theory and by the new science of microbiology that developed rapidly in its wake.[4]

3.12 Reception of the new theory and its implications—their transformative impact—was, nevertheless, highly variable not only across but within countries, among actors at different locations in the structures of politics, medicine, and public health and with different stakes in the outcome of the changes underway. Describing late twentieth-century scientific conflict over the dangers posed by the ozone layer, Litfin remarks that there is no straight path from knowledge to policy consensus. 'Information is incorporated into preconceived stories and discourses; it is framed, interpreted, and rhetorically communicated. In policy controversies, information begets counter information. Knowledge is embedded in structures of power: disciplinary power, national power, and socioeconomic power' (Litfin 1994:51). Late nineteenth-century bacteriological knowledge was embedded not only in structures of disciplinary and national power, but also in structures of—and struggles over—the power of experts and zealots: medical elites, physicians in private practice and in public health, and lay advocates who adopted disease prevention as a cause. These are Sahlins' interested actors who 'bend categories to their own ends in the course of action' (Sewell 2005: 203-04).

3.13 Smoking and HIV/AIDS. In sharp contrast to infant mortality and tuberculosis, HIV/AIDS burst suddenly upon the world much like the Black Death in the fourteenth century, pushing all four countries into more or less immediate confrontation with a new and exotic threat to their populations. HIV/AIDS was an 'event'—a crisis—*sui generis*. On this *tabula rasa* congeries of meanings were imposed—'no single event has had a more dramatic and illuminating impact [on conceptions of disease] than AIDS' (Rosenberg 1988:13)—careers were made, old institutions transformed, and new ones created.

3.14 Cigarettes and tobacco, on the other hand, were old friends. Recognition of the dangers they presented—the transformation of the cigarette and smoking from symbols of 'modernity, autonomy, power, and sexuality' to symbols of weakness, irrationality, and addiction (Brandt 1992:70)—came slowly, unevenly, and with extreme reluctance. This transformation was not a side effect of crises comparable to

the Boer War or a massive influx of immigrants, but rather the end result of two somewhat different sets of social processes: first, a cascading and cumulative series of observations by physicians and epidemiologists in the 1940s and 1950s that led to the linking of rising rates of lung cancer in men to cigarette smoking; second, the media prominence accorded to these findings (orchestrated initially by scientific bodies), the intense controversy that surrounded them (generating large bodies of competing research, the identification and targeting of villains and victims, and, of course, more media coverage), and finally, the emergence over time of national (and international) crusaders against tobacco. If these processes appear to have much in common (saving the precipitating political crises) with those that surrounded the transformation of infant mortality and tuberculosis, that is hardly accidental. I turn now to the variable role of interested actors both in shaping these public health 'events' and in responding to them.

Actors and Interests

4.1 The power of events to precipitate social change lies in their capacity to shake up existing assumptions about the social 'rules of the game'—the conventions around which we organize our lives—and to redistribute resources among social actors. Scientific discoveries, wars, and plagues created openings for new categories of actors and new opportunities for action with the potential to transform public health. Whether or not those opportunities were seized and by whom was highly variable, however, contingent on the particular circumstances—historical, social, political —at the time and on the interests of the various actors involved. I illustrate how the conjunction of interests and opportunities played itself out in different settings with a series of intra- and cross-national comparisons.

4.2 Power and procrastination in early 20th century public health. In the United States the years from the turn-of-the-century until the first world war were arguably the period of urban public health officials' greatest influence. New York City was in the vanguard, the earliest city in the country to implement mandatory notification of tuberculosis cases to public health authorities (1897) and among the earliest to require pasteurization of milk (1912), well ahead of its European counterparts. In Canada, Toronto was similarly advanced. Montreal, on the other hand, was an extreme laggard, not only relative to other North American cities but even relative to its peers in France (laggards themselves compared with New York and Toronto). These differences were clearly reflected in each setting's record of decline in death rates from tuberculosis and infant mortality (Nathanson 2007). Given their similarity in other important respects, notably in their experience of the late nineteenth and early twentieth century events outlined earlier, how can the marked differences among these locations in public health action be explained?

4.3 The cast of characters in early twentieth century dramas of public health was much the same in France and Montreal as it was in New York and Toronto: medical and public health professionals; businessmen, social reformers and women's organizations; civic leaders and political authorities; and, in Montreal, the Catholic clergy.[5] Differences lay in the interests espoused by each group of actors and in their relative power to effect those interests. Let me begin with the contrast between Montreal and Toronto.

4.4 The two cities were comparable in many respects. Port cities, immigrant gateways, centres of industry and commerce, both grew rapidly in the late nineteenth and early twentieth centuries. Moreover, in both cities the dominant commercial class was anglophone and Protestant, this despite large francophone and Roman Catholic majorities in Montreal and in the province of Quebec. Their city fathers shared the devotion to economic development and the aversion to spending money on anything so economically unproductive (in their view) as public health that were common to Canadian municipalities of the period. Other similarities include the stature of each city's medical elite—among the country's best and well aware of developments in modern bacteriology—and the relative weakness of women's organizations as public health actors (in contrast, for example, to New York City).

4.5 The differences, nonetheless, were profound. Montreal laboured under what was already a long history of real and perceived inequities in the distribution of wealth and power between French- and English-speakers. Its advantages of geography and prosperity were more than outweighed by the countervailing politics of ethnicity, language, and—perhaps of greatest importance—religion. The medical community was plagued by individual and institutional conflicts largely along linguistic lines, and the powerful French-Catholic clergy were antagonistic to secular public health activities they saw as competitive with their own interests. The voluntary sector was weak and itself divided by language and religion (Copp 1981, Pierre-Deschânes 1981, McQuaig 1979). These barriers to concerted action were compounded by the geographic/political separation between wealthy hilltop enclaves with excellent services and the urban flatlands. 'The political separation of these communities coincided with the withdrawal of their upper class populations from involvement in Montreal civic affairs ... [Furthermore, after 1910] [p]olitics increasingly tended to focus on emotionally charged nationalist issues which, however important in the larger sense, militated against the development of strong public interest in municipal affairs' (Copp 1974:147).

4.6 In this context of class and ethnic polarization, without political support, and confronting an array of antagonistic interests, it is hardly surprising that the tenure of Montreal's director of public health, Louis Laberge (lasting 28 years, from 1885 to 1913), was marked by continual battle with the city's politicians for sufficient resources to maintain, let alone expand, public health services and, concomitantly, by the highest rates of infant mortality and tuberculosis in North America. Neither the scientific discoveries that coincided with Laberge's assumption of office nor the intense concern of Montreal's francophone physicians with the survival of francophone Canada in light of their compatriots' high infant mortality were sufficient to overcome the intransigence of the city's history and politics.

4.7 These internal divisions were largely absent in Toronto. Further, at the same time that Laberge was struggling with municipal indifference, his counterpart in Toronto, Charles Hastings, was the beneficiary of actions at the provincial and municipal levels that substantially increased the power and resources of the city health department. Building on these advantages, Hastings created a forceful, active health department, highly centralized, with minimal dependence on the work of voluntary groups. He was not

unique. The history of post Pasteurian public health offers other examples of individuals—Hermann Biggs in New York City is a prime example—who, through fortuitous combinations of contemporary ideology and politics with personal qualities of energy, ambition, and political savvy, advanced their own careers in parallel with the cause of public health. Louis Laberge's inability to effect the transformations in Montreal that Hastings and Biggs accomplished in Toronto and New York should not be attributed to personal failings but to the extraordinarily difficult circumstances with which he was confronted. 'The scope or extent of agency...varies enormously between different social systems, even for occupants of analogous positions....Structures, in short, empower agents differentially...'(Sewell 2005:145).

4.8 Among actors with the highest stakes in the fortunes of early twentieth century public health were ordinary medical practitioners. In broad terms and across the four countries for which I have data, the new bacteriology was embraced by public health officials and medical elites (often the same individuals), who saw it as a source of increased legitimacy and status for themselves and their profession, but was greeted with suspicion and even hostility by local doctors fearful of competition from newly-fledged entrepreneurs of public health. How the ensuing conflicts were resolved depended far more on where local doctors perceived their interests to lie and on their relative power compared to other interested actors than on the 'mystique of modern science'(Fox 1975:179). I illustrate these points with two comparisons: first, between the fate of tuberculosis reporting in France and New York City and, second, between French practitioners' inaction on tuberculosis and their active engagement with infant mortality.

4.9 One of the earliest preventive measures adopted as a direct result of the post-Pasteurean revolution in understanding of disease causation was mandatory reporting of tuberculosis cases to public health authorities with the goal of interrupting transmission. Private physicians were at this period almost uniformly opposed to tuberculosis notification. The New York City Health Department proceeded, nonetheless, to make reporting obligatory for all its physicians in 1897. French health authorities, by contrast, waited another 66 years, to 1963. This difference is largely accounted for not only by the high level of political support enjoyed by the New York City Health Department (comparable to Toronto's), but also by the weakness of organized medicine in New York (and elsewhere in the United States) at the time, compared to the power of the *corps médical* in France.[6]

4.10 The circumstances that confronted physicians in France and New York City at the end of the nineteenth century were similar in many respects. Medical practice was highly competitive and the majority of local doctors, American and French, struggled to make a living. In both locations, by contrast, not only did 'the physicians who promoted public health...[represent] the elite of the profession' (Duffy 1990:196), but in both cases these elites were extremely well connected politically. What did distinguish the two settings was the organization of French local practitioners into powerful *syndicats* (unions). Not only were the *syndicats* organized for the specific purpose of protecting the economic interests of local practitioners but also they were able to take advantage of French physicians' remarkably high level of insertion into local and national politics to ensure that those interests were fully represented. New York (and American) medicine on the eve of the twentieth century was 'fluid, chaotic, and riddled with factions'(Fox 1975:179). Physicians lacked the political power enjoyed by the French (and that the Americans later acquired) to block public health measures they opposed.

4.11 French practitioners' opposition to these measures was, in fact, selective. Hostility to state mandated reporting of tuberculosis cases was more than matched by enthusiasm for public maternal and infant welfare programs. This enthusiasm may be attributed in part to the patriotically-driven fears of population decline alluded to earlier—*la patrie en danger*. Equally important, however, was the power of the *syndicats* to ensure that medical assistance to mothers and babies was structured to protect both physicians' economic interests and their position of authority in the relation between doctor and patient. The *corps médical* did not hesitate to bask in the 'favorable reputation created by the work of Pasteur and Lister,' while, at the same time, being highly discriminating in their approach to many of the public health reforms this work implied

4.12 The forgoing illustrations demonstrate that what are transformative events in one social and cultural context are mere happenings in another. Events 'cannot be understood apart from the values attributed to them: the significance that transforms a mere happening into a fateful conjuncture. What is for some people a radical event may appear to others as a date for lunch' (Sahlins 1985: 154). 'Date for lunch' is perhaps the wrong analogy. From the perspectives of French physicians and the Catholic clergy in Montreal the germ theory was nothing so benign as a date for lunch, unless it was with one's own worst enemies. Its implications threatened interests they held dear, and they resisted these 'transformative' implications with all the considerable power at their command.

4.13 Opportunities siezed and ignored in late twentieth century public health. Identifying the transformative power of AIDS, a staff member of France's principal non-governmental AIDS organization (AIDES) remarked to me that his country's policies on injection drug use had made more progress in the preceding two years (1995-97) than they had in the previous 20: '*C'est le Sida qui a tout déclenché*' (literally, it's AIDS that got everything unlocked).[7] Nevertheless, like the power of the germ theory to transform early twentieth-century public health, the power of AIDS to change ideologically entrenched drug use policies was highly variable, dependent on 'the interested action of the historic agents' (Sahlins 1985: xiv). In the early history of HIV, among the sharpest contrasts in response to recognition of the AIDS-drugs connection was between Great Britain and the United States.

4.14 HIV/AIDS in injection drug users was placed on the public agenda in the mid- to late 1980s by experts in medicine and public health. Expert ownership—the power to define and describe the danger that threatened—was contested from the outset (not only in Britain and the United States) by advocates for the 'war on drugs' (including representatives of the criminal justice system and moralists of various stripes); and sometimes (although not invariably) by drug treatment professionals (i.e., competing experts). Public health and medical experts' ability to sustain their ownership claims depended on each country's historical

and current approaches to the control of narcotic drugs, on the political climate in which HIV/AIDS emerged, on contingencies of timing and opportunity, and on the cultural credibility of experts. These variations were, nevertheless, variations on a common theme: the balance of power between public health advocates for the proposition that 'HIV is a greater threat to public and individual health than drug misuse '[8] and proponents of the view advocated by a director of the United States Office of National Drug Control Policy, that '[We cannot] allow our concern for AIDS to undermine our determination to win the war on drugs' {cited in Gordon 1994:171}. This balance was weighted heavily in favour of medical experts in Britain and heavily against them in the United States.

4.15 Reflected both in my own work (Nathanson 2007) and in the writings of British historians and scholars of health policy are, first, the dominance 'of medical influence in [British health] policymaking since the late nineteenth century'(Berridge 1997:66) and, second, the critical role played by medical civil servants withiin government 'in acting as gatekeepers for the main thrust of outside medical expertise' (Berridge 1997:69). Credible public health knowledge was monopolized and deployed by closely linked experts based within as well as outside the government: medical civil servants, the British Medical Association and the Royal Colleges, and government-appointed advisory bodies who conduct much of their business in secret.

4.16 The early dominance of British AIDS/drugs policy by medical experts was facilitated by the convergence of cultural with political authority. Medical experts were well-positioned bureaucratically and politically when AIDS/drugs came along. Their status in and outside of government as partners in narcotics drugs policy dated from the mid-1920s, long before the advent of AIDS/drugs. Syringe-exchange programs were consistent with drug policy initiatives already in place; and there was strong ministerial support for harm-reduction approaches (i.e., syringe exchange and methadone maintenance). Of nearly equal importance in the case of AIDS/drugs was the established process of expert consultation closed to the media and the public. Controversial decisions arrived at behind closed doors run less risk of being derailed by unaccredited outsiders than decisions made in full view of television and the press.

4.17 Experts in the United States—however credentialed—enjoyed no authority (cultural or political) comparable to their counterparts in Britain; the relative absence of structural and cultural supports for medical expertise was particularly marked in the domain of narcotics drugs policy. There was no comparable history of collaboration between 'experts' and drug enforcement bureaucrats; there was, rather, a history of mutual mistrust (Musto 1973). Political space for a discourse privileging HIV prevention over the drug war was nonexistent at the federal level. There has been expert mobilization, most notably around the push in 1998 to legalize federal funding for needle-exchange programs. Nevertheless, however unassailable their science, the experts failed, and the window of opportunity to 'unlock' U.S. federal drug-control policies was closed. Injection drug use and drug users are heavily burdened with stigmatizing cultural meanings. Medical and public health experts in Britain were historically and structurally positioned to transform those meanings and 'thereby [reorient] the possibilities of human social action' in this domain (Sewell 2005: 219). Their American counterparts were not so positioned, and no comparable reorientation was possible.

4.18 The mortal dangers of cigarettes and smoking were revealed over time in the middle years of the twentieth century, with far less immediate dramatic impact than the discovery of AIDS. The transformations wrought—global changes in the meaning and practice of smoking—have been no less profound. Each country (among those I studied) followed a different pathway to arrive at those changes: contingencies of history and social/political structure shaped who would act and the opportunities available for action. These contingencies are illustrated with particular force—given how much the two countries' have in common—by a comparison between the Canadian policy trajectory and that of the United States.

4.19 Sharing the same border and with comparable histories of colonization and immigration, Canada and the United States are both democratic, federal, decentralized, 'developed' states with relatively affluent populations. Of particular relevance to popular and political response to revelations of the threat posed by cigarette smoking, both countries have strong social movement/advocacy group sectors, longstanding in the United States, of more recent vintage in Canada.[9] There are, nonetheless, important differences between the two countries, and in the (1970s and 1980s) history of tobacco policy those differences proved crucial. Although Canada and the United States are both federal states, Canada is governed by a parliamentary system, and political power is highly concentrated: 'The point of departure for an understanding of the Canadian system is an appreciation of the almost unchecked power...of a united cabinet that commands a majority in the legislature' (Radin and Boase 2000:69). Canadian federal authorities had the power to take controversial decisions and to make them stick; for this reason (among others) Canadian antitobacco advocates addressed their demands for change to the central state.[10] Political power in the United States federal government is diffused across three branches, and there were many opportunities for tobacco policy initiatives to be derailed. American advocates responded by seeking other targets.

4.20 Additional dimensions of Canadian history and political structure that favored addressing the central state were: a long history and perceived legitimacy of government intervention in the economy and in health programs; a federal health ministry seeking a role in health promotion to counterbalance the provinces' exclusive authority over the delivery of medical care; and health civil servants positioned to exert major influence on tobacco policy (comparable to the role of health civil servants in the making of British AIDS/drugs policy). The specific forms that Canadian policy initatives took—advertising bans and highly visible package warnings —were shaped by aspects of Canada's political (and legal) structure as well: relatively weak constitutional obstacles to the regulation of commercial speech, and the fact that these regulations fell within the scope of federal powers (see fn. 10). Antitobacco advocacy in the United States was shaped by very different opportunities and constraints. Blocked at the federal level, the first wave of tobacco-control activists organized—and found their targets—locally, in smoking individuals and smoke-filled rooms. They constructed the tobacco-control problem as a contest between the 'rights' of smokers and nonsmokers rather than—as in Canada—a question of the state's obligation to protect the

public's health.[11] Advocates' adoption of policy initiatives—bans on public smoking—that targeted the individual in preference to the state was shaped both by structural obstacles to action at the federal level and by a political culture that privileged risks to individuals over risks to the collectivity.

4.21 The forgoing comparisons were selected to illustrate how seemingly parallel historical instances of scientific and medical discovery may play themselves out very differently depending on the historical and political context into which those instances were dropped. Changes in public health practice in the cities of North America wrought by the germ theory of disease were made possible by alliances of ambitious and entrepreneurial health officers with powerful, reform-minded politicians.[12] Where such an alliance was absent or blocked, the germ theory had little transformative impact. Similarly, the impact of AIDS on policies affecting injection drug users and of smoking risks on tobacco policies were shaped by the contingent conjunction of activist health civil servants with political structures that gave them scope to follow their activist inclinations. Intervening between instances of discovery and their transformation into 'events' were preexisting conditions of culture and structure and the multiple—and highly contingent—actions of historic agents.

Discussion and Conclusion

5.1 'Big structures, large processes, huge comparisons' and 'eventful sociology' have much in common. Both analytic approaches focus primarily on the elucidation of historical processes, both emphasize the importance of time, place, and sequence in the analysis of those processes, and both are highly attuned to the impact of contingent contextual variables on how those processes unfold and on their ultimate impact. The ultimate aim of both approaches is to account for large-scale social change. There are, nonetheless, critical methodological and conceptual differences. Each approach has something important to tell the other.

5.2 Sewell bases his exegesis of 'a theory of the event' on two sustained narrative examples, Sahlins' account of Captain Cook's landing in Hawaii and its fateful aftermath and his own telling of the events that preceded, surrounded, and followed the 'taking of the Bastille' in Paris on July 14, 1789 (Sewell 2005:225-270). Each of these is a singular event (or 'sequence of occurences') in which context, meaning, agency, and structure are almost inextricably intertwined. Sewell is highly critical of 'experimental logic' as applied to historical events (2005:98). I would argue (as I believe Tilly would) that only through comparison across historical instances where one or more of the innumerable potentially relevant variables can be 'held constant' (following what is, in its essence, experimental logic) is it possible to disentangle the roles of context, meaning, agency, and structure in the unfolding of events. Only when seemingly parallel occurrences—the bacteriological revolution wrought by Pasteur, the advent of HIV/AIDS—have disparate consequences can the action of these conceptual elements be revealed. Analyzing the case of Captain Cook, Sewell himself employs thought experiments to alter the conditions of Cook's arrival in the Hawaiian islands. Had Cook arrived in a different season of the year, had he not met with a storm on his departure that forced his ship to return, the meanings attributed to him, his role in Hawaiian internal politics, and his ultimate fate might have been quite different, and Hawaiian social structure might have altered more slowly or not at all. Perhaps not entirely content with thought experiments, Sewell elaborates his argument for an 'eventful history' by drawing on works of comparative history whose authors are able to (figuratively) 'hold constant' some aspects of the conditions at hand so as to identify the critical importance of others that varied. I conclude that an analytically useful 'theory of the event' (useful, that is, to sociologists) *must* be grounded methodologically on the judicious employment of 'multiple [comparative] narratives' (Sewell 2005:98).

5.3 Such a theory must also make way for mental processes—the analysis of interpretation and meaning—processes that Tilly found 'pernicious' but that are central to Sewell: 'Making sense of the taking of the Bastille requires us to reconstruct the sequence of action and *interpretation* that led from the rupture (the assault on the Bastille...) to the new articulation (the encoding of a new conception of revolution...)' (Sewell 2005:236, emphasis mine). Similarly, knowledge of the *meanings* attributed to disease and scientific discovery is necessary (if not sufficient) to fully understand the marked variation in how actors differently positioned and confronting different social, political, and economic circumstances have responded to those conditions. Discussing Theda Skocpol's analysis of revolutions (Skocpol 1979), Tilly observes with seeming approval that 'she would have nothing to do with "purposive" accounts starting from the interests and organization of various revolutionary actors'; only large processes—social and political structures, class and/or feudal relations, the relative power of elites—would do. Tilly's call for 'genuine historical work,' cited earlier, emphasizes time, place, and sequence but has no place for meaning and little for the agency of historic actors. Perhaps for this reason, he fails to 'see' events—happenings that derive their importance from the meanings actors attribute to them—as a category of theoretical interest. This category, as elaborated in the work of Sahlins and Sewell and further refined in the present article, offers an approach to theorizing the 'symbols and idioms' Tilly recognized as important but could not locate in his theoretical scheme, and goes some way toward filling the theoretical gap that he identified.

5.4 From a causal analytic (i.e., sociological) perspective, the most problematic aspect of 'eventful history' is undoubtedly the notion that an 'event' is identifiable only by its 'transformative' consequences. At what point a happening becomes an 'event' and what changes in structure and culture are of a sufficient scale to qualify as 'transformative' are largely matters of judgment: one scholar's event may be another scholar's 'date for lunch'.[13] Sewell does offer a few hints: events are relatively rare, events radically redefine 'the rules of the social and political game,' (i.e., they are 'transformative,' which brings us right back to our starting point). This problem may be insoluble in the abstract. In practice the same set of circumstances—widely diffused scientific or medical discoveries, for example—may radically change the rules of the game in one location while in another leaving those rules more or less intact. Guided by our theory of history, we regard the former case as an 'event' and look for the elements— transformations in meaning and the actions of interested agents—present in the first case and absent (or differently inflected) in the second. I commend this approach to any sociologist contemplating the employment of historical data to

unravel the causes of social change. And to ‘big structures, large processes, huge comparisons,’ I would add ‘deep meanings.’

Notes

[1] Gusfield is, of course, employing ‘event’ in its dictionary sense as ‘something that happens’ (Webster 1985:430), more akin to happening than to event in Sahlins’ terminology, where event is a term of art meaning occurrences in human affairs that result in social change.

[2] There are few reliable data on infant mortality rates (number of deaths of infants under one year of age for every 1,000 live births) at the national level for the United States before the 1920s (Preston and Haines 1991)and essentially no data for Canada (McInnis 1997). Data for Massachusetts, which had relatively reliable death registration from the 1860s, show a pattern similar to that of the UK and France.

[3] By the end of the nineteenth century, Europe and North America were linked by British, French, German and United States-owned cables.

[4] Exemplifying Gusfield’s point that the mode ‘of conceiving of the reality of a phenomenon [is] closely related to the activities of resolution,’ (Gusfield 1981:6) the form taken by these newly-disovered ‘solutions’ further reinforced the definition of the ‘problem’ as one of individual behaviour change.

[5] With relatively few exceptions, public health action in North America in the early twentieth century was local, dominated by the large metropolises of New York, Boston, Chicago, Toronto, Montreal and other major cities. Public health action in France was organized from the center (Paris) and extended out into the country in various (and contested) ways. Although New York or Montreal (say) and France are incommensurate geographically and politically, the constellation of forces that shaped public health action at the time are parallel.

[6] By 1908 84 U.S. cities had adopted mandatory tuberculosis notification.

[7] Injection drug use is, of course, second only to sexual intercourse as a means of HIV transmission.

[8] The citation is from the 1988 report of the British ACMD (Advisory Committee on the Misuse of Drugs). The 1990 report of the Canadian NAC-AIDS (National Advisory Committee on AIDS) employed identical language.

[9].Canadian adoption in 1982 of a Charter of Rights and Freedoms (similar to the U.S. Bill of Rights) was associated with a major increase in popular protest: ‘Canadians, far from being deferential to authority, are among the most likely [to participate in politics through collective action], ranking slightly ahead of Americans in their propensity for protest’ (cited in Meyer and Staggenborg 1998:216).

[10] Specifically, cigarette ad bans and package warnings were within the scope of the Canadian federal government’s exclusive (not shared with the provinces) criminal powers.

[11] Passive smoking was an issue in Canada as well as the United States, but it was much less central to activists’ campaigns.

[12] This is, of course, an hypothesis. To confirm or refute it would require an analysis across all (or a random sample) of North American cities at the time.

[13] Sahlins was fully aware of this problem, but elided it, stating that he dealt only with the concrete, leaving ‘abstract problems to haunt me another time’ (cited in Sewell 2005:210).

References

BERRIDGE, Virginia (1997) ‘Two Histories of Harm Reduction; Opium and Tobacco’in *8th International Conference on the Reduction of Drug Related Harm* (Paris, 23-27 March).

BLUMER, Herbert (1971) ‘Social Problems As Collective Behavior’in *Social Problems* 18:298-307. [doi:10.1525/sp.1971.18.3.03a00020]

BOCK, Gisela and Pat Thane (1994) ‘Editors’ Introduction. Pp. 1-20 in *Maternity and Gender Policies: Women and the Rise of the European Welfare States 1880s - 1950s*, Gisela Bock and Pat Thane (editors). London and New York: Routledge.

BRADEN, Christopher R., Ida M. Onorato, and Joseph H. Kent (1996) ‘Tuberculosis--United States.’ Pp. 85-97 in *Tuberculosis*, William N. Rom and Stuart M. Garay (editors). Boston: Little, Brown and Company.

COMACCHIO, Cynthia R. (1993) *Nations Are Built of Babies: Saving Ontario's Mothers and Children, 1900-1940*. Montreal: McGill-Queen's University Press.

COPP, Terry (1974) *The Anatomy of Poverty: The Condition of the Working Class in Montreal, 1897-1929*. Toronto: McClelland and Steweart.

COPP, Terry (1981) ‘Public Health in Montreal, 1870-1930’in *Medicine in Canadian Society. Historical Perspectives*, E. D. Shortt (editor). Montreal: McGill-Queen's University Press.

DUFFY, John (1990) *The Sanatarians: a History of American Public Health*. Urbana: University of Illinois Press.

FOX, Daniel M. (1975) ‘Social Policy and City Politics: Tuberculosis Reporting in New York City, 1889-1900’in *Bulletin of the History of Medicine* 49(Summer):169-95.

GORDON, Diana R. (1994) *The Return of the Dangerous Classes: Drug Prohibition and Policy Politics*. New York: W.W. Norton and Co.

GUSFIELD, Joseph R. (1981) *The Culture of Public Problems: Drinking-Driving and the Symbolic Order*. Chicago: University of Chicago Press.

HAYS, Samuel P. (1995)*The Response to Industrialism 1885 - 1914*. Second edition. Chicago: University of Chicago Press.

KUHN, Thomas S. (1970) *The Structure of Scientific Revolutions*. Chicago: The University of Chicago Press.

LITFIN, Karen T. (1994) *Ozone Discourses: Science and Politics in Global Environmental Cooperation*. New York: Columbia University Press.

MCINNIS, Marvin (1997) ‘Infant Mortality in Late Nineteenth Century Canada’ in *Infant and Child Mortality in the Past*, Alain Bideau, Bertrand DesJardins, and Hector P. Brignoli (editors). Oxford: Clarendon Press.

MCQUAIG, Katherine (1979) ‘The Campaign Against Tuberculosis in Canada, 1900-1950.’ McGill University, Montreal, Canada.

MEYER, David S. and Suzanne Staggenborg (1998) ‘Countermovement Dynamics in Federal Systems: a Comparison of Abortion Politics in Canada and the United States’ in *Research in Political Sociology* 8:209-40.

MUSTO, David F. (1973) *The American Disease: Origins of Narcotic Control*. New Haven: Yale University Press.

NATHANSON, Constance A. (2007) *Disease Prevention As Social Change: the State, Society, and Public Health in the United States, France, Great Britain, and Canada*. New York: Russell Sage Foundation. <http://www.russellsage.org/publications/books/070104.556942/view?searchterm=Nathanson>

PIERRE-DESCHÂNES, Claudine (1981) ‘Santé Publique et Organisation de la Profession Médicale au Québec 1870-1918’in *Revue D'Histoire De L'Amerique Francaise* 35.

PRESTON, Samuel H. and Michael R. Haines (1991) *Fatal Years: Child Mortality in Late Nineteenth-Century America*. Princeton: Princeton University Press.

RADIN, Beryl L. and Joan P. Boase (2000) ‘Federalism, Political Structure, and Public Policy in the United States and Canada’in *Journal of Comparative Policy Analysis: Research and Practice* 2:65-89.

ROSENBERG, Charles E. (1988) ‘Disease and Social Order in America: Perceptions and Expectations.’ Pp. 12-32 in *AIDS and the Burdens of History*,. Elizabeth Fee and Daniel M. Fox (editors). Berkeley: University of California Press.

SAHLINS, Marshall (1984) *Islands of History*. Chicago: University of Chicago Press. URL: <http://www.press.uchicago.edu/presssite/metadata.epl?mode=synopsis&bookkey=70463>

SALOMON-BAYET, Claire (1986) ‘Penser la Révolution Pastorienne.’ Pp. 17-62 in *Pasteur et la Révolution Pastorienne*, Claire Salomon-Bayet (editor). Paris: Payot.

SEWELL, William H. Jr. (2005) *Logics of History: Social Theory and Social Transformation*. Chicago: The University of Chicago Press. URL: <http://www.press.uchicago.edu/presssite/metadata.epl?mode=synopsis&bookkey=153695>

SKOCPOL, Theda (1979) *States and Social Revolutions: a Comparative Analysis of France, Russia, and China.* Cambridge: Cambridge University Press.

TILLY, Charles (1984) *Big Structures, Large Processes, Huge Comparisons*. New York: Russell Sage Foundation. <http://www.russellsage.org/publications/books/0-87154-880-1/view?searchterm=Tilly>

WEBSTER’s Ninth New Collegiate Dictionary. 1985. Springfield, Mass.: Merriam-Webster Inc.