Abstracts

Sociology and Social Policy

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Tsai, Y. and Sigelman, L., The community question: a perspective national survey data – the case of the USA. *British Journal of Sociology*, **33**, 1982, 579–588.

In everyday life we use a variety of taken-for-granted terms which often have different meanings when used by different people. One such term is 'community'. The concept of community has been a central concern of many key individuals throughout the history of sociology. In recent years it has become the focus of much discussion and debate which has become known as the 'community question'. 'The community question concerns the extent to which and the manner in which the organisation and content of primary and interpersonal ties are affected by the large-scale division of labour associated with modern urban society' (p. 579). The current debate has been summarised by Wellman,[1] who identified three fundamental perspectives: the 'community lost', the 'community saved' and the 'community liberated' perspectives. The 'community lost' perspective considers urban society as profoundly disruptive of communal solidarity, because people from an urban environment have limited social networks with weak social ties and are bound to their enviroment only by secondary affiliations. In contrast, the 'community saved' perspective rejects such pessimism, arguing that close primary ties continue to flourish in urban environments. In between these two views is the 'community liberated' perspective, which argues that the contemporary urban dweller is no longer restricted by immediate kinship groups or the intimate ties of the tight neighbourhood existence. Rather, such close relationships now encompass entire urban areas or even whole nations.

This taxonomy was constructed on the basis of a small number of single community studies, and Tsai and Sigelman report on data collected as part of the General Social Surveys conducted by the National Opinion Research Center in order to test for a wide variety of communities. A number of questions about respondents' social networks and leisure activities were repeated in successive NORC surveys. The pooling of four years' data allowed the construction of

three residence categories: city dwellers, residents of rural areas, and residents of suburbs and small towns. Using these data the following hypotheses were tested:

A. According to the 'lost' perspective: other factors remaining equal, residents of cities are less likely to socialize with relatives, neighbours, and friends from outside the neighbourhood than are residents of rural areas, with those who live elsewhere falling in between but displaying greater similarity to the rural dwellers.

B. According to the 'saved' perspective: other factors remaining equal, residents of cities are no different from their suburban, small-town, and rural counterparts in the frequency with which they socialise with relatives, neighbours, and friends from outside the neighbourhood.

C. According to the 'liberated' perspective: other factors remaining equal, residents of cities are less likely to socialise with relatives and neighbours than are residents of rural areas. However, residents of cities are more likely to socialise with friends from outside the neighbourhood than are residents of rural areas. In each instance, those who reside in suburbs or towns occupy an intermediate position, but display greater similarity to the rural dwellers (p. 583).

The hypotheses were tested using three separate multiple regression analyses. 'Sociability' with relatives, neighbours and friends from outside the neighbourhood were the three dependent variables and age, gender, race, number of siblings, marital status, number of household members, household composition, geographical mobility, level of education, family in care, social class, employment status, frequency of church attendance, number of memberships, city residence and suburban or town residence were the independent variables for each regression model.

The authors conclude from these analyses that urbanism has had some impact on kinship and neighbourhood ties, as the 'community lost' perspective would suggest. These data also indicate some real differences in social interaction pattern based on residence. Such differences do not support the 'community saved' perspective. The data suggest that while kinship and neighbourhood ties appear to decline as a result of urbanism, urban dwellers are compensated by their more extensive social networks, which extend beyond their immediate neighbourhood. These data are more consistent with the 'community liberated' perspective.

COMMENT

When we think of the extensive sociological literature about community this article appears to add little to it. Yet if we accept that these analyses

support the perspective of the 'community liberated' – and I would prefer it to be only a tentative acceptance – then we should ask the question whether the aged report similar experiences. I suspect that from the viewpoint of most old people the 'community lost' perspective is still extremely salient. Repeated surveys of the elderly report little evidence of extensive solid networks among old people outside the neighbourhood. A re-analysis based on the responses of an aged subsample might give us some insight. Other analyses using data from outside the USA might also be informative.

NOTE

1 Wellman, B., The community question: the intimate networks of East Yorkers. *American Journal of Sociology*, **84** (1979), 1201–1231.

Clarke, M., Where is the community which cares? *British Journal of Social Work*, **12**, (1982), 453–469.

It is not only the term community which we take for granted. Community care finds itself in the same situation. This article is concerned with both terms by focusing on three questions. First, what is a community in modern industrialised society? Second, what evaluated assumptions do we make about community care? Third, can communities be redeveloped? Conceptually Clarke supports Wellman's model of the community liberated[1] although, unlike Tsai and Sigelman, he does not substantiate his view with empirical data. Thus Clarke concludes: 'For most people in industrialized societies "community" remains as a network of sustaining relationships which is not constrained, except to a limited degree, by time and place, and managed with increasing sophistication for the maintenance of personal identity, self-development and satisfaction' (p. 461). However, Clarke questions whether all members of society can adapt to the new concept of community. The disadvantaged individual, for example, lacking perhaps education and economic security, will be denied access to many of the wide relationships available to the majority of citizens. Such disadvantage will affect many older people.

What Clarke makes clear in this article is the relationship between the 'community liberated' perspective and community care. He argues that the assumption of community care is that the community is a residential neighbourhood. Whether or not care is undertaken *in* the community or *by* the community it is clear that the success of community care relies on the concept of community as a residential neighbourhood.[2]

The 'community liberated' perspective does not make this assumption. However, as Clarke points out, it is the very people who require community care – the elderly, the mentally handicapped and the socially disadvantaged – who are unlikely to have the resources necessary to establish supportive social networks with people outside a residential neighbourhood. Clarke's main concern is that community care will only be 'successful' in a modern industrial society characterised by the 'community liberated' perspective when the social agencies providing care are part of the 'machine of social control'. Unless we reconstruct the idea of community.

Clarke does not provide a satisfying answer to this proposal. He cites the example of the Community Development Projects, which had been set unrealistic goals. Their aim was to revitalise populations, put them on their feet and then allow them to carry on by themselves. Whilst it is clear that the activities of the Projects re-established many of the communities served, there is little evidence to suggest that the communities could be sustained once the project was completed. These experiences support the 'community lost' perspective. Clarke argues that the failure of the Community Development Projects in particular and community care in general is the authoritarian nature of many of the agencies involved. This very characteristic also militates against the successful reconstruction of community, even a 'community liberated'. Clarke suggests that the introduction of various independent social agencies who have provided community care has reduced the monopoly power of public agencies like social work. In itself this could be beneficial to the clients of public agencies by reducing bureaucratic authoritarianism.

COMMENT

This article highlights the difficulty of evaluating the 'community question' clearly. Although Clarke's comments appear sound from a 'common-sense' perspective they were substantiated by little or no evidence. To do this we need to pursue the different theoretical perspectives and collate the numerous data sets which have been collected for different communities throughout industrialised society. Perhaps by focusing on the elderly we can also arrive at an understanding of how changes in the 'community' influence changing patterns of 'community care'. Clarke's article ends uneasily; he does not really discuss how we might reconstruct the idea of 'community', he only indicates the dangers which lie ahead if we don't.

NOTES

1 Wellman, B., The community question: the intimate networks of East Yorkers. *American Journal of Sociology*, **84**, (1979), 1201–1231.
2 Bayley, M. Mental Handicap and Community Care. Routledge and Kegan Paul, London, 1973.

Hall, D. and Bytheway, B. 'The blocked bed: definition of a problem.' *Social Science and Medicine*, 16, 1982, 1985–1991.

Another taken-for-granted term widely used by doctors and hospital administrators is the 'blocked bed'. This phenomenon may also be known by the less derogatory term 'misplacement'. The literature on the old in hospital is full of these terms, but what do they mean? Hall and Bytheway provide us with an answer to this question: they mean different things to different people. The primary concern of their article is with the ways in which bed-blocking is categorised and defined. They describe a simple study in which they invited the 127 Area and Regional Health Authorities in the United Kingdom to define the term 'blocked bed' as used in their authority. The study deliberately focused on how they defined the term.

From the 127 Health Authorities circulated 99 returned a completed questionnaire. All respondents understood the term 'blocked bed' but not all were able to provide a definition, some admitting that they had never attempted to define it and others saying that an 'official' definition did not exist. About half of the respondents provided a definition, and from these Hall and Bytheway constructed the following composite definition: 'A blocked bed is a bed occupied by a patient who in the consultant's opinion no longer requires the services provided for that bed, but who cannot be discharged or transferred to more suitable accommodation' (p. 1987).

Although the authors found a high level of correspondence between their composite definition and individual responses from the authorities they found that there were two kinds of emphasis: some respondents emphasised *the use of the bed* and others the *patient's needs*.

Twenty-seven authorities with appropriate operational definitions provided various statistics about the blocked bed. These statistics often related to the use of the bed rather than to the patient's needs. Hall and Bytheway argue that because bed blocking in these authorities came to be associated with patients who exceed some arbitrary fixed period, or the average length of stay for their medical condition, this reflects the acute-medicine ideology in which particular conditions are associated

with standardised treatment regimens. This observation is underlined by the fact that most bed-blocking is reported to occur in the acute hospital sector. The term 'blocked bed' is rarely used in the chronic hospital sector. Thus 'the significance of the blocked bed, then, as it is commonly defined and described, is that it represents certain beliefs about the purpose of hospitals. It takes their resources as given, and then attempts to fit patients to the available services. Blockage is a symptom not just of a mismatch between services and needs, but also of frustration at the shading of the line between medical and social intervention' (p. 1989).

COMMENT

The value of this article is not so much in its discussion of the reasons for bed-blocking, but in its presentation of the definitions provided by health authorities. It makes little sense to attempt to speculate about the reasons for bed-blocking from only the responses of a short self-completed questionnaire from a minority of health authorities, although I agree that the direction in which the speculation was going was probably likely to be fruitful given suitable data. That data would have been best obtained from individuals who control access to hospital beds. One imagines that focused interviews with these consultants would have underlined the acute-medicine ideology suggested by Hall and Bytheway. However, the information collected is not insignificant. It tells us that people do understand the term in different ways, but perhaps surprisingly it tells us that there is some agreement between different health authorities. The composite definition should also serve as a good reference definition of the 'blocked bed' as well as providing future researchers with a useful operational definition.

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