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DEBATE

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Bridge building, medical sociology and beyond: an interview with Graham Scambler

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ABSTRACT
In this wide-ranging interview Graham Scambler provides an overview of his long academic career. He discusses how he became a medical sociologist, his early work on epilepsy and stigma, his part in the development of sociology textbooks for medical students, the diversity of his work and his many collaborations, his 'theoretical turn', his longstanding interest in critical realism and his attitude to 'bridge building' between philosophy and empirical work.

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Critical realism; medical sociology; fractured society; class/command dynamic

Graham Scambler is Emeritus Professor of Sociology at University College London (UCL). He is perhaps best and most recently known to readers of this journal as one of the editors of *Structure, Culture and Agency: Selected Papers of Margaret Archer* (Brock, Carrigan, and Scambler 2017), as author of *A Critical Realist Theory of Sport* (Scambler 2024a) and as a recipient of the Cheryl Frank Memorial Prize for the book *Sociology, Health and the Fractured Society: A Critical Realist Account* (see Scambler 2018a). More broadly, he is known in critical realist circles as a longtime advocate of 'bridge building' and especially between abstract discourses of philosophy and social theory and empirical discourses whose focus on application can lead to thinly theorized approaches. Given this concern the appeal of critical realism to his work over the years is self-evident.

Scambler was born in Finchley North London in 1948, in 1960 he passed the 11+ and attended the grammar school, Worthing High School for Boys. In 1968 he moved on to the University of Surrey and studied Philosophy and Sociology and was awarded a BSc in 1971. He subsequently began a PhD in Philosophy at Birkbeck College, University of London, supervised by David Hamlyn, before switching in 1972 to Bedford College, University of London, and beginning a PhD in sociology supervised by George Brown. In the same year, he began research and teaching at University of London medical schools and this continued for the next fifteen years, undertaken successively at St. Bartholomew's (1972–1975), Charing Cross (1975–1978) and Middlesex Hospital Medical School (1978–1987). He was eventually awarded his doctorate in 1983 for a thesis focused on the stigma experienced by adults with epilepsy living in the community. According to

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Scambler, somewhere along the way he had become a medical sociologist, albeit one who considered himself a sociologist who happened to study health. In 1987 he was appointed at University College London when Middlesex Hospital Medical School was absorbed by UCL and in 2001 he was promoted to Professor of Medical Sociology. He retired in 2013 but continues to write.

Scambler's main contributions to critical realism have been published over the last quarter of a century. However, he began publishing in the mid-to-late 1970s and started publishing regularly in the 1980s and over a long career his empirical and theory work has mainly ranged over long-term illness, health inequalities, sex work and sport. By his own admission, his work took something of a 'theoretical turn' in the mid-1980s and especially from 1987. His first major publication was the textbook *Sociology as Applied to Medicine* in 1982 and this was one of the first of its kind dedicated to medical students. The first and second editions were jointly edited with Donald Patrick and the book is, since 2018, in its seventh edition, and has since the third edition been solely edited by Scambler and includes contributions by various others.[1] These include Annette Scambler (his wife who he had first met as an undergraduate) and Sasha Scambler (his daughter) and he has at various times collaborated with both on other projects.[2] He is (at time of writing) the author of ten single and co-authored books, and another ten edited collections, as well numerous chapters in edited collections, handbooks and encyclopaedias.[3] In addition to work published in *Alethia* (Scambler 2001a) and *Journal of Critical Realism* (Scambler 2006d, 2017b, 2020b, 2023a), he has published articles, essays and reviews in a wide range of journals including, for example, *The Lancet* (Hopkins and Scambler 1977; Napier and Scambler 2014; Scambler 1998), *Social Science and Medicine* (Scambler and Higgs 2001; Scambler and Scambler 1985), *British Medical Journal* (Boyton and Scambler 1988), *Journal of the Royal Society of Medicine* (Scambler 1993), *British Medical Anthropology Review* (Scambler 1994), *Critical Public Health* (Scambler and Goraya 1994), *Sociology* (Scambler 1996, 2007b, 2012c; Scambler and Higgs 1999); *Social Theory & Health* (Scambler 2007c, 2013b), *Aging & Society* (Moffatt and Scambler 2008), *Sociology of Health and Illness* (Scambler 2009b, 2009a; Scambler and Hopkins 1986), *Contemporary Sociology* (Scambler 2014c), *Sociological Review* (Scambler 2018c) and *Frontiers in Sociology* (Scambler 2019b, 2022).[4] Many of his works have been cited hundreds of times.

Scambler, was Visiting Professor of Sociology at Emory University in 1998 and was for many years an Adjunct Professor in its Department of Sociology. From 1976 to 2011 he was London Director of the 'Comparative Health Care' summer programme for Emory undergraduate students. In 2003 he cofounded with Paul Higgs the journal *Social Theory & Health* and remained as co-editor until stepping down in 2013.[5] In 2010 he was elected an Academician of the Academy of Social Sciences, UK and remains a Fellow. He was Visiting Professor of Sociology at Surrey University from 2014 to 2022 and is an enthusiastic and prolific blogger and maintains his own site.[6]

The following interview with Professor Graham Scambler was conducted by Professor Jamie Morgan for *Journal of Critical Realism*.[7]

Jamie Morgan (JM): As I note in the introduction, you've referred to yourself in the past as someone who somewhere along the way became a medical sociologist, albeit one who considered himself a sociologist who studies health …

Graham Scambler (GS): My intention when I graduated from Surrey University was to continue to pursue philosophical studies. As you note, I actually began a PhD with David Hamlyn at Birkbeck College, University of London – but I'd met my future wife Annette as an undergraduate and, factoring in the need for a family income, I switched my allegiance to sociology. By chance I got a job as a research associate at St Bartholomew's Hospital Medical School on a study of epilepsy in the community.

JM: It's remarkable how much of life turns out to be chance encounters followed by decisions that seem to create trajectories …

GS: Yes, it's as if I became a sociologist, and a medical sociologist at that, by accident. It was an unanticipated change of direction but I'm not sorry I ended up a sociologist rather than a philosopher. But I still wanted to do a PhD and the epilepsy study provided an opportunity. I signed up in sociology to be supervised by George Brown at Bedford College, also of the University of London. At that time the Medical Sociology Unit at Bedford College, directed by Margot Jefferys, later in conjunction with George Brown, was the premier base for medical sociological research in the country. It was from this point on that others saw me as a medical sociologist. It became a kind of master status attached to me. It seemed a natural progression to publish and lecture on health.

JM: I'm curious though, presumably the academic world was different then. Was their pressure to publish?

GS: This was a long time before the REF and the RAE, which only got going in 1986.[8] The pressure was much lighter than it was to become. For many years I was left to my own devices, not least because I was largely an unknown quantity in the medical school environment. As it happens, I've spent my whole academic career in University of London Medical Schools, but I've always insisted, perhaps in vain, that I'm a sociologist whose range of interests is wider than the health field. At least, this is how I've seen myself.

JM: Well, the kinds of things you've written and the way you've approached the subject is very obviously influenced by matters of context that extend far beyond the narrow and otherwise instrumental foci one might have adopted and that surely reflects a sociological mindset. It's not just a matter of self-identification seemingly, the emphasis is *sociologist* who studies health and it is evident from your work and interests that you range over the many influences on medical experiences and outcomes – the mind and body as society in microcosm perhaps …

GS: I have never lost my early interest in philosophy and social theory, but it is true that through the 1970s I was actively engaged in empirical research around health issues. It was from my first study of epilepsy that I came up with what I called a 'hidden distress model of epilepsy'. The focus was on stigma, and what I found amongst the adults I interviewed was that it was a personal sense of shame plus a fear of encountering stigmatisation ('felt stigma') rather than actual instances of stigmatisation on the part of others ('enacted stigma') that most disrupted their lives. The paper in which I made this

distinction between felt and enacted stigma remains my most cited paper (Scambler and Hopkins 1986). I followed this up with a pilot study of whether or not women define menstruation as a form of illness; fortunately, Annette completed the main study and as might be anticipated women were more open with her than with me, a man in his mid-20s.

JM: And just so we get a sense of this, Annette is also an academic sociologist?

GS: Yes, Annette is a sociologist whose interests focus on gender and health. She taught in the London medical schools with me and was a tutor at the Open University for 25 years. Also, three of our four daughters studied sociology at university, and two of them went on to work in the health field: Sasha is currently Reader in Medical Sociology in the Dental School at King's College London, and Miranda is a public health practitioner. The other sociology graduate, Nikki, is Disability Support Manager at the University of the Creative Arts. Rebecca could well have studied sociology too, but her excellence at art led her to study graphic design and she now works as a freelance graphic designer.

JM: If we return to your unfolding career …

GS: As you note in your introduction, I was involved in the late 1970s in co-editing with Donald Patrick *Sociology as Applied to Medicine*, the first edition of which was published in 1982 and which was the first widely used sociology textbook for medical students up and down the country.

JM: And presumably there was some demand for this – or if not demand then, once created, a sense that it was just what was needed? Would you say that recognition that sociology was something medical students needed to have a sound grasp of was something students (and hospital staff) were receptive to?

GS: Margot Jefferys had been instrumental in making sociology a compulsory subject in our medical schools and thereafter it was 'required' by the General Medical Council.[9] Of course, not all our colleagues in the basic medical and clinical sciences approved of this, and through the 1970s and 1980s we often had to fight our corner in assorted academic committees. I remember David Blane and I walking down a corridor at Charing Cross Hospital and encountering the Professor of Pharmacology, who said 'I can never see you two without thinking of anarchy and bombs'. On another occasion, this time at the Middlesex Hospital Medical School, my colleague Ray Fitzpatrick finished his inaugural lecture on the pharmaceutical companies only for the Professor of Pharmacology, who had been sitting in uninvited, to stand up and announce to the students 'I want you to forget everything you have been told!'. Nor were the medical students always receptive. But we had our allies too and were once supported by the main University of London medical education committee in denying access to the London medical schools to Cambridge students who wanted to transfer to London for their clinical studies. This arose because Cambridge was refusing to appoint a sociologist to teach sociology. The Vice-Chancellors (VCs) of the two universities met and apparently described us as 'a bunch of Ayatollahs'.

JM: Not something you'd expect to hear from a VC these days if they expected to stay in post.

GS: Well they didn't put it in writing! We lost in the end, but we'd made our point. I have to say I've personally always enjoyed teaching medical students. They are often very smart, and I found it a rewarding challenge to gain their attention and interest. One of my most pleasing achievements was receiving a consecutive series of 'top teacher' awards generated by UCL's medical students in the run up to my retirement in 2013. Predictably enough, however, the payoff for our sociology teaching tended to come later, when they were qualified doctors working in hospitals or in the community. What we were saying to them really struck home when they were seeing 'real patients' living complex lives in 'real communities'.

JM: The need to humanise patients perhaps, to push back on treating the person as a decomposable (in both senses) set of parts and symptoms? Was this tendency itself a sociological phenomenon; something to do with the time and place and the way medicine was starting to be perceived?

GS: Yes, the salience of biopsychosocial models of disease was gradually being accepted, if not necessarily by our colleagues in the basic medical sciences.

JM: For clarity you might want to briefly explain what that phrase means …

GS: The biopsychosocial model insists that mental and physical health can only be properly understood through a multiple-system lens, incorporating the influence of biology, psychology and, via sociology, the social environment. This underlined the importance of our sociology teaching, and incidentally of our textbook, which – as you say in the introduction – would go on to achieve a seventh edition in 2018. In a peculiar sense, I think the fact that we were marginal academics in the medical school environment freed us up. We were given a free rein because so few of our colleagues knew what our brief was, or indeed who we were. I remember deciding on the spur of the moment in 1984 that students might like to read George Orwell's *1984* and come to the lecture theatre to discuss it. Attendance was entirely voluntary, but a surprising number took me up on it. I don't think that would, or could, happen now when lectures must be detailed online in advance. In fact, I'm tempted to think, with the hindsight that comes with retirement, that as sociologists have increasingly become integrated in medical school curricula they have become 'tamed' in the process. But present teachers may have a different view.

JM: OK, moving on a little, you've mentioned in print previously that around the mid-1980s your work took something of a 'theoretical turn' …

GS: My first degree was in philosophy as well as sociology and as I've said I always had an underlying interest in philosophy and theory, so much so that my instinct in my PhD epilepsy study was to get my philosophical and theoretical stance sorted before collecting any data. Indeed, George Brown (my supervisor), had initially to curtail this enthusiasm.

George, in retrospect I think wisely, counselled me to wait and to develop my theory as the study progressed: to see it as a dialectical process, you might say.
JM: And he understood this to be different than naïve empiricism – observation offers the prospect of unmediated access to the truth of the matter …

GS: George was a sophisticated thinker and methodologist. He didn't want my theoretical inclinations set in stone at the start of the study. I largely followed his advice. But two other factors intervened around this time, (this is the late 1970s and early 1980s I'm talking about here). The first was the opportunity to teach on an intercalated BSc in 'Sociology as Applied to Medicine' for London University's medical students.

JM: Intercalated?

GS: After two years of pre-clinical study these medical students could opt to take a third year 'out' to complete what was called an 'intercalated' degree, and every year a few chose to study with those of us who taught sociology across the university's medical schools. The students were exceptionally bright and motivated and for several years I taught with colleagues on a social theory module and, as sole teacher, ran a module entitled 'Conceptual Foundations of Contemporary Sociological Thought'. As it happens it was reading for this unit that took me to Roy Bhaskar's *A Realist Theory of Science*, which deeply impressed me (Bhaskar 1975). I picked out a couple of chapters for a student to prepare for our weekly seminar. It was a sign of the quality and enthusiasm of these students that this student read and reported back on the whole book. What most caught my attention in Bhaskar's book was his explication and innovative response to the 'epistemic fallacy', namely, the reduction of being (ontology) to what might be known about being (epistemology). Anyway, from this point on I avidly read and digested Bhaskar's work.

JM: OK, but if one scans the titles of your work from around the mid-to-late 1980s Jurgen Habermas is the name that leaps out …

GS: This brings me to the second factor, my commitment to social theory was a project I quite deliberately initiated to demonstrate that those of us employed in medical schools – that is, doing what was seen as 'applied sociology' – were 'proper sociologists'.

JM: And – recalling some of what we have already discussed – what did people think a 'proper sociologist' was at this time?

GS: A proper sociologist was one who had an appointment in a sociology department and taught sociology students.

JM: Surely more than that, since your remedy was to explore social theory?

GS: No, I think any sociologist employed somewhere like a medical school was seen as 'applied'. And I think those of us based in medical schools were in any case seen as under the thumb of the medics.

JM: And this project presumably had some published consequence (since that is how academics typically persuade themselves they have done something) …

GS: The result was a volume I edited entitled *Sociological Theory and Medical Sociology* (Scambler 1987a).[10] In this collection those of us who taught in medical schools tried to show the relevance of a selection of classical and modern sociological theorists to understanding and explaining issues of health and health care, in the process affirming our own credentials as fully fledged sociologists. My own chapter focused on the work of Jurgen Habermas. You say his name 'leaps out' and I had at this time started to read his work.

JM: Any particular reason why? Fit, recommendation, prominence, happenstance …

GS: Frankfurt School critical theory had been around for quite a while, and I initially read Habermas's *Legitimation Crisis*, which I still think very prescient. I moved on to his two-volume magnum opus, *Theory of Communicative Action* which was translated into English in 1984 and 1987 I think. In the latter Habermas provides insight on the ways in which broader aspects of social order and change impinge on the everyday encounters between doctors and patients. In my chapter I showed, for example, how in what Habermas calls 'systematically distorted communication', the medical model of hospital-based interventionist births can be routinely imposed on women in cases where there is no evidential support, or in this instance even against the evidence, despite both doctor and patient genuinely believing all is for the best.

JM: 'All is for the best' in the sense of?

GS: Despite both doctor and patient acting in good faith and sincerely believing an agreed treatment was the best way forward. As well as 'communicative action', where doctor and patient together pursue the best evidence-based treatment option, Habermas' model also allows for 'open strategic action' ('I'm the doctor and I know best') and 'concealed strategic action' that takes the form of manipulation (for instance, when the doctor intimidates the patient by using abstruse medical jargon).

JM: There's been a lot of interest in Frankfurt school critical theory in the UK over the years – including from critical realists and fellow travellers – Chapter Five of William Outhwaite's *New Philosophies of Social Science* and his *Understanding Social Life* are good examples spanning the ten years to the mid-1980s or so (Outhwaite 1975, 1987), although Ted Benton's early *Philosophical Foundations of the Three Sociologies* has only a few scattered references, mainly Herbert Marcuse I think. Alan Norrie has a great deal more to say later (see also Nevasto 2024).

GS: Habermas was certainly attracting interest prior to publishing *Theory of Communicative Action*. In any case, my interest in him has remained with me. Notwithstanding certain departures from his evolving theories, and his retreat from Marxist thinking, I continue to use his conceptual framework. In particular, I deploy his notion of an historical de-coupling of system (economy and state) from the lifeworld (embracing the private sphere of the household and the public sphere), and the accelerating colonisation of the latter by the former.

JM: You might want to just clarify here how economy and state can become separate from a lifeworld that 'embraces' the public sphere as well as the private …

GS: Well, as Habermas argued, the public sphere of the lifeworld, whose steering media is influence, and the private sphere, whose steering media is commitment, have become increasingly responsive to – or colonised by – the system comprising the economy, through its steering media of money or capital, and the state, through its steering media of power. Just look at the ownership and editorial control of our main news outlets, TV networks and digital platforms.

JM: OK, but that is not quite what I was getting at; since a reader might be a little confused here I was asking what a lifeworld of public and private refer to insofar as these can be different in some sense than economy and the state – not least because the state might be interpreted to involve the public sphere …

GS: We're talking Weberian ideal types here. The lifeworld represents an everyday world characterised by communicative action, or action oriented to understanding and consensus.[11] The contrast here is with the system, comprising economy and state, characterised by strategic action, or action oriented to outcome. The thesis is that more and more of routine everyday communicative interactions and activities are being penetrated or colonised by strategic action via the steering media of money and power. This applies to both private households and to the wider public sphere. This is not the occasion to go into detail but a strong part of the appeal of this framework is the fact that it allows for, even encourages, theorising that embraces macro-, meso – and micro-sociological research. Thus, in the Habermas chapter I mentioned earlier, I was able to trace causal linkages between broad aspects of social change, the evolving role of medicine as a profession and individual doctor-patient encounters.

JM: Does that make you a critical theory critical realist? Might that be 'a thing'?

GS: I'm fairly sceptical about labels, for reasons we might get on to, but I wouldn't object to being called any of critical theorist, critical realist or neo-Marxist. But I have retained this Habermasian frame. In a paper I wrote for *Sociology* in 1996 I argued that the sociological project might be best understood in terms of breathing new life into the lifeworld, which Habermas calls lifeworld rationalisation or a decolonisation of the lifeworld. But I came gradually to incorporate Bhaskar's critical realist approach to being, most obviously by seeking causal explanations for the 'events' we 'experience' in the realm of the 'real'.

JM: And along the way your interest had spread much wider than epilepsy?

GS: Yes, and beyond the health domain too. Annette and I edited a volume called *Rethinking Prostitution* (Scambler and Scambler 1997), which was much discussed at the time, principally because it both incorporated the latest research and, unusually, gave a voice to people working in the sex industry via the English Collective of Prostitutes. After this I published a few follow-up papers, including one on a small study of escort workers from Eastern Europe who had come to London to make good money and

open up new options for their futures. But by the noughties I was mainly writing theory. In fact, I was advised by my then Head of Department to stick to theory so my CV looked more coherent and less heterogeneous.

JM: But, if we get back to your interest in critical realism, you were attracted by not just the idea of epistemic fallacy but by depth realism?

GS: Yes. It is real or beneath-the-surface social structures or relations, as well as cultural recipes and individual and collective agency, that in my view we must factor in to explain social phenomena. Rather like gravity for physicists, the engines of social statics and social dynamics are only detectable via their impacts on our 'on-the-surface' experience of events and phenomena.

JM: But just to be clear, you subscribe to the common commitments that tend to be basic for critical realists: ontological realism, epistemological relativism and judgemental rationality …

GS: Well, I rather baulk at the term 'epistemological relativism'! I would rather refer to epistemological fallibilism, or something like that. But otherwise, yes.

JM: So you don't think there can be several legitimate ways to come to know phenomena, or are you interpreting this term differently?

GS: Relativism for me is strictly self-refuting. If you argue for it you are in the process giving the lie to it. But I would certainly accept that time and place, or context, are very relevant to what we can be said to know.

JM: Let me put this differently, can a neurologist say something different relative to a psychiatrist and yet both be more or less adequate accounts founded in currently justified bodies of knowledge – to the best of our understanding … Would this be self-refuting – relative positions and different foci and concerns?

GS: Maybe we are intending something different by the term 'relative'. There are certainly different perspectives and approaches, often deriving from different paradigms or institutionalised disciplines. Moreover, these clearly change over time. My unease with the term epistemological relativism is that it implies a philosophical acceptance of relativism versus universalism, which I reject. As I said, I prefer to espouse a version of fallibilism, or the notion that we might always turn out to have got things wrong. Maybe I should come clean at this point and admit that for all my longstanding love of philosophising and theorising, my concern as a sociologist has been to bring critical realist thinking into sociology with a view to better grounding and refining sociological practice.

JM: And this shares a sensibility with say Bob Jessop, Andrew Sayer or Margaret Archer, but might, as is the case with these three, also allow for diversity?

GS: Yes certainly. I like to see critical realist thinking put to use. But given this agenda, I was quickly surprised and mildly disappointed to find that colleagues working in the critical realist field were often doing so in intellectual silos: mostly they were dedicated to addressing philosophical conundrums of marginal salience or interest to quantitative or qualitative researchers. And the debates they entered were typically with each other. I felt that some of the early critical realist gatherings were overly reliant on a handful of pioneers, impressive though they undoubtedly were. It wasn't always easy to get involved. I also thought there was a bit too much evangelising on behalf of critical realism. But then I have always worked very largely on my own. My own engagement with critical realism was motivated by a desire to break down silos, to build bridges between its philosophical and theoretical arguments on the one hand and the practical business of conducting empirical research on the other. As I saw him more often and got to know him better, I sensed that Roy agreed with putting critical realism to use in this way (as is reflected in his work on interdisciplinarity and disability for example).[12] But the result of my bridge-building motivation, I think, is a falling between two stools. I sit somewhat uncomfortably between the two main silos: (i) philosophy/social theory and (ii) empirical research.

JM: Well, I imagine there are quite a few who would dispute that the degree of influence of critical realism as a framework for empirical work reduces to the scope and structuring of its conferences and to its high profile debates regarding the status of theory and its refinement, but I take your point. This is an argument that has rumbled on for quite a while and we will likely return to it later. OK, let's turn to some of the first work you did that was explicitly informed by critical realism …

GS: I'm certainly not being reductionist in the manner you imply. I am merely saying that I found many critical realist gatherings, or at least those I attended, revolved around the same key speakers and it was easy to feel something of an outsider. But back to your question. Despite acquainting myself with Roy's work from the 1970s onwards, it was only in the 1990s that I sought to apply it to my own studies, initially in collaboration with my colleague at Middlesex/UCL, Paul Higgs. I had grown personally dissatisfied with the dominant sociology of health inequalities which I felt owed too much to social epidemiology's positivist paradigm and, relatedly, sidestepped vitally important sociological issues. In particular, I critiqued the over-usage of large secondary datasets that relied on proxies for social class (like NS-SEC) and that by definition omitted any consideration of the less than one per cent whose behaviour by my reckoning was largely responsible for enduring and, post-Thatcher, widening health inequalities.[13] If you want to understand and explain health inequalities sociologically, study the wealthy and powerful (today's ruling class if you will). This became my mantra. With deliberate provocation, I called this the 'greedy bastards hypothesis' or GBH, to try and stir up a debate, though to little effect (often people chasing grant money preferred to keep their heads below the parapet).

JM: I take it the grievous bodily harm expansion of the acronym is also not accidental?

GS: No, quite deliberate! Over the next few years I refined the GBH by identifying a largely global hard core of capitalists I termed 'capital monopolists', whose clandestine boardroom decisions exercise a decisive influence on national economic, social and health

policy. Zygmunt Bauman called them 'nomads' because they have no loyalty to any particular nation state. I came to call this the 'class/command dynamic'.

JM: Kees van der Pijl, Leslie Sklair, William Robinson and various others have done a lot of work on the idea of a transnational capitalist class. Is this what you have in mind? The rise of transnational corporations, networks such as the World Economic Forum ('Davos man') and the existence of the Bilderburg group. Without getting 'conspiracy theorist' about this, different ways to think about alignment of interests, the nature of modern capital, influences on global governance etc.

GS: I think my work certainly overlaps with that of these theorists. The 'class/command dynamic' leads to the formula: capital buys power to shape national policies in the interests of its further accumulation. It was a version of neo-Marxism in its invoking of class relations and class struggle. It was also explicitly critical realist in that I contended that a combination of retroductive inference from the 'demi-regs' revealed in quantitative research on health inequalities, plus abductive inference from qualitative and ethnographic research, functioned to expose beneath-the-surface or 'real' relations of class acting – after the manner of gravity for physicists – as generative mechanisms. This was an argument I have been elaborating ever since.

JM: Whilst one can reasonably assume most readers will know what you mean, given this is *Journal of Critical Realism,* not everyone who comes across this interview will be critical realist (online diffusion being what it is these days). For the sake of less familiar readers, you might just briefly explain what a demi-reg is, and what retroduction and abduction are.

GS: Tony Lawson coined the term 'demi-regs' to point to the patterns of statistical association revealed by quantitative research. These might hold for some period in some place (s) and provide an impetus to inquiry: their identification is not an end in itself.[14] In relation to health inequalities they abound in socio-epidemiological research. As I understand it, retroduction represents the inference from such demi-regs to the mechanisms that 'must' exist for the demi-regs to occur and recur. Abduction represents the equivalent inference to mechanisms from qualitative rather than quantitative research**.**

JM: And a generative mechanism is the organisation of things, that gives rise to identifiable powers (ways of acting) expressed causally in tendencies and the events from which they are identified … .[15]

GS: Yes, with the qualification that there may well exist countervailing powers, with the result that generative mechanisms cannot simply be read off from the surface patterning of events. I have written a lot about class, for example, but gender and race relations and so on are simultaneously active and can neutralise class's causal potency.

JM: But back to the argument …

GS: I went on to suggest that in the field of health inequalities the 'media of enactment' of class relations might be conceptualised as a series of asset flows known to be important

for health and longevity: biological, psychological, social, cultural, symbolic, spatial and material. Weak flows are associated with poor health, and strong flows with good health. The merit of thinking in terms of 'flows' is that they can strengthen or weaken over time and compensation can occur between flows. For example, if a redundancy results in a weakening of the flow of material assets, this might be compensated for by strong biological, psychological or social asset flows.

JM: This seems quite appealing – it is easily grasped and visualised as structured, dynamic, and interdependent. But it seems worth asking, in what sense do an elite play a decisive role in the health outcomes for everyone else – what kind of causation is this (for the GBH)? It doesn't, for example, take any great insight to understand that years of austerity politics affect the economic circumstances of the working and non-working poor and this will have adverse impacts on mental and physical health (stress, poor diet, poor access to health professionals and so on) …

GS: The social and health policies that best serve the vested interests of the capital monopolists and their allies (Dave Byrne calls their allies a 'concierge class') typically involve ramping up the exploitation of the working class. The political austerity post-2010 is a case in point. It has involved increasing workplace precarity via zero hours contracts, reducing trade union rights, redefining unemployment, weaponing stigma to cut benefits to so-called 'scivers' through Universal Credit, legislation favouring private landlords, slashing funding to privatise healthcare, and so on. These, as you say, add up to an attack on the health of poorer people.

JM: How was your work received?[16]

GS: The main criticism I encountered was that it's difficult to measure/operationalise the notion of an asset flow. So much the worse for positivist ideas about reducing chunks of reality to variables, was my response.

JM: And, as I understand it, your daughter Sasha became a collaborator in this enterprise?

GS: Yes, she had done a PhD on people living with juvenile Batten Disease supervised by Paul Higgs at UCL and drawing on the theories of Pierre Bourdieu.[17] Like me she was attracted also to critical realism. My reading of Bhaskar had by this time embraced his dialectical critical realism (as for others, my interest in his later writings – his 'spiritual turn' – dissipated somewhat). It might be getting ahead of ourselves, but Sasha and I were invited in 2015 to contribute to a guest-edited special issue of *Social Theory & Health* and we opted to ask what dialectical critical realism might add to our understanding of health inequalities. Referring to the idea of 'absence', we argued that the mechanisms that give rise to and sustain differential access to wealth and power are absent from most commentaries on health inequalities, and that this absence signals acquiescence in the presentation of reality other than it is.

JM: So, you subscribe to the idea that there are 'real determinate absences'?

GS: Initially, when I wrote about 'absence' I focused on how the capital monopolists went missing in classifications like NS-SEC. Later, in the spirit of dialectical critical realism, I was much impressed by Roy's statement that 'being is but a ripple on the surface of the ocean of non-being'. In the paper with Sasha, after a positive mention of sociology as lifeworld decolonisation (pace Habermas), we insisted that sociology is necessarily pitted against any ideology that comes between it and its accounts of how things are, why, *and how they might have been, and might yet be, other than they are*. This for me is at the very core of Bhaskar's post-Hegelian concept of absence. In his terminology, the pursuit of this insight is part and parcel of an emancipatory project rooted in contesting those 'power 2' relations, constituting constraining ills, that deprive *most humans* of the capacity to satisfy basic needs.[18] Power 2 relations, enabling for the few and constraining for the many, are another way of articulating Habermas' theory of lifeworld colonisation.

JM: OK, we've got a sense now of when you started to take an interest in critical realism and when you started to explicitly write about it. To give us a focal point it might be useful to orient on the books, *Sociology, Health and the Fractured Society: A Critical Realist Account* and *A Critical Realist Theory of Sport* and on your role in editing *Structure, Culture and Agency: Selected Papers of Margaret Archer*. But before we do that perhaps we might just discuss how you became involved in Bob Carter and Caroline New's ESRC project which culminated in *Making Realism Work,* since this might provide an opportunity to expand later on your ideas on silos and 'bridge building'. As I understand it (from my interview with Caroline) you deploy the GBH in that project …

GS: As I said earlier, I have always been a solitary thinker and writer, possibly to my disadvantage. This might also help explain my rare attendance at conferences (Paul Higgs advised that I turn up occasionally because otherwise people would think I'd died).

JM: A ghost writer (sorry, couldn't resist).

GS: I wouldn't give up the day job. In any case, my points of reference have largely been the authors I have read. I was an only child after all! So my occasional collaborations have been exceptional (albeit over the years these have accumulated). As I mentioned, it was the largely positivistic and to my mind crucially self-limiting literature on health inequalities that first led me to draw on critical realist thinking. This led me, with Paul Higgs and Ian Rees Jones, to contribute to Bob Carter and Caroline New's pioneering volume.

JM: Did you know them already; had you met at an IACR conference, or was it a 'by reputation' situation?

GS: I can't now recall the initial contact. It may be that Caroline and Bob had come across our early writings. Anyway, we attended a workshop, from memory, in 2003. The result was another outing for the GBH. But through my personal reading I was coming to appreciate a growing familiarity with Maggie Archer's work. I had been reading both Roy and Maggie's books for some time before I met and got to know them. It was a

real pleasure later on to have the opportunity to have discussions with them. I first met Roy in the mid-noughties, after he had been appointed to the Institute of Education in 2007. I used to meet him in his room at the Institute (now actually part of UCL), or in a local pub, and we later invited him in 2012 to give one of our annual 'Social Theory of Health' lectures.

JM: And Archer?

GS: I had heard Maggie give talks before but met her personally when I was invited to give a talk at Warwick in 2014. Sometime later, at her request, I tried to secure a post and office for her at UCL.

JM: And this was after she'd retired from Warwick?

GS: Yes, she had retired from Warwick in 2010 and was seeking a base in London. We met and I arranged with the Vice-provost for Research at UCL for her to be awarded an honorary chair within the Institute of Education. But despite an agreement having been negotiated, the administrators at the Institute prevaricated about how or even if she could deposit funding and it fell through. Over time I came to incorporate Maggie's contributions to critical realism in my own writings. It was less her thematic concept of the morphogenetic society that I drew on than her analysis of 'internal conversations'.

JM: For background purposes, this refers in general to Archer's argument that personal reflexivity provides a 'missing link in mediation'. She notes:

> Agents possess properties and powers distinct from those pertaining to social forms. Among them feature all those predicates, such as thinking, deliberating, believing, intending, loving and so forth, which are applicable to people, but never to social structures or cultural systems. Beyond that, the statement specifies only that the causal power of social forms 'is mediated through agency', but it does not tell us anything about the mediatory process involved. (Archer 2003, 8)

With this in mind, rather than focusing on 'introspection', she reframes the issue of inner life as an engaged object-subject turn taking first person perspective (knowing oneself to be oneself over time) whose reflexivity may take various forms – introduced as three 'modes' of reflexivity plus an additional category:[19]

1. Communicative reflexivity: when internal dialogue is undertaken it is not completed except insofar as 'subsequent decisions about what to do, how to act and, ultimately, who to be are held open to the dialogical influences of those with whom they share their concerns' (Archer 2003, 167).
2. Autonomous reflexivity: 'the lone exercise of a mental activity, which its practitioners recognise as being an internal dialogue with themselves and one which they do not need and do not want to be supplemented by external exchanges with other people' (Archer 2003, 210).
3. Meta-Reflexivity: 'being reflexive about our own acts of reflexivity' (Archer 2003, 255).

And:

- Fractured reflexivity: a particular person is impeded from developing a mode of reflexivity or the mode of reflexivity they have developed is no longer acting to facilitate subjectively dealing with an objective environment and this means that reflexivity is 'suspended' (Archer 2003, 298).

GS: Yes, that's a perfect summary of the analysis I drew on. I appreciate that the idea that 'we talk to ourselves' has generated a lot of discussion around the putative duality of structure and agency, but I have used it in a particular applied or substantive sense.

JM: So you weren't at all attracted to the idea of internal conversation and reflexivity because Archer first introduces it using the example of a 'Graham' drawn from her interviews (see Archer 2003, 10).

GS: I must have missed that, sadly! But there is a serious point here. Archer is at least attempting to bring qualitative research into her work on social theory, albeit in a fairly modest way. Her work is actually the focus of Chapter four of *Sociology, Health and the Fractured Society*, where I introduce 'two ideal types of special salience for health inequalities'. First, I suggest that the capital monopolists can be characterised as 'focused autonomous reflexives', that is, as people who are self-contained and not reliant on others for how they see themselves or for deciding their courses of action. Second, I argue that 'vulnerable fractured reflexives' is a useful way to capture those who are insecure about self, how to 'be' and how to act, and as such are likely candidates for poor health and even premature death. I argue that the first are instrumental in the production and reproduction of health inequalities and the second are, to reiterate, most at risk of sickness and premature mortality. And for me, both agency and culture are structured without being structurally determined; so reflexive agency retains its causal power – via power 1 relations – for all that this is only relatively rarely exercised.[20]

JM: If I can quote from the introduction to the book:

> [T]his book comes under the rubric of what I call *meta-reflection*. By this I mean that it is a contribution that draws on a now vast body of empirical research and offers a theoretical synthesis. One largely unintended consequence of the neo-liberalization of British and other universities is a rapid turnaround of research outputs, be they empirical studies or theoretical or conceptual explorations, Meta-reflection has become in my view an increasingly invaluable but neglected enterprise … enter critical realism. (Scambler 2018a, 2)

GS: Obviously I had something slightly different in mind than Archer's meta-reflexivity here. I was pointing to a need – conspicuous in relation to empirical research on health and health inequalities – for what is an increasingly scarce resource in academia, namely time to think, and a framework and body of theory both consonant with the best research and doing justice to the causal power of social structures and relations. By the time I came to write *Sociology, Health and the Fractured Society* (Scambler 2018a) I had sown a number of critical realist seeds. It was my second book addressing critical realism as applied to health, the first being *Health and Social Change: A Critical Theory* (Scambler 2002). In the 2018 book I argued that post-1970s class-based, state

sanctioned and enacted, social and health policies, most notably political austerity after 2010, precisely fitted Engels' charge of 'social murder'. Overall, this book was an attempt to pull threads together.

JM: Some of which, I guess we have already mentioned in regard of GBH etc.

GS: Yes indeed. However, the fractured society book also contained some innovations. For example, I complemented the class/command dynamic with a handful of others. One of these, which I called the stigma/deviance dynamic, revisited my earlier work on stigma. Stigma here refers to shame, and deviance to blame. The stigma/deviance dynamic, which can only be fully grasped as a by-product of the class/command dynamic, asserts that stigma is being 'weaponised for neoliberal times'. I draw this out in an article from the same year in the *Sociological Review,* arguing that 'blame is being heaped on shame' (Scambler 2018c).[21] If citizens, like those with disabilities for example, can be blamed as well as shamed for any problems they encounter, in my terminology rendered 'abject', then they can be maltreated by the class-led state with near impunity. They can have their benefits reduced or even withdrawn. My use of Bhaskar is also quite innovative. I use his work to cement my argument that the sociological community needs to go beyond professional, policy, critical and public sociology to encompass 'foresight sociology' (considering alternative and improved ways of ordering our affairs), and 'action sociology' (active political engagement to resist and counter ideological obfuscation). In a nutshell I followed Bhaskar in suggesting that to fight for the rights of an individual is – logically – to fight for the rights of all individuals in equivalent circumstances, and that this – also logically – is the straightest road to human flourishing. This is a theme I've also made much of in my latest book, but we'll doubtless come to that.

JM: Before we do, *Sociology, Health and the Fractured Society* went on to win the Cheryl Frank Memorial Prize …

GS: That came as a total surprise. I had no idea it was being considered by the awards panel. I was hugely grateful, partly because it represented a recognition that what I was doing was worthwhile, but also because of my respect for the panel who selected it. So receiving an unexpected email from Doug Porpora (President of IACR) was a significant boost.

JM: And recipients are usually invited to give a keynote at IACR which is then published in *Journal of Critical Realism* …

GS: I was duly invited to give a keynote, and even started drafting one, but I was unable to attend the next conference, which if I remember correctly was an overly expensive overseas option for me since by then I had retired and lacked financial support. There was mention of me doing it in London at a later date, but this never materialised. But by this time Tom Brock and Mark Carrigan had approached me to help edit a collection of Archer's writings, which I thoroughly enjoyed, although my contribution was largely restricted to writing the Introduction. I was pleased and relieved that Maggie approved

of my summary of her very considerable body of work. This collection was published in 2017, two years before I won the Cheryl Frank Memorial prize.

JM: OK, we're fast approaching the present day. Prior to writing your award winning book you had already retired …

GS: I retired in 2013 when I reached sixty five. But as you will have gathered I didn't stop writing. Annette calls it 'working' but I prefer writing! When I looked at the statistics, I was slightly surprised to find that I've been as productive after as before retiring (see, for example, Scambler et al. in press). I'm not sure how to interpret this. I continue to write in cafes and bars, as I always have, and I guess it's a mix of enjoyment and, possibly, addiction. But I love it. I've retained my links with UCL, was invited to do a stint as a visiting professor at Surrey University, where if you recall I was an undergraduate, and I still teach on an Emory University Summer Programme in London on Comparative Health Care (Annette and I were visiting professors at Emory in 1998, and I had previously been London Director of the Emory Programme for 35 years).

JM: This brings us somewhat circuitously to your book *A Critical Realist Theory of Sport* (Scambler 2024a) …

GS: The book is in many respects a companion volume to that on health. It was also my second book exploring critical theoretical/realist sociology and sport. The first was *Sport and Society: History, Power and Culture* (Scambler 2005b). My latest effort deploys essentially the same basic-to-dialectical critical realist approach to understanding and explaining sporting institutions across the transition from welfare-state to rentier capitalism. Sport, in other words, in our fractured society. I tried to include a wide range of amateur-to-elite sports but devoted a chapter to a case study of rugby union.

JM: Why rugby?

GS: Partly because I used to play myself and it has long been a sport I've followed. And partly because I wanted to explore how elite rugby players, and elite athletes in general, have become hypercommodified units.

JM: And this means?

GS: Perhaps my interest in health is pertinent here too. We inhabit an increasingly metric society and it intrigued me how professional rugby players, who are bought 'units', are now subject to continuous monitoring. It's why coaches sit on the side of pitches perusing their laptops. The latest technology, smart mouthguards, will tell them all they need to know about a player's performance even as it unfolds. I was also intrigued that doctors and physios are hired to return players to the pitch as expeditiously as possible, regardless of the long-term effects of any injuries and of professional ethical injunctions to 'do no harm'. This is now an issue of legal concern in relation to repeated concussions and other phenomena.

JM: And this is associated for you, drawing on Bourdieu's terminology, with a particular 'habitus' …

GS: Yes, I proffered an elite sporting habitus: single-minded, self-belief, will-to-win, embodied identity, body trauma, subcultural ethos and being 'in the moment'.

JM: An evocative term …

GS: I also used the critical realist idea of upwards and downwards causality. Upwards causality, to express it simply, refers to flows of causality emergent from the genetic and biological via the psychological to the social, and downwards refers to flows of causality emergent from the social via the psychological to the biological and genetic. Both are obviously highly relevant to sporting prowess.

JM: And you distinguish amateur and elite sports and identify how they …

GS: I do, but what I've argued is that amateur sport, including schools sport, is increasingly being influenced by changes at the professional or elite level. For example, the celebration of 'big hits' in rugby. And this has health sequelae (complications from prior conditions etc.). Allyson Pollock, a public health specialist, has actually argued that school rugby should be banned given the health dangers.

Returning to the notions of upwards and downwards causality, humans conceived of and compete at Wimbledon, cells did not conceive the competition; but 'the right cells' are a vital part of the equation, as is good coaching. In the case of elite sprinters, I suggested that social factors afford amenable *contexts* for acknowledging, enhancing and realising the ambitions of would-be Olympic 100 metres champions; psychological factors can in socially deliverable contexts *condition* pertinent reactions; and biological factors *matter,* possibly exceptionally in the case of top-level sprinting, but in the absence of favourable social and psychological factors can be neglected or wither on the vine. As in the health book, I put forward a rough agenda for incorporating foresight sociology (how we might improve things) and action sociology (how we might need to take on vested interests).

JM: And what would you say the book achieves?

GS: I hope two things. Persuading sociologists of sport that critical realism has something important to offer them. And second, making a case that the fractured society that rentier capitalism has nurtured and fuelled has had profound consequences for sport as it has for many other social institutions. In this context I argued, albeit not originally, for a global orientation. But I also stressed the salience of climate change, which is already heavily impacting sport in, predictably enough, poorer countries in the Global South. These are matters I confront head on in my latest book, which focuses on health once more rather than sport.

JM: And that is *Healthy Societies: Policy, Practice and Obstacles* (Scambler 2024c).

GS: Yes. I find it interesting that my more recent publications have been described – critiqued – as 'polemical'. The editor of the mainstream British journal *Sociology* recently rejected a paper on 'muckraking sociology' using precisely this terminology ('we don't take polemical pieces'). I reject this judgement. My principal goal in writing *Healthy Societies* was to help reorientate sociological and public health thinking. I defend and develop the concept of the 'healthy society'. The core thesis is that it is no longer, if it ever was, acceptable to research and address the maldistribution of health in a single country like Britain. This is partly because all countries are obviously part of a global order and do not stand alone. But it's also, I argue, because it is demonstrably wrong for one country to accomplish greater material, social and health equality by subduing and exploiting others, by exporting premature death and suffering elsewhere. In my book I include chapters not only on the global order but on climate change and warfare.

JM: Issues that have concerned many of the more innovative realist thinkers … [22]

GS: I argue that a credible public health agenda for the twenty-first century must be oriented to creating a healthy society, one which eschews exploitative economics geared solely to domestic growth, climate change denial and the selling of sophisticated weaponry to any and all-comers. I try to be honest about the obstacles to achieving the social transformation that this will require, once again drawing on a mix of Habermas' critical theory and Bhaskar's critical realism. I also suggest how such an 'unlikely' transformation might come about, emphasising the potential causal roles of extra-parliamentary social movement alliances, a timely legitimation crisis, utopian realism, widespread public anger and unpredictable 'trigger events'. As far as sociology is concerned, I warn of the dangers of us being bystanders, and even collaborators with increasingly oppressive regimes. Sociologists must be fully engaged via foresight and action sociology.

JM: Is it your last book?

GS: I'm not sure. It depends on whether or not I have more to say. I am conscious that most of what I've published is addressed to colleagues in the discipline. I think I write clearly, but not always accessibly. On an altogether higher plane, I have always thought Bhaskar wrote very clearly, if with an excessively lively conceptual imagination. I'm currently trying to draft a more readable version of my academic arguments. I should also mention that when I retired one of my daughters, Rebecca, offered to create a website for me 'to give you something to do'. A decade later I have 'published' more than 460 blogs, averaging 1,000 + words, and to my astonishment my website has to date had over 380,000 views.[23] So this is another outlet, and one that clearly reaches beyond disciplinary colleagues. Will it ever feature in the metrics of university accomplishment? Fortunately, my CV no longer matters to me and I no longer update it!

JM: OK, let's draw this together. Let me put to you a few questions-cum-comments that you might respond to. In some of your work you use the term 'disconnected fatalism' and I suppose in some way your work counts as a contribution against the grain … Do you think, however, your work might have been substantively different had you not come

across Bhaskar's work all those years ago? We also suggested earlier that we might come back to silos and bridge-building and you have particular views on what matters …

GS: Disconnected fatalism is for me an important ingredient of the fractured society. It picks up on the hyper-individualism promoted by neoliberal ideology in rentier capitalism on the one hand, and the fatalistic sense of impotence many – especially working class – people have when facing a future of relative poverty and hardship. A perfect example: at the time of this interview we are anticipating a general election in which neither of the two main parties is offering real, let alone transformative, change. Both are opting for more of the same, and 'the same' is continuing austerity and precarity. Returning to critical realism, I think the principal contribution Bhaskar, Archer and others have made to my thinking and theorising is to ground it philosophically and to proffer an ontology of structural relations like class, acting as generative mechanisms, that 'must' exist, and on an enduring basis, for the now considerable positivistic literature on the maldistribution of health inequalities to deliver the results it has. At the risk of simplifying, class as a beneath-the-surface social structure, 'must' exist in the realm of Bhaskar's real for our experiences of events on-the-surface to be as they are.

Maybe critical realism is a way of articulating, or theorising, what I had been thinking and trying to say. I think Roy said somewhere that natural and social scientists have long thought and acted like critical realists without conceiving it as such. To revisit an earlier point, what I would like, if I can devise an effective way of doing it, is to build more sturdy bridges between abstruse ruminations on critical realist philosophy and the conducting of empirical research.

JM: An aspiration that continues to be shared by many, at least to some degree.[24]

GS: I have always felt that I may have fallen between two stools: not taken overly seriously by either highly focused philosophers and theoreticians or by researchers. It's a bit like doing interdisciplinary research. Everyone encourages academics to pursue it, and then along comes the REF and punishes them! But the *Journal of Critical Realism* is publishing more applied work year by year which is greatly encouraging. Let's try and wean more talented critical realist thinkers away from the kind of abstruse discussions of the (conveniently) imagined case studies once beloved of Oxbridge philosophers and invite them to engage with real issues *at the level of the real* in the social worlds we collectively inhabit!

Notes

1. See Patrick and Scambler (1982) and subsequent iterations edited by Scambler from the third edition.
2. For example, Scambler and Scambler (1993, 1997, 1998, 1999, 2003, 2010, 2013, 2015, 2019).
3. For books see, for example, Scambler (1987a, 1989, 2001b, 2002, 2005a, 2005b, 2012a, 2018b, 2020a, 2024c); Fitzpatrick et al. (1984); Scambler and Higgs (1998); Tjora and Scambler (2013, 2020). For chapters see, for example, Scambler (1987b, 1990, 1991, 1992, 1997, 2006a, 2006b, 2006c, 2007a, 2009b, 2010, 2012b, 2013a, 2014a, 2014b, 2017a, 2019a, 2024b); Hopkins and Scambler (1976); Scambler and Hopkins (1988); Scambler and Graham-Smith (1992);

Fitzpatrick, Robinson, and Scambler (1993); Scambler and Scambler (1998, 1999); Scambler, Ohlsson, and Griva (2004); Higgs, Jones, and Scambler (2004); Collyer and Scambler (2015).

4. See also, Scambler, Higgs, and Jones (2002); Scambler and Hopkins (1990); Scambler (2004).
5. Visit: https://www.palgrave.com/gp/journal/41285
6. Visit: https://www.grahamscambler.com/ and https://scholar.google.com/citations?user=ZU2Rug0AAAAJ
7. See also in this series Archer and Morgan (2020); Rescher and Morgan (2020); Porpora and Morgan (2020); Norrie and Morgan (2021); Lawson and Morgan (2021a, 2021b); Jessop and Morgan (2022); Elder-Vass and Morgan (2022); Sayer and Morgan (2022); Alderson and Morgan (2023); Groff and Morgan (2023); Little and Morgan (2023); Patomäki and Morgan (2023a, 2023b); Danermark and Morgan (2023); New and Morgan (2024); Outhwaite and Morgan (2024). Additional: Collier and Calder (2008, 2009).
8. Note from Jamie, broadly speaking, the Research Excellence Framework (REF) replaced the Research Assessment Exercise (RAE) as the means by which research output quality is assessed in the UK and funds for research are allocated to universities. The RAE ran to 2008 and the REF then followed (with its first cycle completed 2014). Visit: https://www.ref.ac.uk/
9. Note from Jamie, for background see Jeffery's obituary: https://www.theguardian.com/news/1999/mar/17/guardianobituaries1
10. Note from Jamie: as an act of 'it's a small world', this was reviewed at the time by Priscilla Alderson who would go on (much later) to become a critical realist. See Alderson (1988).
11. Note from Graham: According to Habermas 'The world gains objectivity only through *counting* as one and the same world *for* a community of speaking and acting subjects. The abstract concept of the world is a necessary condition if communicatively acting subjects are to reach understanding among themselves about what takes place on the world or is to be affected by it. Through this *communicative practice* they assure themselves at the same time of their common life-relations, of an intersubjectively shared *lifeworld*' (Habermas 1984, 12–13).
12. Note from Graham: see, for example, Bhaskar and Danermark (2006); Bhaskar, Danermark, and Price (2018).
13. Note from Graham, for the NS-SEC visit: https://www.ons.gov.uk/methodology/classificationsandstandards/otherclassifications/thenationalstatisticssocioeconomicclassificationnssecrebasedonsoc2010
14. Note from Graham: there is more to them than just this since they are not restricted to closed system situations. See Lawson (2003, 105–107).
15. Note from Jamie: for more on methodology see Sayer (Sayer 1992). For context see Bhaskar (1979); Collier (1994); Archer et al. (1998); for recent discussion of the concepts see Ritz (2020); and for recent discussion re contemporary trends, Morgan (2021).
16. Note from Jamie: Sean Creaven has recently taken up some of this way of thinking. See Creaven (2023, 2024a, 2024b); see the review, Morgan (2024a). There are, of course, various others working on issues in health care and associated fields with some interest in critical realism and this has been variously reflected on *Journal of Critical Realism*. See, for example, Alderson (2021a, 2021b); Alderson, Sutcliffe, and Mendizabal (2020); Bärnthaler and Dengler (2023) Danermark (2019); Monaghan (2024); Samsonsen and Heggdalsvik (2024); Smirthwaite and Swahnberg (2016).
17. Note from Jamie: Batten Disease is a disease of the nervous system. It effects, among other things, growth and circulation, and causes seizures, mental and visual impairment. The disease is fatal.
18. Note from Graham: in the glossary of *Dialectic* Bhaskar defines power 2 as, 'the capacity to get one's way against either the overt wishes and/or the real interests of others in virtue of structures of exploitation, domination, subjugation and control, i.e. generalized master-slave type relations' (Bhaskar 1993, 402).
19. For a useful figure summarizing turn taking object-subject relations to the self, see Archer (2003, 99); for summaries of claims regarding self-consciousness, personal identity and social identity see Archer (2003, 119–120); for a useful figure itemising the modes of reflexivity see Archer (2003, 165).

20. Note from Graham: to complement power 2, Bhaskar defines power 1 as ‘the transformative capacity intrinsic to the concept of agency as such’ (Bhaskar 1993, 402).
21. See also Scambler (2023b).
22. Note from Jamie: see, for example, Buch-Hansen, Koch, and Nesterova (2024); Hosseini and Gills (2023) and Patomäki (2023); the last is reviewed in Morgan (2024b).
23. See previous note. Visit: https://www.grahamscambler.com/
24. Note from Jamie: see, for example, Price and Martin (2018); Wiltshire and Ronkainen (2021); Fryer (2022); Brönnimann (2022).

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No potential conflict of interest was reported by the author(s).

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