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Critical engagement in fields of power: Cycles of sociological activism in post-apartheid South Africa

Karl von Holdt
University of the Witwatersrand, South Africa

Abstract
In this article, the author argues that socially engaged sociology cannot be understood as a practice isolated in the quadrant of 'public sociology' as suggested by Michael Burawoy's organization of sociology into four distinct quadrants but that it is closely associated with critical policy sociology as well as critical professional sociology. The author uses a case study of hospital transformation in post-apartheid South Africa to demonstrate the way sociological activism cycles through public, policy and professional sociological fields and to explore the nature of each of these fields as contested fields of power characterized by dominant and subordinate sociologies. The author resurrects Eddie Webster's concept of *critical engagement* and expands its scope to suggest that the stance of the progressive – or radical – sociologist, who is engaged and committed to subaltern publics but retains a critical independence, is reproduced in the field of professional sociology in the form of what Burawoy calls critical sociology and in the field of policy sociology as critical policy sociology. The latter is a possibility that cannot be entertained in the Burawoy model, where policy sociology occupies a quadrant constituted by instrumentality and a lack of reflexivity. The practice of critical engagement, then, has to be understood as combining public sociology, policy sociology and critical sociology in a practice that may produce new knowledge that enables a more complex comprehension of domination across these fields, the better to challenge it.

Keywords
Critical engagement, hospital transformation, policy sociology, public sociology, sociological field

Corresponding author:
Karl von Holdt, University of the Witwatersrand, Society, Work and Development Institute (SWOP), Private Bag 3, Wits, 2050, South Africa.
Email: karl@yeoville.org.za

Introduction: Public sociology in a period of post-transition reconstruction

Public sociology is a socially engaged practice. It entails engaging in fields of power characterized by domination and subordination, and it requires that the public sociologist be a partisan for the dominated (Burawoy, 2007: 55). But it requires that the public sociologist do this in a particular way: not just as an activist but also as sociologist, bringing critical sociological knowledge to bear.

As a social practice, public sociology is shaped by its social and political context. What does socially engaged sociology mean in South Africa, in a time of transition from apartheid to democracy? I argue in this article that for us it necessarily means coming to grips with problems of the transformation of society, grappling with the legacy of apartheid and unequal social structures and rebuilding institutions and strengthening democracy. In such a time, public sociology necessarily has to go beyond the stance of critique and engage with the field of policy formation and intervention if it wishes to have any impact on society.

In the article, I draw from my experience over a period of 10 years working on a project to transform the functioning of a public hospital in South Africa. I start my account using Burawoy's model for thinking about the field of sociology by dividing it into four quadrants – professional sociology, critical sociology, policy sociology and public sociology (Burawoy, 2004, 2007). I show how our mode of work entailed a movement over time from public sociology to policy sociology to critical sociology and back to policy and public sociology again. This cycle between different kinds of sociology seems to be central to the practice of a socially engaged sociology in a society such as ours, which is undergoing complex and fractious processes of change and contestation in many sites at the same time.

This experience suggests that conceiving of socially engaged sociology as a practice isolated in the quadrant of 'public sociology' fails to capture the complex relation between the social or political arena on the one hand and engaged sociology on the other, as well as the complex relations between the different modes of sociological practice in the different quadrants. Indeed, my case study demonstrates that each of these quadrants is a contested terrain characterized by dominant sociologies and subordinate sociologies. I draw on the concept of 'critical engagement,' which was elaborated by Eddie Webster[1] (1995) as a way of thinking about the tensions in socially engaged sociology, which he practiced over many years under apartheid and after. Such a conception, I suggest, better enables us to think about critical sociology as a practice across several different fields of power, including the field of sociology itself, the field of policy formation and the public sphere.

This notion of critical engagement across several sites, including the different modes of sociological practice, allows us also to think about the relationship between social engagement and theoretical innovation. Keim (2011) makes use of the South African case to argue that socially engaged knowledge-formation creates the possibility for the development of southern sociological perspectives – which she terms 'counterhegemonic sociology' – and which may make discipline-shaping interventions on the international sociological terrain. Thus, public sociology should be thought of not merely as a kind of 'outreach' through which sociological wisdom is made accessible to the public

but also as a practice of knowledge formation that may have far-reaching implications for the discipline of sociology itself.

Transition and transformation

The democratic breakthrough in the period from 1990 to 1994 posed the task of overcoming the legacies of apartheid – encompassing not only racial segregation and racial discrimination but also spatial injustice and great inequality and poverty – in order to build a democratic society. The health sector was among many that required deep restructuring. The public health sector was fragmented into several racially segregated government departments, each with its own governance structures and budgets, and there was also a growing gap between public and private healthcare, contributing to the deep disparities in the services available to blacks and whites, rural and urban dwellers, those on private medical aid schemes and those who had to make use of public healthcare provision. For example, in 1986, there were 8.2 hospital beds per thousand white people and 4.2 beds per thousand black people (Heunis, 2004: 465). By 2000, the difference in infant mortality rates was still 49 per 100,000 for blacks, versus 11 per 100,000 for whites (Dudley, 2006).

In the context of the transition, public hospitals became increasingly stressed institutions. The redirection of resources to primary healthcare and to the poorer provinces, within a conservative fiscal framework, meant that many hospitals were subjected to diminishing budgets. The pressures for transformation – deracializing access to the health system, redistributing resources, integrating the various health departments including under-resourced and dysfunctional departments for blacks, and deracializing management structures – led to the loss of technical skills, the weakening of management systems and the breakdown of managerial authority (Schneider et al., 2007; Von Holdt and Murphy, 2007).

Baragwanath hospital, located in Soweto, had always been a showcase hospital which the apartheid regime tried to use to demonstrate the quality of health services provided for blacks, with the result that high-tech academic medicine coexisted with overcrowding and a lack of resources (Von Holdt and Maseramule, 2005). With 2800 beds, Baragwanath epitomized a mass production version of hospital services, making it the biggest hospital in the southern hemisphere and almost impossible to manage in a coherent fashion. The new democratic government renamed it the Chris Hani Baragwanath Hospital, in honor of the leading figure in the South African Communist Party (SACP) and African National Congress (ANC) who was assassinated by right-wing dissidents during the transitional period.

In 2000, the National Health, Education and Allied Workers Union (NEHAWU) approached the Congress of South African Trade Unions (COSATU) research institute, NALEDI, where I was working at the time. The union asked us to assist in the transformation of the hospital into a 'people's hospital,' by which they meant improving the quality of clinical and healthcare services for the community, at the same time as improving the quality of working life for union members.

Thus began a 10-year project to transform the functioning of Chris Hani Baragwanath Hospital. The project started with intensive research and discussions with staff and

managers across different units, and it ended with the implementation of a project to transform the management structures and practices of the surgical division, consisting of some 750 beds.

Phase 1: Public sociology: research and mobilization

My colleagues and I started investigating conditions in the hospital through a series of discussions with shop stewards from NEHAWU and the other trade unions, as well as with the CEO. We then concentrated our research on a series of interviews and focus group discussions with workers and staff, who are at the heart of providing clinical care to patients, running wards and providing services such as laundry and kitchens that enable wards to function. Thus, we listened at length to ward cleaners and ward clerks, to nursing assistants and nursing sisters, to doctors and matrons, to drivers and kitchen workers and laundry workers, to physiotherapists and pharmacy assistants and professors. While we interviewed managers as well, the emphasis was on developing an analysis of hospital functioning from below.

According to the doctors and nurses we interviewed, the hospital was experiencing poor clinical outcomes and higher levels of morbidity and mortality than ought to be the case. We found (Von Holdt, 2010: 9–10) that:

> Over-centralization, fragmentation into silo structures, low management capacity and understaffing were the primary causes of institutional stress and poor health care outcomes. … These issues constitute a systemic dysfunctionality that affects all aspects of hospital functioning. Poor maintenance, failure to repair or fix equipment, lack of linen, dirty linen, procurement failures, the breakdown of lifts, dirty wards, budget overruns, poor labour relations, unfilled posts, inability to budget or control costs, failure to supply drugs or medical sundries, ill discipline, lost records – there is no end to the list of frustrations and problems that staff experience.

This research, which took place in several different phases over a period of about three years, was synthesized into an analysis of the problems in the institution and their causes, and a series of proposals for altering the structures and management practices of the institution. The problem analysis and proposals were presented back to union shop stewards, as well as the wider range of constituencies in the hospital, and finally synthesized into a hospital transformation plan on which agreement was reached at a hospital-wide, two-day strategic forum, in which all stakeholder groups and levels of staff were represented.

The process was unique for the institution, in the sense that it was a bottom-up analysis of the experiences and suggestions of the rank and file workers, both menial and professional, who experienced the dysfunctionality and frustrations of the work environment – and the way this compromised patient care and recovery – every day. In almost every interview we heard expressions of anger, outrage, pain and hopelessness about the way clinical processes and patient care were undermined by the deep dysfunctionality of the institution and the seemingly uncaring attitudes of senior managers and officials in the Department of Health.

The research process gave voice to those who were disempowered and rendered voiceless by the system of management in the hospital and the health system more broadly, and it transformed their anger into a plan for change. It is important to note here that the voiceless consisted not only of less-skilled workers at the bottom of the medical hierarchy but also of the highly skilled professional nurses and clinicians, including powerful professors. Apartheid had elaborated a management structure – particularly in black hospitals – which ensured that professionals were subordinated to the managers and administrators and thus to the political requirements of maintaining apartheid. Post-apartheid, the displacement of professionals from managerial decision-making continued with the formation of a new administrative stratum.

This process corresponds to Burawoy's concept of organic public sociology as a process of giving voice to and empowering those who are dominated and disempowered by structures of power and in this sense contributing to the *formation of a public*. Of course, both the trade unions in the hospital and the professionals already had voices and sources of power in the institution prior to our arrival, but they were confined to immediate technical or collective bargaining issues and fragmented into different interests. What sociological analysis brought to this process were *research skills* and the ability to synthesize a range of views into a *systematic analysis* of the problem. Proposals for change could be developed from this analysis and provide the basis for a further mobilization of the newly constituted public, in order to alter the field of power in which they were embedded.

The proposals were presented to officials at the Department of Health, which promised to provide the necessary resources to implement the plan, promises which were repeatedly broken. In 2005, when a new MEC for Health (effectively, a provincial minister of health) was appointed in Gauteng province, and the only result was further inaction, unions and clinicians planned a public demonstration and mobilized constituencies in the hospital and beyond. This culminated in a big march bringing together professors and cleaners, nurses and clerks, shop stewards and matrons, community organizations and local churches, through Soweto to the hospital, where a petition was handed over to the MEC. The result was that the provincial government allocated 5 million rand (US$500,000) towards the transformation project at the hospital.

Throughout this process, sociology played a role in constituting a public with a strong base among those who worked in the hospital and allied to publics in the community with a stake in the hospital. Sociology also helped that public mobilize around *an alternative plan* for efficiency and transformation in the hospital. This plan drew on the problems experienced from below – by those who actually provided healthcare and the support services it requires – as well as on consultations with experienced health system managers with an interest in transformation.

Although this most closely resembles what Burawoy calls 'organic' public sociology – that is, a sociological practice closely involved with grassroots constituencies (Burawoy, 2007: 28) – from its inception it entailed a strong *policy sociology* dimension, in that it was concerned with producing an alternative plan for transformation.

The practice of public sociology is not exclusively defined by partisanship in the contestation between subordinated social groups and dominant authorities. Of course, the public arena is shaped by such contestation, but also by tensions and contestations between subordinated groups with different interests and complex relations. For

example, relations between nurses and cleaners or nurses and clinicians, as well as between the various unions representing different occupational categories, involved contestations over the meaning of work, discipline and authority, which had to be mediated through the analytical and interlocutory practices of public sociology if a coherent transformation plan with broad support was to be developed.

More important for the purposes of this article, however, is the tension between the position of the public sociologist and that of the subordinated publics with whom he or she engages. For example, the analysis that emerged out of our research made it clear that one of the reasons the hospital was unable to function effectively was that managers had not been delegated sufficient authority to manage its operations. We therefore proposed greater power for the hospital CEOs. NEHAWU, the biggest and most active of the unions we were working with, opposed this proposal. Practically, much of their power derived from both political and administrative bargaining at central level, and they were anxious about the devolution of power to the hospital – particularly because their shop stewards were frequently involved in intractable conflict with managers at different hospitals. There was tension between concerns about immediate industrial relations and a longer-term transformative vision. After vigorous debate, over time, the union came to adopt our proposal.

A similar problem was presented by the pervasive breakdown of authority and discipline in the hospital. Workers and shop stewards had taken advantage of this lack of structure to challenge any attempt to improve discipline. Our research indicated that most workers resented the ill-disciplined minority, thought it was unfair that they were never punished, and believed that the quality of healthcare could not be improved under such conditions. As sociologists, we had to stand by our analysis of the problem of discipline and conduct complex discussions, through which it was agreed that discipline had to be restored but also that good performance should be recognized and that management should be responsive to workers' grievances.

Webster's concept of *critical engagement* was developed precisely to understand such tensions. Unlike a trade union activist, the sociologist remains independent, refusing to subordinate critical analysis to the political demands of organic publics. This is not to say that tension and compromise can be avoided – or that the authority of the sociologist and their knowledge is uncontested. The public sociologist has to be prepared to listen to, learn from and be criticized by subaltern publics. At times, the public sociologist is forced to recognize the limits and biases of his or her knowledge and accept that just as research involves appropriating the practices and knowledges of research subjects, so the sociologist may be appropriated by publics in unanticipated ways.[2] The public sociologist, like the activist, is working with the 'art of the possible,' in a public terrain shaped by pre-existing discourses and symbolic structures. Thus, she or he may feel compelled to compromise in a way that the professional sociologist seldom does.[3]

Phase 2: From public sociology to policy sociology

The COSATU policy institute, NALEDI, put in a bid and won the contract to implement the transformation plan. We were now in a position to hire professionals in the fields of hospital management, information systems, nursing management and human resources,

who could begin the process of implementation. At this point, in terms of Burawoy's model, policy sociology became our team's dominant practice: we were paid consultants of the government, hired to transform the functioning of the hospital.

However, this would be a simplistic way of understanding the process that took place over the next three years. We were paid consultants, it is true, but we were also implementing a plan that had been developed through a process of public sociology research and mobilization, and that was supported by a mass constituency. Moreover, while the plan was supported by certain officials, including the CEO of the hospital and others in the provincial office of the government, the majority of government officials as well as a layer of senior managers in the hospital were opposed to the empowerment of the CEO, the clinicians, the nurses and the unions that the plan entailed.

In the face of this resistance from powerful forces within both the hospital and the central offices of the health department, the plan could only be implemented because it had strong support from the trade unions and from clinicians in the surgical division where it was first to be rolled out. The chain of accountability to government officials, through which the plan could have been diluted or neutralized, was weakened by the fact that it was rooted in the base of the trade unions. The power of the trade unions to play this role was linked not only to their organization in the workplace but also to their political alliance with the ANC, through which they had direct access to the MEC (provincial minister of health).

To the extent that this phase of the project involved a contract with the government and the employment of professional experts to implement the plan, it was a form of *policy sociology*. But to the extent that it was closely related to the formation and empowerment of a public that lacked voice in the system, and involved implementing the plan developed with that public, it was a *continuation of public sociology on a new front*. At the same time, the contestation over the content of the plan – and the resistance from department officials as well as from senior managers in the hospital – demonstrated that the terrain of policy sociology is itself a contested one, characterized by relations of domination and subordination.

Here, Burawoy's model seems to lose its coherence. According to his four-quadrant schema, the policy sociologist is paid by a client to investigate a problem defined by the client. Therefore, such a sociological practice lacks reflexivity; in other words, it fails to develop a critique of the problem and the discourse that defines it. A further implicit assumption is that the client is in a position of power and that such a research program necessarily furthers the project of domination.

However, in reality, there is policy and there is policy; the domain of policy-making and policy research is itself a contested one. A critical policy sociology – starting from a position of critiquing the dominant policy discourses and allied to organizations of subordinated publics – is indeed possible. It should be added here that in SWOP's experience, certain clients – and these may include government or trade unions – do require that the policy sociology they commission be relatively independent. It may therefore present them with unpleasant truths that redefine the problems they want investigated.

The quadrant of policy sociology turns out not to be homogeneous but presents, instead, a field of power in which policy is contested. In our case, as an example, the policy field was contested from two directions: first, there was a prevailing view in the

government, linked to a global discourse, that clinicians make bad managers and that administrators should manage the provision of clinical services, while the role of clinicians remained restricted to direct patient care. Second, there was the view put forward forcefully by the proponents of marketization, that private provision of healthcare is more efficient and effective than public provision and that rather than trying to fix the hospital within a public health paradigm, it should be privatized.

In Burawoy's scheme, policy sociology is distinguished from public sociology by its lack of reflexivity. If critical policy sociology can itself be reflexive, then either Burawoy's vertical axis (reflexivity) is no longer coherent – with fundamental implications for his analysis of the field of sociology – or critical policy sociology is not in fact a form of policy sociology but instead a form of public sociology, by virtue of its reflexivity. Intuitively, developing and implementing the concrete and practical details of hospital transformation is a form of policy work. However, if it is reflexive and critical in relation to dominant powers, then it may be appropriately classified as public sociology. This dilemma of classification is an important one. Concrete research into the nuances of public and policy sociology might help to clarify distinctions and what is at stake in making them.

Let me return to our intervention. Our critique of the public hospital's functioning had to counter both this market vision of health services and the bureaucrats' policy perspective that clinicians not only made poor managers but were also a troublesome category of employees because of their self-confidence and independence – and, generally, whiteness.[4] In our policy proposals we argued for clinician-led services and demonstrated their effectiveness, yet we have still not been able to win this struggle within the public health system, as will become clear.

Over a period of two years, with the support of the CEO, trade unions, staff and clinical leadership, the transformation plan was implemented in the surgical division. The plan was based on the principles of decentralization of authority and accountability to and within the hospital, the integration of management functions under clinical leadership, adequate resourcing and training of management, consultations with staff and unions, and the training and upgrading of workers.

This transformation had a remarkable impact, improving clinical organization, functioning, administrative efficiency, staff morale, teamwork and patient care (Doherty, 2011; Von Holdt et al., 2010). However, there was considerable indifference and resistance from senior administrators in the hospital and officials in the Department of Health.

This phase of the project ended in 2009, when the forces opposed to the plan were able to remove the CEO and, over a period of about a year, paralyze and dismantle all of the changes that had been introduced in the surgical division. One of the reasons was that the unions and some of the key constituencies in the hospital had become exhausted by the constant process of bureaucratic attrition through which the project was eroded and blocked. In addition, the pressures and detailed work of implementing the plan in the surgical division meant that insufficient attention was paid to sustaining the mobilization and active involvement of these constituencies and organizations.

This reveals the ways that the terrain of policy sociology itself, with its emphasis on technical expertise and detailed project management, may weaken some of the dynamics that are integral to a transformational project on the terrain of organic public sociology,

where the connection to grassroots constituencies is the central feature. However, I want to stress that in the complex processes of transformation in the surgical division, constant attention was paid to empowering health workers – such as nurses, clerks and cleaners – to take charge of their domains and tasks and to innovate in order to improve the quality of healthcare.

Phase 3: From the terrain of public to professional/critical sociology

By the time the project was dismantled, I had already moved from NALEDI to the University. The project had been exhausting, largely because of the constant war of attrition between us and the officials who opposed it, with the final demoralization coming when the CEO was removed and it became clear that the project would be dismantled. This move signified a shift from the domain of public to the domain of professional sociology.

Being in the University – and somewhat detached from the exigencies of public and policy sociology – gave me the space to reflect critically on the experience and begin attempting to understand it sociologically. This could be described as a process of *critical sociology*, as the 'normal' categories of analysis that we use in everyday life and that are current in much public and policy sociology seemed unable to provide a path into the problem – a path of explanation for why, despite its successes, the project had failed. I refer here to categories such as the state, bureaucracy, neoliberalism and even healthcare.

The result of this reflection was a paper in which I identified informal rationales that clash with the formal rationales of the state bureaucracy and serve to displace or subvert the ostensible purposes of the health department and its institutions, namely, providing healthcare to the public (Von Holdt, 2010). In practice, healthcare was a secondary goal of these state institutions; the primary dynamic was the formation of a black elite within and alongside the state. This entailed rapid upward mobility, a profound ambivalence towards the racially contested notion of expertise, fragile authority and repeated attempts to 'save face;' through these informal dynamics, the more formal structures and processes of the state became increasingly dislocated from the ostensible purposes of state institutions, and those tasked with actually providing health services – particularly nurses and doctors – became increasingly marginalized.

This process of critical sociological reflection on the data generated through practices of public and policy sociology, provided the basis for conceptual breakthroughs in the field of professional sociology and a rethinking of its dominant categories, forged in the historical crucible of western modernity. Such reflection may, with further intellectual endeavors, ultimately constitute a 'counterhegemonic sociology,' forged in Southern experience, with the potential to reshape disciplinary boundaries. Such a sociological project, however, demands the investment of considerable time and intellectual focus.

It so happened that the paper I produced through critical sociological practices circulated among progressive intellectual circles, which overlapped with intellectual circles within the state. The result was a call from the presidency to coordinate a large-scale research project into such dynamics across a range of different state institutions.

Phase 4: Back to 'policy' sociology

Again, on the face of it, this was a return to the quadrant in Burawoy's box labeled policy sociology, for a paying and powerful client. However, the inspiration for this policy research was a set of insights that had been generated by organic public sociology, which brought the voices and experiences of subordinated publics to the surface. Despite the dismantling of the project, its recycling in the field of critical sociology and its circulation in policy circles can be seen as the outcome of an activist public sociology project that came to influence perspectives high up in the state – in the Presidency – and led to a renewed bout of research.

In this new round of research, involving a team of some six consultants and policy analysts, we were guided by the questions I posed in my sociological analysis and were regarded as critically independent researchers who could provide senior state officials with fresh insights into the problems of institutional functioning in the state. As a further result of this work, I was appointed to the National Planning Commission, located in the Presidency. I am at the same time a member of the NEHAWU health policy committee, which is also a policy structure but is located in one of the organizational bases through which an alternative public asserts its right to contribute to health policy debates in South Africa. For example, this union has been a critical force in putting National Health Insurance (NHI) on the agenda of the ANC and the state. If this is policy sociology, it is closely related to public sociology in its assertion of a grassroots perspective on institutional transformation and health delivery to the public. These roles are performed at the same time as I direct an academic institute in the University.

Public sociology and critical engagement

This case study describes a process through which a project to transform public health institutions moved through a cycle of organic public sociology, policy sociology, critical sociology in the professional field and back to policy/public sociology. There is both a simultaneity and a sequence to this process of circulation backwards and forwards through the four quadrants in Burawoy's model.

While each quadrant imposed its own discourse and its own dynamics on sociological practice, at the same time, the sociological practice in each quadrant was linked to the practices in the other quadrants. It is worth paying some attention to each of these dimensions of sociological practice: the *internal dynamics of each quadrant* of sociology on the one hand, and, on the other, the relations between *interlinked practice across different quadrants*.

To start with the first dimension – the internal dynamics of each quadrant – analysis of the different phases revealed that each quadrant presents a field of power with both dominant and subordinated sociological practices and ongoing contestation over the validity, truth or authority of competing accounts of social reality. As argued above, the field of public sociology is necessarily a contested one because of its intersection with the public domain, itself a site of symbolic struggle over the meaning, hierarchies and directions of the social world. Likewise, the field of policy sociology intersects with the public domain and dominant policy discourses and may be challenged or subverted by

critical policy sociology linked to subaltern publics. The client–sociologist relationship that is held to define this field does not necessarily subordinate the sociologist to pragmatic ends. Indeed, the client itself may be a subaltern organization or an organization such as an NGO with a stake in subaltern worldviews.

Professional sociology, too, is a contested field, with authoritative versions of sanctified knowledge challenged by counter-narratives emanating from the practices of critical sociology. Sociologists working in countries of the Global South may experience professional sociology as the dominant sociological categories and paradigms of western social science, and a critical sociology may be founded on critiques of this dominant sociology and attempts to constitute alternative perspectives.

I now turn to the second dimension of the practice of sociological activism – *the relationship between practices in different quadrants*. As I commented above, over time, our work on public hospital transformation moved between different quadrants of the sociological field – from public, to policy, to critical and professional sociology. What I want to stress, though, is that these varied sociological practices in different sociological fields *constituted different facets of the same overall project* – a project to understand and transform state institutions in a democratizing society – in such a way that it would empower those who work there and improve public services.

Thus, the move from public sociology to policy sociology did not constitute an abandonment of the project of implementing the transformation plan developed by workers and staff. Rather, it was an essential moment in the implementation of that plan. Indeed, the formation of the plan was simultaneously a public and policy project. Likewise, the move to the field of professional sociology in the University provided a space for critical reflection on the nature of the post-apartheid state, followed by a return to policy and public sociology informed by the insights of critical sociology. Thus, there was a single vision and an interlinked set of practices directed towards the transformation of the state – but located at different times and phases, in different sociological fields.

Public sociology – the engagement with nurses, cleaners, clerks and doctors – provided the inspiration and foundation for the project, but all the other sociologies were necessary to it as well. A public sociology that remained at the level of critique would have been unable to provide a path forward for union members and other staff. In South Africa's context of post-apartheid reconstruction, public sociology has necessarily to go beyond critique and provide policy proposals around which subaltern publics can mobilize.

On the other hand, the impasse that resulted from the resistance and inertia of the bureaucracy presented an obscure puzzle in the fields of public and policy sociology. It was only the move into the University – and the sustained reflection and writing that the field of professional sociology provides – that allowed a new analysis to emerge. Thus, public sociology was dependent on the analytical insights provided by professional sociology.

However, the critique of the state was a moment not only of professional sociology, but also of critical sociology. That is, it provided the basis for a critique of conventional sociological understandings of the state, with at least the potential for a larger critique of the sociology of modernity from a postcolonial perspective. Thus, not only does public sociology depend on critical sociology, but critical sociology also depends on public sociology.

It becomes clear, then, that a common feature of the different sociological practices across the quadrants of sociology is the critique of the dominant discourses and categories in that field. Each of the four quadrants of sociology is itself *a field of power*, characterized by domination and contestation. In the public sociology field, there is a critique of the power and practices of the government bureaucracy and, to a lesser extent, of the union leadership. In the policy field, there is a critique of dominant policy discourses. In the field of professional sociology, there is a critique of the dominant strands of sociology and the formation of critical sociology. In all four quadrants, the stance of critique is founded on the perspectives of subaltern publics – those who are not served by the dominant structures of power and knowledge but instead are rendered voiceless by them.

This is where Eddie Webster's concept of *critical engagement* can expand its scope. Originally used to think about the tensions integral to a socially engaged practice, it may be elaborated to draw connections between critical sociological practices across the four quadrants. Through the concept of critical engagement, Webster (1995) stressed that the sociologist retains her or his critical independence in the public field – working with the trade unions but never subordinated to them, and differing with them when necessary:

> Pressure exists on scholars to make a clear declaration that their research and teaching should be constructed as support for, and on behalf of, particular organizations. To prevent this subordination of intellectual work to the immediate interests of these organizations, I prefer the stance of critical engagement. Squaring the circle is never easy, as it involves a difficult combination of commitment to the goals of these movements while being faithful to evidence, data and your own judgment and conscience. (Webster, 1995: 18)

It seems to me that this stance, which implies reflexivity, is the one adopted by the sociologist committed to subaltern publics in his or her engagement in all sociological fields – public, policy, critical and professional.

This account of an attempt to transform a state institution also suggests a blurring of two distinctions in Burawoy's model: that between professional and critical sociology and that between policy and public sociology. Professional and critical sociology take place on very similar terrain, marked by the protocols of social scientific practices such as peer review, and they are entwined with each other in the sense that the latter is a critical response to the former. Likewise, policy and public sociology both engage with the public terrain, and practitioners of either may align themselves with dominant or subaltern publics or projects. As I argue above, the two were entangled with each other from the inception of the hospital transformation project, with one being dominant in the first phase and the other becoming dominant in the second phase. Public sociology without policy implications is difficult to imagine.

It may be more useful to think about the relations between each of these two binaries as a continuum in a single field rather than sharply distinguished fields. Thus the policy/public sociology field would range between the critically independent sociologist aligned with subaltern publics at one pole and the subordinated commercially motivated sociologist aligned with dominant powers at the other pole. The professional sociological field would range from the dominant, sanctified sociology at the one pole to the critical

counter-sociology at the other. It may even be argued that the position of the dominant, sanctified sociology in the professional sociological field tends to be aligned with the domination of existing corporate and political powers in the public terrain and thus with the position of the subordinated and commercially motivated sociologist in the public/policy field.

Finally, there is something further to be said about the relationships between the different sociologies in the context of the Global South. It can be argued, as Keim does, that this critical engagement in the public sphere as well as in the policy field – the grappling with complex and intractable problems of domination, subordination and social change – produces *new knowledge*. Engagement with the practice of social change reorients the sociologist towards his or her own social reality, particularly subaltern experience, and away from the narratives and categories of the dominant sociology – which is to say, the sociology that is produced and organized in the West. In practice, such engagement becomes a site of conceptual innovation, a place where we have to think afresh about our theories and our understandings. Out of this may emerge a reconstructed sociology, what Keim calls a 'counterhegemonic sociology,' which challenges or re-fashions the dominant sociology. But it can only do this with a strong base in the field of critical sociology in the university, where the space and time and resources for such a project can be mobilized.

I want to argue, then, that the idea of 'public sociology' as an independent practice in its own field does not provide a sufficient interpretive framework for understanding the active engagement of sociologists in South Africa and perhaps other countries of the Global South. Critical engagement has to be understood as combining public sociology, policy sociology and critical sociology in a practice that may produce new knowledge, enabling a more complex comprehension of domination across these fields, the better to challenge it.

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Notes

1. Eddie Webster has been my colleague for many years and was the founding director of the Institute I now direct.
2. An example of this is afforded by my earlier research on unionization in a steel factory. Shop stewards smuggled me into a meeting in the heart of the steelworks, against the injunctions of the management, at which point it became uncomfortably clear that my presence was a way for shop stewards to demonstrate their rejection of the management's authority. The result was an angry letter from the management to the University, a nasty incident for my supervisor to deal with.
3. Although, as Burawoy points out, professional sociologists make other compromises.
4. In post-apartheid South Africa, state institutions are key sites for redressing the inequities of apartheid, where blacks were excluded from the ranks of senior professionals and managers. The result is a racially charged environment, where the persistent preponderance of experienced whites in senior professional positions can exacerbate tensions.

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Author biography

Karl von Holdt is Associate Professor and the Director of the Society Work and Development Institute, University of the Witwatersrand, Johannesburg, where he has been a senior researcher since 2007. Prior to that he was at the Congress of South African Trade Unions (COSATU)-linked policy institute, NALEDI, served as coordinator of COSATU's September Commission on the Future of Trade Unions (1996–1997), and before that was editor of the *South African Labour Bulletin*. He has published *Transition from Below: Forging Trade Unionism and Workplace Change in South Africa* (2003); *Beyond the Apartheid Workplace: Studies in Transition* (2005), co-edited with Eddie Webster; and co-authored with Michael Burawoy, *Conversations with Bourdieu: The Johannesburg Moment* (2012). His current research interests include the functioning of state institutions, collective violence and associational life, violent democracy, citizenship and civil society. He serves on the National Planning Commission of South Africa.

Résumé
Dans cet article, j'explique pourquoi la sociologie socialement engagée ne peut pas représenter une pratique isolée dans celui des quatre quadrants distincts proposés par Michael Burawoy pour organiser la sociologie qui correspond à la 'sociologie publique', mais qu'elle est étroitement associée aux formes appliquée et savante de la sociologie critique. J'utilise une étude du cas de la transformation d'un hôpital de l'Afrique du Sud postapartheid pour démontrer que l'activisme sociologique est cyclique dans les champs de la sociologie publique, appliquée et savante et pour explorer la nature de chacun en tant que champs de pouvoir contestés caractérisés par des sociologies dominantes et subordonnées. Je reprends le concept d'*engagement critique* d'Eddie Webster et j'étends sa portée en suggérant que la position du sociologue progressiste – ou radical – qui a des engagements et des responsabilités envers des publics subalternes mais conserve une indépendance critique est reproduite, dans les champs de la sociologie savante et de la sociologie appliquée, sous les formes que Burawoy appelle sociologie critique et sociologie critique appliquée, respectivement. C'est une possibilité qui ne peut pas être envisagée dans le modèle de Burawoy, dans lequel la sociologie savante occupe un quadrant constitué par une instrumentalité et une absence de réflexivité. Il faut donc comprendre la pratique de l'engagement critique comme l'utilisation d'une combinaison de sociologie publique, de sociologie appliquée et de sociologie critique d'une manière susceptible d'élargir les connaissances. Ceci offre une compréhension plus complexe de la domination au sein de ces champs et de meilleures possibilités de la contester.

Mots-clés
Champ sociologique, engagement critique, sociologie appliquée, sociologie publique, transformation d'un hôpital

Resumen
En este artículo, argumento que la sociología comprometida con lo social no puede entenderse como una práctica aislada en el cuadrante de la 'sociología pública', como lo sugirió Michael Burawoy en su organización de la sociología en cuatro cuadrantes distintos, sino que está estrechamente asociada con una sociología política crítica y una sociología profesional crítica. Utilizo un caso de estudio sobre la transformación de un hospital en la Sudáfrica post-apartheid para demostrar la manera en que el activismo sociológico se desarrolla cíclicamente a través de los campos sociológicos público, político y profesional, y para explorar la naturaleza de cada uno de estos campos como campos contestatarios de poder caracterizados por sociologías dominantes y subordinadas. Resucito el concepto de Eddie Webster del *compromiso crítico* y amplío su alcance para sugerir que la postura del sociólogo progresista, o radical, involucrado y comprometido con los públicos subalternos, pero que conserva una independencia crítica, se reproduce en el campo de la sociología profesional en la forma de lo que Burawoy llama sociología crítica y en el campo de la sociología política como sociología política crítica. Esta última es una posibilidad que no se puede contemplar en el modelo de Burawoy, donde la sociología política ocupa un cuadrante constituido por la funcionalidad y la falta de reflexividad. La práctica del compromiso crítico debe

entenderse entonces como la combinación de la sociología pública, la política y la crítica en una práctica que puede producir conocimiento nuevo que permita una comprensión más compleja de la dominación a través de esos campos, lo mejor para desafiarla.

Palabras clave
Campo sociológico, compromiso crítico, sociología política, sociología pública, transformación de hospital