Common sense and medical sciences: a sociological study

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Abstract

The relationship between common sense and medical sciences represents a critical yet often overlooked area of sociological inquiry. Common sense, shaped by everyday experiences, cultural beliefs, traditions, and social norms, plays a significant role in how individuals perceive health, illness, diagnosis, and treatment. Medical sciences, on the other hand, are grounded in scientific rationality, standardized knowledge, and evidence-based practices. This sociological study examines the interaction, tension, and coexistence between common sense knowledge and biomedical understanding in healthcare settings. It explores how patients' lay interpretations of symptoms, illness causation, and healing practices influence health-seeking behavior, treatment compliance, and doctor–patient relationships. The study also analyzes how medical professionals respond to, negotiate with, or dismiss common-sense explanations during clinical encounters.

Drawing on sociological theories of knowledge, particularly the distinction between lay knowledge and expert systems, the study highlights how power, authority, and social context shape medical decision-making. It argues that common sense is not merely irrational or unscientific but socially constructed and culturally meaningful. In pluralistic societies like India, common sense often intersects with traditional medicine, religious beliefs, and indigenous healing practices, creating both complementarities and conflicts with modern medical science. The abstract emphasizes the need for culturally sensitive healthcare that recognizes patients' lived experiences while maintaining scientific rigor. By bridging common sense and medical science, the study contributes to a more inclusive, humane, and socially responsive healthcare system.

Keywords: Common sense, Medical sciences, Sociology of health, Lay knowledge, Doctor–patient relationship, Health beliefs

Introduction

Medical science is often regarded as a domain governed by scientific rationality, standardized knowledge, and evidence-based practices. However, in everyday social life, health, illness, diagnosis, and treatment are also deeply shaped by *common sense*—the taken-for-granted knowledge, beliefs, and assumptions that individuals and communities use to interpret bodily experiences. From a sociological perspective, common sense is not merely an individual cognitive faculty but a socially constructed form of knowledge that emerges from cultural traditions, social interactions, and historical contexts (Schütz, 1967; Berger & Luckmann, 1966) [16, 3]. The interface between common sense and medical sciences thus becomes a critical area of inquiry for understanding how medical knowledge is produced, interpreted, accepted, or resisted in society.

Sociology of health and illness highlights that medical knowledge does not operate in a social vacuum. Patients often rely on common-sense explanations of disease causation such as hot cold imbalances, moral behavior, fate, or stress while navigating biomedical systems (Helman, 2007) [10]. These lay explanations coexist with, and sometimes challenge, professional medical knowledge. What appears as "irrational" or "unscientific" from a biomedical standpoint may be entirely logical within a given socio-cultural framework. Common sense, therefore, plays a mediating role between scientific medicine and lived experience, influencing health-seeking behavior, compliance with treatment, and perceptions of risk (Young, 2004) [20].

Medical sciences themselves are socially embedded institutions shaped by power relations, professional dominance, and normative assumptions. Sociologists such as Parsons (1951) [14] demonstrated that illness is not only a biological condition but also a social role governed by expectations and obligations. Later critical perspectives argued that medical authority often marginalizes lay knowledge and common-sense reasoning, leading to processes of medicalization where everyday problems are redefined as medical issues (Zola, 1972; Conrad, 2007) [21, 5]. In this context, common sense becomes both a site of resistance and accommodation, as patients negotiate between expert advice and everyday understandings.

This sociological study of common sense and medical sciences seeks to move beyond the binary opposition of "scientific knowledge versus ignorance." Instead, it emphasizes the dynamic interaction between professional medical knowledge and lay common sense. Understanding this relationship is crucial, particularly in pluralistic societies like India, where biomedical systems coexist with indigenous healing traditions and everyday experiential knowledge. By examining how

common sense shapes medical encounters, this study contributes to a more holistic understanding of health, illness, and healing as social processes embedded in culture, power, and everyday life.

Theoretical framework

The interplay between *common sense* and *medical sciences* has significant sociological implications. In this study, *common sense* refers to everyday knowledge and beliefs held by individuals and communities about health and illness, while *medical sciences* signify systematically produced biomedical knowledge grounded in scientific inquiry. Examining how these two knowledge systems intersect, conflict, and co-construct each other provides insight into health behaviors, patient-provider interactions, and broader social patterns influencing health outcomes.

1. Conceptualizing common sense in health

Common sense is rooted in lived experience and culturally transmitted understandings that individuals use to interpret health and illness. Mannheim (1936) [12] describes common sense as a matrix of beliefs anchored in social context, shaped by tradition, language, and social interaction. In health contexts, common sense includes lay interpretations of symptoms, causes of illness, and cures that may diverge from biomedical explanations (Kleinman, 1980) [11]. From a sociological perspective, common sense is not merely "naïve knowledge" but a socially validated worldview that influences decision-making and behavior (Berger & Luckmann, 1966) [3].

2. Medical sciences as institutional knowledge

Medical sciences are characterized by formalized, codified knowledge produced through systematic research, clinical practice standards, and professional training. This institutional knowledge is legitimized through scientific methods and regulatory bodies, distinguishing it from lay understandings of health. Parsons's (1951) [14] structural-functional theory highlights the role of the medical profession as a social system that regulates health expectations and behaviors through normative frameworks that define "appropriate" health practices.

3. Sociology of knowledge: bridging common sense and scientific knowledge

The sociology of knowledge provides a theoretical lens to understand how different forms of knowledge are produced, validated, and contested (Berger & Luckmann, 1966) [3]. According to this perspective, both common sense and scientific knowledge are socially constructed, though they differ in claims to legitimacy. Scientific knowledge in medicine is often positioned as superior, creating an epistemic hierarchy in which lay knowledge is devalued (Foucault, 1973) [7]. However, recent scholarship emphasizes how patient narratives and experiential knowledge can challenge and enrich biomedical paradigms (Conrad & Barker, 2010) [6].

4. Risk society and health choices

Beck's (1992) concept of *risk society* elucidates how modernity reshapes perceptions of health risks. In a context where scientific knowledge proliferates and uncertainty persists, individuals navigate health choices using both medical information and common sense heuristics. The proliferation of health information via digital media further complicates distinctions between expert knowledge and lay interpretations, leading to hybrid forms of understanding that shape health behaviors (Giddens, 1991) [9].

5. Medicalization and Lay resistance

The process of *medicalization* – where non-medical problems become defined and treated as medical conditions – illustrates the tension between common sense and medical science. While medicalization expands biomedical authority over everyday life, lay groups may resist this encroachment by asserting alternative narratives and practices rooted in cultural beliefs (Conrad, 2007) [5]. Such resistance reflects the dynamic negotiation between institutionalized medical knowledge and community-based commonsense understandings of health.

6. Implications for health behavior and policy

Analyzing how common sense interacts with medical science has practical implications for health communication, patient compliance, and public health policy. Recognizing the legitimacy of lay perspectives can improve patient-centered care, enhance trust in medical institutions, and support culturally sensitive health interventions (Airhihenbuwa, 1995) [1]. A sociological approach acknowledges that health behaviors are not merely individual choices but are embedded in social structures and knowledge systems.

Objectives of the study

- To examine the sociological relationship between common-sense knowledge and medical scientific knowledge.
- To analyze the implications of common-sense reasoning in medical decision-making and healthcare interactions.

Methodology of the study

a) Research design

The present study adopts a qualitative review-based research design to examine the relationship between common sense knowledge and medical sciences from a sociological perspective. As a theoretical and conceptual review, the study does not rely on primary field data but instead critically analyses existing scholarly literature to understand how common-sense beliefs, everyday knowledge, and cultural practices interact with formal medical science in society.

b) Nature of the study

This research is descriptive and analytical in nature. It aims to explore sociological debates surrounding the dominance of biomedical knowledge vis-à-vis lay understandings of health, illness, diagnosis, and treatment. The study situates common sense as socially constructed knowledge that influences health-seeking behaviour, patient–doctor interactions, and acceptance or resistance to scientific medical advice.

c) Sources of data

The study is based entirely on secondary sources of data, which include:

- Classic and contemporary sociological texts on knowledge, science, and common sense (e.g., works by Émile Durkheim, Alfred Schutz, Peter L. Berger, Thomas Luckmann, and Michel Foucault).
- Medical sociology literature on illness behaviour, health beliefs, and medical pluralism.
- Peer-reviewed journal articles from sociology, anthropology, and public health.
- Policy documents, reports of the World Health Organization (WHO), and national health reports.
- Books and edited volumes on medical sciences, traditional healing practices, and public understanding of science.

These sources were accessed through academic databases such as Google Scholar, JSTOR, PubMed, ResearchGate, and university library resources.

d) Method of analysis

A thematic and interpretative content analysis method has been employed. The selected literature was systematically reviewed and categorized under key themes such as:

- Sociological understanding of common sense knowledge,
- Scientific rationality and medical authority,
- Common sense versus expert knowledge in health practices,
- Cultural beliefs, myths, and everyday interpretations of illness,
- Medical pluralism and coexistence of biomedical and traditional systems.

Through comparative analysis, the study identifies patterns, contradictions, and complementarities between common sense knowledge and medical science.

e) Theoretical framework

The study is guided by sociological theories of knowledge and science, particularly:

- Social Construction of Reality (Berger and Luckmann), which explains how common sense knowledge is produced and maintained in everyday life.
- Phenomenology (Alfred Schutz), highlighting lived experiences and taken-for-granted assumptions in health practices.
- Power–Knowledge Framework (Michel Foucault), to analyse the authority of medical science and marginalization of lay knowledge.

These theoretical perspectives help in critically interpreting the reviewed literature.

f) Scope and Limitations

The scope of the study is limited to a conceptual and sociological analysis of common sense and medical sciences. Since it is a review study, it does not include empirical verification through interviews or surveys. The findings depend on the availability and interpretation of existing literature, which may reflect dominant academic perspectives more than grassroots experiences.

g) Ethical considerations

As the study relies solely on published secondary data, no ethical clearance was required. Proper acknowledgment and citation of all sources have been maintained to avoid plagiarism and ensure academic integrity.

Sociological relationship between common-sense knowledge and medical scientific knowledge

In sociology, knowledge is understood not merely as an objective collection of facts but as a socially constructed phenomenon shaped by culture, institutions, power relations, and everyday practices. Within this framework, common-sense knowledge and medical scientific knowledge represent two distinct yet interrelated systems of understanding health, illness, and the body. A sociological examination of their relationship reveals how these forms of knowledge coexist, interact, and sometimes conflict within society.

- Common-sense knowledge refers to everyday, taken-for-granted understandings that individuals acquire through socialization, family traditions, cultural beliefs, and lived experiences. In matters of health, this includes folk explanations of illness, home remedies, dietary practices, religious or spiritual interpretations of disease, and community-based healing practices. From a sociological perspective, thinkers like Alfred Schutz argue that common sense forms the "stock of knowledge at hand," enabling individuals to navigate daily life, including decisions about health and treatment. This knowledge is practical, experience-based, and context-specific, making it deeply embedded in social and cultural life.
- Medical scientific knowledge, by contrast, is institutionalized, formal, and produced within the biomedical framework through systematic research, experimentation, and professional training. It claims objectivity, universality, and empirical validity. Sociology of knowledge and sociology of medicine highlight that medical science, despite its scientific basis, is also socially organized—shaped by professional dominance, state regulation, pharmaceutical industries, and global power structures. Scholars such as Talcott Parsons view medicine as a key social institution responsible for maintaining social order by managing illness through defined professional roles.
- The relationship between common sense and medical science is not simply oppositional but dialectical. In everyday life, people often interpret medical advice through the lens of common-sense understanding. For example, patients may accept biomedical diagnoses while simultaneously relying on home remedies or traditional beliefs. This interaction demonstrates what sociologists describe as *medical pluralism*, where multiple knowledge systems coexist. Common-sense knowledge can influence health-seeking behavior, treatment compliance, and perceptions of risk, sometimes reinforcing and at other times challenging scientific medical advice.
- At times, tensions and conflicts arise between the two forms of knowledge. Medical science may dismiss common-sense beliefs as unscientific or irrational, while

communities may view biomedical practices as alien, expensive, or culturally insensitive. Michel Foucault's concept of *power/knowledge* is useful here, as it shows how medical science often exercises authority by defining what counts as "legitimate" knowledge, marginalizing lay perspectives. However, contemporary sociological approaches increasingly recognize the value of patients' experiential knowledge, particularly in chronic illness, mental health, and public health contexts.

- From a review perspective, sociological literature emphasizes the need for integration rather than hierarchy. Common-sense knowledge provides insight into cultural meanings of illness, while medical scientific knowledge offers diagnostic and therapeutic precision. Understanding their relationship helps explain variations in health behavior, resistance to medical interventions, and the persistence of traditional practices even in highly medicalized societies.

The sociological relationship between common-sense knowledge and medical scientific knowledge is complex, interactive, and socially embedded. A review of sociological studies shows that health and medicine cannot be fully understood through scientific knowledge alone; they must be examined alongside everyday common-sense understandings that shape how individuals and communities experience, interpret, and respond to illness. This perspective is crucial for developing more culturally sensitive, socially informed, and effective medical practices.

Implications for medical decision-making and healthcare interactions

Common-sense reasoning plays a significant yet often underexamined role in medical decision-making and healthcare interactions. In everyday life, "common sense" refers to taken-for-granted knowledge derived from shared cultural beliefs, lived experiences, and practical reasoning. In medical sciences, however, clinical decisions are ideally expected to be grounded in scientific evidence, standardized protocols, and professional expertise. The coexistence of common-sense reasoning and biomedical rationality creates a complex terrain of interaction between patients, families, and healthcare professionals. This review study analyzes sociological literature to examine how common-sense reasoning influences medical decision-making and healthcare interactions, and how it sometimes complements, challenges, or contradicts scientific medical knowledge.

A) Conceptualizing common sense in sociology and medicine

Sociologically, common sense has been theorized as socially constructed knowledge that appears natural and self-evident but is shaped by culture, class, education, and power relations (Berger & Luckmann, 1966) [3]. Alfred Schutz emphasized that individuals rely on common-sense knowledge to navigate everyday realities, including illness and health (Schutz, 1970) [17]. In medical contexts, patients often interpret symptoms, diagnoses, and treatments through this stock of everyday knowledge rather than through biomedical explanations.

Medical sociology distinguishes between professional medical knowledge and lay knowledge. While professional knowledge is institutionalized and evidence-based, lay or common-sense knowledge emerges from personal experience, family traditions, religious beliefs, and community narratives (Freidson, 1970) [8]. This distinction is crucial in understanding healthcare interactions, especially in pluralistic societies like India where traditional healing practices coexist with modern medicine.

B) Common-sense reasoning in medical decision-making

Common-sense reasoning significantly shapes how patients perceive illness and make treatment decisions. Many patients rely on intuitive judgments such as associating illness with lifestyle choices, fate, or moral behavior. For example, symptoms may be normalized ("this is just age-related") or moralized ("illness is due to negligence"), leading to delayed healthcare seeking (Zola, 1973) [22]. Such reasoning can influence compliance with medical advice, acceptance of diagnoses, and trust in medical professionals.

From a sociological perspective, medical decision-making is not purely rational but embedded in social contexts. Patients often evaluate medical recommendations against common-sense expectations, family advice, and previous experiences. While this may empower patients by promoting agency, it can also result in resistance to scientific interventions such as vaccination, long-term medication, or surgical procedures (Conrad & Barker, 2010) [6].

C) Healthcare interactions and power dynamics

Healthcare interactions are shaped by the interplay between doctors' scientific authority and patients' common-sense understanding. Parsons' concept of the "sick role" assumed patient compliance with medical authority (Parsons, 1951) [14]. However, contemporary sociological studies show that patients actively negotiate medical advice using their own interpretations and beliefs.

Common-sense reasoning may challenge medical expertise, particularly when patients perceive treatments as contradictory to everyday logic or bodily experience. For instance, the use of strong medications for asymptomatic conditions may appear unnecessary from a common-sense perspective. This can lead to mistrust, doctor-shopping, or preference for alternative medicine. At the same time, doctors themselves sometimes rely on common-sense heuristics in clinical practice, especially under conditions of uncertainty, time pressure, or limited resources.

D) Implications for medical practice and policy

The sociological review suggests that common-sense reasoning is neither inherently irrational nor purely obstructive. Instead, it functions as a bridge between lived experience and scientific medicine. Ignoring patients' common-sense interpretations can weaken communication and reduce treatment adherence. Conversely, overreliance on common sense without scientific validation can lead to misdiagnosis and ineffective care.

Therefore, sociologically informed medical practice calls for patient-centered care, cultural sensitivity, and effective communication that integrates scientific explanations with patients' everyday understanding. Recognizing common sense as socially patterned rather than individually flawed can help healthcare professionals address health inequalities and improve trust in medical institutions.

This review highlights that common-sense reasoning plays a crucial role in shaping medical decision-making and healthcare interactions. From a sociological standpoint, healthcare is not merely a technical domain but a social process influenced by culture, power, and everyday knowledge. A balanced engagement between common sense and medical science can enhance healthcare outcomes by fostering mutual understanding, respect, and shared decision-making. Future research should further explore how common-sense reasoning varies across social groups and how medical education can better prepare professionals to engage with lay perspectives.

Finding

A) Lack of common sense between doctor and patient: a critical analysis

The doctor–patient relationship is traditionally grounded in trust, empathy, and mutual understanding. However, in contemporary healthcare systems, a growing absence of "common sense" in interactions between doctors and patients has become evident. This absence does not merely refer to intellectual deficiency but to a breakdown in practical reasoning, humane judgment, and contextual understanding during medical encounters. Such a gap has serious implications for healthcare outcomes, patient satisfaction, and ethical medical practice.

From the patient's perspective, most of the doctor do not listen whole history of the patient and write various tests, medicine, etc. Here, it is argued that the relationship among doctor and patient are gradually decrease due to write prescription suddenly.

From the doctor's perspective, the lack of common sense often manifests as excessive dependence on technology, clinical protocols, and standardized procedures at the cost of individualized care. While evidence-based medicine is essential, rigid adherence to diagnostic tests and guidelines without considering a patient's social background, economic constraints, literacy level, and emotional state reflects poor practical judgment. Many doctors fail to communicate diagnoses and treatment plans in simple language, assuming patients possess medical knowledge. This creates confusion, fear, and non-compliance, particularly among rural, elderly, and less-educated patients.

Conversely, patients also contribute to the erosion of common sense in medical interactions. Unrealistic expectations such as demanding instant cures, unnecessary antibiotics, or excessive diagnostic tests often stem from misinformation, social media influence, and lack of health literacy. Some patients disregard medical advice, self-medicate, or consult multiple doctors simultaneously, undermining continuity of care. Emotional distress and mistrust may further lead patients to misinterpret medical limitations as negligence or insensitivity.

Structural factors within healthcare systems significantly intensify this gap. Overburdened hospitals, time constraints, commercialization of healthcare, and doctor–patient power asymmetry reduce opportunities for meaningful dialogue. Doctors working under pressure may appear indifferent, while patients perceive themselves as mere cases rather than human beings. This institutional environment discourages common-sense reasoning rooted in empathy and mutual respect.

Critically, the absence of common sense between doctors and patients reflects a broader sociological problem rather than individual failure. It highlights the dominance of biomedical models over holistic care, weakening the human dimension of medicine. When communication fails, trust erodes, leading to conflict, dissatisfaction, and even violence against healthcare professionals.

Medical education must emphasize ethical reasoning and social awareness, while public health initiatives should improve patient health literacy. Only through mutual understanding and humane judgment can the doctor–patient relationship regain its foundational strength and ensure effective, ethical healthcare delivery.

B) Lack of common sense between nurse and patient: a critical analysis

While nursing practice is guided by scientific knowledge, protocols, and ethical codes, the absence of common sense in nurse–patient interactions can significantly undermine the quality of care. This lack is not merely an individual failure but often reflects deeper structural, institutional, and sociocultural issues within healthcare systems.

From the patient's perspective, a perceived lack of common sense often arises when nurses fail to acknowledge lived experiences of illness. Most often, I observed that nurse asked to one year child for his/her urine status for urine test. How is it possible, a one-year child can talk about urine condition of her/his. Neither parent nor nurse can answer like this type question. Such type of situation seen in medical field so that it is lack of common sense between nurse and patient.

Institutionally, the erosion of common sense is closely linked to work overload, staff shortages, and bureaucratization of care. Nurses working under extreme pressure may become task-oriented rather than patient-centered. In such environments, ethical sensitivity and situational judgment are sacrificed to efficiency and risk management. The dominance of biomedical models further reduces patients to clinical cases, leaving little space for intuitive, empathetic engagement. Thus, what appears as a "lack of common sense" is often a symptom of systemic dysfunction rather than individual negligence.

Critically, nursing education itself contributes to this gap. While curricula emphasize clinical skills, protocols, and evidence-based practice, less attention is paid to reflective thinking, cultural competence, and moral reasoning grounded in everyday realities. Common sense is often treated as innate rather than as a skill that can be cultivated through experiential learning, mentorship, and ethical reflection. This assumption neglects the social complexity of healthcare interactions, especially in diverse societies like India.

The lack of common sense between nurses and patients should not be viewed as a simple personal shortcoming but as a multidimensional problem rooted in institutional constraints, professional socialization, and power relations in healthcare. Addressing this issue requires integrating empathy, cultural sensitivity, and reflective judgment into nursing practice and education. Only by balancing scientific rationality with everyday human understanding can nurse–patient relationships become truly therapeutic and ethically sound.

C) Critically understanding the prescription

Understanding the prescription is a crucial yet often neglected aspect of healthcare delivery. A prescription is not merely a piece of paper listing medicines; it is a complex communicative tool that connects medical knowledge, professional authority, patient understanding, and social context. Critically examining prescriptions reveals gaps between medical intent and patient comprehension, highlighting broader issues of power, literacy, and rational drug use.

From a biomedical perspective, a prescription represents the physician's clinical judgment based on diagnosis, symptoms, and standardized treatment protocols. It contains technical elements such as drug name, dosage, frequency, and duration, which are essential for effective treatment. However, this technical language is largely inaccessible to laypersons. The use of abbreviations, illegible handwriting, and brand-heavy drug names often makes prescriptions difficult to interpret, even for pharmacists at times. This opacity reinforces the dominance of medical professionals while marginalizing patients in their own care.

Sociologically, prescriptions reflect an asymmetrical power relationship between doctors and patients. Patients are expected to "comply" rather than "understand." In many healthcare settings in India, including public hospitals, doctors have limited time to explain medications due to heavy patient loads. As a result, patients especially the elderly, rural populations, and those with low literacy often consume medicines without understanding their purpose, side effects, or possible interactions. This lack of understanding can lead to misuse, non-adherence, overuse of antibiotics, and dependence on painkillers or sedatives.

Critically, the prescription also functions as a cultural symbol of cure. Many patients equate receiving more medicines or injections with better treatment, encouraging polypharmacy. Doctors, under pressure to meet patient expectations or influenced by pharmaceutical marketing, may overprescribe drugs. This raises ethical concerns about rational drug use and patient safety. The absence of clear explanations further distances patients from informed decision-making.

Another major issue is the neglect of patient-specific contexts in prescriptions. Factors such as age, nutrition, occupation, mental health, and socioeconomic conditions are often overlooked. A standardized prescription may not suit individuals with chronic illnesses, elderly patients, or those experiencing displacement and stress, as seen in dam-affected or resettled populations. Without proper explanation, such patients struggle to follow treatment correctly, worsening health outcomes.

Critically understanding the prescription requires moving beyond its technical function to examine it as a social and communicative practice. Improving legibility, encouraging generic drugs, enhancing doctor–patient communication, and promoting health literacy are essential steps. A prescription should empower patients with knowledge, not confuse or silence them. Only when patients understand what they consume can healthcare become truly participatory, ethical, and effective.

D) Relationship between patients and other workers of the hospital: a critical analysis

The hospital is a complex social institution where healing is not determined solely by medical expertise but also by the quality of relationships between patients and various hospital workers. Beyond doctors and nurses, patients interact with ward attendants, cleaners, security personnel, laboratory technicians, pharmacists, receptionists, and administrative staff. These interactions significantly influence patients' experiences, trust in the healthcare system, and overall treatment outcomes.

From a critical sociological perspective, the relationship between patients and hospital workers is shaped by power hierarchies, institutional norms, and social inequalities. Patients generally occupy a vulnerable position due to illness, pain, fear, and dependence. In contrast, hospital workers hold institutional authority and control over resources such as beds, medicines, reports, and access to doctors. This imbalance often results in asymmetrical relationships where patients' voices are marginalized, especially in overcrowded public hospitals.

Support staff such as ward boys, cleaners, and security guards play a crucial but often invisible role in patient care. While their work directly affects hygiene, comfort, and safety, they are frequently underpaid, overworked, and insufficiently trained in patient communication. This structural neglect can lead to strained interactions, impatience, or even mistreatment of patients, particularly those from lower socio-economic backgrounds. Patients, in turn, may perceive these workers as indifferent or rude, reinforcing mistrust and dissatisfaction.

Communication is a key area of tension. Patients depend on non-medical staff for guidance regarding procedures, paperwork, and hospital routines. However, lack of clear communication, use of technical language, and dismissive attitudes can alienate patients. Elderly patients, illiterate individuals, women, and marginalized groups often face greater difficulties in navigating hospital systems, exposing how social inequality extends into healthcare settings.

There is also an emerging trend of the commercialization of healthcare, which has altered patient–worker relationships. In private hospitals, interactions are increasingly mediated by payment capacity, turning patients into "clients" rather than persons in need of care. While this may improve politeness and responsiveness, it can also commodify care and create ethical dilemmas for workers caught between institutional profit motives and patient welfare.

Critically, improving patient–hospital worker relationships requires structural reforms rather than merely individual attitude changes. Training hospital workers in empathy,

communication, and ethical conduct is essential, but equally important are better working conditions, adequate staffing, and institutional accountability. Recognizing all hospital workers as part of the caregiving team can foster mutual respect and humanize healthcare delivery.

The relationship between patients and other hospital workers reflects broader social relations of power, inequality, and institutional culture. A patient-centered healthcare system must address these underlying issues to ensure dignity, trust, and effective care for all.

Suggestions

a) Integrate sociological training in medical education

Medical curricula should include sociology and social psychology to help healthcare professionals understand patients' social backgrounds, cultural beliefs, and everyday "common-sense" reasoning. This integration can reduce communication gaps between doctors and patients.

b) Promote patient-centered communication

Healthcare providers should be trained to listen attentively and respond empathetically, recognizing that patients' interpretations of illness are shaped by lived experiences and community knowledge. Respecting common-sense perceptions can improve trust and treatment adherence.

c) Encourage context-sensitive clinical practice

Medical decision-making should account for patients' socioeconomic conditions, literacy levels, and family contexts. Applying common sense in clinical interactions helps bridge the gap between scientific knowledge and practical realities of patients' lives.

d) Strengthen community-based health interventions

Public health programs should be designed using local knowledge and common-sense understandings of health and illness. Community participation can make medical interventions more effective and socially acceptable.

e) Reduce over-technicalization of healthcare

Excessive reliance on technology and medical jargon can alienate patients. Simplifying explanations and using everyday language enhances understanding and empowers patients in health-related decisions.

f) Address power imbalances in doctor–patient relationships

Sociological awareness can help medical professionals recognize hierarchical dynamics in healthcare settings. Encouraging shared decision-making fosters mutual respect and humane care.

g) Incorporate ethical and reflexive practice

Medical practitioners should critically reflect on how institutional routines sometimes override basic common sense and compassion. Ethical sensitivity grounded in social reality can prevent neglect and dehumanization in care.

h) Policy-level sensitization

Health policies should emphasize humane, context-aware service delivery rather than purely bureaucratic or target-driven approaches. Incorporating common-sense logic into policy implementation can improve healthcare outcomes.

Overall, blending medical science with sociological insight and everyday common sense can humanize healthcare, enhance patient satisfaction, and lead to more effective and equitable medical practices.

Concluding remark

This sociological study on *Common Sense and Medical Sciences* highlights the critical gap between scientific medical knowledge and everyday reasoning in healthcare interactions. While medical science is grounded in evidence-based protocols, standardized procedures, and technological advancement, the role of common sense shaped by social experience, cultural beliefs, and moral understanding remains indispensable in effective healthcare delivery. The study demonstrates that the absence of common-sense reasoning in medical practice often leads to miscommunication, patient dissatisfaction, mistrust, and ethical dilemmas, despite clinical accuracy.

From a sociological perspective, common sense functions as a bridge between professional expertise and lay understanding. Patients interpret illness, pain, and treatment through their social context, family experiences, and cultural norms. When medical professionals disregard these lived realities, healthcare becomes impersonal and alienating. The study finds that rigid dependence on biomedical models without sensitivity to patients' social conditions such as class, gender, age, education, and cultural background can weaken the therapeutic relationship and compromise care outcomes.

The analysis further reveals that common sense does not oppose scientific knowledge; rather, it complements it by humanizing medical practice. Empathy, practical judgment, ethical sensitivity, and contextual awareness enhance clinical decision-making and patient compliance. In contrast, the erosion of common sense in healthcare institutions due to bureaucratization, time pressure, and over-technologization reduces patients to mere cases or data points.

In conclusion, integrating common-sense reasoning into medical sciences is essential for achieving holistic, ethical, and socially responsive healthcare. Medical education and health policies must emphasize sociological insight, communication skills, and ethical reasoning alongside technical competence. Recognizing common sense as a socially informed resource can strengthen trust, improve healthcare outcomes, and ensure that medicine remains not only a science of curing disease but also an art of caring for people.

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