

Medical Sociology News
Vol 31 No 3
Winter 2005



CONTENTS

BSA Medical Sociology Group Committee	4
Editorial: The End of an Era!.....	6
New Editorial Team	7
News and Notices.....	9
Forthcoming Events - National and International	11
- Study Groups.....	15
Conference Reports.....	18
Study Groups' Annual Reports 2004-05.....	28
Articles	35
Missing Connections: Medical Sociology and Feminism.....	35
Ellen Annandale, University of Leicester	35
Social Structure and Health: A Narrative of Neglect?*	53
Graham Scambler, University College London	53
Interview with Professor Sally Macintyre	70
PhD Abstracts	79
Book Reviews	86
Agony Aunt	100

BSA Medical Sociology Group Committee 2005/2006

Gillian Bendelow

Co Convenor

Dept of Sociology
School of Social Science and
Cultural Studies
University of Sussex
Falmer
BRIGHTON

Tel: 01273 877558

G.A.Bendelow@sussex.ac.uk

Paul Godin

Department of Applied
Psychosocial Sciences
St Bartholomew School of
Nursing and Midwifery
City University
24 Chiswell Street
LONDON

Tel: 020 7040 5933

p.m.godin@city.ac.uk

Kim Clarke

Addictions Division
Institute of Psychiatry
c/o Blackfriars Community
Drug & Alcohol Team
151 Blackfriars Road
LONDON

Tel: 07969 587 134

kim.clarke@kcl.ac.uk

Nina Hallowell

Co Convenor

Public Health Science
Medical School
University of Edinburgh
Teviot Place
EDINBURGH

Tel: 0131 650 3230

Nina.Hallowell@ed.ac.uk

Richard Compton

Dept. of Nutrition & Dietetics
Kings College London
Franklin Wilkins Building
150 Stamford Street
LONDON

Tel: 0207 848 4305

richard.compton@kcl.ac.uk

Julia Lawton

RUHBC
School of Clinical Sciences
& Community Health
Teviot Place
University of Edinburgh
Medical School
EDINBURGH
EH8 9AG

Tel: 0131 650 6197

J.Lawton@ed.ac.uk

Oonagh Corrigan

School of Sociology
Politics and Law
University of Plymouth
Drake Circus, PLYMOUTH

Tel: 01752 233225

oonagh.corrigan@plymouth.ac.uk

David Rankin

RUHBC, School of Clinical Sciences
and Community Health
The University of Edinburgh
Medical School EDINBURGH
Tel: 0131 651 3053
a.d.rankin@ed.ac.uk

Richard Tutton

IGBiS
University of Nottingham
NOTTINGHAM
Tel: 0115 846 8151
Richard.tutton@nottingham.ac.uk

Louise Woodward

R&D, Nottinghamshire Healthcare
NHS Trust/
University of Nottingham
Duncan MacMillan House
Porchester Road
NOTTINGHAM
Tel: 0115 9691300 x40685
louise.woodward@nottshc.nhs.uk

Chris Yuill

***ex officio representation on
committee BSA Executive Medical
Sociology Study Group Liaison***
School of Applied Social Studies
Faculty of Health
The Robert Gordon University
Garthdee Road, ABERDEEN
Tel: 01224 263379
c.yuill@rgu.ac.uk

***Medical Sociology News
Editorial Team ex officio
representation on
committee***

Maureen Porter

Department of Obstetrics &
Gynaecology
University of Aberdeen
Aberdeen Maternity Hospital
Foresterhill
ABERDEEN
Tel: 01224 554875
m.a.porter@abdn.ac.uk

Nicola Gibson

British Sociological
Association
Bailey Suite
Palatine House
Belmont Business Park
Belmont
DURHAM DH1 1TW
Tel: 0191 383 0839
Fax: 0191 383 0782
Bsa.medsoc@britsoc.org.uk

EDITORIAL: THE END OF AN ERA!

The bumper issue you find in front of you is the last one from the Aberdeen team. We have enjoyed the experience of working together very much. After three years and nine issues it is time to hand over the baton to Liverpool. We are grateful for the steady supply of conference announcements, PhD summaries, conference reports, book reviews and articles. Without your contributions no editorial team can hope to publish a quality newsletter.

This edition brings you both papers from the two plenary sessions of the 2005 Medical Sociology Conference in York, which is good news for those of us who were unable to attend (and for one of our conference reporters, Patsy Staddon). Both articles address social organisation and health, Ellen Allandale's in relation to gender and capitalism and Graham Scambler's the theorising of agency and structure. They both make for compelling reading, particularly for those interested in social theory and health and in health inequalities.

We also bring you the promised interview with Sally Macintyre which was conducted by our opportunistic team during her recent visit to Aberdeen to receive an honorary Doctor of Science. She makes us think about the direction in which medical sociology is going and our usefulness to outside organisations. Our thanks go to Aberdeen University Press Office for the photographs of Professor Sally Macintyre and colleagues. Also included in this issue are notices and reports from Med Soc regional and study groups, book reviews, PhD abstracts and of course correspondence with our dear Aunt Marge. We feel that with another packed Christmas issue we are going out with a bang and hope you agree!

Medical Sociology News turns to the power of the Internet in 2006. After the success of the JISCmail list for communication of conference announcements, new books, jobs etc., the next issue of *Medical Sociology News* is going to be web-based. We cannot help feeling that this is the end of an era for the old style MSN (which has a 30 year history), but have every confidence that the new format will prove equally successful and valued by the BSA MedSoc community. We are pleased that a team from Liverpool has come forward to take over from us, and in a short introduction below, they outline some of the reasons

for the change to on-line format and their vision for the future of MSN. We wish them all the best and we hope they have the same amount of fun as we had as editors.

Lastly, a final 'Happy Christmas' from Aberdeen to all MSN readers. We hope you enjoy a doubtless well-earned rest over the festive period.

Maureen Porter
Lydia Lewis
Fiona French
Steve Brindle
Chris Yuill
Edwin van Teijlingen

New Editorial Team

A team from the Health and Community Care Research Unit, the Mersey Primary Care Research & Development Consortium and the Departments of Public Health and Primary Care at University of Liverpool will be submitting a proposal to the Medical Sociology Committee to undertake the editorship and production of Medical Sociology News from 2006-2009.

While recognising the advantages of a printed paper format and the success of the team from Aberdeen in developing Medical Sociology News (MSN) into an attractive edition, discussions with the current editorial team from Aberdeen and members of the BSA Medical Sociology Committee about rising printing and distribution costs and falling subscriptions have lead us to propose that in future MSN should move to an electronic format, to be downloadable by all Medical Sociology Group members, free from subscription charges. While keeping much of the current format and 'look', links to MSN will be circulated via the existing Medical Sociology Group JISC Mail and be available via the BSA website.

We believe that this format gives a number of advantages, as it will not only make the journal more accessible to more group members through open electronic access, but would enable the new editorial team to

dispense with many of the administrative tasks such as dealing with subscriptions, mailings etc. It would also enable the publication to be more accessible to other BSA members and to the wider international community. To reflect this change of format, we propose that the title of *Medical Sociology News* will be changed to *Medical Sociology online* (MSo). We aim to produce two editions a year, with the possibility of further issues depending on the material available to us, and the workload involved in producing each issue. To allow us time to set up the first edition of MSo, we anticipate that the first online edition will be available in May/June 2006, with a further edition to follow in the autumn.

While we wish to retain as many of the newsletter functions as possible, we aim to develop the existing newsletter by setting up a peer-reviewed system for longer papers submitted to MSo. We believe that this will further encourage and maintain the high quality and relevant submissions that MSN has attracted in the past. To this extent we may be able to counter the fear expressed in the editorial of the summer edition of MSN (Vol. 31 No.2) that MSN would become another 'victim' of the RAE.

The new team at the University of Liverpool are: Jude Robinson (Health & Community Care Research Unit), Helen Bromley (Dept. Public Health) Paula Hodgson (Dept. Primary Care), Suzanne Hodge (HaCCRUC), Julia Hiscock (MPCRDC), Mona Killey (HaCCRUC), and Clare Thetford (HaCCRUC).

Copy for the first 2006 on-line issue should be sent to Jude Robinson at: j.e.robinson@liv.ac.uk.

NEWS AND NOTICES

2006 World Congress of Sociology - Postgraduate Bursaries

The Trustees of the Foundation for the Sociology of Health and Illness (owners of the journal) have generously agreed to offer up to four bursaries to support the participation of postgraduate students in the meeting of Research Committee 15 Sociology of Health at the 2006 World Congress in Durban (23-29 July). The bursaries will have a minimum value of at least £500 but applicants are invited to make a case for additional support up to a maximum of £750.

Eligibility

1. Applicants must be EU citizens, registered part-time or full-time, for a PhD at a UK HEI and with no means of support other than a scholarship and associated part-time teaching or research assistance.
2. Successful applicants must join the ISA as student members and register as members of RC15. No payment will be made until confirmation of membership is received from ISA.
3. Applicants must submit a paper to an RC15 session by **15 November 2005** and have received confirmation from the session organizer that the paper has been accepted.

Procedure

1. Applicants must submit a letter of application including an outline budget and case for support, a brief CV and a copy of the confirmation of acceptance from the session organizer. This should be accompanied by a letter from the head of the department where they are registered, confirming their status as a student dependent on a scholarship and associated earnings, and that they have access to sufficient funds to cover the balance of costs involved in attendance for the duration of the World Congress. Heads of department should also comment on the applicant's ability to benefit from the opportunity of participating in the World Congress.
2. Applicants must submit a brief report to the Foundation within six weeks of their return, in a form suitable for publication in the MedSoc newsletter or on the Foundation website, describing their experiences and the benefits gained from them. Full payment will only be made once this report has been received.

The Award Panel will consist of Professor Robert Dingwall (Nottingham) and Dr Ellen Annandale (Leicester). Applications should be submitted **in hard copy only** (three copies) to Professor Robert Dingwall no later than **31 January 2006** at Institute for the Study of Genetics, Biorisks and Society, Law and Social Sciences Building, University of Nottingham, University Park, Nottingham NG7 2RD. The Award Panel will communicate their decisions no later than **28 February 2006**.

.....

**Sociology of Health and Illness Foundation:
Awards for Post-Graduate Study**

The Foundation for the Sociology of Health & Illness (the charity which owns the journal 'Sociology of Health & Illness'), in addition to its usual part-funding of postgraduate awards, is offering one fully-funded 1+3 PhD studentship worth £72,500 over a four-year period, for a full-time PhD on a medical sociological topic. This award is to be named the Gerry Stimson Award, after Prof Gerry Stimson who has recently retired from Imperial College and who played a large part in setting up the journal in the 1970s.

In addition, the Foundation is doubling the value of its annual part-funded PhD award scheme. Now the Foundation is offering 1+3 awards worth £3,000 per annum to the student and £3,000 per annum to the host department for a full-time or a part-time PhD on a medical sociological topic. One such award will be offered for a start in 2006/07.

Applications for both the Gerry Stimson Award and the part-funded award must be made by the would-be supervisor to the Foundation by 31/1/06. One application will suffice for consideration for both the Gerry Stimson Award and the part-funded award. Application forms, guidance notes and further details can be found on the Foundation website: **<<http://www.shifoundation.org.uk/>>**.

The Foundation is not offering any part-funding for MSc studies in 2006/07.

.....

FORTHCOMING EVENTS

The British Sociological Association Annual Conference 2006

Sociology, Social Order(s) and Disorder(s)

Friday 21st - Sunday 23rd April 2006

Harrogate International Centre

Plenary Speakers

Jock Young (City University of New York and University of Kent)

Geoff Payne (British Sociological Association President)

Angela McRobbie (Goldsmiths College, University of London)

Understandings of social order(s) and disorder(s) are central to sociological theory and investigation. Shifting definitions and determinants of, for example, stability/instability, insiders/outside, tradition/innovation, equality/inequality, criminals/victims, safety/risk, health/illness and so on are part of many sociological projects, from the study of class, stratification and citizenship, through the study of migration and labour markets, gender and ethnic inequalities, and criminal justice to questions around the digital worlds of the web, hyperspace and virtual reality. Similarly, different effects of 'disorder' on households, communities, cultures, economies and politics, and different means of securing 'order' are researched in a range of settings. Sociologists make sense of 'order' and 'disorder' in varying ways and in numerous sites from the local to the global.

Papers, posters and other forms of presentation will be structured around themes that include:

- Identity, citizenship and rights
- Cities, markets, space and place
- Crime, deviance and law
- Risk, safety and justice
- Classical social theory, order(s) and disorder(s)
- Gender, sexuality and relationships
- International order(s) and disorder(s)
- History, order(s) and disorder(s)
- Culture, media and cyberspace
- Researching order(s) and disorder(s)

Booking Form and further information available from:

www.britsoc.co.uk/conference; e-mail Conference2006@britsoc.org.uk

Organising team: Eamonn Carrabine, Pam Cox, Paul Iganski, Maggie Lee and Nigel South (University of Essex).

**Qualitative Research on Mental Health Conference
29 June – 1 July 2006, Tampere Hall, Tampere, Finland**

Call for papers

Qualitative mental health research focuses on questions pertaining to individual, social, and cultural meanings related to mental health. These include, for example, how the sufferers of mental health problems make sense of their experience, how the social milieu of the sufferer can enhance or hinder coping with the problem, and what happens in treatment settings and encounters. Moreover, qualitative mental health research is interested in questions regarding the ways in which mental health problems are understood in the media and in society at large.

The first conference of Qualitative Research on Mental Health will be held in Tampere, in South-West Finland. It will gather together researchers from different disciplines, such as psychology, social psychology, nursing science, public health, social work, sociology and anthropology. The aim of the conference is to create an opportunity for and to enhance multidisciplinary discussion on mental health from the viewpoint of qualitative research methodology.

The programme of the conference will be composed of keynote lectures, paper sessions and poster presentations. Keynote speakers will include: Dana Jack, Fairhaven College, Western Washington University; Ian Parker, Manchester Metropolitan University; Vieda Skultans, University of Bristol; Els van Dongen, University of Amsterdam and Jarl Wahlström, University of Jyväskylä.

Deadline for abstract submissions is 28 February 2006

The conference is part of the activities of the International Qualitative Research on Mental Health research network. The main organisers are the Research Institute for Social Sciences and the Department of Sociology and Social Psychology (University of Tampere) in collaboration with the Dept. of Psychology, Dept. of Social Policy and Social Work, the School of Public Health (University of Tampere) and the Dept. of Social Psychology and Sociology (University of Kuopio).

.....

Mixed Methods Conference & Workshops 2006
- Call for Abstracts

Following the success of the inaugural conference in 2005, Homerton School of Health Studies Department of Research & Postgraduate Education will be hosting the second annual Mixed Methods conference in July 2006. This year, we will also be offering pre-conference workshops on mixed methods research. The conference and workshops will take place at **Fitzwilliam College, Cambridge, UK on 8-11 July 2006.**

Abstracts are invited from researchers utilising mixed methods in creative ways, particularly those working within the social sciences, health and education. The following themes provide the framework for the conference:

Philosophical and methodological issues in mixed methods design;
Real world application of mixed methods research;
Mixing art and science in imaginative ways.

To submit an abstract please read the guidelines and use the online form at
www.health-homerton.ac.uk/research/events/MM2006call.html

Keynote speakers: Professor Abbas Tashakkori, Professor Trisha Greenhalgh, Professor Donna Mertens and Professor Andrew Sparkes.

Workshops: Professor John Creswell, Professor Vicki Plano-Clark, Professor Michael Fetters, Professor Donna Mertens, Professor Max Bergman, Alicia O'Cathain and Dr. Tessa Muncey.

For more information please visit
www.health-homerton.ac.uk/research/events/mixedmethods.html

To request a brochure please contact Charlotte Bates: email: **bates@health-homerton.ac.uk**; phone: 01223 885969; address: Homerton School of Health Studies, The Maris Centre, 45 Hauxton Road, Cambridge CB2 2LT

.....

The British Sociological Association
MEDICAL SOCIOLOGY GROUP
Annual Conference 2006

**CALL FOR PAPER/POSTER
PRESENTATIONS**

Thursday 14th – Saturday 16th September 2006
The James Watt Centre, Heriot-Watt University,
Edinburgh

Plenary speakers will be

Professor Linda McKie

School of Law & Social Sciences
Sociology & Social Policy Group
Glasgow Caledonian University

Professor Robert Dingwall

IGBiS, Law & Social Sciences Building
University of Nottingham

The abstract submission deadline is April 28th 2006

**Abstract submission form and further details available from the
BSA Website: www.britsoc.co.uk/msconf or e-mail:
bsamedsoc@britsoc.org.uk**

Forthcoming Events - Study Groups

Scottish Medical Sociology Group

New convenors wanted

Scottish Medsoc organises several seminars each year and the occasional conference and needs more convenors to help with organising these events. As convenor, you will decide on topics and speakers. There is a budget to help with this. If you are interested in becoming a convenor and would like more information please contact Linda McKie l.mckie@gcal.ac.uk and Gill Hubbard gill.hubbard@stir.ac.uk.

No previous experience required and doctoral students are welcome to apply.

.....

Celebrating 60 Years of Medical Sociology: One Day Conference

Friday 17th March 2006 10am - 4.30pm: City Chambers, Edinburgh

Programme includes: Professor Robert Dingwall (University of Nottingham): 'Interactionism in medical sociology since 1951'; Dr Edwin R. van Teijlingen (University of Aberdeen): 'Medical sociology in Aberdeen: the early years'; Professor Paul Atkinson (Cardiff University): 'Interactionism in perspective'; Professor Mike Bloor (Glasgow University): 'What's wrong with ethnography? Then and now'; Dr Ailsa Cook (Glasgow University): 'Communication in care homes for older people' and Dr Ann Wakefield (University of Manchester): 'Reflexive sociology: troubles with commitment to a research project amongst members of the research team'.

Organisers:

Professor Linda McKie (Glasgow Caledonian University) & Dr Gill Hubbard (University of Stirling)

Details and booking

<http://www.crfr.ac.uk/events/researchingsociallife.html> or contact Laura Marshall on 0131 651 3001; e-mail: l.marshall@ed.ac.uk

.....

Sociology of Mental Health Study Group

Please look out for our panel and 'meet and greet' sessions at the BSA Annual Conference in April 2006. We also plan to hold our annual symposium at the end of June again next year on the theme of social capital and mental health, and will be circulating a call for abstracts in the coming months. Details of the Group's recent activities can be found on our web page: www.britisoc.co.uk/MentalHealthSG.

For further information, the convenors can be contacted at:
I.lewis@abdn.ac.uk; louise.woodward@nottshc.nhs.uk

.....

West Midlands Medical Sociology Group

Dr. Geraldine Brady and Dr. Caroline Vautier have recently taken over as joint convenors of this group. A programme of forthcoming events will be advertised at the beginning of next year. The new convenors would like to thank the previous convenors, Wendy Martin and Steven Handsley, for their contribution to the Group and look forward to meeting the current WMMS Group members, as well as to furthering interest in the Group.

Convenors contact details:

Dr Geraldine Brady
Centre for Social Justice
Coventry University
Richard Crossman Building
Priory Street
Coventry CV1 5FB
Tel: 02476 795843

Dr Caroline Vautier
Dept of Public Health &
Epidemiology
Warwick Medical School
Medical School Building
University of Warwick
Coventry CV4 7AL
Tel: 02476 575882
Fax: 02476 528375

.....

London Medical Sociology Group - 2006 Spring Programme

Venue: King's College London, Room 1.16, Franklin Wilkins Building, Stamford Street, London SE1 8WA. Nearest tube and rail: Waterloo.
MEETINGS: 6PM - 7PM

Everyone is welcome to attend LMSG meetings. The group has no formal membership. At each meeting there is a presentation by a speaker, followed by discussion that continues over drinks and supper in the local pub.

- 11 Jan **Telling the story: narrative synthesis in health research**
Jennie Popay, University of Lancaster;
Lisa Arai, Helen Roberts City University
- 8 Feb **'Walk this way': public health and the social organisation of walking**
Judith Green, London School of Hygiene & Tropical Medicine
- 8 Mar **Managing the 'enterprise' of primary care? Neo-liberalism and NHS LIFT**
Rachel Aldred, Goldsmiths College
- 12 Apr **Gender and a failed professionalisation project? The Bedford College course in Hygiene 1895-1920**
Mary Ann Elston, Royal Holloway, University of London
- 10 May **Ethical issues in the pre-implantation genetic diagnosis clinic: staff views and experiences**
Kathryn Ehrich, Kings College London

Joint LMSG Organisers: Richard Compton (Convenor),
Jacqueline Davies, Martin Hyde, Miranda Leontowitsch (Treasurer).

To receive details of all LMSG meeting, please contact
Miranda Leontowitsch: mleontow@hscs.gul.ac.uk

.....

Conference Reports

Reports on the BSA Medical Sociology Group Conference 2005 from students who received free places*

Mark Pearson, School of Sociology, Politics and Law, University of Plymouth

My partaking in the BSA Medical Sociology Conference came at a good time for me. I am nearing the end of the first year of my Ph.D., and have spent the summer endeavouring to constructively revise my introductory chapter. I certainly felt that I needed some external stimulation to re-invigorate my research.

Thankfully, the conference was able to provide this stimulation. My background is not in Sociology, let alone the sub-discipline of Medical Sociology, so I approached the conference with some trepidation. I took an eclectic approach to the session streams in a bid to gain as wide an overview as possible. Thus, I was able to attend sessions that not only touched upon my own research topic of Evidence-Based Practice, but also those that provided an introduction to areas that are entirely new to me, such as the sociological study of complementary and alternative medicine, and of masculinities. I feel that these sessions, and the two plenaries, have given me a much broader and deeper appreciation of the Medical Sociology field that will feed substantively into my own thesis.

In addition to directly increasing my knowledge of the field, the conference has also contributed to the development of my academic skills in other areas. Aside from the many beneficial conversations that I had with other delegates, I was able to make contacts with others whose work and assistance I shall be able to draw upon substantively in the future. Moreover, participating in the sessions has given me an overview of how I might go about presenting my own work at the conference in the future, and the confidence to consider doing so.

I shall also be able to use my experience at the conference to guide my role on the steering committee for the University of Plymouth Postgraduate Symposium, which will be held in January 2006. The

organisation of the Medical Sociology conference was very tight – sessions were kept to time, signposting was clear, and refreshments were readily available. Although the Plymouth conference will be on a somewhat more modest scale, I can use the BSA conference as a highly effective role model.

mark.pearson@plymouth.ac.uk

.....

Andrew Paterson

Immediately before the conference I attended the BSA/ESRC Summer School in Coventry for postgraduate research students. Finding out that other past and present PhD students are much like me made me more relaxed about Medsoc but it also meant that I was late turning up for the conference. I arrived in the dark and in the rain and ended up getting lost in York University campus!

Fortunately, I bumped into someone I had met in Coventry who helped me find my way and I managed to get in just in time for dinner. My initial impression of my fellow conference members was that they seemed much more academic and serious than me; something I am sure is not uncommon for a first timer like myself. However, as the conference progressed this impression wore off and I began to see that, as with the BSA course, everyone was very nice and willing to enjoy themselves.

This was especially so with those who presented and attended the gender stream on the Friday morning, in which I gave a paper. I had been quite worried about presenting but everybody was very supportive both before and after. My slot – 10am on Friday – also helped, as a lot of people were around, resulting in every seat being taken. This somewhat unexpectedly calmed my nerves, and at one point I even caught myself speaking with my written paper (for reading from) rolled up in my hand! I was given lots of useful feedback about my research on masculinities and health lifestyles, especially regarding interviewing.

After my own paper I stayed around for other papers in the stream. Most of these were also on masculinity, which would appear to be a popular topic just now. During the breaks my fellow gender presenters and I chatted about our topics and shared ideas. This was very enjoyable,

and I intend to stay in touch. Later, I attended some presentations on quite different topics from my own. These included stimulating papers on media coverage of medical mal-practice, on answering respondents' own questions, on the surveillance of SARS, and on competing methods of medical training.

These talks have informed me about some of the wider ways in which sociology can be applied to medicine and health. The conference has also benefited me in other ways. Meeting others in my line of study will certainly be useful. Perhaps the greatest help, however, will be the confidence the conference has given me, both in terms of how my work is progressing and also in terms of presenting. Furthermore, I was glad that my initial impressions were proved wrong, and the atmosphere was relaxed and friendly at all times with the disco on Friday night confirming that medical sociologists do indeed like to have fun.

.....

**Patsy Staddon, University of Plymouth and Avon & Wiltshire
Mental Health NHS Trust**

It would be hard to say which gave me most delight and amazement - being awarded a free place both at the Summer School and at the MedSoc Conference, or having my paper, "Alcohol and the Social Control of Women" accepted for presentation at the Conference!

The most enjoyable and useful ESRC Summer School ended too late for me to reach York in time to hear the plenary speakers, and if someone were able to email me their notes from Ellen Annandale's talk in particular, it would be a great favour. However I was able to enjoy many other presentations, despite having the anxiety of giving my own (11 a.m. on the Saturday!) looming over me!

I think of them all, my three favourites were, firstly, I.Laitinen's paper, presented by Elizabeth Ettorre. This paper, "Empowering Depressed Women: Changes in 'Individual' and 'Social' feelings in Guided Self-Help Groups in Finland", resounded for me with my own research with women with alcohol problems: the way that power relationships affect the healing processes in women, the achievement of empowerment in small groups, and the way that such groups develop and are characterised by a mind of their own. I also picked up some useful tips

to suggest to the group I facilitate in Bristol, such as videoing ourselves and each other, to develop more positive self-images.

Equally exciting was the presentation by I.D.Gardner, "Women Who Self-mutilate: The Emergence of a Counter Discourse as a Challenge to Psychiatry". Again, I found many parallels with my own work, for example the importance of not taking away from women their coping mechanisms, without an understanding of their motivation and pain. I particularly admired her reference to self-mutilation being, in a sense, a gesture of hope; a taking of control by the woman concerned. Again, for me, this resonates with what I am finding with women who use alcohol in ways which may be seen as problematic.

It was not the first time that I had listened to Nicky Charles, who spoke on "Stigma, Domestic Violence and Mental Health" but I was still greatly impressed by her reflections on the effect of stigma on moral worth, and the way that social networks are restricted by the internalisation of victim-blaming, making it even harder to heal. Once more, I could not fail to recognise parallels with the effects on women of conventional alcohol treatment and conventional "recovery networks" such as Alcoholics Anonymous.

My own paper was received with kindness and courtesy, and I wished I had spent less time in worrying about Med Soc's possible criticisms of my work! I am really glad to have been able to go to the Conference, and hope to attend many more.

patsy.staddon@plymouth.ac.uk
.....

Joana Sousa Ribeiro, Economic Faculty - University of Coimbra, Portugal

As I am in the first year of my PhD, it was good to have the opportunity of receiving a bursary to attend the Medical Sociology Conference in York. As a post-graduate student in Sociology, I have already attended other Conferences but this was the first time, and hopefully it will not be the last, that I have attended a Conference abroad focusing on medical sociology issues.

As an International Student I did not have any difficulties on arrival at York's University campus. In fact, plenty of information was given in advance, which allowed us to maximise our profit from the Conference itself - one hundred and seventy-eight paper sessions, four posters, five workshops and two plenary sessions. Facing this offer, the major problem was how to choose which presentations to attend. Fortunately, the presentations were arranged into topic areas. These were very diverse, reaching areas as different as Genetics, Inequalities, Lay/Professional Interface, Reproduction, Theory, Experience of Health and Illness, Gender, Life Course, Ethnicity, Health Service Delivery and Organisation, Mental Health, Methods, Risk, Health Policy, Health Technologies, Primary Care, Ethics, Cancer, Contemporary and Alternative Medicine, International Health and Teaching Health Professions. What was most interesting to me was that the programme included the traditional subjects that one normally comes across in conferences concerning health services research, but also more interdisciplinary and innovative streams. Personally, I was particularly interested in the sessions that integrated the streams of "Lay/Professional Interface", "Ethnicity", "Health Policy", "Primary Care" and "International Health", and these were really worth it.

The 30 minute format (20 minutes for the speakers and 10 minutes for questions) was a good way to manage the time and, as a presenter myself, I felt that it encouraged me to get straight to the point with my talk, providing me also with the chance of having feedback from some experienced researchers and academics. As there were not any allocated coffee breaks, which I regretted a little, the end of the sessions was a good opportunity to share some information.

I would just like to point out that, in my opinion, I think it would be more interesting if we had the opportunity to pose some questions to the orators of the plenary sessions, mainly because in both cases they had widely recognized work in the medical sociology field and presented inspiring models. For an international student like me, sometimes it is a little hard to begin an informal conversation with such recognizable academics.

I noticed that the publishers do not have a passive role in this event. In fact, they not only presented a large number of exhibition stands selling books and journals, but also organised a Publishing Workshop, where

general advice about developing a publication strategy and specific guidance about compiling articles for peer-reviewed journals were particularly useful for a novice researcher like me.

Attendance at the Medical Sociology Conference was a good opportunity to recharge my batteries in the pursuit of a PhD. To sum up, I am grateful to the British Sociological Association Medical Sociology Group for these three days, where all elements - the research and academic endeavour, a high standard of accommodation as well as time to socialize and establish informal networks – converged to make for a very worthwhile conference experience.

.....

Michelle Kealy, La Trobe University Melbourne, Australia

I attended the BSA Medical Sociology Group Annual Conference in York (15-17 September 2005) as the recipient of the international student bursary (£500). Arriving the day before the conference began, I was fortunate to spend a very pleasant afternoon on a walking tour of York - something I can recommend to any visitor! Time did not permit an insider view of the Minster, the National Railway Museum, or indeed any of the other many sights in the beautiful city of York, but I did find time to sample some delicious local cuisine in the evening. Thursday 15th September dawned dreary and damp and I was pleased to locate the conference building after kind assistance from the York University Information Centre. It was with great relief that I was able to give my presentation on the first day of proceedings, enabling me to then sit back and concentrate on the many varied and excellent papers delivered during the rest of the conference.

Highlights of the conference included attending the plenary sessions: Ellen Annandale (*Missing Connections: Medical Sociology and Feminism*) and Graham Scambler (*Social Structure and Health: A Narrative of Neglect*) and also the Publishing Workshop - again Ellen Annandale (Social Science & Medicine), with Rachel Gear (Oxford University Press) and Janet Rimmington (Taylor & Francis). Working in an academic climate here in Australia of "publish or perish" (no doubt typical of many settings), it was useful to hear about some of the possible pitfalls and also the essential steps to successful publishing.

The quote "your profile is your currency", by Rachel Gear, seemed to ring true for the majority of participants present at the workshop.

I used the conference sessions to achieve maximum diversity of exposure to different research topics and found a rich and varied choice of interesting papers but not enough hours in the day! The high standard of presentations was impressive and I enjoyed listening and learning about a range of issues, challenges and successes in sociological research. A particular challenge of mine was processing social theory - as a novice researcher coming from a clinical background. I found I learned from a variety of fascinating topics covered at the conference, which included, for example, the multiple issues live kidney donors and their recipients face; alcohol and the social control of women; mass media coverage of child organ retention; and clinical governance. There were many sessions that I highlighted to attend but didn't make it because the stream I was in provided more than enough stimulation.

As a first exposure to a sociological conference, BSA Med Soc delegates were friendly and kind. I was impressed with the feedback that presenters received from the audiences; this ensured frequent lively discussion in the sessions, which was both constructive and supportive. Hopefully I will be able to maintain new friendships forged at the conference - people I met either at sessions or over coffee or late afternoon drinks.

Coming to BSA Med Soc provided me with a wonderful opportunity to meet with and learn from some of the best researchers in medical sociology in the United Kingdom. Congratulations to the conference organisers for a stimulating and thought-provoking few days; it was well worth the trip from 'down under'!

.....

***Free places awarded by the SHI Foundation and BSA Medical Sociology Group to increase access to the BSA Medical Sociology Group annual conference to postgraduate students who are registered at a British post 1992 university.**

Report of the Teaching Medical Sociology Workshop

The fifth BSA Medical Sociology Group Teaching Medical Sociology Workshop was held at the Medical Sociology Conference in York on Friday, 16th September 2005. Some twenty medical sociologists attended the workshop. The organisers Edwin van Teijlingen and Chris Yuill had prepared a short presentation highlighting some of the issues addressed at the previous four meetings. They also suggested that this year's discussion might start from a consideration of medical sociology textbooks as there has been a real boom in the market with several textbooks being published in the past few years.

The workshop participants raised a large number of issues around the teaching of medical sociology to health-care profession students. Several of these issues have been summarised below.

- ❑ Students equate medical sociology with public health, or as someone put it: "We teach social issues, such as gender, social class, ethnicity and their relationships with health and illness, but not sociology." Related to this, was a debate about whether our teaching of medical sociology to health care professionals is or should be a-theoretical. This raised questions such as: "Are the students there to learn nursing or sociology?", and "Why do they need to know theory?" This also raised questions about the possible de-skilling of medical sociologists. One wondered whether or not we are simply teaching transferable skills?
- ❑ Some pointed out that whilst we might be teaching social factors to the majority of students, there is satisfaction in really reaching a few and having the pleasure of seeing them gain a real insight into sociology - developing what C Wright Mills called 'the sociological imagination'.
- ❑ Some raised the point that psychology has a higher status, not just in the curriculum, but also in the wider society. Psychologists seem to be much better than medical sociologists in interacting with the media and claiming expertise. (A point also made by Sally Macintyre in her interview - Ed.) It was noted that other disciplines such as anatomy and bio-medical science have struggled with the notion of how to get more of their core material included in an already busy medical or nursing curriculum. Someone who had been teaching for some ten years commented that the contribution

- ❑ of medical sociology at his university in one particular health-care profession's curriculum had varied from ten sessions to two and up to four again, all in response to demands from the curriculum designers.
- ❑ At what point in the curriculum do we want to teach medical sociology? How do we strike the balance between students still being enthusiastic and motivated to change the world, but not yet indoctrinated (socialised into their profession), AND students being able to see the clinical relevance of sociology to their practice and outlook?
- ❑ Where do we fit in an integrated curriculum? Many felt it was hard to fit our discipline into Problem-Based Learning (PBL) sessions. Also how do we fit into the different types of assessments and assignments? Sociology is a discipline not amenable to multiple-choice questions, or right and wrong answers.
- ❑ Health-care students value practice, time on the ward or in the community and seem more responsive to practitioner-teachers who seem to them to have more to offer in the way of anecdotes about patients. Some suggested that it is always good to have an enlightened clinician making positive comments about the importance of sociology for practice. Suggestions included: 'work with clinicians'; and 'make your teaching clinically relevant'.
- ❑ A further motivating factor for the student is getting your sociology contribution included in the exam. As students often work towards exams, anything not examined is seen as unimportant.
- ❑ How do we get sociology on the curriculum, is not the same question as: "How do we get sociology on the political agenda of those driving curriculum change?" It is critical that we have an identity in the curriculum. This led to questions about the profile of medical sociology and the BSA Medical Sociology Group. Does the BSA Medical Sociology Group have any political influence?

In the end there was very little discussion about the use of textbooks, but more a general discussion about the kind of issues involved in teaching medical sociology.

The next day there were four papers in a row in the conference stream 'Teaching Health Professions' chaired by Edwin van Teijlingen. The first paper was by Kay Aranda and Kate Law 'Tales of sociology and nursing education', which was a sociological analysis of a series of

letters in the nursing press on the nature and utility of sociology within the nursing curriculum. Kay and Kate mentioned that the idea for this piece of work come out of last year's workshop. The second presentation by Heidi Lempp and co-authored by Clive Seale (in the audience) covered 'The "hidden" curriculum in undergraduate medical education: Medical students' perception of teaching quality.' The third paper by Nicola Gale, PhD student at the University of Warwick, addressed the issue of 'Training for uncertainty revisited: "Reflective" embodied learning in osteopathy and homeopathy.' The final paper by Caragh Brosnan presented a sociological analysis of two different approaches in Medical Education, under the title, 'Struggling for capital, searching for certainty: Constructing legitimate medical knowledge in a traditional and problem-based curriculum.' All four papers generated a lively and wide-ranging discussion.

The BSA Medical Sociology Group is committed to supporting and encouraging the teaching of medical sociology to a wide range of students who are training to become health care professionals.

Edwin van Teijlingen, University of Aberdeen

Chris Yuill, The Robert Gordon University, Aberdeen

Study Groups: Annual Reports 2004-05

West Midlands Medical Sociology Group

Co-convenors: Wendy Martin (University of Warwick) and Stephen Handsley (The Open University)

In 2005 the focus of the West Midlands Medical Sociology Group has been to promote the profile of postgraduate research as well as provide a forum to facilitate collaborative links for people with an interest in medical sociology. In particular, the meetings have provided an arena to share ideas and information, offer mutual support and promote interest in medical sociology within the West Midlands.

The West Midlands Medical Sociology Group first held two meetings at the University of Warwick that provided an opportunity for members to present and discuss their current research that had originated from their postgraduate studies. In February, Dr Tina Miller (Oxford Brookes University) presented her research that informed the recent publication of her book entitled *'Making Sense of Motherhood: A Narrative Approach'*. Tina highlighted the significance of narrative as a method to understand early motherhood, and showed how the moral and 'risky' context in which pregnancy and motherhood takes place shaped the subjective experiences that her participants felt able to voice at different times during their journey from pregnancy into early motherhood. In May, Stephen Handsley (The Open University) presented his research *'Caregiving, Mental Health and Ethnicity: An Irish Dimension'*. Stephen pointed to the important, and at times neglected, role of caregivers for people with mental illness in Irish communities living in the UK. Both these presentations were well attended and were followed by lively and interesting discussions.

The West Midlands Medical Sociology Group also organised a postgraduate forum focussing on social aspects of health, illness and medicine that took place in May at the University of Warwick. The aim of the postgraduate forum was to provide a supportive, informal and constructive venue for research students to share ideas, to discuss work in progress and explore different research approaches. The forum stimulated a great deal of interest and following a process of peer review of abstracts, 13 research students gave PowerPoint presentations about their research. The range of topics included

HIV/AIDs, ethnicity, embodiment, diabetes, research with children, complementary/alternative medicine and the role of health professionals. There were presentations from postgraduates at all stages of their studies, some developing their research design, some in the process of fieldwork and analysis, and one postgraduate was even waiting for his viva the following week! We were delighted to welcome Dr Simon Williams (University of Warwick) who gave the keynote address on his current research *Vulnerable bodies? Sleep, health and emotions*. Throughout the day there were lively and supportive discussions and it was agreed that the postgraduate forum not only led to important collaborative links between research students but provided an important stepping stone for emergent researchers in medical sociology who wish to disseminate their research at inter/national conferences.

Event organisers: Wendy Martin, Stephen Handsley and Alan Bradley (West Midlands Medical Sociology Group) and Dr Alan Dolan (Forum for Health, Medicine and Society, Institute of Health, University of Warwick)

For further information about the West Midlands Medical Sociology Group and details of future events please contact the co-convenor Wendy Martin: **W.P.Martin@warwick.ac.uk** and/or visit the BSA Medical Sociology Group website: **<http://www.britsoc.co.uk/>**

.....

Social Aspects of Death, Dying and Bereavement

Convenor: Karen Kitchen, University of Sheffield, with assistance from Jenny Hockey and Sheila Payne

We had a very successful one day conference for this group on 21st June 2004 in Sheffield, when we welcomed Professor Jenny Hockey of the University of Sheffield as the plenary speaker. The 2005 meeting will be held on November 28th, again in Sheffield, around the theme of ageing and death. Liz Lloyd from the University of Bristol is the plenary speaker. Abstracts of up to 250 words are welcome, with a closing date of the end of September. Enquiries about the event should be directed to the convenor at: **k.kitchen@sheffield.ac.uk**

.....

Human Reproduction Study Group

Convenor: Dr Sarah Earle, The Open University

Established in the 1970s, this Group has as its aim to promote the sociological study and understanding of human reproduction.

Review of the year

Two successful events were held this year. The Study Group's 5th Annual Conference (University College Northampton, December 2004) attracted 36 delegates, and 32 oral papers and posters were presented during the one-day event. The following titles provide a flavour of these:

- ❑ Recognizing 'self' within the research process
- ❑ Embodiment: Maternal Bodies & the Research Process
- ❑ The Power of Practice: Surrogacy
- ❑ 'Just a Bystander?' Men's Place in the Process & Outcome of Fetal Screening
- ❑ Foretelling the Future: Women's Responses to Innovative Pregnancy & Childbirth Technologies
- ❑ Personhood & Reproduction: Understanding Below-Replacement Fertility in Athens
- ❑ Researching 'Young' Fatherhood: Issues & Findings
- ❑ The End of Informed Decisions: On the Medicalisation of Prenatal Testing

A Study Group Meeting was held at the BSA Medical Sociology Group Conference in September 2004. This was well attended and attracted new members to the group. A further group meeting is planned for September 2005 in York. This meeting provides members with an opportunity to network and provides others with an opportunity to find out more about study group activities. The 6th annual conference will be held on 8th December 2005 in Milton Keynes. A symposium on the issues surrounding 'Reproduction, Identity and Loss' is also planned for 2006.

For further information about the group contact the convenor at:
s.earle@open.ac.uk

.....

London Medical Sociology Group

Convenor: Richard Compton, Dept. of Nutrition & Dietetics, Kings College London

The London group continues to operate very successfully. In the past year, our meetings have been extremely wide ranging in content, with presentations on chronic illness and the 'expert patient', resilience across the life course, patient advice/liaison services in the NHS, participation in medical consultations, risk and uncertainty among stroke survivors, stigma among dyslexic students, emotional bodies, and the historical evolution of the 'Third Age'. All were pretty well attended, some extremely so; thanks are due to all our speakers. We have sessions on globalisation and health, and variation in asthma care for ethnic minorities arranged for the autumn, and are already planning an exciting and diverse programme for the new year. Our aim is to include presenters at every stage of a medical sociological career, ranging from reports on PhD research in progress to the analyses of emeritus professors. Offers of talks are always very gratefully received.

People from a wide range of backgrounds – not just sociological or academic – attend our meetings and are always made very welcome. Although every session ends with a social occasion in a convenient local venue where speakers can be informally questioned, useful information about people or happenings transmitted, and matters of recent concern within the health and illness field (and well beyond) discussed, our special Quiz Night that tends to fall relatively early in the festive season has now become the high point of the medical sociologists' calendar both in the metropolis and further afield. Last December's was a great success, with excellent food, drink and a range of challenging and/or engrossing rounds involving everything from music, identifying great sociological works, recalling biographical details of the famous, and recognising key events of the year. Those living in our (broad) catchment area are therefore advised to keep a space in their diary on 14th December, 2005.

There has been some change in the organization of the London Group. Paul Godin has stood down as Convenor, Susan Robinson as Treasurer, and Mark Newman as Mailing Officer, each after a number of years of dedicated activity for which we are all very grateful. We hope

that the reconstituted committee will be able to make as great a contribution to the local medical sociology scene.

Convenors contact details: richard.compton@kcl.ac.uk

.....

Sociology of Mental Health Study Group

Convenors: Lydia Lewis, University of Aberdeen and Louise Woodward, Nottinghamshire NHS Trust and the University of Nottingham

The Group was established in 2004 and in its first year has flourished with an expanding membership and the hosting of its first highly successful annual symposium. The group's main activities, between September 2004 and August 2005 have been as follows:

AGM

A first AGM was held at the BSA Med Soc conference, University of York, on Friday 18th September 2004, 12.30-1.15pm. The aim of the meeting was to promote the Group, establish an initial membership base and consult with members about the aims, scope and activities of the Group. Following the meeting, a report was written and circulated, and comments received at the meeting were used to establish the web site and start planning a first Group event.

Web Site

We have worked hard, and with the help of BSA staff, to establish and maintain the Study Group's web site. This includes group aims and activities, a list of member details which aims to provide a networking function and also an 'issues' page, on which members are invited to post issues of interest or concern. The site can be accessed at: www.britsoc.co.uk/MentalHealthSG

Membership

The group already has a large membership which includes members of mental health organisations, mental health practitioners, service users and providers as well as academics. The current membership figure is 107.

Annual event

The Group hosted its first annual event, entitled *Sociology of Mental Health: Rethinking the Boundaries* at Nottinghamshire Healthcare NHS Trust on Thursday, 30th June 2005. The event was a resounding success, with 75 delegates from a wide range of working backgrounds in attendance, and 17 papers presented during the course of the day. Needless to say this made for an exciting day's proceedings, which in general were characterised by enthusiasm and vibrancy. Funding for the event was gratefully received from the Sociology of Health and Illness Foundation, and provided, among other things, for four members of mental health organisations (Aberdeen Mental Health Users Network, Edinburgh Users Forum and Active Involvement in Mental Health [High Peak Region]) to attend and present their work. A fuller report of the event, including a summary of delegate feedback, is available on the Group's web site.

In general we have had an energetic year establishing the Study Group, its membership and activities, and feel that it has considerable potential for continuation and expansion in the future.

Convenors' contact details:

Lydia Lewis
Department of Sociology
University of Aberdeen
Aberdeen AB24 3QY
E-mail: I.lewis@abdn.ac.uk
Tel: 01224 272760 x3285

Louise Woodward
R&D Department
Nottinghamshire Healthcare NHS Trust
Duncan Macmillan House
Porchester Road
Nottingham NG3 6AA
Email: louise.woodward@nottshc.nhs.uk
Tel: 0115 9691300 x40685

.....

Wales Medical Sociology group

Convenors: Dr Sue Philpin & Dr Lesley Griffiths

Seminars have been held regularly between November 2004 and April 2005. Speakers and topics have included:

- Dr. Ingrid Eysers (University of Surrey) 'Time to care: time as a resource in the provision of care';
- Dr Sue Philpin (Swansea University) 'The use of ritual to deal with anomaly in an intensive therapy unit';
- Dr Anne Arber (University of Surrey) 'Reputation and pain talk in hospice palliative care team meetings';
- Dr. Lesley Griffiths (Swansea University) 'Telling the story: mental illness and ECT from patients' and carers' perspectives';
- Dr. Jonathan Gabe (Royal Holloway) 'Is nursing down the line part of a professional project? The case of NHS Direct for England';
- Professor L. Prior (Cardiff University) 'Talking about the gene for Cancer. Language and metaphor in clinical genetics';
- Dr. Alex Faulkner (Cardiff University) 'Partitioning and convergence in the regulation of biomedical technology';
- Pauline Griffiths (Swansea University) 'Insider or exploiter? Participant Observation in an acute medical admissions unit'.

Contacts: s.m.philpin@swansea.ac.uk; l.j.griffiths@swan.ac.uk

.....
Sociology of Cancer Study Group

Convenor: Jonathan Tritter, University of Warwick

We met at the Annual Medical Sociology Group Conference in 2004, and had a lively discussion of key themes arising from members' interests and papers presented. We sought additional members for the Organising Committee and Laura Potts has taken a more central role in the Committee. Once again despite interest in attending and presenting at a Sociology of Cancer conference, and an enthusiastic consensus on a theme for it, insufficient numbers meant that we did not convene a conference. The issue seems in part to be around the ideal timing for this, and the fact that the membership is drawn from both clinical and academic fields – a strength of the group but hard to factor into organising. Despite this, we continue to maintain and update the group website and new members continue to join the group.

Contact: j.tritter@warwick.ac.uk

ARTICLES**Plenary Presentation at the BSA Medical Sociology Group
Conference 2005****Missing Connections: Medical Sociology and Feminism****Ellen Annandale, University of Leicester****Introduction**

We only need to cast our minds back to the 1970s to find a strong connection between medical sociology and feminism. Health and illness was of vital concern to feminists and medical sociology, then in its ascendancy as a new sub-disciplinary field, drew on feminist insight. They shared a common disciplinary project which was to distinguish the biological from the social – in feminist terms, sex and gender – and claim the social as their own. Today - 30 years on, the connections between feminism and medical sociology are at best peripheral and, at worst, totally absent. It is difficult to find much, if any, direct reference to health in sociological accounts of gender and social change in the western world. In a raft of otherwise excellent books published over the last decade by feminist sociologists, education, work, the family, sexuality, identity and political representation all figure highly, but health fails to get more than a passing mention - if that (see, for example, Apola *et al.* 2005, Charles 2002, Delamont 2003, Hughes, 2002, Marshall 1994, Pilcher 1999, Walby 1997). Within theoretical writing the absence is even more marked (e.g. Evans 2003). It may seem inappropriate to say that health is missing in feminist writing when there has been an explosion of work in areas such as the body, genetics and new reproductive technologies, but more often than not, attention stops either at the body's surface (in terms of appearance, for example) or probes the body's interior in a highly reductive manner (Birke 1999, Klein 1996). Psychoanalytic feminism is especially guilty. I particularly like this remark from John Wiltshire, referring to Julia Kristeva's work

...in this feminism, mortality is suspended – that is part of its exhilarating quality, no doubt: the implied female subject in such writing is young, bold and free, menstruates regularly and without discomfort, never suffers from lower back pain or ulcers, and not

even her reading of Derrida and Lacan can give her a headache.
(Wiltshire 1997: 16)

Prominent feminists like Judith Butler, Donna Haraway and Elizabeth Grosz have no interest in health and illness (Kuhlmann & Babitsch 2002, Shildrick & Price 1998). This is light years away from the 1970s and early 1980s when feminist sociology effectively developed *through* an interest in health and health care.

But what of the other side of the coin - medical sociology; is it fair to say that medical sociologists have lost their connection with feminism? On first glance it seems simply wrong to say this – after all, a scan of journals such as *Sociology of Health & Illness*, *Social Science Medicine* and *Health* will quickly reveal scores of really interesting articles on gender and health: on topics such as health inequalities, the experience of illness, reproduction, the delivery of health care, and so on. There is then no shortage of research and no shortage of publications on gender and health within sociology and the wider social sciences. The problem as I see it is that gender is everywhere and it's nowhere. Although it would be imprudent to stretch the point too far, 'gender' has become somewhat taken-for-granted. So much so that we seem rarely to reflect critically upon what concepts like gender, patriarchy – even feminism itself - mean for us anymore. When medical sociologists use the term 'gender' in reference to women's health it typically connotes potential or actual disadvantage (the same often now applies, of course, to the growing body of men's health research). But the reasons for how and *why* this disadvantage comes about are often rather murky. All too often, research focuses only on a cluster of proximate causes (be they quantitatively or qualitatively defined) and the relationship between gender and health loses its structural moorings. Without these moorings we are left with similarities and differences in women's and men's health status, and similarities and differences in their *experience* of health and illness, for which we have no real explanation beyond a generalised sense that they are related to women's and men's positioning within society.

As I will discuss in more detail later, as what has conventionally been thought of as 'biological sex' and 'social gender' become less fixed and more fluid, the traditional distinctions between male and female experience are breaking down and being reconfigured in new, more

complex and highly problematic ways with significant implications for patterns of health and illness and for the qualitative health experience of individuals. It is my argument that in order to fully understand these changes medical sociology and feminism need to be brought closer together.

Thinking about sex and gender

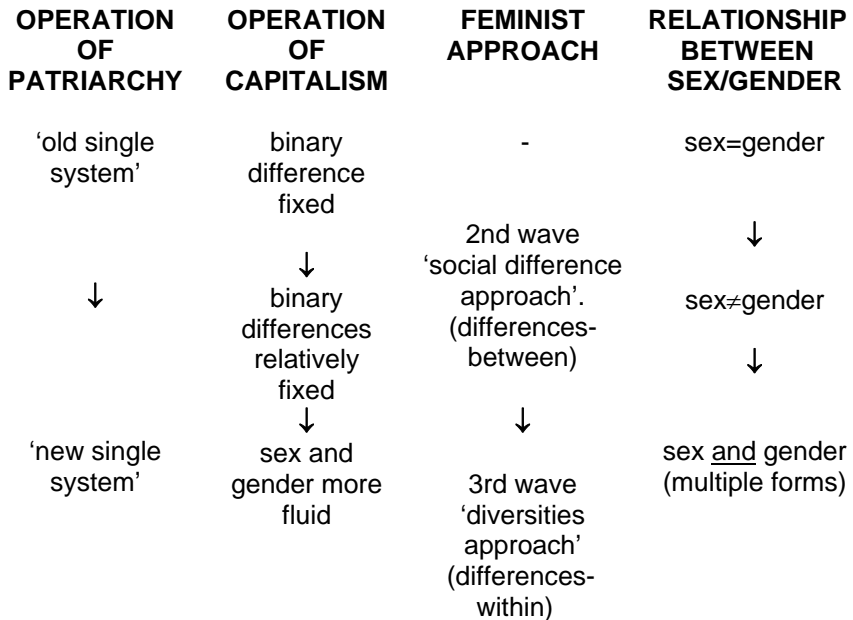
The story of how and why medical sociology and feminism came together, how they parted, and how they might be brought back together can be told through changing conceptualizations of the relationship between sex and gender. As far back as the seventeenth century, women writers were acutely aware that mind/body dualism had enabled men simultaneously to define themselves as rational agents, while equating women with a defective biology that excluded them from agency. It therefore made perfect sense for feminists, centuries on, to challenge this biological determinism with a new dualism of their own: the distinction between sex and gender. This distinction enabled them to argue that women's oppression is *socially* caused, rather than *biologically* given. The conceptual distinction between sex and gender, the biological and the social which took off in the 1970s, has proven unshakeable¹. Even those who appeal for an appreciation of the interdependence of sex and gender in the production of health and illness persist in using the terms and, in effect, try to parcel out when sex (biology) is most important, when (social gender) is most important and, when they are equally important (e.g Krieger 2003). Effectively, researchers are calling for greater precision in the use of these concepts, rather than a fundamental questioning of them.

The sex/gender distinction is as equally well embedded in the wider consciousness of society as it is in social scientific thought. This means that it is an object of enquiry as well as a conceptual tool. It is the lens through which debates on women's oppression and liberation have been refracted for many years (and increasingly the focus for understanding men's health in gendered terms). In this respect it is important to appreciate that the meanings attributed to 'sex', to 'gender' and to their inter-relationship have varied over time. I wish to suggest

¹ The term gender was in use before this time. Feminists and feminists fashioned their own use of the distinctive use of the term as a social counterpoint to biological (sex).

that they are intimately tied to particular configurations of patriarchal capitalism.

Fig 1: Patriarchy, capitalism and feminist conceptualisations of sex and gender:



Patriarchy has traditionally operated by conflating sex and gender (that is, sex equals gender) - through what I will term the *'old single system'* of patriarchal capitalism. Within industrial capitalism, production and consumption were predicated on a relatively fixed binary difference between men and women (that is, male 'biological sex' maps onto male 'social gender' and female 'biological sex' onto female 'social gender'). This 'old single system' benefits patriarchy insofar as it is male sex and its associated social gender that enjoys the benefits of political and economic primacy. Gender follows directly on from sex and women's inferiority is a natural product of her (inferior) biological make-up. The heyday of this old single system in the West was probably the 1950s

when production and consumption depended on a relatively fixed binary difference between men and women. Men were the producers, women the consumers. Products and services were targeted to a segmented gender market, but it was women who were incited to do the purchasing and servicing for the household. Slicing through the tight connection between sex and gender (that is, arguing that sex does *not* equal gender) provided what I will loosely call 'second wave' feminisms of roughly the 1970s onwards, with the conceptual wherewithal to challenge the old single system of patriarchal capitalism. It enabled them to argue that women's relatively poor health is the result of social (or gender) oppression, not biological inferiority. The sex/gender distinction was truly a conceptual treasure trove for sociological research on health and health care, spawning influential work in areas such as reproduction and childbirth and gender equalities in health.

Problems with the sex/gender distinction

Notwithstanding the wealth of groundbreaking insights that emerged, two inter-related problems followed in the wake of the 'second wave' distinction between sex and gender. First (sex)biology came either to matter too much (for example in radical feminist influenced work on reproduction) or not to matter much at all (for example in liberal feminist inspired work on health status) and the interplay between the biological and the social was neglected. The second and related problem was a tendency to draw a firm divide between male and female experience, be this on biological or on social terms. While on the face of it, (social) gender is treated as a variable against sex (which is more fixed), in reality gender effortlessly maps back onto a binary biological difference. Researchers still read gender through sex (or biology) as assumptions are typically made about which social/cultural/ political/economic factors are relevant for male, and which are relevant for female, experience of health - often in advance of empirical research. Health and illness are irrevocably drawn towards opposition as part of this process. An unfortunate consequence of the binary logic that flows from the sex/gender distinction is that positively valued health is typically attached to men, and negatively valued illness to women. The ironic consequence is that feminism can end up entrenching women's ill-health, effectively colluding with patriarchy by not letting them be well. And, of course, as a corollary, construed as well by comparison, men (in general) cannot be ill (Annandale and Clark 1996).

These difficulties of second wave feminism reflect a more fundamental underlying problem: that of trying to treat gender as variable, when sex (male/female biological difference) is taken to be fixed and dichotomous. This suggests that perhaps 'social gender' can only fulfil its initial feminist promise and be truly variable, when it is no longer necessarily associated with either men or women, when it is no longer tightly bound to the sex(biology) dichotomy? Or, we might say that fulfilling the 'gender' promise requires feminists to mount a two-headed attack whereby *both* (biological) sex *and* (social) gender are seen as malleable and carrying multiple meanings? It could be argued that patriarchy loses its moorings when *diversity* (i.e. differences within women's and within men's experience) replaces binary differences between them.

Operating as a *critique* of second wave feminism, this kind of approach - typically identified, of course, with 'third wave' or postmodern feminism of the mid-1980s onwards - disrupts the conceptual strait-jacket of the second wave '*difference*' approach, since when sex and gender *both* become more fluid, men can no longer be identified so readily with positive health and women with negative health. Rather, the experience of health and illness can more appropriately be seen to cross-cut gender in complex ways. Insofar as the process of individualization which many sociologists argue characterises contemporary social life generally and the experience of health and illness specifically (e.g Beck and Beck-Gernsheim 2002) resonates with the postmodern feminist vision of both sex and gender as multiple and malleable entities, it could be said to appropriately reflect the contemporary social world in which men and women live out their lives.

The 'new single system' of patriarchal capitalism

Not only traditional gender roles ('the social'), but also distinctions between sexed (or 'biological') bodies are diminishing through what Rosemary Hennessy (2000) dubs the continual tooling and retooling of the desirous subject. It has been argued that capitalism 'shapes biology in its own image' (Dickens 2000). It also shapes the way we think about the relationship between the biological and the social, sex and gender. Social scientists, as well as some biologists (including feminist biologists such as Lynda Birke, 1999), have recently drawn our attention to openness as a counter to biological determinism. It is pointed out that, as self-actualising agents bodies have agency in relation to their environment as they constantly interact to change, both inside and out.

And, as Emily Martin (1999) and others have shown, within society at large, people are moving away from a fixed mechanical view towards a conceptualisation of the body as fluid, flexible, and ever-changing.

As discussed earlier, during the old single system of industrial capitalism, sex (as biology) and (social) gender were seen as dimorphic with biological sex determining social gender. Typically men earned the family wage, while women, when not drawn into the workforce as a reserve army of labour, worked unpaid in the home. But this dichotomy doesn't make sense for late capitalism which relies heavily upon fluid and malleable identities formed equally, if not more, in the sphere of consumption as the sphere of production. The social body is being reformed as the once steadfast roles of male breadwinner, female homemaker and all that accompanied them in attitudinal and behavioural terms are being torn apart by far-reaching changes in employment, education, family and household structure, leisure and consumption (although of course this varies enormously by factors such as 'race', social class and age).

The opening up of the *biological body* (as described by social and natural scientists) and the opening up of the *social body* in the manner just described, means that sex (biology) is no longer so directly tied to gender in the traditional manner of the 'old single system' of patriarchal capitalism. The mapping of what has traditionally been thought of as male sex onto male gender, and female sex onto female gender, has begun to give way to a more flexible, or open, system. This is not to say that (biological) sex and (social) gender are no longer connected – as mentioned earlier, it is still not possible to think about one without the other - but rather that *they are being drawn into a new, more complex, shifting and arguably more pernicious relationship*. A new sex/gender tapestry is being woven. A '*new single system*' wherein (biological)sex and (social)gender *depend* on each other for understanding just as much as before, but where the meaning of biological sex and the meaning and enactment of social gender, as well as the connections between them, are far more fluid (Annandale 2003).

The 'new single system' of patriarchal capitalism profits from the new markets that an increasingly 'diversified' gender economy operates. The self-culture of late modern capitalism is an extremely fertile ground for the commodification of sex and gender (and the body) as malleable

entities. Indeed, sex/gender isomorphism has been readily seized upon, indeed advanced by, the marketing industry. Celia Lury (2002) argues that features which might once have been considered natural such as one's sex or 'race' have acquired the 'mutability of culture'. A good illustration of this is the Benetton clothing company which makes diversity its brand-identity. Brand iconography reveals, for example, that in the Benetton world 'race' is not about one's skin colour, physical characteristics and so on, but about style. And people are not shackled by outmoded ideas of what is appropriate for men and women. But corporations like Benetton cleverly play on both sides of the fence – keen on the one hand to profit from the fissures between sex and gender, but also keen to deal in traditional gendered images. This became very obvious earlier this year (2005) when Benetton joined forces with corporate giant, Mattel to launch the 'Barbie loves Benetton' girls' fashion range. Branded with a pink heart logo, four dolls called Paris, London, New York and Stockholm Barbie trade in traditional female stereotypes. Thus 'diversity' exists alongside binary difference.

Destabilised sex/gender identities have become an indispensable condition for the cross-marketing of products and lifestyles that were previously more or less confined to either men or to women, such as cigarette smoking and cosmetic surgery, with dubious or nebulous benefits to health and well-being. Marketing and the media position women (and increasingly men) in diverse and contradictory ways. In the case of alcohol, for example, in Britain women have been problematized as 'ladettes' and sexual aggressors who are losing their femininity and also viewed as liberated women living in an increasingly gender-neutral world:

The ladette takeover. '...a generation of women are hitting the bottle harder than men, fuelling fears of a timebomb linked to alcohol abuse.' (Daily Mail 2004)

Gender neutrality: 'There has been a convergence of taste and consumption: 'women get tattoos, like football, watch strippers, buy erotic fiction and go on lone holidays...while men learn to use cosmetics, do aerobics, cook and read magazines.' (Guardian 2000)

Media and corporate representations of the ladette are of a young woman who only *appears* to have it all. Here the vicissitudes of the 'new

single system' of patriarchal capitalism are transferred to individual consumers who are positioned as inherently unstable themselves. The young female drinker is volatile and unreliable, and needs to be constantly reminded of this lest she forget. For example, the Christmas 2004 campaign of the Portman Group (which represents the UK drinks industry) was targeted at women and dubbed, 'If you drink, don't do drunk'. It portrayed women as voluble Jekyll and Hyde characters. The television advertisement features a young woman sitting at her desk in an office. As the ad campaign puts it, 'she looks like butter wouldn't melt, dressed as she is in her smart business suit'. But, as the copy continues; when the interviewer asks her what she likes to do at the weekend, we see an altogether different side as Ms Jekyll turns into Ms Hyde. Along with her two friends, she is seen getting very drunk and – again, as the campaign copy puts it, 'putting herself and others into increasingly embarrassing and risky situations... starting with vomiting in the nightclub toilets and ending up in the gutter holding on to one of her friends for support'. This is captioned with the comment: '*Not a pretty sight*'. More widely, drinking is positioned as a male undertaking that women take on at their peril. If they do so, they risk subverting natural female virtues such as modesty and their looks. So, as the *Observer* newspaper put it in 1999, 'if she [a woman] drinks like a man she may start to look like one.'

It is not just young women who are implicated. Women are construed as irresponsible whatever their age and circumstances. In a recent survey Mintel Marketing Intelligence identifies, 'two new types of women behind' what they call the bad behaviour trend among thirty- to forty-somethings: on one side is a new group of women who are single or divorced, who are fed up that they can't find a partner or have just left one and are saying 'to hell with the whole thing and rewarding themselves with things they enjoy like alcohol and cigarettes', and on the other side are married women for whom the pressure of work and home life is growing all the time. These are the women who it is said are struggling to live up to media icons like Nigella Lawson who is seen to have a top career and a home life.

A no-win situation then: women are in dire straits whatever their circumstances. The clear message is that liberation has let them down and in the process generated a lucrative market of unstable identities and individual women who need to be shown the light. My argument is

that this fluidity of identities is actively fostered through the new single system of patriarchal capitalism. The drinks industry for example, actively positions women in multiple contradictory ways. Mintel currently values the UK drinks industry at £38 billion and identifies women as a fast rising consumer group. Although young people remain the key market drivers, persons in their mid 50s to mid 60s are identified as a vital rising market too – the very age cohort of women whose health (as I will discuss later) appears to be suffering a downturn relative to men. The recent World Health Organisation's report, Women and the Tobacco Industry (Samet and Yoon eds. 2001) makes clear that tobacco companies need to recruit 4,000 new smokers a day worldwide to maintain their current market size. Selling tobacco products to women currently represents the single largest product marketing opportunity in the world.

The impact on morbidity and mortality

As mentioned earlier, within feminism discussion about the remaking of sex/gender has typically been concerned with the body's *surface*. Yet the changes associated with this protean 'economy of differences' of the 'new single system' of patriarchal capitalism, self-evidently extend *beneath* the surface. They reach deeply into the interiors of the body and change traditional health profiles. As health problems that were once largely the province of men begin to increasingly affect women (for example, lung cancer), and vice versa (for example, melanoma), the materiality of the body is modified and takes on characteristics more typical of the so-called 'opposite' sex (the damaged lung, skin lesions and so on).

At the population level, traditional patterns of male/female morbidity and mortality appear to be shifting in the west. For example, the widening gender mortality gap favouring women which characterised the period from around 1870 to the early 1970s has been closing in many nations.

Table 1: UK Life Expectancy

Years: age*	1961	1971	1981	1991	2001	2003	Overall gain
Males	67.8	69.1	70.8	73.2	75.7	76.2	8.4
Females	73.6	75.3	76.8	78.7	80.4	80.5	6.9
Gap	5.8	6.2	6.0	5.5	4.7	4.3	
Healthy years**:	1981	1991	2001	Over- all gain			
Males	64.4	66.1	67.0	2.6			
Females	66.7	68.5	68.8	2.1			
Gap	2.3	2.4	1.8				

* United Kingdom, ** Great Britain

Source: *Social Trends 35, table 7.1 (2005)*

Table 1 shows improvements in life-expectancy for both men and women, but a gradual chipping away of the female mortality advantage, as reflected in the reducing gap. In fact, the main contribution to longevity for both men and women comes from accelerated improvement at older ages, and it is here that men have fared especially well in recent years. This trend is mirrored in many other countries such as Australia, Sweden, Germany, France and the USA.

Somewhat ironically then, the 'old single system' of patriarchal capitalism may have conferred a mortality advantage to women. Binary difference may have kept them away from the dangers to life and limb that cut male lives short. Now, as differences between men and women attenuate and inequality is reconfigured, women appear to be losing out and men gaining². Interestingly, very little popular attention has been given to men's improvement at older ages. Ironically, the tendency of the UK men's health lobby to draw attention to the historically invisible character of men's ill-health may unwittingly have contributed to this.

² Although of course this leaves aside the important question of whether longer life is a good thing anyway.

Figure 2: Major mortality

Lung cancer

- Male rates still higher. But since mid-1970s, rise for women, decline for men in many western countries (e.g Griffiths & Brock 2003).
- In 1950, lung cancer accounted for 3% all female cancer deaths, by 2000 it accounted for 25%. Overtaken breast cancer (US Surgeon General, 2001).
- Opinion that women are 'in the throes of an epidemic of tobacco-related disease' which is yet to reach its peak (US Surgeon General, 2001).

Heart Disease

- Coronary heart disease (CHD) is major cause of death of women and men in UK (UK women amongst highest rates in world). Concern that CHD is incorrectly perceived to be a 'male disease' (British Heart Foundation 2003)

The major contributors to changing patterns of morbidity and mortality are heart disease and cancer. There is ongoing debate over whether women and men have a different biological vulnerability to heart disease and cancer, but it is generally recognised that social factors are very important. There is a lag effect whereby health behaviours linked to cancer and coronary heart disease such as cigarette smoking, alcohol consumption and diet initiated 20 or so years ago show up in later statistics. The commonsensical explanation for changes in mortality in the west is, as I have explained, a social one: that men and women are becoming 'more similar' in their health behaviours and particularly that women are 'paying the price for liberation'. It is common to hear that young women are setting off an illness time-bomb that will go off in 20 or so years' time as they 'become more like men'. Thus, writing in the *British Medical Journal* very recently, Madeleine Brettingham (2005:656)

concludes that, 'the historic gap between men and women's life expectancy could vanish as more and more women accustom themselves to the work hard-play hard culture of modern Britain.'

As was discussed earlier in respect of media representations, explanations are typically couched in attitudes and beliefs such as heightened health consciousness amongst men and the taking up of damaging health behaviours, notably cigarette smoking – which is generally considered a major cause of women's declining mortality advantage - by women. This explanation is mirrored within the medical and social sciences, where the 'state of the art' view is also that change is afoot. Mel Bartley, for example, remarks

We might guess that, as the home and work situations of women and men become more similar (as women become more likely to have full-time jobs of similar status to men, and as work, marriage and children are combined in more similar ways), any remaining health differences between men and women may disappear' (Bartley 2004:139-140)

Similarly, Jacques Vallin *et al.* (2001) claim that there has been a convergence in life expectancy due to a 'convergence of behaviour patterns between men and women'. Researchers point out that the so-called 'gender paradox' whereby women live longer, but are apparently sicker than men throughout their lives, has been a product of blinkered thinking, a product of research designs which set out to *find* male/female differences (a point made earlier in this paper). Recognising the complexity, McDonough and Walters remark that

Rather than fixed paths, we see multiplicity and diversity in the relationships among gender, stress and health that call for more refined conceptualisation of 'gendered reality'...The research challenge is to explore the ways in which gender continues to be an important representation of inequality, while recognising the diversity of experiences within genders (2001: 556, 557).

There is nothing intrinsically wrong with these summaries. Rather, the difficulty is that we seem to have a problem in search of a theory. Without this we can unwittingly lapse into accepting popular representations of change (such as those already discussed) rather

than providing a critical commentary on them. With their vision of both sex and gender as multiple and malleable entities, many 'third wave' or postmodern feminisms tilt precariously in this direction. They come painfully close to endorsing the flourishing academic and more popular 'new feminist' literature of authors like Rosalind Coward (2000), Naomi Wolf (1994) and Katie Roiphe (1993) who claim that feminism's very success means that it is no longer needed. As Beverly Skeggs (1997) and Imelda Whelehan (2000) aptly remark, this 'new feminism' offers a markedly individualistic kind of radicalism, one that feeds easily into the rhetoric of individualism where the way forward for women is lifestyle choice and self-determination largely unfettered by the erstwhile constraints of sex and gender.

I wish to suggest that if we make the 'new single system' of patriarchal capitalism as the object of our study, this provides us with the conceptual wherewithal to interpret the new biological embedding of experience reflected in changing patterns of morbidity and mortality and the experience of illness as direct and visible representations of how, to paraphrase Rosemary Hennessy (1993) (who gives no attention to health and illness), the common experience of health-related oppression is produced differently, and experienced differently, through systematically driven processes of sex/gender fragmentation.

Heart disease is a good concluding illustration of this. Although deaths from heart disease are falling for both men and women, heart disease is the leading cause of premature death for both men and women in the UK (typically occurring some 7 to 10 years later in women than in men) and the number of people living with cardiac morbidity is increasing. But it is only recently that popular opinion has begun to shift away from heart disease as a 'male disease'. Quite a lot has been done very recently to debunk this myth. For example, the British Heart Foundation (2003) has made women's awareness a focus of attention and so-called 'gender sensitive' health policies have sought to draw attention to the differential presentation of symptoms in men and in women. It might be argued that as perceptions of male female differences attenuate, it will become much easier for the general public to think of heart disease as a female (as well as a male) disease. This perceptual shift has been the source of some attention in the corporate world. In the USA for example, the National Heart, Lung and Blood Institute (which is part of the National Institutes of Health) has formed the 'Heart Truth' initiative in

partnership with, among others, cereals giant General Mills. The new *Berry Burst Cheerios* boasts a 'circle of healthy hearts programme' for women. In Britain, Nestle has equally positioned Shredded Wheat – traditionally geared to men's health - to the women's heart health market. In 2003, for example, ex-gymnast and TV sports presenter Gabby Logan told us in a television advertising campaign that men and women are not as different as they seem: so 'women need to take care of their hearts too.'

The drug *Zoroc Heart-Pro*, the world's first over the counter statin is niche marketed to a range of target consumers. The message is geared to a segmented market of males and females and different age groups. *Heart-Pro* is considered to be a key industry test case because it is now sold over the counter to healthy people as a preventative medicine. A suite of magazine advertisements has been directed to women. One such advertisement shows a woman holding up a 55th birthday card. The wistful look on her face suggests that the occasion is as much worrisome as it is a cause for celebration as the copy advises that she is now of an age when she needs to think about taking *Zoroc Heart-Pro* to prevent a heart attack (even if she doesn't have risk factors like high cholesterol or high blood pressure). Even if she exercises and eats healthily, it can still help her.

Conclusion

If I can then return to my starting theme: the missing connections between medical sociology and feminism. Back in the mid-1980s, Ellen Lewin and Virginia Olesen (1985) felt confident in claiming that more than any other domain of life, 'health 'embodies almost all the crucial elements necessary to achieve an understanding of ...society itself'. 'Health permits the revelation of most of the elements of western cultures which bear most directly on the construction of gender and its consequences for women, men, and the larger social order' (p. 19). While other domains - such as religion or the law - provide insights, Lewin and Olesen make clear that none take us as far as health does, precisely because health is so all encompassing. Many feminists seem to have forgotten this and pushed health and illness out of view. Medical sociologists in their turn seem perplexed by the increasingly complex social relations of gender in the west, and unable to fully account for health-related change, in good part - I would argue - because they have lost their original anchor in feminist thought. They often work with vague

derivatives of feminist theory, failing to appreciate the significant differences between them, and the implications of this for their research. I therefore argue that there is a need to bring feminist theory and gender-related research on health and illness within medical sociology much closer together than they are at present. Contemporary health-related changes are highly complex and reach deeply into the interiors of the body. They are part of what Teresa Ebert (1995) - writing outside of the domain of health - refers to as 'an economy of differences'. What we know as social (gender) and (biological) sex are drawn into a new symphysis within the 'new single system' of patriarchal capitalism. Within this new single system the common experience of health-related oppression is produced differently, and experienced differently, through systematically driven processes of sex/gender fragmentation. *Together*, medical sociology and feminism provide us with the wherewithal to reflect critically on this process.

References

- Aapola, S., Gonick, M. and Harris, A. (2005) Young Femininity. Girlhood, Power and Change. Basingstoke: Palgrave
- Annandale, E. (2003) 'Gender and health. Does biology matter?', in S. Williams, G. Bendelow & L. Birke (eds) Debating Biology: Sociological Perspectives on Health, Medicine and Society. Routledge.
- Annandale, E. and Clark, J. (1996) 'What is gender? feminist theory and the sociology of human reproduction'. Sociology of Health & Illness, 18 (1): 17-44.
- Bartley, M. (2004) Health Inequality. Cambridge: Polity Press.
- Beck, U. & Beck-Gernsheim, E. (2002) Individualization. London: Sage.
- Birke, L. (1999) Feminism and the Biological Body. Edinburgh: Edinburgh University Press.
- Brettingham, M. (2005) 'Men's' life expectancy is catching up with women's', British Medical Journal, 331, 24 September, p. 656.
- British Heart Foundation (2003) Take Note of Your Heart. A Review of Women and Heart Disease in the UK. London: British Heart Foundation.
- Charles, N. (2002) Gender in Modern Britain. Oxford: Oxford University Press.

- Coward, Rosalind (1999) Sacred Cows. London: Harper Collins.
- Delamont, S. (2003) Feminist Sociology. London: Sage.
- Dickens, P. (2000) Social Darwinism. Buckingham: Open University Press.
- Ebert, T. (1995) 'Writing the political: resistance (post)modernism', in J. Leonard (ed.) Legal Studies as Cultural Studies. NY: State University of Albany Press.
- Evans, M. (2003) Gender and Social Theory. Buckingham: Open University Press.
- Griffiths, C & Brock, A. (2003) 'Twentieth century mortality trends in England and Wales, Health Statistics Quarterly, 18: 5-17.
- Hennessy, R. (1993) Materialist Feminism and the Politics of Discourse. London: Routledge.
- Hennessy, R. (2000) Profit and Pleasure. London: Routledge.
- Hughes, C. (2002) Women's Contemporary Lives. London: Routledge.
- Klein, R. (1996) '(Dead) bodies floating in cyberspace: post-modernism and the dismemberment of women' in D. Bell and R. Klein (eds) Radically Speaking. Feminism Reclaimed. London: Zed Books.
- Krieger, N. (2003) 'Gender, sexes, and health: what are the connections – and why does it matter?', International Journal of Epidemiology, 32:652-657.
- Kuhlmann, E. and Babitsch, B. (2002) 'Bodies, health, gender – bridging feminist theories and women's health,' Women's Studies International Forum, 25 (4): 433-442.
- Lewin, E. and Olesen, V. (1985) Women, Health, and Healing. London: Tavistock.
- Lury, C. (2002) 'From diversity to heterogeneity: a feminist analysis of the making of kinds', Economy and Society, 31 (4): 588-605.
- McDonough, P. and Walters, V. (2001) 'Gender and health: reassessing patterns and explanations.' Social Science and Medicine 52: 547-559.
- Marshall, B. (1994) Engendering Modernity. Feminism, Social Theory and Social Change. Cambridge: Polity Press.

Martin, E. (1999) 'The woman in the flexible body', in A. Clarke and V. Olesen (eds) Revisoning Women, Health and Healing. London: Routledge.

Pilcher, J. (1999) Women in Contemporary Britain. London: Routledge.

Roiphe, K. (1993) The Morning After. Boston: Little Brown.

Samet, J. M. and Yoon, S. (2001) Women and the Tobacco Industry. Geneva: WHO.

Shildrick, M. & Price, J. (1998) 'Vital signs: texts, bodies and biomedicine', in M. M. Shildrick and J. Price (eds) Vital Signs. Feminist Reconfigurations of the Bio/logical Body. Edinburgh: Edinburgh University Press.

Skeggs, B. (1997) Formations of Class and Gender. London: Sage.

U.S Surgeon General (2001) Women and Smoking. Rockville, MD: U.S Department of Health and Human Services.

Vallin, J., Mesle, F. and Valkonen, T. (2001) Trends in Mortality and Differential Mortality. Strasbourg: Council of Europe.

Walby, S. (1997) Gender Transformation. London: Routledge.

Whelehan, I. (2000) Overloaded. London: The Women's Press.

Wiltshire, J. (1997) Jane Austen and the Body. London: Cambridge University Press.

Wolf, N. (1994) Fire with Fire. London: Vintage.

.....

Plenary Presentation, BSA Medical Sociology Conference, 2005**Social Structure and Health: A Narrative of Neglect?*****Graham Scambler, University College London**

Medical sociology has always displayed a marked heterogeneity of practitioner and substance. Moreover its origins have lent it a strong practical or applied as well as a theoretical ethos. It has straddled boundaries. Arguably these properties have strengthened rather than weakened it and have helped consolidate it institutionally. The aim of this paper is neither to attack medical sociology's heterogeneity nor to bemoan its 'sense of direction', if it has one, but rather to turn a spotlight on a single – I contend, growing and worrying – area of neglect, namely, the study of causal linkages between social structures and aspects of health and healing. In a way this is to respond to C. Wright Mills' neo-classical injunction to 'do it big' in an era in which medical sociologists have been exhorted institutionally to tighten their belts and 'do it small' (if often) (Ritzer, 2001; Scambler, 2005). So some of us should 'do it big', or, as de Vries (2003) put it in a previous plenary lecture to our group, at least lose our fear of being enjoyably and challengingly irresponsible or 'useless'.

The thrust of my contention, that we should take pains to incorporate the study of the causal powers of social structures into medical sociology, owes much to a particular realist concept of social structure, and it is to the explication of this concept that the paper initially turns. This is followed by a brief account of what I have elsewhere called the 'jigsaw model' (Scambler, 2002, 2005a), a largely heuristic device to facilitate the empirical investigation of the causal play of social structures on social phenomena across a range of contemporary figurations. These two opening sections comprise the paper's preliminaries. The bulk of what follows is given over to substantive illustration. A summary scene-setting excursus on the explanatory role of class relations as a social structure causally responsible for health inequalities in the figuration of

British nation-state is succeeded by a more detailed analysis of the shifting structural antecedents of felt and enacted stigma associated with chronic and disabling illness (Scambler, 2004).

Four premises ...

This paper rests on a number of premises which must here be stated rather than grounded:

(1) Acceptance of agency is crucial and possible, albeit with qualification. The opportunities, contexts and scope for its exercise are fashioned by what Archer (1995) calls 'structural conditioning'. Structural conditioning is a mediating process best understood as an 'objective influence which conditions action patterns and supplies agents with strategic directional guidance'. This influence is exercised through the definition of the situational logics in which agents find themselves or enter into during the lifecourse. Thus, 'it is the situations to which people respond which are mediatory because they condition (without determining) different courses of action for those differently placed, by supplying different reasons to them' (Archer, 1995: 201).

(2) Even when agency is exercised, the sequelae are rarely quite as planned or predicted. This applies at the levels of both individual and collective action. Bhaskar (1989) observes that although individuals neither work in order to reproduce capitalism nor marry to reproduce the nuclear family, 'it is nevertheless the unintended consequence (and inexorable result of), as it is also a necessary condition for, their activity'. He adds, significantly, that when social forms change, the explanation will not normally reside in the exercise of agency, 'though as a very important theoretical and practical political limit, it may do' (Bhaskar, 1989: 35). Agency survives, then, but it is: framed by structural conditioning; generally ineffective in shaping and controlling change; and, in our contemporary 'postmodern' culture, increasingly protean.

(3) After Bhaskar (1978, 1989), social structures might usefully be seen as *real*, *intransitive* and possessed of *causal powers* that, when *exercised*, become *generative mechanisms* giving rise to *tendencies* in *open systems*. These technical terms require some elucidation. Bhaskar makes a pivotal distinction between three ontological strata, maintaining that natural and social world alike consist not only of events (the *actual*) and experiences (the *empirical*), but also of underlying mechanisms (the *real*) that are intransitive (that is, they exist whether or not they are detected) and that govern or facilitate events. Social structures, real and intransitive, also have causal powers that may or may not be exercised. When they are exercised, they become generative mechanisms issuing in tendencies. Tendencies here refer

not to a pattern of events but to 'the force itself' (Fleetwood, 2002: 7). Moreover, tendencies/generative mechanisms impact in open systems, that is, in systems where 'invariant empirical regularities' do not obtain (ie. there are no spontaneously occurring closures, nor any opportunity to create them experimentally). It follows that the criteria for the rational 'testing' of theories cannot be predictive but must be 'exclusively explanatory' (Bhaskar, 1989a). What Lawson (1997) calls 'demi-regularities', of course, offer crucial clues to the causal powers of social structures.

(4) Returning to the notion of structural conditioning, Archer differentiates three aspects. *Involuntary placement* recognizes that the social environment is pre-structured by 'material and cultural emergents' prior to agents' engagement with it. These emergents account for the nature of the extant role-array, the positions available at any given time and the advantages/disadvantages associated with them (Archer, 1995: 201). *Involuntary placement* distributes *vested interests* to those differently placed, that is, modes of praxis or behaviour appropriate to the furtherance of people's resources and therefore life-chances. People's vested interests, either in maintenance or change, are not subjectivist phenomena but objective features of situations. People do not always act in accordance with their vested interests, and the notion of *opportunity costs* provides a mediating mechanism by means of which the vested interests associated with structural situations in society become more efficacious in explaining the consciousness and conduct of agents. Opportunity costs are attached to the various modes of praxis or activity by which individuals may pursue their human needs and culturally constructed wants, 'meaning that particular action-responses to structurally determined agential circumstances are likely to induce either rewards (in terms of greater societal enfranchisement or improved life-chances) or costs (in terms of reduced autonomy or freedom of action and stagnant or declining life-chances) – or a different balance between the two – and indeed to induce these effects differentially for members of different agential groupings' (Creaven, 2000: 211).

These four premises provide a kind of conceptual scaffolding to support what follows. One additional point needs also to be emphasized. Acceptance (1) of an agency that is neither unstructured nor structurally determined, (2) the omnipresent promise or threat of contingency, and (3) the 'upstream' causal powers of biological and psychological

structures/generative mechanisms, carries the implication that a sociology focused on social structures of the type commended here is not only destined to be explanatory rather than predictive but can only ever make its explanatory contribution, not causally seal, even those phenomena so characteristically its own.

... and a model

Consider phenomena paradigmatically within sociology's compass, like changes in the patterning of consumption or of household composition. How might these be explored with a view to explanation through social structures? The *jigsaw model* offers a pertinent device. It has three components. The first is a 'best guess' at the *overall picture* of the dynamic, complex and highly differentiated social world in which we live and participate. At the very least this should embrace the principal continuities/discontinuities comprising our current 'glocalized' social domain (ie. an admix of the global and local) (Robertson, 1990). Figure One lists what I have elsewhere - in studies of health (Scambler, 2002) and sport (Scambler, 2005a) - taken to be the more sociologically conspicuous features of contemporary Britain. The second component is a series of applications of the model that can be articulated in terms of *logics, relations* and *figurations*, each application contributing a discrete 'piece of the jigsaw'. The concept of logic here captures the coherence, thrust and causal potential of social structures as generative mechanisms. Each of these logics is associated with a set of relations that can be studied via their effects on events across any number of discrete figurations. For example, the logic of the regime of capital accumulation is associated with relations of class that impact on events in settings ranging from strategy formation in transnational companies to dyadic encounters. And the third component of the jigsaw model is a process of *dialectical reasoning* by means of which the sense of the overall picture informs applications of the model and applications of the model inform the sense of the overall picture. The same figuration can and should be re-visited in terms of a variety of logics/relations. The optimum way of grasping the model is via an illustration, and the 'greedy bastards hypothesis' affords a case in point.

Figure One: Pertinent Aspects of the Overall Picture

- | | |
|--|--|
| (1) Glocalization (ie going global
<i>and</i> local) | (5) Culture-ideology of
consumerism |
| (2) Re-invigoration of class
relations at the expense of
command relations | (6) Postmodern culture |
| (3) Politics of personal
responsibility | (7) Problematic of family
(dis-)enchantment |
| (4) De-standardization of work | (8) New dynamic for identity-
formation |

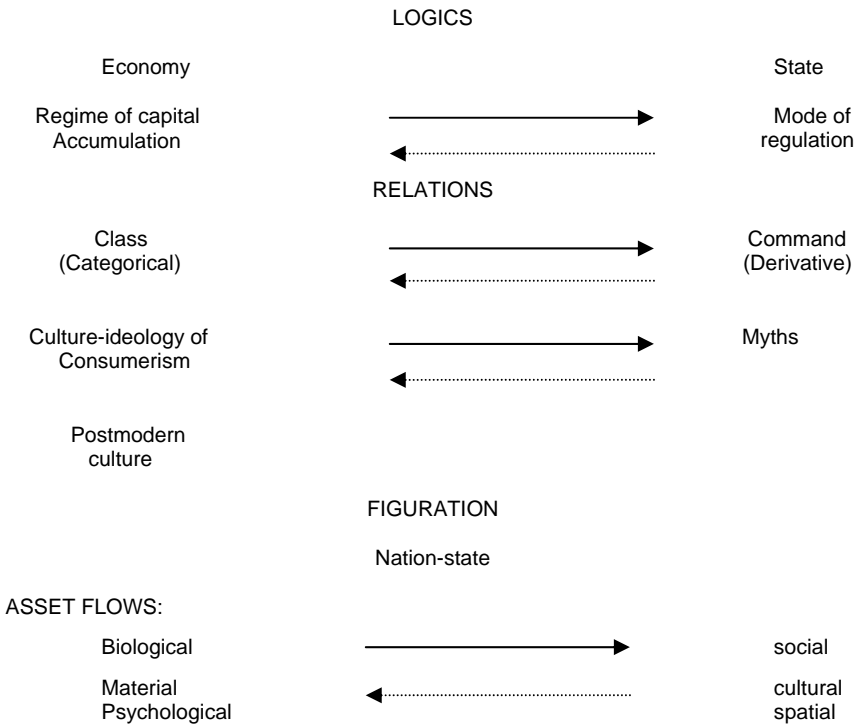
Health inequalities and the GBH

The greedy bastards hypothesis or GBH, a technical term, has been explicated elsewhere (Scambler & Higgs, 1999; Scambler, 2001, 2002). Reference to it here is solely instrumental: to show the jigsaw model in action. The GBH invites medical sociologists to re-focus their enquiries, to divert their quasi-epidemiological attention from the *statistical* linkage between socio-economic group/status and mortality/morbidity (epitomized in 'the gradient'), spawning inexhaustible data on the lot of the poor and powerless, to the *sociological*, and causal, linkages between the logics of the regime of capital accumulation and of the mode of regulation and their respective relations of class and command and mortality/morbidity, promising novel data on the vested interests and opportunity costs of the rich and powerful. The GBH asserts that causal responsibility for Britain's enduring health inequalities might most reasonably be laid at the feet of the wealthy and powerful. It presents these inequalities as largely unintended consequences of the evolving strategic actions of the (weakly globalized) power elite of the state, informed by those of the increasingly irresistible hard core of the (strongly globalized) capitalist-executive. Figure Two summarizes the GBH, framing both (1) the *categorical* role of the logic of the regime of capital accumulation of the economy and its class relations and *derivative* role of the logic of the mode of regulation of the state and its command relations for health inequalities in Britain in what has variously been called disorganized or global capitalism or second modernity, dating from the end of the postwar welfare consensus in the early 1970s; and (2) the principal media of enactment of the GBH, that is,

those capital or asset ‘flows’ most salient for health status and longevity, particularly at critical junctures of the lifecourse.

Figure Two: The ‘Greedy Bastards Hypothesis’ (GBH)

Health inequalities in Britain are the largely unintended consequences of the evolving strategic actions of the (weakly globalized) power elite of the state, informed by those of the increasingly irresistible hard core of the (strongly globalized) capitalist-executive.



A point worth emphasizing is that although command relations have become more answerable to those of class in the post-welfare state era of disorganized capitalism, the former, in the absence of the immanent threat of a legitimation crisis, reflect a more not less interventionist state, encouraging some to write not only of the ‘marketized’ but of the ‘regulatory state’ (Moran, 2003). This gives a new and important twist to

the historian Landes' (1998) general observation that 'men of wealth buy men of power'. The paradoxical by-product of the new mode of regulation of the state in disorganized capitalism has been a more not less insistent and colonizing political will, epitomized of late in Blair's neo-liberalism 'Mark II'.

Of course the point of formulating the GBH was less to highlight the personal voracity of the big-hitter 'greedy bastards' in the capitalist-executive than to show that these substitutable personnel mostly surf on prevailing social structures, conspicuously those of Britain's re-invigorated relations of class. Workers whose health is indirectly hit, for example when companies re-locate, out-source, downsize or terminate final salary pension schemes, strategies for which greedy bastards claim recognition and reward, are often neither surfing nor waving but, to borrow Stevie Smith's phraseology, drowning.

Explicating stigma structurally: chronic illness and disability

Goffman's work, concocted out a home brew of Parsonian structural-functionalism and symbolic interactionism, is noteworthy for its unique, unorthodox relationship to the concept of structure (Cheal, 2005). Rather than study social structure per se, he shifted the emphasis to face-to-face interaction and focused on the *structure of interaction*: 'to describe the rules regulating a social interaction is to describe its structure' (Goffman, 1967: 144). There was little sense here, however, of the causal input of structures like class and command, structures having something of the 'external' character of Durkheimian social facts. If the post-Goffman sociology of stigma was framed by medical sociology's 'personal tragedy' orientation to chronic and disabling illness in the 1980s, and by disability theorists' 'social model' through much of the 1990s, one theoretical strain since 2000, resonant with much disability theory, points towards the evolution of a more comprehensive *political economy* of stigma. Class and command, it is increasingly recognized, intrude forcibly on the sociology of stigma. Before this strain is developed, a few points of conceptual clarification are in order.

There is a strong case for insisting on an analytical distinction between stigma and deviance. Mankoff (1971) usefully distinguished a generation ago between 'ascribed' and 'achieved' deviance. Ascribed deviance, exemplified by most instances of chronic and disabling illness, is deviance for which the bearer is not held responsible, while achieved deviance carries the extra burden of presumed culpability. Ascribed

deviance, thus defined, resonates with Goffman's (1968) explication of stigma. For him, stigmatized individuals offend against 'norms of identity or being', whether this is manifested via ('tribal') racial or religious affiliation, character faults or bodily deformity. It is not so much what they *do* - that is, their behaviour - but what they *are* - namely, 'imperfect beings'. Their deficit is not *moral* but *ontological* (Scambler & Hopkins, 1986). Elsewhere and below I refer to the logic of culpability and relations of deviance to capture the moral (Mankoff's achieved deviance), and to the logic of shame and relations of stigma to capture the ontological (Mankoff's ascribed deviance and Goffman's stigma) (Scambler, 2004). To make this analytic distinction is not to imply that *in practice* things are this clear-cut, or that the pity or harm evoked by an ontological deficit is necessarily less injurious than that occasioned by a moral deficit.

In my 'hidden distress model of epilepsy', largely characteristic of the personal tragedy orientation to chronic illness and disability of the time, I focused on the idea of ontological deficit, formalizing a distinction between *enacted* and *felt stigma* (Scambler, 1989). The former refers to episodes of discrimination against people with epilepsy exclusively on the grounds of their social and cultural unacceptability, while the latter has two referents: the first of these is the shame accompanying 'being epileptic', and the second is the fear of enacted stigma. The bottom line of the hidden distress model of epilepsy was that it is felt rather than enacted stigma that most disturbs the quality of life of people with epilepsy, a finding that has often been replicated since (Jacoby et al, 2005).

For all its indisputable linkage to the personal tragedy approach, the hidden distress model of epilepsy was at least set against the background of interactionist accounts of deviance and the social order (Scambler, 2004). Thus, people with epilepsy were said to fall foul of a settled symbolic order or universe experienced as 'natural' rather than socially constructed in two principal respects. First, they possess an ontological deficit or unacceptable imperfection: they are not as they ought to *be*. And second, they prompt what Albrecht and colleagues (1982) term 'ambiguity in social interaction': their seizures render their behaviour unpredictable; they cause 'psychosocial dramas' in public spaces; and during and after seizures they appear provocatively and embarrassingly needy of comfort and care. But the question not posed in the hidden distress model of epilepsy was: why did the symbolic order

or universe prevailing at the time deliver *these* norms of identity or being (Craig & Scambler, In Press)? Or, in the terminology of the jigsaw model, why *this* logic of shame and *these* stigma relations?

Several authors inside and outside of disability theory have openly called for a political economy of stigma. Link and Phelan (2001) offer a conceptual model of stigma acknowledging that the labelling, stereotyping, distancing from others and loss of status that characterize stigma are only made possible by the differential distribution of social, economic and political power. More particularly, Parker and Aggleton (2003) call for a post-individualist account of the stigma of HIV that recognizes stigma's functioning 'at the point of intersection between *culture*, *power* and *difference*'. Stigma and stigmatization, they insist, are at the core of the construction of the social order; and the social order, referred to above as the symbolic order or universe, 'promotes the interests of dominant groups as well as distinctions and hierarchies of ranking between them, while legitimating that ranking by convincing the dominated to accept existing hierarchies through processes of hegemony' (Parker & Aggleton, 2003: 6). Stigma and discrimination are intimately linked to the reproduction of inequality and exclusion. Stigma, and deviance too, mark and patrol the boundaries of the social or symbolic order, this order ultimately comprising a form of 'symbolic violence' (Bourdieu, 1977).

The logic of shame and stigma relations are typically reproduced rather than produced during the face-to-face encounters analyzed so sensitively by Goffman (Scambler, Forthcoming). In many figurations, in fact, this dyad is derivative of the logic of the regime of capital accumulation and class relations and/or the logic of the mode of regulation and command relations. Shame, as disability theory claims, is often attributed to the non-productive and/or recipients of welfare. This requires some elaboration.

If the logic of shame and stigma relations might be said to issue in a theory of enacted and/or felt stigma, or *stigmatization*, the logic of the regime of capital accumulation and class relations issues naturally in a theory of *exploitation* (Higgs et al, 2004), and the logic of the mode of regulation and command relations issues no less naturally in a theory of *oppression*. What is missing from orthodox sociological explorations of stigmatizing conditions prior to the consolidation of disability theory in the 1990s is an acknowledgement that the disadvantage accruing to those regarded as shameful through stigmatization is more often than

not mixed in with, even secondary to, exploitation and oppression. It is empirically rare for an individual to be *simply* stigmatized or exploited or oppressed, which is not to say that one of the underlying dyads of logic/relations might not be categorical.

Consider the British government's 'welfare-to-work' programmes directed at those with chronic illnesses or disabilities. Based on the premise that the relatively low employment rates amongst these groups contribute to the twin evils of poverty and social exclusion, these programmes were designed to facilitate the transition from out-of-work benefit receipt to paid employment. The strategies deployed were: education, training and work placements; vocational counselling and support services; in-work benefits; incentives for employers; and the improvement of physical accessibility. Revealingly, what underpinned these strategies was an insistence on the exercise of 'demonstrable' personal responsibility. Charting these initiatives throughout the 1990s, Bambra and her colleagues (In Press) conclude that they have 'helped' some with disabilities and chronic illnesses get off benefits and into work.

But welfare-to-work schemes, like the philosophy of personal responsibility imported from the USA, can only be explained sociologically in terms of the renewed virulence of the logic of the regime of capital accumulation and relations of class relative to that of the logic of the mode of regulation and relations of command in global or disorganized capitalism. The 'benefits' of the new work opportunities for disabled and chronically ill 'clients' has to be set against the partial transformation of their stigma into deviance under pressures to contain labour costs and social transfers. In short, any putative gain, or reduction in stigmatization, has to be set against costs in terms of the requirement to actively avoid culpable deviance and in the currencies of exploitation and oppression. Indeed, the very notion of work as 'crucially definitional of social membership' is too rarely interrogated (Galvin, 2005).

A related argument can be advanced in relation to caring for people with chronic and disabling conditions. Galvin (2005: 403) notes that when, as has occurred with increasing vehemence since the mid-1980s, 'caring is framed within a rationality which glorifies the ability to be self-reliant, the need for help can only be seen as unpalatable and, when combined with the principles of economic rationalism which are responsible for the shrinking of the public sector and an increasing

reliance on market principles, support for disabled people is seen to be a matter for individuals and their families to sort out'. Furthermore, are not those who rely on - become a burden to - others parading a moral deficit (Bryan, 2000)? Behind this shift since the Thatcher decade, of course, is (categorical) class exploitation reflected in (derivative) state oppression.

In light of the most accurate and comprehensive overall picture of disorganized capitalism available to us (see Figure One above), a number of general theses linking social structures/generative mechanisms pertinent to enacted and felt stigma associated with chronic and disabling illness suggest themselves:

(1) Across many figurations, including that of the British nation-state, the logic of the mode of regulation and command relations of the state have become increasingly derivative of the logic of the regime of capital accumulation and class relations of the economy.

(2) As a functional by-product of (1) and the resultant resurgence of neo-liberalism Marks I and II, the citizenship entitlements of welfare statism have been progressively eroded and displaced by a philosophy of 'positive welfare' (Giddens, 1994), at the core of a new culture-ideology of consumerism (Sklair, 2000). Neo-liberal forms of positive welfare, rationalized by this culture-ideology of consumerism, emphasize the significance of *personal responsibility*.

(3) A neglected aspect of (2) has been that across many figurations the logic of shame and its stigma relations has become increasingly derivative of the logic of culpability and relations of deviance, with people being expected, even morally required, to address and overcome their ontological deficits. To the pity elicited by imperfection has been appended the blame of failure to normalize (secure self-inclusion) (see the discussions of welfare-to-work and caring above).

(4) Accompanying the processes encapsulated in (1) to (3) has been the *aestheticization* of the normal/abnormal binary, adding the cultural disadvantaging charge of 'ugliness' to most types of stigma and many types of deviance.

(5) Together (1) to (3) are symptomatic of a change in the way in which power is exercised in disorganized capitalism, a change best captured by Foucault's (1979) notions of technologies of the self and governmentality. Power is now significantly exercised through the

individual self-policing required by the philosophy of personal responsibility. Foucault, however, was too dismissive of domination, missing the ideological backdrop to governmentality. Doctors have become unwitting agents of governmentality, a function facilitated by medicine's decline in status and the new proximity of public sector professionals in the old middle class to the working class.

(6) Although enacted and felt stigma have become aspects of governmentality across many figurations (Craig & Scambler, In Press), with the result that the disadvantage often associated with chronic illness is typically infused to some degree with exploitation and oppression, there is a novel fluidity to identity formation, *and to the logics of shame and culpability*, in disorganized capitalism's postmodern culture. This allows not only for self-turnover but also for forms of resistance that Foucault strived, and failed, to frame, and in which disability theorists have set such store.

In relation to chronic illness and disability, in sum, there is a need to go beyond Goffman's inspired essays on the structure of face-to-face interaction, front- and back-stage, and the encapsulation of stigma as personal tragedy. Stigma relations need to be studied as part of a nexus of social structures/generative mechanisms, and recognition accorded the fact that stigmatization is rarely the sole ingredient of disadvantage, other notable companions being exploitation and oppression. There has been a tendency too for stigma relations to become increasingly derivative of relations of deviance, a tendency itself due to command relations becoming more derivative of those of class.

Concluding comments: returning to social structures

Following a heavily annotated introduction to critical realist approaches to theorizing social structures, and a no less brief mention of the jigsaw model, with its logics, relations and figurations, I have concentrated on the salience of social structures for sociological explanations of – in ascending order of comprehensiveness – health inequalities, and the stigma associated with chronic and disabling illness. The resulting 'pieces of the jigsaw' have been presented against the background of the 'overall picture' of a much-changed Britain in disorganized capitalism.

There are two fundamental tensions that might be highlighted. The first is between social structure and culture. It has been argued here that the postmodernizing of culture should be interpreted in part as an

epiphenomenon of a culture-ideology of consumerism functional for disorganized capitalism; in short, that although culture might have evolved very differently, it was most unlikely to have done so in a way that jeopardized the system imperatives of economy and state. Class and command relations, promising exploitation and oppression respectively, almost inevitably underpin the symbolic violence implicit in what appears a very 'natural' social or symbolic order, and in which relations of stigma are embedded. This does not mean that culture is structurally determined. But postmodern culture tends to be disinhibiting rather than emancipatory (Scambler, 2002). *It affords a potential for stigma resistance and reduction to the extent that these are structurally permissible.* Identity politics *with* the structural flow are likely to be more effective than identity politics *against* the structural flow.

With regard to chronic and disabling illness, it has been suggested that in the figuration of the British nation-state the logic of shame and relations of stigma have become increasingly derivative of the logic of culpability and relations of deviance, and that this shift can be traced causally to the renewed virulence of the logic of the regime of capital accumulation and its class relations relative to the logic of the mode of regulation and its command relations. If this is so, it has negative implications for stigma resistance and for stigma reduction programmes.

The second tension to note is the time-honoured one between structure and agency. It has been maintained that agency is structured but not structurally determined. Building on Archer's analysis cited earlier, one's (initially involuntary) placement brings vested interests that the mediating mechanism of opportunity costs helps translate into one's consciousness and conduct. Reasons for action, structurally filtered, typically become rationalizations appropriate to one's vested interests. Freedom of will, presupposing as it does a potential for rational action, too readily shades into weakness of will (Scambler, 2005a).

But all choice is structured, and postmodern culture favours a 'rhetoric of choice' that is often (a) an ideological device covering for a profiteering consumerism, and (b) a legitimacy device allowing for the political attribution of deviance to those who willfully self-exclude. Structural forces like class, command and gender become 'invisible': 'for the less privileged, the choice rhetoric can serve to worsen their situation and create a pessimistic outlook on life, since according to such an ideology there is no one to blame but oneself, that is, if one has

not made the 'right' choices or has not succeeded in achieving one's aims' (Brannen & Nilsen, 2005: 423).

It is appropriate to conclude with a brief comment on *why* social structures, omnipresent in classical sociology, are being neglected. The current division of labour in sociology is taken from Burawoy's (2005) superb ASA Presidential Address in 2004. Burawoy (2005: 9-10) commends what he calls 'public sociology', involving 'a dialogic relation between sociologist and public in which the agenda of each is brought to the table, in which each adjusts to the other'. This concept is strikingly similar to my notion of a critical reflexive sociology (Scambler, 1996). 'Policy sociology' refers to sociology 'in the service of a goal defined by a client'. The *raison d'être* here is to provide solutions to problems that clients' present, or 'to legitimate solutions that have already been reached'. 'Professional sociology' underpins both public and policy sociologies, supplying each with 'true and tested methods, accumulated bodies of knowledge, orienting questions, and conceptual frameworks'. Finally, 'critical sociology' is committed to examining the foundations – 'both the explicit and the implicit, both normative and descriptive' – of the research programmes of professional sociology.

Part of what I have called the taming or 'colonization' of medical sociology, of which the neglect of classical concerns with social structures in medical sociology is a part, has arisen through concentrations of effort in policy and professional sociologies, a by-product of opportunity (the carrot of survival and reward) and hazard (the stick of redundancy) originating from outside the discipline (Archer's structural conditioning is just as relevant here). As Burawoy states, contributions to these sociologies are vitally important. My thesis is that we have a *collective* responsibility to ensure the healthiness also of critical and public sociologies, and in discharging this responsibility we are presently at risk. Vital though they are, policy and professional sociologies can also provide cover for structured acts of moral cowardice.

***Editors' note:** In the plenary Graham gave at the Medical Sociology Conference 2005 he included a section on sex work, but due to considerations of space this was omitted in this publication. We thank Graham for his cooperation in this matter.

References

- Albrecht, G, Walker, V & Levy, J (1982) Social distance from the stigmatized: a test of two theories. *Social Science and Medicine* 16 1319-1327.
- Archer, M (1995) *Realist Social Theory: The Morphogenetic Approach*. Cambridge; Cambridge University Press.
- Bhaskar, R (1978) *A Realist Theory of Science*. London; Verso.
- Bhaskar, R (1989) *The Possibility of Naturalism* (2nd.Ed). Hemel Hempstead; Harvester Wheatsheaf.
- Bhaskar, R (1989a) *Reclaiming Reality: A Critical Introduction to Contemporary Philosophy*. London; Verso.
- Bourdieu, P (1977) *Outline of a Theory of Practice*. Cambridge; Cambridge University Press.
- Bryan, W (2000) The disability rights movement. In Eds Adams,M, Blumenfeld,R, Hackman,R, Peters,H & Zuniga,X: *Readings for Diversity and Social Justice: An Anthology on Racism, Anti-Semitism, Sexism, Heterosexism, Ableism and Classism*. New York; Routledge.
- Burawoy, M (2005) For public sociology. *American Sociological Review* 70 4-28.
- Cheal, D (2005) *Dimensions of Social Theory*. London; Palgrave.
- Craig, G & Scambler, G (In Press) Negotiating mothering against the odds: gastrostomy tube feeding, stigma, governmentality and disabled children. *Social Science and Medicine*.
- Creaven, S (2000) *Marxism and Realism: A Materialistic Application of Realism in the Social Sciences*. London; Routledge.
- De Vries, R (2003) Protecting our virtue(s): medical sociology at 50. *Medical Sociology News* 29 35-38.
- Fleetwood, S (2002)
- Foucault, M (1979) *Discipline and Punish*. New York; Vintage
- Galvin, R (2005) Researching the disabled identity: contextualizing the identity transformations which accompany the onset of impairment. *Sociology of Health and Illness* 27 393-413.
- Giddens, A (1994) *Beyond Left and Right: the Future of Radical Politics*. Cambridge, Polity Press
- Goffman, E (1967) *Interaction Ritual: Essays on Face-to-Face Behaviour*. New York; Doubleday.

Goffman, E (1968) *Stigma: The Management of Spoiled Identity*. Harmondsworth; Penguin.

Higgs, P, Jones, I & Scambler, G (2004) Class as variable, class as a generative mechanism: the importance of critical realism for the sociology of health inequalities. In Eds Carter, B & New, C: *Making Realism Work: Realist Social Theory and Empirical Research*. London; Routledge.

Jacoby, A, Snape, D & Baker, G (2005) Epilepsy and social identity: the stigma of a chronic neurological disorder. *Lancet Neurology* 4 171-178.

Landes, D (1998) *The Wealth and Poverty of Nations*. London; Little, Brown & Co.

Lawson, T (1997) *Economics and Reality*. London; Routledge.

Mankoff, M (1971) Societal reaction and career deviance: a critical analysis. *Sociological Quarterly* 12 214-218.

Moran, M (2003) *The British Regulatory State: High Modernism and Hyper-Innovation*. Oxford; Oxford University Press.

Parker, R & Aggleton, P (2003) HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action. *Social Science and Medicine* 57 13-24.

Ritzer, G (2001) The McDonaldization of American sociology: a metasociological analysis. In Ritzer, G: *Explorations in Sociological Theory: From Metatheorizing to Rationalization*. London; Sage.

Scambler, G & Hopkins, A (1986) 'Being epileptic': coming to terms with stigma. *Sociology of Health and Illness* 8 26-43.

Scambler, G (1989) *Epilepsy*. London; Tavistock.

Scambler, G (1996) The 'project of modernity' and the parameters for a critical sociology. *Sociology* 30 567-581.

Scambler, G & Higgs, P (1999) Stratification, class and health: class relations and health inequalities in high modernity. *Sociology* 33 275-296.

Scambler, G (2001) Class, power and the durability of health inequalities. In Scambler, G (Ed): *Habermas, Critical Theory and Health*. London; Routledge.

Scambler, G (2001a) Self-turnover, social representations and the culture-ideology of consumerism: a theory for the health domain. Unpublished paper presented at the BSA Medical Sociology Conference.

Scambler, G (2002) *Health and Social Change: A Critical Theory*. Buckingham; Open University Press.

Scambler, G (2002a) The jigsaw model: towards a composite picture of health in society. Unpublished Inaugural Lecture, UCL.

Scambler, G (2004) Re-framing stigma: felt and enacted stigma and challenges to the sociology of chronic and disabling conditions. *Social Theory and Health* 2 29-46.

Scambler, G (2005) Medical sociology: past, present and future. In Ed Scambler, G: *Medical Sociology*, Vols I-IV. London; Routledge.

Scambler, G (2005a) *Sport and Society: History, Power and Culture*. Buckingham; Open University Press.

Scambler, G (Forthcoming) Sociology, social structure and health-related stigma. *Psychology, Health and Medicine*.

Sklair, L (2000) *The Transnational Capitalist Class*. Oxford; Blackwell.

Interview with Professor Sally Macintyre

By Maureen Porter & Edwin van Teijlingen

Professor Sally Macintyre, Director of the Medical Research Council's Social and Public Health Sciences Unit in Glasgow was awarded the degree of Doctor of Science honoris causa from the University of Aberdeen on 5th July 2005.

MP: Tell us Sally, on this momentous occasion, what have been the major influences on your career so far?

SM: Well I was always very interested in health, particularly the social aspects of health. I did a first degree in Sociology and took a couple of health related options - one looking at health and welfare, and one more health economics oriented. And then I got an MRC scholarship for the MSc in Sociology Applied to Medicine at London University. I was very influenced by both Margot Jefferys and George Brown who were there at the time. They were both really good teachers and very interesting in their different ways. George taught a brilliant methodology course and also talked a lot about his own research.



Then I came to Aberdeen as part of an ESRC (then SSRC) funded programme on 'Objectives and needs in medical and social care systems'. Working on it were interesting and talented people such as Phil Strong, Alan Davis, Mick Bloor and Mildred Blaxter. Tony Walter was also there, and David May. And that first year, Julius Roth came over on sabbatical from the USA. We worked out of a small hut. It was quite intimate, and as we'd all started on this programme at the same time, it was all quite intense, a lot of meetings about

what the programme was doing, it was the heady days of symbolic interactionism. So it was actually an incredibly stimulating environment to be in. We were doing things on different topics. I was doing work on decision making among young women who got pregnant before they were married, which is astonishing now, because you wouldn't consider that a research topic, how would they decide



what to do with their pregnancy? And Alan and Phil were looking at a children's hospital, studying interactions there, Tony was looking at an Approved School, Mildred at disability and dependency. So we were all looking at different substantive areas, but we were all very interested in client / agency interactions, doctor / patient interactions etc. The SSRC programme was nominally headed by Raymond Illsley who disappeared to Boston for the first year. Gordon Horobin, Assistant Director at the MRC Unit took over.

MP: You were working in obstetrics, which was almost THE research topic at the time, wasn't it?

SM: Well, again it was very interesting because there was Ann Oakley and Hilary Graham and Lorna McKee and Meg Stacey all working in that area. There was a lot of interest in obstetric care. I remember going to meetings in Warwick that Meg Stacey ran which were on social aspects of obstetrics, and again they were very stimulating because I think probably maternity care was one of the first medical disciplines where sociology and psychology and patients' views were first examined together. Iain Chalmers and Martin Richards were also involved in those Warwick meetings. So it was an important area.

MP: But then you moved completely away from obstetric care, into public health?

SM: Yes, when I got the directorship of the MRC Unit, I felt that the Unit as a whole shouldn't have the same focus as what I'd been doing. That was just about the time of the *Black Report* (1980), and I thought a

broader remit that could actually involve quite a lot of people in the Unit, and also cover quite a lot of substantive areas, was 'Inequalities in Health'. But I very much saw it then as social patterning of health, rather than just socio-economic inequalities.

My idea was to look at gender, class, age, ethnicity and area of residence. I was interested in the social patterning of health and I had a slight problem with the way inequalities were described and whether inequality is the same as inequity? So say women live 7 years longer than men, is that an inequity, is it an inequality? Who is badly done by, by that? If you talk about the social patterning of health it is a more neutral term. Equally, at that time they were just discovering that migrants to Britain from Pakistan, Bangladesh and India had better health. So again what do you mean by ethnic inequalities? So I broadened it out into social patterning of health.

MP: You've been described, I think in one of the Sunday papers, as one of the 'prime movers' in public health. I was wondering how you feel things are going there?

SM: Well, 20 years ago I wouldn't have used the term 'public health research', or thought of myself as a public health researcher. I thought of myself very much as a sociologist. But I've got more interested in the application of medical sociology, and the broader social determinants of health rather than necessarily things like doctor / patient interaction. So that I think is a sort of public health, or at least population health, perspective. But I actually feel a lot of public health research is quite weak. A lot of public health practice has quite a weak evidence base. So I am quite keen to do what people like Iain Chalmers did for clinical medicine 20 – 30 years ago, saying 'Well how do you know what you are doing is beneficial? Is it the most beneficial thing you can do? Maybe it does harm as well as good. What is the evidence base for practice?' I mean a lot of public health doesn't have that evidence base.

MP: At a seminar in Aberdeen recently you said that lots of public money is ploughed into improving schemes but they are not evaluated.

SM: Yes. Area based initiatives for example, urban regeneration programmes; a colleague recently did a systematic review, found that very few of them had been evaluated. If they have, they've been

evaluated in terms of inputs and outputs, such as how many jobs are created, or new roads built etc. But very few public health outcomes have been evaluated. Quite often the evaluations are set up *after* the initiative is developed, or the people evaluating it are the proponents. And that's always a bit dodgy because obviously people sincerely believe they are doing good.

MP: Do you think you are going to make a difference, going to be able to change things for the better?

SM: I don't know. I feel, dare I say it, that a lot of epidemiological and sociological research on inequality has plateaued. It's been a big industry for the last 20 - 30 years, research on inequalities in health, but there are few studies on interventions designed to reduce inequalities in health. I don't think we actually know a lot more than we did. There are either the macro-scale arguments on 'what we need to do is.... change the society and have a revolution', or there's very micro, you know, smoking cessation programmes in general practice in poor communities, but not a lot in between. And not a lot that actually allows you to look at the effects on inequalities. For example, a lot of trials, even of community-based interventions, aren't designed with the power to look at differential effects by social class. So if you look at smoking cessation, it's quite hard from some of the studies to see whether it does have a bigger effect on one socioeconomic group than on another. One of the things colleagues are doing at present is seeing whether we can go back to the initial studies, re-examine the original data, and ask, 'were these things differentially affected by social class or by gender?' So I think I'm moving away from doing entirely analytical, explanatory, or descriptive research on socio-economic inequalities in health, or indeed area or gender inequalities. I think we need to be actually putting our money where our rhetoric is, and saying 'well what would work?'

MP: That's interesting, because when you read the journals, sociology seems to be going in a different direction completely doesn't it? A lot of articles are narrowly focused and almost incomprehensible.

SM: Yes, well I'm afraid I hardly ever read straight sociology any more and I don't think straight sociologists would regard me as a sociologist. I think they'd regard me as a very lapsed sociologist. I think there's a huge gulf now between sort of pure sociology as taught in

universities and the social and public health sciences. The other thing that influenced me was being editor of *Social Science and Medicine*. Really interesting, because you're talking to people all over the world and you're also reading economics papers and health policy papers and health psychology papers. And that broadened my perspective and made me less interested in pure sociology.

MP: You must have seen a huge change in the nine years you were editor?

SM: Yes, and we moved, how can I say it, probably to a much more tighter focussed, theoretically relevant, not necessarily more applied, ...but there are probably fewer of the sort of more discursive sort of theoretical papers. I introduced social epidemiology into it as well, tried to make that more social. Also we had to cut down the length of papers because there was more demand from people wanting to get their papers published and rates of submissions went up. There was horror and lot of resistance in the sociological community. But I still claim that if you've got something interesting to say, you can say it in 8,000 words or less.

MP: So looking back now at this momentous point in your life, how do you feel about the way it's turned out?

SM: Well I have to say, I have actually never planned my professional life. It has all been serendipity and I don't feel I merit success. I've obviously done things in good faith, I hope, and to the best of my ability, but I feel quite surprised to get the sort of recognition I have, and I don't feel that's particularly deserved. I mean, like getting the job of the Director of the MRC Medical Sociology Unit, I was very surprised at that. I do think that there is a strange thing about recognition, which is that it feeds on itself to a certain extent. In 1998 I got an OBE and Fellowship of the Royal Society in Edinburgh and Fellowship of the Academy of Medical Sciences. And I think what starts to happen is people think "oh she's got letters after her name, lets give her more" sort of thing. Or "she must be OK, we'll have her on our committee."

MP: And you sit on many committees

SM: Again I've been in the right place at the right time, and I think I've been the sort of respectable face of sociology for a lot of groups, particularly the MRC. When the HIV / AIDS epidemic hit, people were saying what about behavioural science? I was there in a medical sociology unit. I didn't know anything about communicable diseases, but obviously they called on everybody, so I got into HIV / AIDS research. And there were anthropologists at the time who denied HIV transmission, who said, you know, AIDS in Africa is a colonialist myth and a social construction. I said, 'Would you have a blood transfusion from a re-used needle in Uganda?' at the time. So because I wasn't doing the sort of social constructionist hard line, I think I was the respectable face. Well to be quite honest, I got pulled into a lot of committees initially because I was female, and they need females on committees, and because they could tick about 5 boxes, social scientist, female, north of the border, Glasgow, deprivation, you know. I'm actually quite good at committees, and I find committees quite interesting. I think as a sociologist, committees and committee functioning is quite interesting. If you are on a couple of committees and people think, you know, you do your job reasonably well, then you get on other committees. And I think I'm reasonably efficient at that sort of committee work. You learn to just read the stuff you need thoroughly and skim the rest.

MP: So have you found it's interfered with the rest of your life?

SM: Well, I've continued to climb, ski, go on expeditions, do other things, so... Sometimes it's frustrating, particularly if you go down to London for committees and things, you can't have a regular commitment such as an evening class. But also I know people in London and one of the things {I value} when I go to London for a meeting, is I can arrange to meet them for dinner and then get the sleeper back. Or I can meet somebody for lunch. So that's actually quite nice, it keeps links going. So no, I don't think it's ruined my life. I'm amazed at most academics I know who work terribly hard. I hardly ever work at weekends, I hardly ever work in the evenings, I might work a bit late and then go home, but actually I'm astonished by most academics who take a briefcase home and work.

MP: Did you make a deliberate decision not to do that?

SM: Yes, yes, I think I value my life more and I don't see why I should do that. So if I want to spend a weekend gardening or going up a hill or going to the theatre, going to the cinema, I do that. And actually I try and operate as a bit of a role model at work. So, for example one of the things I do, which some of my senior colleagues do as well, is I *visibly* go to the gym at lunchtime. I walk out with my kit bag and say, "I'm going to the gym". I don't believe in this sort of macho, you know, somehow working all the hours God gave you sort of demonstrates your worth. I think it's actually almost the other way round. If you can do things efficiently and well, and then disappear off and go to the theatre, that's better.

EvT: Do you find that if you do things efficiently and you seem to be doing the job well, that you get asked to do more because people see you as efficient?

SM: Yes, that's certainly true, but I think I've learnt more recently to say 'No'. So a lot of things I just say 'No, I won't be on that committee'; or with reviewing papers, I only review ones which I will benefit from reviewing. And I feel I've done enough editorial stuff, and also if I've just done a bunch I'll just say no. And I'll always try and suggest somebody else or get back to them and say "I can't do it at the moment". The same with grant proposals, I say no.

EvT: Another lesson. Where do you think medical sociology is going in its widest sense?

SM: I'm not terribly sanguine about medical sociology. I think it's partly because I've moved away from straight medical sociology. Partly because some medical sociology is very theoretical and I'm less interested in that. I'm not sure whether medical sociology has ever come up with the goods, and I think health psychology and health economics are coming up fast in the inside lane. When I was on the MRC Health Services Research Committee as a sociologist, there were things that psychologists could provide for research proposals, and economists could provide, and even the anthropologists could provide. I was never quite sure what the sociologists could provide, because they didn't have tools. They couldn't say, "well, here's some quality of life

measure that we've devised", or "here's some psychometric test." Also a lot of the sociological comment coming from referees tends to be negative, always negative. And the more {hard} scientific the committee at MRC, the more positive everybody else was. They just thought, "this is a brilliant proposal". Nobody in sociology ever says that, they always nit-pick. Psychologists would be quite critical, but in a focused way and say, "you need to have this measure or that's the wrong measure". But sociologists would say, "oh you've started in the wrong place" or "it hasn't got a sociological perspective". So I think sociologists sometimes misunderstand the fact that there was a lot of goodwill on the part of DH and MRC, to bringing sociologists on board, but I think they just got disappointed because they didn't deliver anything. I think some sociologists are just seen as sniping from the outside, and always critical. And perhaps a bit out-of-date, you know, being anti-biomedicine, anti- the medical model.

It's quite interesting if you look at America where sociology has a much better reputation. If you read American, even magazines, they will cite sociologists telling you interesting things about society, or how things work, predicting things. In Britain that doesn't happen at all and I think it's partly because of British sociology... Cary Cooper for example, I mean if you want to know anything about the work / life balance or organisational behaviour, he's there. He's talking to the press in an intelligent way, and he'll say, "Studies showed that if you do this, this will happen." Sociologists don't tend to do that. ...And then of course there's often isolated sociologists in public health or other departments who get a big load of teaching you know, because we've got to do our community bit and learn about society.

EvT: Maureen and I bring in qualitative methods as much as a sociological perspective but many people equate sociology with qualitative methods.

SM: I know, which I think again is completely the opposite of what the ESRC is doing, or the case in America where they are doing more and more sophisticated statistical methods, often coming from the social sciences. A lot of things like blinding and randomised controlled trials came out of social science, despite the sociological idea of 'horrible medics, we're not going to do anything like that because it came from

the medics'. I think Ann Oakley has written very interestingly about that, where some of these ideas come from.

EvT: When you were in Aberdeen there were links between the research unit and the sociology department but that reciprocal sharing of ideas seems to have disappeared entirely.

SM: Well, it's probably the same in Glasgow. I did actually collaborate quite a lot with the media sociologists {there} which was very interesting, because that gave me insight into media sociology. But now I have no contact with them at all, and I think they just think we're sort of epidemiologists and that's sad.

MP: And in your Unit now, is everybody working on this one research programme?

SM: No, there are seven different programmes including gender, ethnicity, area. Inevitably people develop their own interests. We have a programme on HIV/AIDS and sexual health, which may seem a bit odd structurally. But if you are doing sexual health, you are very interested in gender relationships and power relationships and socio-economic status and area and all these things as well, so a lot of cross-cutting things. We have the quinquennial reviews so we have to stick within a remit.

EvT: We've lots of different units here with different styles of management. Some of it is due to your leadership style, isn't it?

SM: Yes, and I think the MRC in particular puts quite a lot of emphasis on the strategic vision of the Director and the Director says what can and can't be done. But obviously you develop senior staff and hope they'll develop their own interests. But it's probably more cohesive than a university department in the sense that you can argue that this is what the programmes are and these are the cross links.

EvT: Have you any message for the readership of *MSN*?

SM: Life in research can be fun. Lots of good careers in research. It is very interesting, very intellectually stimulating. Not just from the actual research, but also if you are on committees. It's great, you learn from other people...

PhD ABSTRACTS

"Formulating healthcare evidence: case studies in medical techno-practice in the UK, 1990-2000".

The development of multidisciplinary Health Services Research and Health Technology Assessment in the United Kingdom in the 1990s informs government R&D policy for a 'knowledge-based health service'. This thesis comprises health service case studies focused on medical techno-practice in eight publications and an original essay. Perspectives from sociology applied to medicine and health care, science and technology studies (STS), and the multidisciplinary field of 'health services research' are combined.

Health care is marked by complex, hybrid problems, associated with physical hazards and socially perceived risks. Case studies are drawn from three fields of technology and practice: human implant technology (total hip prostheses); cancer detection (testing for early-stage prostate cancer); and outpatient care. The objectives are, firstly, to analyse variability in patterns of health care. This enables, secondly, analysis of observed techno-practice variations in terms of their implications for effectiveness of interventions, social patterns of health care consumption, risks to patients and health care policy. Thirdly, explanations for variability in practices and policies are offered, suggesting the need, fourthly, for sociologically-informed approaches to analysing policy for the introduction of 'new technology' into healthcare systems. The final objective is to make the case for, and contribute to a sociopolitical analysis of the advance of the new healthcare sciences and their articulation with public policy in contemporary advanced health care systems.

Results: the proliferation of costly artificial hips evoked a national policy response that draws heavily upon health technology assessment evidence and processes; early detection of prostate cancer presents dilemmas associated with surgical specialisation, and conflict between policy, clinical beliefs and practices; outpatient care demonstrates tension between modernisation, evidentiality and the obduracy of shared socio-clinical practices. The common threads drawing the case studies together are the observed variability in patterns of health care delivery and practice; underlying patterns of medical beliefs,

professional work organisation and socialisation; the shaping of healthcare risks for patient populations; and linkages between healthcare innovation, modernisation and counteracting controls.

The thesis essay develops a reflexive understanding of healthcare science as a policy-related enterprise, arguing that healthcare evidentiality, its proponents and its institutional vehicles, should be considered as having legitimating and regulatory functions. Evidentiality should be considered one of the societal forces that must be embraced by a socio-politics of the dynamics of healthcare innovation and governance.

Dr Alex Faulkner – PhD by published work
faulknerac@Cardiff.ac.uk

.....

Biographical landscapes: nurses’ and health visitors’ narratives of learning and professional practice

The thesis illuminates biography, learning and practice and advances understanding of the development of professional knowledge and practice. The purpose of the research was to inform the pedagogical development of practice learning using a biographical perspective to investigate how nurses and health visitors use professional practice experiences to learn and generate knowledge and understandings of practice. The research is set within the healthcare policy context of lifelong and lifewide learning.

The literature review builds on my own experiences. An argument is developed for practice learning to be located within a universal knowledge system that provides for the subjective and contextual complexity of nursing practice knowledge and learning. The research strategy is grounded in the theoretical perspectives of interpretive phenomenology and interactionism.

Nine specialist community nurses and health visitors participated in the life story interview of biographical narrative interpretive method. Three transcripts were selected for in-depth analysis of subjective meanings of learning and professional practice. Case comparison of biographical

process structures shows how biographies construct a resource for ways of knowing the world that is incorporated into professional agency.

Five profiles of formal practice learning were accessible for documentary and textual analysis. Two patterns of orientation were reconstructed from this analysis: a *learning practice* constituted as a process of identifying and meeting learning needs through client-centred practice and *public institutions* constituted as a process of support and self-surveillance of the formal learning programme. These mirror biographical learning resources which seem to both construct professional knowledge and constitute the practice learning action environment.

Discourse analysis of accounts of client care situations from follow-up narrative interviews with four nurses and two health visitors showed continuity of how individuals learn and do the process of knowing practice through their own personal theories-of-practice.

Thematic analysis across the findings has led to the creation of a model of biography, learning and practice and utilises the concept of biographicity to inform pedagogical development of practice learning. The research makes a significant contribution to the body of knowledge on implicit, non-formal and formal learning and the development of professional knowledge at a micro practice action level of client-professional interaction.

Margaret A Volante
M.Volante@surrey.ac.uk

.....

The Health Effects of Income Inequality in Argentina

Does income inequality have a pathogenic effect? That is, does income inequality adversely affect the health of individuals, over and above the long-known effects of household income? This research examines the health effects of income inequality in Argentina, a middle-income country with very high levels of inequality. This represents an extension of Richard Wilkinson's work, which focussed only on advanced industrialised countries. I begin by outlining the income inequality hypothesis, its assumptions, and the theoretical mechanisms that link

inequality to health. My own secondary analysis of the 2001 Argentine *Encuesta de Condiciones de Vida* (Survey of Living Conditions) then identifies significant social gradients in self-reported health status and activity limitation because of poor health by household income. Provincial-level analyses show that male and female life expectancy is significantly correlated with income inequality (but that this is not robust to differing measures of income inequality). However, this does not hold true for self-reported morbidity: in contrast to life expectancy, self-reported morbidity is not correlated with income inequality (or poverty), suggesting that self-reported morbidity and mortality are not reasonably interchangeable variables (however, both types of data have been used in the literature to test the health effects of income inequality). Multilevel logistic regression is then used to test eight inter-related hypotheses about the health effects of income inequality; the results largely confirm the presence of a social gradient in health by income quintile, and whilst the models indicate that contextual effects are statistically significant, the influence of income inequality is minimal and not significant. My interpretation of this is to claim modest support for the Wilkinson hypothesis – the ecological relationship between income inequality and life expectancy is significant in Argentina, but when analysed at the individual-level using morbidity data, the hypothesis cannot be supported.

Fernando De Maio

<http://www.sfu.ca/sociology>

Tel: 604-268-6636 (direct), or 604-291-3146

.....

Yrjälä, Ann. 2005. *Public Health and Rockefeller Wealth: Alliance Strategies in the Early Formation of Finnish Public Health Nursing*. Åbo: Åbo Akademi University Press, Finland. ISBN 951-765-255-0, ISBN 951-765-256-9 (digital version, November 2005).

This thesis explores scientific philanthropy and its influence on the formation of public health and public health nursing in the early half of the twentieth century. The study focuses on analysis of the Rockefeller Foundation and public health in general and public health in Finland in particular. Furthermore, the study includes a case study of the planning, implementation and evaluation of a demonstration project in the Municipality of Helsinki (1940-44) as collaboration between Finnish

public health authorities and the International Health Division of the Rockefeller Foundation.

Drawing on the Sociology of Professions and the Sociology of Health and Illness and by linking particularly with scholarly work in the Nordic countries, the UK and North America on welfare state occupations, the author develops a neo-systems theories' approach on the formation of a women's occupation. The major research material consists of archival documents collected at the Rockefeller Archive Center in the U.S. and material describing the activities at a nurses' settlement, the Henry Street Settlement in New York, collected at the Library of the New York Academy of Medicine. A minor part of the research material is collected in Finland and consists of historical documents about the demonstration project in the Municipality of Helsinki. The collected documents consist of travel reports, official diaries and correspondence of the Rockefeller Foundation representatives working at the New York and Paris offices of the foundation related to the collaboration with the Finns. Moreover, the collected documents shed light on the foundation's worldwide fellowship program, its general program and policy documents concerning local public health in the U.S. and Europe and reports on nursing education of the time initiated by the Rockefeller Foundation.

The interpretative framework of qualitative historical sociology in the study is used to identify boundaries of the jurisdiction that was claimed by those actors who worked to professionalize public health nursing. In this so-called boundary-work setting the focus is on jurisdictional claims making concerning knowledge base and modes of practice for the new women's occupation of the time. Furthermore, administrative strategies are explored in the context of early welfare state building and shaping of municipal institutions such as health centres for public health nursing practice and its implications for the legislative institutionalization of this extended form of traditional nursing in Finland. The thesis describes the shift from sectionalized knowledge about public health nursing in the community developed and promoted by voluntary organizations towards a broader and more standardized and generalized public health nursing knowledge and practice as a central part of the interwar formation of Finnish national public health policy.

Ann Yrjälä
ann.yrjala@abo.fi

A Real World View of Private General Practitioners in Delhi

India's proportion of health expenditure from private sources is 78.7%, (among the highest in the world); of this 98.5% is out-of-pocket. The private sector is utilized by 79-85% of the Indian population, across quintiles, including poor and rich, urban and rural, for non-hospital care and also by 84- 94% of the morbid poor. *Thus it is an important source of health care not only for the rich but more importantly for the poor.* Private General Practitioners (PGPs) provide 60-85% of ambulatory health care delivery in India. Even so, they are neglected, looked down upon, criticized by academics, specialists, policy makers and the media and have never been the focus of research.

In-depth interactions were conducted with PGPs, (8+70 [of 71] in seven localities + other doctors) at their clinics and informal interactions with local pharmacists, representatives of pharmaceutical companies, and compounders. This was the first time that qualitative methods - essentially free-flowing and semi-structured interviews with observations - were used in a thesis from a medical academic institute in India. Through pilot fieldwork, we realized that interactions needed to be sensitively conducted to persuade doctors (1) to participate and (2) to share their real world, particularly as this could include potentially discreditable issues. In analysing and presenting the results, we essentially combine a systematic analysis of the practitioners' reported experiences and their views with an observation oriented view through the lens of a medical doctor researcher (me). Many methodological constraints were experienced.

The results describe 1) structural and operational barriers, the difficulties and uncertainties faced, braced and countered by private general practitioners in initiating, sustaining and continuing practice, 2) their professional isolation and marginalization, 3) their typical career trajectories, 4) reasons for inaccurate diagnosis, inappropriate therapeutics (like poly-pharmacy), 5) Underlying reasons for inadequate and inappropriate management of chronic diseases like diabetes and hypertension and 6) socio-economic differences

Multiple in-depth interviews were also conducted with nine patients, with type 2 diabetes, following up/or lost to follow-up with PGPs. We discerned: 4 typical patient movements (trajectories) which had common

barometric variables and reasons for their irregular/loss to follow-up. Analysis delineated 1) How market forces perpetuated situations, where the clinical care which patients received was broadly contingent on how well informed were the lay expectations in that particular locality. The disadvantaged sections of society were unknowingly becoming victims of their disadvantaged backgrounds. 2) Factors at the private primary level which: a) precluded delivery of clinically/professionally appropriate health care, b) eroded the scientific knowledge and prevented uptake of new knowledge in PGPs catering to non-affluent people c) worked against principles underlying chronic care. d) despite, non-affluent patients receiving cheap accessible health-care, "round the corner", perpetuated short-term symptomatic treatment practices with potential long-term harmful effects to individuals, families and communities.

Dr Shifalika Goenka

All India Institute of Medical Sciences, New Delhi

www.ichealth.org

shifgo@yahoo.com; sgoenka@ccdcindia.org

.....

BOOK REVIEWS

Komaromy, C. (Ed) 2001. *Dilemmas in UK Health Care*. 3rd edition. Buckingham: Open University. ISBN 0335208401. Pbk. £17.99.

As will become clear, this must be rather more than a review of book 7 of the 8 books comprising the core of the pioneering Open University course 'Health & Disease' (U205) that has run since 1985 (with the initial inspiration of Phil Strong among others) but was fully remade in 1994 and 2001. Some readers, like myself, may have acted as tutors on what is an impressively inter-disciplinary programme, including some sociology but also biology, epidemiology, demography, history, economics and a little psychology. They, like their students, will have been engaged and challenged by the breadth of material, and may have used texts and diagrams in their non-OU lectures and seminars.

Major topics covered by the volume reviewed here include; how NHS rationing decisions are made; dilemmas in health care management and resulting power tensions; problems of community care; divisions within formal health care labour; methods of evaluating health care; the significance of new medical technologies, and disease prevention (focusing on CHD). Although published several years ago, many of the issues raised remain important – for example, the shift of expertise towards patients is an important theme. As always the OU sets the highest standard in organizing and presenting the material, with clear text, diagrams and tables, plenty of space for annotations, interesting pictures, systematic references to the literature, recommendations for further reading, and a useful list of specific objectives and self-assessment questions concluding each chapter. Arguments are expressed clearly, and readers are often invited to make their own judgments before reading the authors'. The latter include specialists in health studies and policy, economics, industrial relations, epidemiology, biology and medicine. In other words, this is an excellent book.

However, the obvious criticism is that breathtakingly fast change in both society and the NHS, in knowledge and technology, makes this particular U205 book urgently in need of updating. Sadly such revision can never happen since the course itself will be finally and irrevocably withdrawn from the OU's menu at the end of 2007. Recently students have found it demanding in terms of time and intellectual challenge, and

recruitment has fallen off - though still about 500 in 2005. There has been little support among OU decision-makers for a further re-make that would inevitably involve commissioning and coordinating numerous experts from multiple disciplines. The key issue seems to be that while exceptionally wide-ranging in content, U205 has been funded purely by the Science Faculty, and this no longer wishes to spread resources so widely (or imaginatively).

Future students who might have taken U205 will be able to study a narrower new course (Introducing Health Sciences: SDK125), which includes very little sociology but takes a case study approach integrating epidemiology, human biology, biochemistry, a little physics and pharmaceuticals, cognitive psychology, and some health and social care issues. The decision of even a highly innovative university not to build on a highly regarded past success may indicate the strong institutional barriers still facing fully inter-disciplinary scholarship. Or is it simply the squeezing out of the deeply challenging issues and concerns that our own discipline can sometimes raise?

Richard Compton, Kings College London.

Cobb M. 2001. *The Dying Soul: Spiritual Care at the End of Life*. Buckingham. Open University Press. ISBN 0335 20053 2. Pbk £22.50.

In this book Cobb, an ordained Anglican minister, attempts to locate the definition and position of spirituality within palliative care. Spirituality is, he argues, the least explored and understood area of 'the palliative care quadrilateral' (the other 3 being psychological, physical and sociological). He states that spirituality exists as a familiar unknown, appearing to imply an absent but ever-present awareness existing along a life: death continuum that attains import when individuals are faced with death.

The aim of this book is to

“... explore the familiarly unknown fourth side.....which is a way of understanding and responding to the spiritual dimension of being human.” p.2

The book is divided into three sections: Chapters 1-3 consider theoretical dimensions, chapters 4-6 discuss the practice of offering spiritual care, the final chapter brings together the main themes discussed with a view to expanding current discourses concerning the role and delivery of palliative care.

It is interesting to note that the author is a co-founder of the national conference on spiritual care: Body & Soul. This book might be seen to be rehearsing debates that are the core elements of the conference. These debates serve to emphasise the problematic nature of discussion of that which is at once both unknown yet known, begging the question how might spirituality, an intensely subjective and personal entity, be theorised or theoretically located and then translated into practice?

Cobb's analysis leads him away from discussions centred on religion to areas of psychology, science, medicine and philosophy and includes a consideration of what he calls 'the New Age movement' with its philosophy centred within the notion of personhood. In doing so he inadvertently highlights the problematic of the concept of spirituality - it can be all things to all persons and this conundrum is further reinforced when he attempts to answer the question which is the title of chapter 4: *Who cares for the spirit?* One could reasonably ask - what is the spirit? Although acknowledging the ambiguities he continues with the analysis, a course of action, which arguably results in a circular discourse.

The problems raised within the theoretical domain are further emphasised when the position of practice is considered. Cobb articulates well the dilemma posed by the need to offer spiritual care - a qualitative dimension not conducive to measurement within a structured organisation such as the hospice, albeit one positioned to deal with death and dying. He acknowledges that spirituality informs and is informed by the discourse language and practice of palliative care whilst simultaneously recognising that abstract notions of 'the spirit' at times do not sit comfortably with the often perceived 'means to end' rationality of medical practice.

Historically the hospice movement was founded upon Christianity and within this context, spirituality was located within the religious domain. Cobb asks who provides the spiritual care within the essentially secular environment that is contemporary society, where hospices serve multiracial multifaith communities. He argues that today spirituality and spiritual care, the conflation is at times confusing, are the responsibility of the healthcare team....

“Spirituality is the proper concern of all those who have a role in patient care....” p.124

Yet he goes on to question the efficacy of the holistic philosophy he promotes earlier and instead champions the role of the clergy, as they are not compromised by professional (i.e. medical) decisions or vested interest, implying the possible existence of issues of beneficence and non-malificence. Locating issues of spirituality within an ethical dimension further demonstrates the problematic nature of the concept.

The concluding chapter *Developing spiritual care* serves to demonstrate the enormity of Cobb’s project when he argues

“...for the need to address both the subjective and objective aspects of spirituality both of carer and patient.” p.134

This book, whilst not offering concrete definitions and answers, does introduce the reader to wide-ranging debate on an issue we all have ownership of, yet rarely explicitly acknowledge. For those of us working within healthcare it serves to offer a point of and for reflection on our practice.

Calling for substantive discussion as to the constituent elements of spirituality and spiritual care demonstrates the existence of a need for what might be termed a ‘shared knowing’, a platform from which to launch subsequent discussion which allows recognition of the *praxis* necessary to facilitate integration of the practical and abstract aspects of spirituality.

Jessie Ferguson, University of Luton.

Davidson, J. 2003. *Phobic Geographies: The Phenomenology and Spatiality of Identity*. Aldershot: Ashgate. ISBN 0 7546 3244 X. Hbk £40.00]

Before opening a page of the book the sepia cover photograph struck me. This visualization of space leads us straight to Davidson's thesis. In her book analysing agoraphobic experience and meanings, Davidson dispels the popular misconception supported by dictionary definitions of agoraphobia as fear of open spaces. Instead, her study, conducted from a feminist geographical and phenomenological approach shows, through first-hand experiential accounts, how agoraphobia involves a temporary loss of self-identity and self-control usually in crowded social spaces, such as supermarkets and shopping malls. In this sense, the women agoraphobics who tell their stories to Davidson speak of their anguish and feelings of being trapped in particular and manufactured spaces, where the objectifying look of 'Others' can send them into a dizzy panic. Davidson asserts that there is no universal agoraphobic experience, nor strictly speaking any essential features. She borrows Wittgenstein's idea of a 'form of life' to address how she can account for, and understand, the commonalities of agoraphobic embodiment, without extinguishing differences between fellow sufferers.

After the introduction and opening chapter, which outline respectively the shape of the book and review the literature on, for example, the question of why agoraphobic subjects are primarily women, there are six further chapters and the conclusion. Davidson draws on clinical, geographical, sociological and architectural references, as well as geographical research on health, illness and disability to illuminate where the gaps and failings are, and which theory and therapy can help articulate sufferers' stories of spatial embodied anxiety. The research is defined as a 'work in progress' (or process), and is sufficiently reflexive of conducting ethnographic fieldwork, with women identified as experiencing anxiety and phobic panic. Davidson suppresses her own personal experiences of panic, which she only briefly alludes to in the text (chapter 2), and more on this would have been a useful addition to the book. However, the book shifts deftly between the intellectual thinking of Kierkegaard, Sartre, Goffman and Merleau-Ponty and the substantive issues, for example, the synergistic links in pregnant and agoraphobic experiences, "through a phenomenology of women's relations to social space" (p.107).

Although Davidson's intention is to provide non-clinical research into agoraphobia and anxiety, she cannot wholly disregard 'Western' biomedical conceptions of identity. For her respondents are diagnosed agoraphobics, willing to think of themselves in some contexts as 'sufferers' with a medical 'condition'. Those she contacts through self help groups are largely recovering. The book's strength lies in addressing the wider question of women's position politically and historically in terms of "boundaries, distance and location" (p. 24), and connects a higher incidence of agoraphobia in women to how they are expected to live their bodies in the world. For instance, chapter 1 refers to Lewis Mumford's *The City in History* and how the basic form of the agora or ancient Greek marketplace deliberately confined housewives to one part. While in chapter 7, discourse analysis of two self-help videos is useful in illustrating the disparities in the knowledges favoured by professionals in authority and sufferers to (re)present the reality of agoraphobia. Thus the analysis of self-help resources and critique of cognitive behavioural therapy re-emphasises the book's practical and geographical import to a diverse audience – "academics, health professionals and phobic others" (back cover).

Marian Hawkesworth, King's College, University of London.

Blank, R.H. & Merrick, J.A. 2005, *End-of-Life Decision Making*. Cambridge Mass: MIT Press. 9 780262 025744.

This book provides a fascinating insight into the nature of end-of-life decision making in twelve different countries, with diverse political systems, economic status, religious and cultural practices. It demonstrates the complexity of end-of life policies and the relationships between competing sources of moral and ethical reasoning and authority within the different countries. Issues in relation to euthanasia, palliative care and responsibility for decision-making are explored. Although in recent years, there has been a burgeoning of literature in relation to death and dying and end-of-life issues, there remains a paucity of comparative analyses in these areas. The book is ground-breaking in that the issues discussed here, have not previously been studied in some of the countries under review.

What becomes clear throughout this book is that there are both similarities and differences in the end-of-life issues that the twelve countries face and the policy responses that have developed within them. All countries are faced with ageing populations, an increase in chronic and life-threatening diseases, economic dilemmas in relation to health care and the need for palliation. For some countries, there are compounding factors, such as end-of-life issues in relation to younger people with HIV/AIDS in sub-Saharan Africa. Furthermore, ethical decision making is complicated by health care developments and varying degrees of technological development which have led to ambiguity around definitions of death.

The differences in relation to end-of-life decision making lie largely in policy responses which reflect degrees of secularisation, questions about the public/private interface of decision making and the extent of individual and familial autonomy and self determination within the country. Implicit within these various accounts is the notion of power and competing sources of moral reasoning and authority, although there is limited systematic analysis of the nature of this power and the relationship to structural factors and ideologies. A further identifiable difference between the various countries is the degree to which data is systematically collected about end-of-life issues (such as place of death, requests for euthanasia and assisted suicide, economic costs of palliative care). For some countries, there are fairly well established data sets, whilst for others, there is limited data, based on small locally based studies or no data at all. Thus, in the absence of more rigorous research, there is at times, a tendency to rely on anecdote and opinion. Whilst this provides the reader with useful insights, there is a danger of drawing conclusions from such limited data.

Overall, this book provides valuable insights into the complex nature of end-of-life decision-making and should be useful for students of medical sociology, health policy planners and ethicists. It provides a useful starting point for a more systematic comparative analysis of these important aspects of health policy and ethical decision-making.

Anne Llewellyn, Leeds Metropolitan University.

Shilling C, Mellor PA. 2001 *The Sociological Ambition: Elementary Forms of Social and Moral Life*. London: Sage. ISBN 0-7619-6549-1. Pbk £20.99.

Professors Chris Shilling (University of Portsmouth) and Philip Mellor (University of Leeds) have written a fine piece about the genesis, emergence and evolution of sociology as a science, that is distinct from philosophy, psychology, anthropology, or any other social science. It is not really a book that tells the complete history of the discipline, although there are many instructive elements about some of the European founders of sociology, especially Émile Durkheim and Max Weber. The authors rather want to explain how sociological thinking can help us in order to understand humans, groups, symbolic forces, social movements, societies, and socialization. They also raise a discussion about how the discipline has changed during 20th century. Right from the beginning, Shilling and Mellor explain their common goal: "The aim of this book is to provide an analysis, a comparison and overview of those classical theories that have sought to reconstruct the discipline's foundations (p. 1).

The book *The Sociological Ambition* has two main parts and twelve chapters on classical and post-classical sociology, from the early "Sacred sociology" (p. 40) to the late post/modern theory of some contemporary English scholars like Zygmunt Bauman and Anthony Giddens. The first chapters raise fundamental concepts and the initial visions of the first sociologists: Auguste Comte, who created the word "sociology", conceived his discipline as a religious project, while Émile Durkheim wanted to separate the "normal" and the "pathological" in social groups (see note 1, p. 54). Chapters in the second half present the current trends and recent works of less-known social scientists, and articulate (or oppose) their respective contribution with the thoughts of Durkheim, Simmel, Weber, Mauss. Current debates and issues (ethnicity, gender, class and social conflicts) are also analyzed in the chapters of the second part.

The authors of *The Sociological Ambition* focus mainly on social theory, so they only mention here and there a few examples directly related to health or medical studies. For instance in the sixth chapter titled "Normative sociology", they indicate how medical instrumentalism can be viewed "as dependant on the 'existence of congruent religious

orientations in the broader society'," according to the words of Talcott Parsons, whose works are often quoted in this book (p. 97). In the same chapter, Shilling and Mellor also refer to Parsons' famous demonstration about the relationship between the doctor and his patient, in an illustration of pattern-variables in structuring social roles (p. 101). In this case, they describe the doctor-patient relationship in sociological terms, borrowing Parsons' concept of social role that he forged from 1951: "While the sick role temporarily exempts an individual from normal duties, it imposes on them an obligation to seek out and co-operate with a doctor who is charged with facilitating reintegration into 'normal' life and conducting an important role of social control" (p. 101). Chapter 10 also brings a valuable account of recent trends in the rational choice theory (pp. 164 et sq.), and introduces the concept of "social contagion" (p. 169).

Shilling and Mellor's *The Sociological Ambition* is a dense and comprehensive account on current social theory, aimed for sociologists who want to get a general view about their discipline. It is not aimed to serve as an introduction to sociology, as a standard textbook would do. In a sense, what we find here is more like a reflection on sociology as a discipline rather than an analysis of society. Although it is a dense text of 237 pages, non-sociologists will probably be able to follow the authors since all concepts introduced are defined and situated.

Yves Laberge, Institut québécois des hautes études internationales

Gabe, J., Bury, M., & Elston, M.N. 2004. *Key Concepts in Medical Sociology*. London: Sage. ISBN 0 7619 7441 5 07619 7442 3.

In proposing to review this book, there was a welcome sense for me of 'coming home'. But in the event, I found it difficult to review, and I struggled with the delineation of 'key concepts' – 'the building blocks of the field of medical sociology'. Lain end to end, they do not add up to whatever it was that was so inspirational for me in the nineteen-seventies when I imbibed the ethos of the Social Research Unit at Bedford College. Perhaps I was mistakenly looking for 'those hallmark qualities of great sociological investigations' which contributed to the development of themes and explication of issues which are

encompassed by this set of short essays. If medical sociology is as much an approach as a framework for some kind of intellectual mapping, then it may be that the cement between the bricks counts for as much as the bricks themselves. I wondered how current students would use this book and what they would take from it.

It is no small task to review the origins of a concept or the background to an issue, provide an accurate account of its subsequent development, elaborating on a pithy definition, on controversies and variations in use, and then add an assessment of its 'significance to the field' - all in a few pages. Some of the essays are admirable in their breadth, clarity, excellent summation and vision of how research and intellectual exploration in the area might develop from now on. They are scholarly works that I would give to students without hesitation, and will, on occasion, delightedly revisit myself.

There are other essays that I found less than adequate representations of my understandings of the vast and important areas known as 'illness behaviour', 'informal care' and 'lay knowledge'. After all, these headings cover most health care, as Arthur Kleinman (1980) emphasised in his mapping of the 'Popular Sector' of the health care system. I felt that students would find it useful to be given a better sense of how they might use the understandings contributed by medical sociology in these areas, alongside those of health psychology, health promotion and medical anthropology.

There is a short introduction and then the book is divided into five parts: social patterning of health, experience of illness, health, knowledge and practice, health work and the division of labour, and health care organization and policy. With such a broad scope and with twenty-three contributors, it was inevitable that the essays would vary in standard and usefulness. This is perhaps a book to dip into in times of need, and be grateful if what you are searching for is covered by a gem of an essay.

T. Natasha Posner, University of Birmingham.

Katz J S and Peace S (Eds) 2003. *End of Life in Care Homes: A Palliative Care Approach*. Oxford: Oxford University Press. ISBN 0198510713. Pbk £24.95.

Could the principles and practices of palliative care help to improve the quality of care for older people dying in residential and nursing homes in the UK? This is the question that Jeanne Katz and Sheila Peace set out to answer in their edited text. As in other countries, the number of people dying in care homes in the UK is increasing. Yet, as this book clearly demonstrates, staff in these settings care for dying residents with very little training or guidance, and the significant developments made in pain control have not yet moved beyond the fields of hospice and specialist palliative care provision in hospitals.

The book draws on two Department of Health funded studies assessing whether the principles and practice of palliative care have permeated the ethos of residential and nursing homes, and the feasibility of applying appropriate aspects of palliative care to people dying in these settings.

Katz and Peace begin with an introduction to the history and principles of palliative care and details of the OU studies. In Chapters 2 and 3, Peace discusses the development of residential and nursing home care in the UK and Siddell and Komaromy look at who dies in these homes. In Chapters 4 and 5, Katz examines how dying is managed in homes in the UK, noting that most home managers questioned in the OU studies were unfamiliar with the concepts of palliative care.

Chapter 6 explores the way in which staff care for other residents and relatives following a death. Komaromy calls for recognition that the dying trajectory is part of a continuum, alongside a palliative care approach to help staff manage the boundary between living and dying.

The role of external health workers and the training needs of carers are discussed in Chapters 7 and 8. Katz addresses the important question of whether or not it is possible or desirable to apply elements of a philosophy developed in one setting to another and uses case studies to illustrate issues in relation to end-of-life care. Chapter 10 is concerned with people dying in long-term care facilities in the United States.

The final two chapters consider the social and policy context that has made the care of people dying in care homes an important issue (this, it could be argued, might more usefully have been dealt with in earlier chapters), factors affecting the provision of palliative care in nursing and residential homes, and directions for the future.

Katz and Peace identify considerable potential for the introduction of palliative care principles and practice into residential and nursing homes in the UK. Education, they argue, must be accompanied by support from managers and paradigmatic shifts in understanding concerning the purpose of care in these institutions.

Despite some overlap between chapters (difficult to avoid in edited texts) and occasional editorial oversights, this volume fills an important gap in the literature on death and dying and could usefully find its way onto the bookshelves of gerontologists, geriatricians, policy-makers and care home managers.

**Ann V Salvage, Freelance Researcher/Research Student at
Roehampton University.**

Durrant, R, Thakker J. 2003. *Substance Use and Abuse: Cultural and Historical Perspectives*. London: Sage.

Synthesizing an impressively diverse range (and vast amount) of existing scholarship, this book reiterates a lesson that has emerged from three or four decades of research by sociologists, anthropologists, historians, and comparative psychologists in the field of addiction studies: namely, that the problems (e.g., 'drug abuse', 'addiction', or 'dependence') associated with the consumption of psychoactive substances vary according to differing historical and cultural contexts. The point made, if not entirely new, is worth repeating: that adequate explanations of drug use and drug-related problems must take into consideration the interrelation of biological, psychological, social, and cultural aspects of human existence.

Comparing the understandings of different historical periods, among different groups of experts, and within different cultures (and subcultures), Durrant and Thakker demonstrate that even the most basic concepts of drug research are essentially contested. What is a

drug? What are the risks and harms of substances? What constitutes drug use and / or abuse? How can drug-related problems be managed or prevented? The answers to these sorts of questions – and indeed, the questions themselves – are formulated in dramatically different ways by different people at different times. This is made especially clear thanks to the numerous cases of drug use in non-Western contexts that the authors provide. Indeed, one of the most notable strengths of the book is that a consistent effort is made to include a range of substances (and the cultures that use them) that are frequently marginalized in overviews of addiction research. Such cases are not merely curious tidbits or colourful illustrations; they are in fact integral to the argument being made about the myriad variables that influence patterns of drug use.

Rendering evident the historical and cultural contingency of drug-related problems – the main thrust of the book – might be regarded by individuals within the field of addiction studies as an ‘exceptional achievement’ (as Tony Ward claims on the book’s back cover). But this insight will be considerably less astounding to many sociologists of medicine. That mental and physical conditions are bound within specific political, economic, and social contexts is not a startling revelation; moreover, other recent work on what might be called ‘pathologies of desire’ have perhaps done a better job of demonstrating the ways the categories of substance use and abuse take shape as a result of the interests of researchers, therapeutic professionals and industries, political programs, and regulatory laws (see, for example, work by Caroline Acker [2002], Helen Keane [2002], and Marianna Valverde [1998]).

But if *Substance Use and Abuse* is not a remarkable *sociological* achievement, it nevertheless offers a very useful and interesting overview of the field of addiction studies – especially insofar as it highlights the sorts of issues that continue to plague addiction researchers and professionals who have disciplinary (rather than interdisciplinary) or paradigmatic aspirations for their field. Although the authors make efforts to integrate the numerous ‘levels of analysis’ to be found within psychoactive drug studies, from the neurobiological and genetic perspectives of evolutionary theory to the socio-political rationalities of harm reduction and public health strategies, it is not at all clear what an ‘integrated perspective’ could resemble, other than a

tentative, hybrid assemblage of theories, techniques, and aspirations that are at best irrelevant to one another, and at worst, contradictory.

Overall, *Substance Use and Abuse* is an informative, clearly written text that would be useful to individuals interested in a reflexive, balanced account of the field of addiction studies from addiction 'experts' themselves. However, as a sociological resource *per se* – as a course text, for example – there are probably better choices out there.

Scott Vrecko, London School of Economics.

AGONY AUNT

Dear Aunt Marge,

Re: co-incidence

I experienced a different and less amusing co-incidence than the one that Edwin van Teijlingen described in the previous issue of *Medical Sociology News*. I am not a sociologist, but I have a relevant co-incidence which occurred when I was in labour with our first child. Getting ready for a home birth my husband, who is a medical sociologist with a particular interest in reproductive health, entered into an enthusiastic and animated sociological discussion with my midwife and GP about the organisation of maternity care in the UK.

Both the GP and midwife were very supportive of home birth, but as I was in the middle of having a baby, I felt that the discussion was slightly unreal. I was in labour for a long time as the baby was lying the wrong way round (i.e. face to pubes) and I couldn't help but note the irony of my situation. There I lay with very little progress in my labour, and the people around me mopping my brow and making encouraging noises whilst discussing the different aspects of British maternity care that needed to be conceptualised, problematised, demedicalised, prioritised, and so on. At least it helped pass the time!

Best wishes and good luck with the birth of the next MSN.

Mrs Smith from the Midlands
Mother of all discussions (and three children!)

Dear Aunt Marge,

I wonder if you noticed recently in the press a reference to a research study which had shown that older retired couples were choosing to spend their savings on holidays and high living rather than leaving their money for their children to inherit when they die¹. Even when they sold the family home, and down-sized to that idyllic cottage by the sea/in the country/ wherever, couples often spent the profit on themselves and their lifestyle. This of course has the advantage that fewer funds are

available to the government in the form of inheritance tax, but it means that the children - who are probably in their 50s or 60s when their parents finally die - receive less from their parents' estate.

This has left me, a poor senior lecturer on the point of retirement, with a dilemma. I want to spend all our hard earned savings on a really extravagant lifestyle for what may be the last few years that remain. My wife would prefer us to live modestly, some might even say frugally, and leave the bulk of our estate to our children who, I might add, are well established and successful in their own fields. Please help us to 'do the right thing'.

Your faithful servant on the horns of a dilemma.

1. Blackley, M. 'Inheritance? Sorry but we've spent the lot' *The Scotsman* 19th July 2005

Dear 'faithful servant',

You raised an interesting question, which may be of relevance to several UK medical sociologists. Those of the baby-boom generation, who came into medical sociology in the late Sixties and early Seventies, will now be close to retirement. Although I feel the advice you would be getting from *The Daily Records* money advisor might be more down to earth than what I can offer on the matter.

Sociologists have commented on the fact that we live in a more and more individualist society, and it seems ageing sociologists are no exception. Some would say in reply to your question that we are paying insufficient tax in this country to get the kind of health and social services we would want. Thus paying a wee bit more inheritance tax would be highly desirable, this would help your own children as well as other people's children. Others may say spend it all, but spend it wisely. Buy solar panels for your summer cottage, or 'invest' in a mobile health centre in Sudan.

My personal advice would be, do not spend it on the children. One of the great weaknesses of our society is that we try to guide and control our children far too much. Let them make their own fortunes and their

own mistakes, it is all part of a life-long-learning process. In any case, there will be plenty of sociologists who will have little left to pass on to their family after their meagre earnings have paid for the cost of their nursing home care in the last few years of their lives!

Aunt Marge

August 2005 (composed at a cottage in the South of France).

Dear Aunt Marge,

For many years I have subscribed to that wonderfully disrespectful organ *Private Eye*. Imagine my horror when I found in the 'Pseuds Corner' a reference to our very own *Sociological Research Online*.

However, upon reading the offending piece which was on the topic of 'showering' I had to agree that it was pure gobbledegook, the language clearly intended to obfuscate rather than elucidate. I feel embarrassed when I read some of what passes for sociology these days. Should we not be trying to make sociology relevant to a wider audience, perhaps even addressing real social problems rather than disappearing into an ever more refined (elite?) obscurity?

Yours truly

Old fashioned sociologist

Dear Old Fashioned,

I refer you to the interview with Sally Macintyre in this issue. You will note that she too worries about the increasing irrelevance of sociology to policy makers and the public. I feel that it might be the right time to open a debate on this issue. I look forward to hearing the views of others in future on-line versions of my column, assuming of course that the new team do not give me the sack!

Best wishes

Aunt Marge