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Editorial

Apologies first to the authors of our two papers in the last issue (Michael Bloor and Patricia de Wolfe), for some problems with the lay-out. If readers would like a 'cleaner' version of these papers, they can now download them from our web site at:

<http://www.lshtm.ac.uk/php/news6.pdf>

We also misspelt Patricia de Wolfe's name in the editorial, and left off her address for correspondence from the article (It's Flat 2, 7 Princes Rise, London, SE13 7PW).

We would like to remind contributors that copy should be emailed as an attachment if possible (to judith.green@lshtm.ac.uk). Michael Traynor then formats this text from scratch, by removing all the existing formatting (by turning them into text only files) and then importing the files into the page layout programme. Formatting has to then be re-entered into each paragraph in the newsletter. Because of this, please use tabs to build tables, rather than your word processor's table function. Original documents are used to guide on headings and other intended styles, but we cannot guarantee to maintain any particular formatting. If this is a problem (for instance if the paragraph indents are essential to the way you wanted it to look) then do get in touch before the copy deadline to discuss whether this is possible. Please also remember that we are editing Med Soc News in our own time, rather than as paid professionals, and we simply don't have time to send proofs back to authors for checking.

In this issue Professor Anne Rogers reviews a classic paper still cited more than 40 years after publication - Thomas Szasz's 'The myth of mental illness'. We also publish a draft Code of Publication Ethics for Sociology of Health & Illness, and have reports on the delegates' comments on the 2001 Med Soc conference and from the Sociology of Health and Illness editors. Many congratulations are due to three medical sociologists with recent PhDs - Karen Ballard, Paul Godin and Marilyn Meadows. We reprint abstracts of their theses. Finally Agony Aunt Marge has found a useful self-completion questionnaire for readers this week - on how to judge when it's time to look for a new job...

Finally, the last issue of this year should be the last one by this editorial team and we are looking for a new team to take on the work of editing Med Soc News. It has been an enjoyable experience, and one we can recommend to anyone thinking of taking over. It is a good way to both build links with the wider medical sociology community, and to have an excuse to meet with other sociologists within your institution. It is easiest if there is a small group of people within one institution, or at least close by, so you can divide the tasks up but keep in touch easily. If any groups or individuals are interested, do get in touch so we can tell you a bit more about what is involved.

The Editorial Team

British Sociological Association

Medical Sociology Group Call for Presentations

Annual Conference 2002

The 34th Annual Conference of the BSA Medical Sociology Group will be held on September 27th - 29th at the University of York.

The Plenary Speaker will be Dr Marina Barnard, Centre for Drug Misuse Research, University of Glasgow who will talk on

“Breaking into silence: the rude incursions of the sociologist”

Those wishing to present a paper must submit an abstract by April 26th 2002. Abstracts received after this date will not be considered.

Further details and abstract submission form available from:
British Sociological Association
Unit 3F/G Mountjoy Research Centre
Stockton Road
Durham DH1 3UR
E-mail: bsamedsoc@britsoc.org.uk
&
the BSA Medical Sociology group web site:
<http://www.britsoc.org.uk/about/msconf.htm>





THE COMMONWEALTH FUND HARKNESS FELLOWSHIPS IN HEALTH CARE POLICY



The Commonwealth Fund of New York is pleased to announce the Harkness Fellowships in Health Care Policy, and to invite applicants for the 2003-2004 fellowship cycle.

The Harkness Fellowships in Health Care Policy provides a unique opportunity for promising health policy researchers and practitioners (e.g., physicians, health services managers, government officials, and journalists) who are early in their career to spend six to 12 months in the United States conducting a policy-oriented research project and working with leading U.S. health policy experts.

Fellows must demonstrate a strong interest in health policy issues and propose a research study that falls within the scope of the Fund's national program areas. Among the issues the Fund addresses are improving health insurance coverage and access and improving the quality of health care services. Its quality programs focus not only on general issues but also on the needs of specific groups, including underserved populations, young children, and frail elders. Studies that include comparisons between the United States and the applicant's home country are encouraged.

The Fund will provide extensive support to successful fellows to help them develop and shape their research proposals to fit the U.S. context. Through its extensive network of contacts, the Fund will help identify and place fellows with a mentor who is an expert in the policy area to be studied. In collaboration with the U.K. Selection Committee, a home country mentor, who will act as a liaison with the U.S. mentor and supervise any cross-national comparisons that are to be conducted as part of the study, will also be identified after selection.

The deadline for receipt of applications is October 1, 2002. In order to apply, applicants must be a citizen of the United Kingdom, Australia, or New Zealand and submit a formal application. Up to nine Harkness Fellows in Health Care Policy will be selected annually.

Each fellowship will provide up to \$75,000 (U.S.) in support, which includes round trip airfare to the United States, a monthly stipend, support toward any portion of the study conducted in the home country, project-related travel and other research expenses, tuition for related academic courses, and health insurance. In addition, a family supplement is available to fellows accompanied by a spouse and/or children.

To obtain a brochure and application materials, please contact Robin Osborn, Director, International Program in Health Policy, The Commonwealth Fund, One East 75th Street, New York, NY 10021, United States (Telephone 001 212 606 3809, Fax 001 212 606 3875, Email ro@cmwf.org), or see The Commonwealth Fund's World Wide Web home page (<http://www.cmwf.org>).

CALL FOR NEW MEMBER FOR THE CHARTERED SOCIETY OF PHYSIOTHERAPY'S (CSP) SCIENTIFIC PANEL

The Chartered Society of Physiotherapy (CSP) represents Britain's 35,000 chartered physiotherapists, physiotherapy students and assistants. The Society combines the roles of professional body, educational body and independent trade union. The CSP administers research awards to members through a Scientific Panel. The Panel is composed of academics and clinicians who make decisions about the awarding of grants and awards for research and research-related activity carried out by physiotherapists.

A vacancy has arisen for a non-CSP member to join the CSP's Scientific Panel. The Panel administers the funds of the Physiotherapy Research Foundation (awarded annually) and the Robert Williams Award (awarded every four years). They also provide a peer review forum for abstracts submitted to the annual CSP Congress. The Panel meet twice a year, in November and April.

Applications for Panel membership are sought from individuals with expertise in qualitative research methodologies. It is anticipated that appropriate individuals are likely to have a background in a social science discipline (sociology or health psychology). Applicants need not be physiotherapists but some understanding of the work that physiotherapists undertake would be beneficial. Individuals must be able to make a valuable contribution to the work of the Panel and those with the following skills and/or experience are particularly welcome:

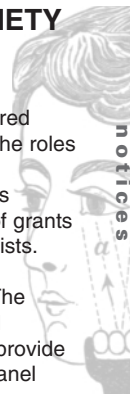
- * Knowledge/experience of a range of qualitative research methodologies
- * currently active in research
- * experienced in health services research
- * experienced in reviewing grant applications and manuscripts

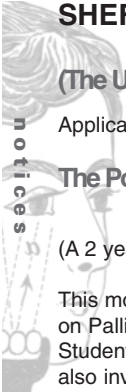
The term of office will be for four years. All travelling and subsistence expenses are paid for attendance at meetings.

Applicants should submit a copy of their curriculum vitae and a one-page statement, highlighting the expertise they would bring to the Panel.

The closing date for applications is Friday 10th May, after which they will be considered jointly by the members of the CSP's Scientific Panel and Research and Clinical Effectiveness Committee. The successful applicant will take up their position on the Panel on 1st September 2002 in time for the next round of applications. The first meeting of the Panel is scheduled for 18 and 19 November, 2002.

Applications should be sent to Marion Attew, Research and Clinical Effectiveness Unit at the CSP, tel 020 7306 6617, e-mail: attewm@cspphysio.org.uk.





SHEFFIELD PALLIATIVE CARE STUDIES GROUP

(The University of Sheffield and Trent Palliative Care Centre)

Applications are invited for:

The Postgraduate Programme in Palliative Care

(A 2 year flexible, part-time course beginning in September 2002)

This modular programme is designed for a multi-disciplinary student group and focuses on Palliative Care from a variety of perspectives.

Students may study for a Postgraduate Certificate, Diploma or Masters Degree, and are also invited to discuss the possibility of “attendance-only” arrangements for specific modules.

Further details from:

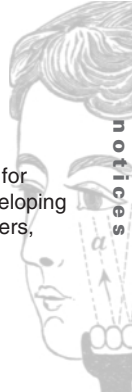
r Jane Seymour or
Professor David Clark
Trent Palliative Care Centre
Sykes House
Little Common Lane
Sheffield S11 9NE

Tel: 0114 262 0174 Fax: 0114 236 2916

Email: j.e.seymour@sheffield.ac.uk
d.clark@sheffield.ac.uk

Website: www.sheffield-palliative.org.uk

Day Courses in Social Research University of Surrey



1) Research Management

Presenter: Roger Tarling

Wednesday, 13 March 2002, 10.30 - 17.00

The course is for researchers who are beginning to assume greater responsibility for managing projects. It will identify the issues and problems which may arise in developing and conducting a research project, including relationships with sponsors and funders, planning and resource management, negotiating access, report writing and dissemination.

2) Qualitative Data Analysis, Methods and Software Tools

Presenters: Ann Lewins and Christina Silver

Tuesday and Wednesday, 30 April - 1 May, 10.30 - 17.00

This two day course addresses current methodological issues in qualitative data analysis. It provides an introduction to analysing qualitative data, drawing on multidisciplinary strategies and exploring the methods and processes of different perspectives. It considers the ways in which the tools provided by a range of CAQDAS software packages can be used to assist the various steps taken in analysing qualitative data. The two days consist of a combination of presentations, discussions and practical workshops, and is designed for researchers and postgraduate students.

Note: the course can only be taken as a two day unit.

3) Introduction to Focus Groups

Presenter: Ann Cronin

Wednesday, 8 May 2002, 10.30 - 17.00

This course is an introduction to the methods involved in organising and conducting focus groups and in managing and interpreting the data they generate. It covers planning, developing questions, moderating, analysing and reporting focus group results. The course also provides the opportunity for participants to experience being a member of a focus group. This course is designed for those people who have little or no experience of running focus groups.

4) Analysing Qualitative Data

Presenters: Geoff Cooper and Jo Moran-Ellis

5) Thursday 9 May, 2002, 10:30 - 17:00

This day course aims to familiarise participants with some of the theoretical and philosophical bases of a range of qualitative methodologies and analyses. Drawing on these foundations, it then goes on to introduce participants to practical and technical aspects of analysing qualitative data using a grounded approach. The course is intended for those looking for ways of analysing their own qualitative data.

6) Designing Samples for Surveys

Presenter: Sara Arber
Wednesday, 16th May, 2002, 10:30 - 17:00

The aims of probability and purposive sampling methods will be contrasted. The procedures of Simple Random Sampling, Stratified (proportionate and disproportionate), Cluster (multi-stage) Sampling and Quota Sampling will be examined, including the standard errors, costs and resources associated with each. Sampling frames and procedures for minimising non-response will be discussed

7) Attitudes and How to Measure Them

Presenter: Patrick Sturgis
Wednesday 22 May, 2002, 10.30 - 17.00

This one day course will provide an overview of theories of the attitude, drawing on research traditions in psychology, sociology and political science. Empirical approaches to attitude measurement and ways of assessing the validity and reliability of attitudinal data will be reviewed. Issues in attitude scale construction such as the optimal number of response alternatives, the provision of middle and don't know options and response sets will be discussed. The course will finish with a practical session in the computer laboratory using coefficient alpha to assess scale reliability.

Cost of the courses: £110.00 per person standard rate; £90.00 per person for educational institutions and charities; For the two day course (Qualitative Analysis, Methods and Software Tools) £180.00 per person standard rate; £160 per person for educational institutions and charities; for all courses there is a standby rate for full-time PhD students at £20 per person, per day. Standby places are not guaranteed, they are only available should there be places on the course.

Bookings can be made via the web page on
<http://www.soc.surrey.ac.uk/daycourses/dcindex.html> email:
day.courses@soc.surrey.ac.uk or telephone 01483 689458 and speak to Elizabeth Stutchbury

Social Sciences in Medical Education: National Interdisciplinary Workshop

Supported by C-SAP The Centre for Learning and Teaching - Sociology, Anthropology and Politics, Part of the LTSN - Learning and Teaching Support Network

27-28 June 2002 University of Durham, Stockton Campus (George Stephenson College)

With projected expansion in the numbers of medical students and the establishment of several new medical schools (e.g. Peninsular, East Anglia, Sussex) and new joint ventures (e.g. Newcastle/Durham; Leicester/Warwick; Manchester/Keele), medical sociologists are increasingly being drawn into the teaching of social science to medical trainees. This workshop aims to bring sociologists and anthropologists already involved in teaching social sciences in medical education, and those who may become such teachers in the future, together to discuss common principles and devise shared goals.

Medical education aims to “foster the development of a caring, knowledgeable, competent and skilful medical graduate who broadly understands health and disease of the individual, the family and society, and who is able to benefit from subsequent medical education and adapt to future developments in practice”. Such graduates should also have “respect for patients and colleagues that encompasses, without prejudice, diversity of background and opportunity, language, culture and way of life” (GMC Tomorrow’s Doctors, 1993).

What is the current and future role of the medical anthropologist or sociologist in this task? The aim of this workshop is to provide a forum for sociologists and anthropologists actively engaged in medical education, to discuss shared pedagogical approaches and curricular materials and pursue common goals to enable fulfilment of this role. It is the first step towards the development of a network of social scientists working in medical education that will feed into larger policy initiatives in the field.

For further information contact:

Dr. Andrew Russell
University of Durham
Department of Anthropology
43 Old Elvet
Durham, DH1 3HN

Telephone: 0191-374-7203
Fax: 0191-374-2870
E-mail: A.J.Russell@durham.ac.uk





2nd Annual Sociology of Cancer Study Group Conference

Thursday 28 March 2002 University of Warwick

This conference seeks to explore research that focuses on peoples' experience of cancer, the ways they - patients, carers, families and friends - make sense of the illness and strategies that they adopt to live with cancer. We welcome submissions from researchers that work on any aspect of cancer and from wide array of disciplines and institutional contexts. We are also happy to provide space for posters should people wish to submit them.

The conference includes both formal refereed papers as well as workshops based on pre-circulated articles and papers. These workshops are intended to promoted discussion, sharing experience and the development of conceptual and theoretical ideas.

Provisional Programme

9:00-9:30	Registration and Coffee
9:30-11:00	Paper Session 1
11:00-11:15	Coffee
11:15-12:45	Paper Session 2
12:45-2:00	Lunch
2:00-3:30	Parallel Workshops based on circulated articles Workshop One The impact on the researcher of studying cancer Workshop Two Ethics Committees: Challenges and dilemmas
3:30-4:00	Workshop feedback, General Discussion and Closing
4:00-4:30	Tea

Conference Fee £15 including lunch and refreshments. Student discount available
To register, submit an abstract or for further information contact:

Dr Jonathan Tritter
Department of Sociology
University of Warwick
Coventry CV4 7AL UK

Or email J.tritter@warwick.ac.uk

Or see our the Group website
<http://www.warwick.ac.uk/fac/soc/Sociology/staff/cancerR.doc>

ROYAL HOLLOWAY, UNIVERSITY OF LONDON DEPARTMENT OF SOCIAL AND POLITICAL SCIENCE

MSc in MEDICAL SOCIOLOGY

MRC STUDENTSHIPS AVAILABLE FOR FULL-TIME STUDY in 2002/3

Applications are invited for this well-established course which aims to equip students to undertake social research in health and health care.

The course may be taken over 50 weeks full-time or 100 weeks part-time (daytime classes normally 1 day per week).

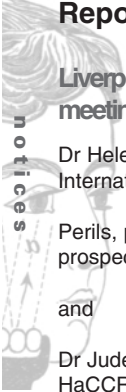
Course units comprise Sociology of Health & Illness, Health Care Organisation, Theory & Methods of Social Research and Quantitative Methods for Postgraduates. Assessment is by coursework, take-home essay papers and a 10,000 word dissertation.

Candidates should have or expect to obtain a good first degree in sociology, a related Discipline, or in an interdisciplinary programme including a substantial element of sociology. Applications from students with appropriate professional qualifications will be considered on an individual basis. Applicants wishing to be considered for an MRC studentship are advised to apply as soon as possible, and preferably not later than April.

Further details and application forms can be obtained from the Postgraduate Secretary in the Department of Social and Political Science (email claudia.boscolo@rhul.ac.uk Tel 01784 44368) or from our website at <http://www.rhul.ac.uk>.

Informal enquiries should be addressed to the Course Director, Dr Mary Ann Elston. Email m.elston@rhul.ac.uk, or Tel 01784 443688. The Department also has an active PhD programme. Informal enquiries should be directed to Dr Jonathan Gabe, Director of Graduate Studies, email j.gabe@rhul.ac.uk, Tel 01784 443144.





Reports from regional and national groups

Liverpool (BSA) Medical Sociology Group have two meetings planned. The first meeting, on Friday 15th March 2002 consists of two short papers:

Dr Helen Bromley
International Health Division, Liverpool School of Tropical Medicine

Perils, pitfalls, predicaments and possibilities:
prospects for cross-cultural qualitative health research

and

Dr Jude Robinson
HaCCRU, University of Liverpool

Deconstructing and reconstructing professional
identities within primary care

The second meeting will take place in May:

Professor Steve Harrison
Department of Social Policy, University of Manchester

New Labour, medicine and the new bureaucracy

Friday 17th May 2002

All meetings will be held in Room B.09. Basement of the Whelan Building, Quadrangle, University of Liverpool. All are welcome, and refreshments will be provided at the meetings.

For further details, and if you would like to be added to our mailing list, please contact Jude Robinson, LMSG, HaCCRU, University of Liverpool L69 3GB, or email j.e.robinson@liv.ac.uk

British Sociological Association London Medical Sociology Group - 2002 Programme

Venue

King's College London, Room 1.16, Franklin Wilkins Building, Stamford Street, London SE1 8WA.

Nearest tube and rail: Waterloo

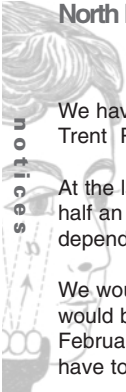
MEETINGS 6PM - 7PM



13 March	HRT: A lifestyle drug?	Karen Ballard King's College, University of London
10 April	Dereifying methods: studying social structure in the health arena	Graham Scambler UCL, University of London
8 May	Immunology, genetics, and SLE: Looking at an autoimmune disease from an anthropological point of view	Andrea Stöckl Cambridge University
12 June	Health in the media	Clive Seale Goldsmith's College, University of London
10 July	Genetic susceptibility and identity - a case study of haemochromatosis	Paul Atkinson Cardiff University
11 September	The social construction of health behaviour	David Armstrong King's College, University of London
9 October	Moral issues in GP consultations	Kathryn Ehrich King's College, University of London
13 November	Risk thinking in psychiatric wards City University	Jaqueline Davies, Paul Godin & Bob Heyman
11 December	Christmas social	(all welcome)

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.

For further copies of this programme please contact Paul Godin 020 7040 5933. To receive details of all LMSG meetings by e-mail contact Mark Newman, m.newman@mdx.ac.uk or visit the BSA website: britsoc.org.uk/about/medsoc.htm Joint LMSG Organisers: Richard Compton, Paul Godin (Convenor), Rachel Grellier, Bairbre Kelly, Chris McCourt, Mark Newman, Susan Robinson & Margaret Rogers.



North East and Midlands Group

We have scheduled a seminar afternoon for July 17th 1-4.30pm. This will be held at the Trent Palliative Care Centre.

At the last meeting there were four speakers who each presented their work for about half an hour, leaving time for discussion between slots. This seemed to work well and, depending on your response, we will probably run with the same format.

We would be very grateful if you could indicate whether you want to attend and if you would be able to present a paper or discussion topic. Please contact us by the end of February to enable us to put together and distribute a detailed programme. Places may have to be limited due to space

Please contact: Pauline Hutchinson 0114 2620174 fax 0114 236916 email spcsg-conferences@sheffield.ac.uk

Scottish Medical Sociology Group

On the 1st February 65 delegates participated in a one-day conference on the topic Ethical Issues in Social and Health Research held at Glasgow Caledonian University. Speakers explored a range of ethical issues in social and health research and contributors focused upon practical and theoretical issues in contemporary research. Whilst contributors drew upon their own particular specialist area of research, the ethical dilemmas and challenges raised were applicable to all areas of sociological enquiry.

Mairi Levitt, Centre for Professional Ethics, University of Central Lancashire opened the conference with a presentation entitled 'Better together? Philosophical and sociological perspectives on ethics in research'. She considered the distinct theoretical underpinning to ethics and the social construction of ethical issues and debates. The legal dimension of research ethics was addressed by Sarah Elliston, Department of Law, University of Glasgow. She reflected upon the relevance of the Adult Incapacity (Scotland) Act 2000, Mental Health Act, 1984 and Children's Act for researchers and research participants.

The morning ended with a consideration of codes of practice and Joan Orme, Professor of Social Work, University of Glasgow, introduced the new Code of practice for social work research and delegates considered these developments alongside the BSA review of the ethical practice statement.

In the afternoon presentations considered Ethical issues in research with people with learning difficulties, Kirsten Stalker, Senior Research Fellow, Social Work Research Centre, University of Stirling, Consent and Older People: from Ritual to Relationship Jan Dewing, Consultant Nurse, Milton Keynes PCT & General NHS Trusts and Associate Fellow Royal College of Nursing, Getting Blood out of a Stone? The Ethics of Research with Young People, Janet Shucksmith, Centre for Educational Research, University of

Aberdeen. A theme that ran through all three presentations was the socio-political positioning of some groups of research participants and that these groups were often thought to require a deficit model of consent. Yet good research practice and codes of practice combined with constant reflection upon power differentials between the researcher and researched provided ways forward.

Delegates were drawn from a range of academic departments and universities, NHS primary care trusts and health boards and research divisions within the Scottish Executive. Debates focused upon consent and the potential to share good practice with other researchers and ethics committees. This conference was as a summative point in the group's consideration of ethics, with three half-day seminars held last year. However, the group will continue to monitor developments in Scotland with ethics committees and legislation.

In the coming year the group will consider data archiving and the first of these sessions will be:

Data Archiving: Whose data are they anyway?

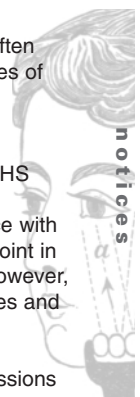
Odette Parry, Research Unit in Health, Behaviour & Change, University of Edinburgh
Polish Seminar Room, Medical Library, University of Edinburgh
1.30 - 4.pm Friday 22nd March

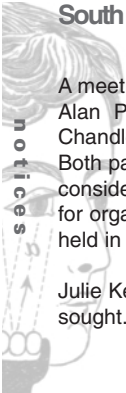
Odette Parry has presented the following abstract for her seminar:

'Research data are increasingly perceived to be, and treated as, 'global commodities'. Hence, data, once treated as the private property of individual investigators, are now being made available to the international research community. Although the majority of data archives, world wide, deal exclusively with the storage and provision of quantitative data, Denmark and the UK have set up qualitative data archives. There has, however, been some resistance among qualitative researchers in the UK who have raised concerns regarding the deposit and re-use of qualitative data. Archiving raises a number of ethical issues for both quantitative and qualitative researchers particularly in respect of the ownership and control of data. While they have received inadequate attention within the discipline of sociology, we may find the example of other disciplines like oral history, who have a long tradition in archiving, to be a useful resource in addressing these complex issues'.

The Polish seminar room is in the basement of Erskine Medical Library, George Square, Edinburgh. If you require further details on how to get there please look at the website: <http://www.streetmap.co.uk>. For organisational and catering purposes we would appreciate it if you could indicate whether or not you can join us by emailing one of us. Please note that there will be a small charge for tea and coffee.

Gill Hubbard (gill.hubbard@stir.ac.uk) and Linda McKie (l.mckie@gcal.ac.uk)





South West Regional Group

A meeting was held at the University of Plymouth on Saturday November 24th when Prof Alan Petersen talked about his research on the new genetics & subjectivity and Joan Chandler presented a paper mapping out her research interests in 'solo living' and health. Both papers provoked a useful discussion and raised many issues for further consideration. Many thanks to both the speakers and to Linnie Price and Tracey Collett for organising the event. We hope that the next meeting in spring/summer 2002 will be held in Exeter.

Julie Kent is standing down as convenor of the group and a new convenor is now being sought.

PhD Abstracts

Karen Ballard (Department of Social and Political Science, Royal Holloway, University of London)

Women on the verge of HRT: Factors influencing women's decisions about taking hormone replacement therapy.

Over the past twenty to thirty years there has been an increased number of women using hormone replacement therapy (HRT), both during and after the menopause. While there is a tendency to interpret this as medicalisation of the menopause, the role that women play in the use of HRT also needs to be explained. This thesis critically evaluates the concept of medicalisation and its application for explaining women's increased use of HRT. Integrating social factors within medicalisation, using both qualitative and quantitative methods, the process, the potential, and the extent to which medicalisation of the menopause occurs through the use of HRT, is examined.

The data illustrate that although the menopause went through the process of medicalisation long before HRT became available, the discovery of oestrogen increased the potential for medicalisation. However, a variety of social factors, both limit and augment the extent to which medicalisation occurs. Thus, while women are knowledgeable about the use of HRT for the prevention of diseases such as osteoporosis, they often do not take the therapy for this purpose because they perceive themselves to be at minimal risk. In addition, women are aware of the image of HRT as the 'elixir of youth', yet their beliefs about their aging image means that they rarely wish to take the therapy for this purpose. Moreover, women's beliefs about medicines shape their views about HRT and its uses. However, the conflicting and changing nature of medical knowledge surrounding HRT often leaves women feeling uncertain about treatment decisions. Being viewed as the medical 'expert', doctors are frequently consulted for advice and often influence women's use of HRT.

Karen Ballard
Course convenor for MSc in General Practice
Guy's, King's & St Thomas' School of Medicine
King's College London





Marilyn Meadows (Department of Sociology, Anglia Polytechnic University:

Supervisors: Professor Michelle Stanworth and Dr Shirley Prendergast

Birth control in local context: the diffusion of information and practice amongst groups of women in contemporary Cambridge.

September 2001

Women have long used a variety of practices to shape their fertile capacities. However, today in this country the most effective forms of contraception are only available from medical practitioners. While medicine considers the contraceptive consultation as a place where experts advise and women patients uncritically accept suitable contraceptive means, feminists describe it as a site of domination where medicine imposes patriarchal constraints upon women's bodies. Neither position has room for women as active negotiators within the consultative process.

This thesis seeks an understanding of how women acquire, share and deploy contraceptive knowledge. Four differently located groups of women were questioned about sources of contraceptive learning and experiences of contraceptive access. Findings suggest that over time all women gathered contraceptive understandings from a variety of sources. The least valued sources were parents, partners and doctors whilst the most valued involved independent learning through reading and the exchange of experiences with other women.

However, women of different ages and from different backgrounds commanded qualitatively different resources. These differences had implications for medical encounters. In general, more highly educated women with more access to medicalised sources felt better able to negotiate on common ground. The less highly educated women were more likely to depend upon establishing 'trust' with their doctors. None of the women were passive; all manipulated medical encounters in pursuit of their own contraceptive preferences.

Whilst differences must be addressed, the key finding of this thesis is that, whatever their resources, all women actively deploy their accumulated knowledge within the medicalised contraceptive consultation. This finding has important implications for both feminism and medicine. For feminism it offers a better understanding of women resolutely seeking to control their fertility in effective ways, using the differential resources they have to hand. For health professionals it presents a challenge. The contraceptive consultative process would be far more effective if women were recognised, accepted and involved as active shapers of their own conceptive destinies.

Paul Godin Department of Sociology, University of Essex

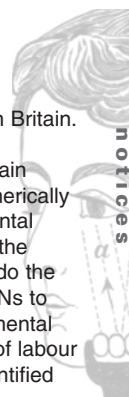
Supervisors: Joan Busfield & Colin Samson

Doing the frontline work: A historical sociology of community psychiatric nursing in Britain.

This study traces how community psychiatric nurses (CPNs) first appeared in Britain during the 1950s and then grew unremittingly in number to become the most numerically dominant occupational group within the workforce of the specialist community mental health services. Though strategies of professionalisation can be identified within the development of CPNs, their history is rather characterised by their willingness to do the work that other occupations would not or could not do. This not only enabled CPNs to grow in number but also ensured that they worked at the frontline of community mental health care, in an equivalent position within mental health care services' division of labour to that of traditional mental hospital nurses. Thus features of asylum nursing, identified by sociologists in the mid-twentieth century (Hughes, Goffman, Etzioni), still have relevance to understanding the work of CPNs today.

In the half century of CPNs' existence the nature of their work has altered along with the development of mental health care services. This thesis explores how these changes can be understood as being related to changing modes of production and governmentality within broader society. The growth of CPNs in the 1970s was largely predicated upon the work of injection administration that was organised as a homogenous block treatment. As a new framework of community care developed in the 1990s CPNs became key operatives of the 'Care Programme Approach', a more individualised, flexible and consumer orientated method of care. This is one of many ways in which the work and development of CPNs can be understood to reproduce the transition from Fordist to post-Fordist methods of production. Furthermore, changes in mental health care and the work of CPNs can be understood as reflecting the changing nature of governmentality within liberal society, such that today CPNs may be regarded as operatives within what Castel calls the 'epidemiological clinic'. As such they are now primarily concerned with the risk assessment and risk management of their clients. Such changing methods of production and control are particularly apparent within the frontline work of community mental health care, which is largely undertaken by CPNs.

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Sociology of Health and Illness Editors' Report

24th September 2001

Submissions

Between April (6th) 2001 and September (11th) 2001 we received 51 new papers and 27 revised papers and decisions were as follows:

	Acc	Acc	Acc	Rej	Rej	Waiting	Waiting	Total
	Minor	Subs	Resub			Refs	Eds	
New								
Sept 01	-	-	2	3	10	29	7	51
April 01	3	-	2	10	7	14	9	45
Sept 00	-	1	1	9	20	24	2	57
Revised								
Sept 01	9	1	3	1	5	7	1	27
April 01	7	-	2	4	11	4	1	29
Sept 00	8	3	1	-	3	7	2	29
Total								
Sept 01	9	1	5	4	15	36	8	78
April 01	10	-	4	14	18	18	10	74
Sept 00	8	4	2	9	23	31	4	81

Submission by Country:

	UK	Rest of Europe	North America	Australia & NZ	Other	Total
New						
Sept 01	28	7	10	4	2	51
April 01	16	11	14	3	1	45
Sept 00	31	6	7	5	7	56
Revised						
Sept 01	12	3	5	4	3	27
April 01	15	7	4	2	1	29
Sept 00						
Total						
Sept 01	40	10	15	8	5	78
April 01	31	18	18	5	2	74
Sept 00	52	9	7	6	7	81

Refereeing and Publishing

Between April and September 2001 the number of new and revised papers submitted remained constant, in comparison with previous totals. Viewing submissions by country, we have seen an increase in the proportion of papers submitted from the UK in the past six months, echoing levels of the April - September time frame the previous year. The number of submissions from North America continues to remain strong. The Editorial team will continue to monitor this situation with regard to managing Journal publication over the RAE cycle, but it is likely to lead to increased competitive pressure at certain times. The Journal Editors have recognised that indexing in Medline is a crucial step in future Journal plans, and especially important for Journal recognition within North America, and advise of their intention to submit a bid for inclusion later this Autumn.

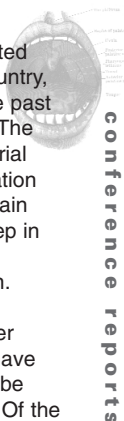
We have noted significant changes in refereeing behaviour over the Spring/Summer period. Not only have referees taken longer to send their reports, many referees have been unable to send reports at all. However, the reasons for this would appear to be largely seasonal in nature (the exam marking period followed by the long holiday). Of the 52 (45) new papers received over the last six months, 17 (7) have been returned by at least one referee.

The move towards electronic publishing continues apace. The software for the Electronic Editorial Office (EEO) is in a second phase of development, and we are aiming for it to be demonstrated to the SHI Editorial Board at the meeting next Easter. Potentially, the referee function will be one of the areas significantly streamlined by the introduction of the EEO. It is expected that this will be implemented in the course of next summer.

The Editorial team would like to take this opportunity to offer thanks to

- * The Royal Holloway editorial team, for the smooth and efficient management of the editorial transition.
- * Ellen Annandale for the commitment and energy she has shown in her role as Chair of the Editorial Board.
- * Many thanks are also due to Lindsay Prior, who as Book Review Editor will be very much missed.
- * We would also like to thank the other departing Board members, David Hughes and David Blane, both of whom have made major contributions to the continuing success of the Journal
- * Continuing Board Members, for their support and guidance, as we look forward to Volume 24.
- * All those members of the Medical Sociology community who so generously support the journal in refereeing work.

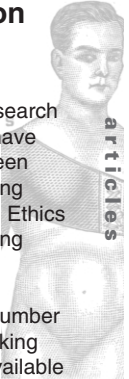
The Editorial team would like to advise of the co-option of Linda McKie and Andrew Webster to the Editorial Board in October 2000. Judy Green was re-elected for a second term in September 2001 and Jonathon Tritter elected onto the Board at the same time. The Journal is also pleased to announce the appointment of the new Chairperson (Judy Green) and the new Book Review Editors (Carol Emslie and Susan Gregory).



Congratulations to Derrol Palmer, University of Huddersfield (previously University of York) who is the winner of this year's New Writer's Prize. The judges were pleased to commend the general standard of papers shortlisted this year.

Robert Dingwall, Veronica James, Elizabeth Murphy, Alison Pilnick
18th October 2001

Sociology of Health and Illness: Statement on Publication Ethics



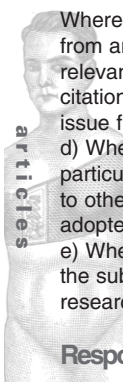
As many readers will know, there is a growing debate in medical journals about research misconduct and publication ethics. The Editors of Sociology of Health and Illness have been monitoring these developments and the model codes of practice that have been emerging. With the agreement of the Editorial Board, they have drafted the following Code of Publication Ethics for SHI. This is based on the Guidelines on Publication Ethics produced by the Committee on Publication Ethics, representing the editors of leading medical journals (www.publicationethics.org.uk). It has, however, been modified in various ways to reflect the different circumstances of sociological research and publication and to give it a more user-friendly format. This development raises a number of important legal issues for the Foundation and the publishers and they are still taking advice on these. However, we thought that it would be useful to make this draft available for wider discussion in the medical sociological community. Subject to any legal considerations, it will be adopted in substantially this form and piloted over the next two years. Comments and suggestions for improvement will be welcomed and either the present editors, or their successors, will review and revise the Code in 2004 in the light of experience and feedback.

This statement is based on the Guidelines on Publication Ethics published in 1999 by the Committee on Publication Ethics (COPE), representing most leading medical journals, with modifications appropriate for social scientific work. Further information about COPE can be found at www.publicationethics.org.uk/. This statement will guide the editorial team, the editorial board and referees in their approach to any ethical issues arising in respect of papers submitted to Sociology of Health and Illness. It seeks to distinguish between issues of responsible professional behaviour, to be promoted by editors, board and referees, and misconduct, possibly deserving formal censure by the scientific community.

Rights of Research Participants

Research participants have fundamental rights to privacy and to make autonomous decisions about whether or not to take part in studies. SHI aims only to publish research that shows respect for these rights and the editors will question as possible misconduct any submission suggesting that these rights were unjustifiably breached.

- a) Where research participants are recruited from among patients or by means of health system sources or health system records, formal and documented approval from an appropriately constituted research ethics committee is required in accordance with national laws and regulations. Authors need not submit this documentation routinely but it must be made available to the editors on request without unreasonable delay.
- b) Where research participants are recruited by other means, approval from an appropriately constituted research ethics committee is not required, except where national laws and regulations direct. However, authors must be prepared to show that their work meets appropriate ethical standards, possibly by reference to the published code of a relevant professional association. Authors need not submit this documentation routinely but it must be made available to the editors on request without unreasonable delay.
- c) Fully informed consent should always be sought where possible and appropriate.



Where this is not possible, authors should justify this decision by reference to approval from an appropriately constituted research ethics committee, the published code of a relevant professional association, by explicit discussion in the submitted paper or by citation to other reasonably accessible publications from the research that discuss the issue fully.

d) Where participants are unable to give fully informed consent, researchers have a particular responsibility to demonstrate and document in a submitted paper or by citation to other reasonably accessible publications from the research that their research has adopted a high ethical standard.

e) Where covert research or deception is involved, authors must explicitly justify this in the submitted paper, or by citation to other reasonably accessible publications from the research that discuss the issue fully.

Responsibilities of Authors

1) Who is an Author?

There is no universally agreed definition of authorship. To avoid disputes over attribution of academic credit, it is helpful to decide early on in the planning of a research project who will be credited as authors and who will be acknowledged. In a multidisciplinary project, it is also likely to be useful, at the same time, to identify the relevant professional codes of ethics and to consider any potential conflicts. In matters concerning authorship, the editors will give particular attention to the policy statements of the British Sociological Association, <http://www.britisoc.org.uk/about/author.htm> and the MRC Social and Public Health Sciences Unit, <http://www.msoc-mrc.gla.ac.uk/Reports/PDFs/Publications/AuthorshipPolicy.pdf>. However, certain general points apply.

a) The award of authorship should balance intellectual contributions to the conception, design, analysis and writing of the study against the collection of data and other routine work. If there is no task that can reasonably be attributed to a particular individual, then that individual should not be credited with authorship.

b) All named authors must take public responsibility for the overall content of their paper. Where the paper involves multidisciplinary work, individuals may identify their particular contributions but remain collectively responsible for the overall result, particularly in relation to compliance with the principles set out in this statement.

c) The identity of the principal investigator should always be clear or provided to the editors on request without unreasonable delay. Although he or she need not be named as an author, the principal investigator is always ultimately responsible for the ethical standards of research projects under his or her jurisdiction.

2) Study Design

Research participants have a right to expect that the studies in which they are involved are carried out to appropriate standards of scholarship. Poor quality research is inherently abusive of participants and, hence, unethical. SHI editors and referees will seek to ensure that published papers promote a high standard of scholarship in sociology.

a) Research should have a clear and documented design or strategy directed to specific and justifiable questions rather than being an unguided trawling for data.

b) Where relevant, statistical issues should be considered early in study design, including

- power calculations, to ensure that there are neither too few nor too many participants.
- c) All contributors and collaborators, including participants where appropriate, should agree the design or strategy.
 - d) The design or strategy should be clearly described in any publication and available in full to any legitimate inquirer.



3) Data Analysis

Research participants have a right to expect that data will be appropriately analysed, although inappropriate analysis does not necessarily amount to misconduct. SHI editors and referees will seek to ensure that published papers promote a high standard of scholarship in sociology. Fabrication and/or falsification of data do, however, constitute misconduct, although both must be distinguished from the legitimate editing of qualitative data to protect the identities of research participants. This constitutes misconduct only if its net effect is to alter the substance or evidential value of the data involved.

- a) All sources and methods used to obtain and analyse data, including any electronic pre-processing, should be fully disclosed to the extent consistent with protecting the identity of individual participants or research sites where anonymity has been offered; detailed explanations should be provided for any exclusions.
- b) Methods of analysis must be explained in detail and referenced, if they are not in common use.
- c) The post hoc statistical analysis of subgroups is acceptable, as long as this is disclosed. Failure to disclose that the analysis was post hoc is unacceptable.
- d) The discussion section of a paper should mention any issues of bias that have been considered, and explain how they have been dealt with in the design and interpretation of the study.

4) Plagiarism

Other scholars have a right to expect that any use of their ideas or data will be given proper credit. Plagiarism ranges from the unreferenced use of others' published and unpublished ideas, including research grant applications, to submission a complete paper, sometimes in a different language, which is 'passed off' as the work of the person submitting it rather than the original author. It may occur at any stage of planning, research, writing or publication; it applies equally to print and electronic versions. All sources must be disclosed, and, if large amounts of other people's written or illustrative material are to be used, permission must be obtained and presented to editors. Authors are responsible for any costs involved in this. Plagiarism will always be considered as possible misconduct.

5) Redundant Publication

Redundant publication occurs when two or more papers, without full cross-reference, share the same hypothesis, data, discussion points or conclusions. It is accepted in an interdisciplinary field like medical sociology that it will often be appropriate to publish similar material in journals with different readerships so that findings receive appropriate dissemination. The problem occurs when this is not acknowledged through relevant self-citation, giving a misleading impression to readers. Redundant publication can only constitute misconduct if there is a breach of the following principles and there is a deliberate deception of editors, referees and readers.

- a) Published studies do not need to be repeated unless further confirmation is required. In sociology, however, it is recognised that knowledge often advances by the cumulation of small-scale studies under different social and environmental conditions and that social or cultural changes over time may make it appropriate to repeat previous studies. What is important is that the new work is clearly justified and related to previous studies in order to show what it has added to knowledge.
- b) Previous publication in the proceedings of a conference does not preclude subsequent submission for publication but should be disclosed to editors at the time of submission.
- c) Re-publication of a paper previously published only in a language other than English will be considered, provided that this is fully disclosed to the editors at the time of submission and acknowledged in any published version. The authors will be responsible for obtaining any necessary copyright clearance and meeting any costs involved in this.
- d) At the time of submission, authors should disclose details of related papers, even if in a different language, and similar papers forthcoming or in press.

6) Conflicts of Interest

Conflicts of interest are those of an author's commitments that may not be fully apparent to the reader of a paper or those commitments that may influence the judgements of reviewers or editors. The key question is whether the subsequent revelation of these commitments would make a reasonable reader feel misled or deceived. Commitments may be personal, commercial, political, academic or financial. Relevant interests must be declared to editors by authors. A conflict of interest can only constitute misconduct if there is a deliberate deception of editors, referees and readers.

7) Media Relations

Social science findings are less commonly of interest to the media than those of medical research. Nevertheless, authors may still need to balance the competing interests of funders and investigators in high-profile public dissemination with the scholarly objective of ensuring that new knowledge is only accepted as a valid addition to the discipline, canon or science as a result of rigorous and disinterested peer review. Where possible, publication in the mass media should not precede publication in a peer-reviewed journal, which means that the findings have been affirmed by the scholarly community as a valid addition to the available body of knowledge.

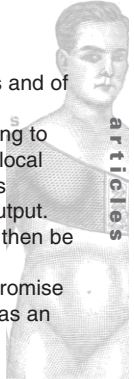
Responsibilities of Principal Investigators

1) Who is a Principal Investigator (PI)?

A PI is the person with overall responsibility for a research team, the holder of a research grant or the supervisor of a PhD student. The PI is always ultimately accountable for the ethical standards of research projects under his or her jurisdiction. As such, PIs may share culpability for research misconduct unless they can show that they have made reasonable efforts to implement processes and structures that promote research of high scientific and ethical quality.

2) What are PIs responsible for?

- a) PIs must ensure that people for whom they are responsible are aware of the requirements of national laws and regulations for the protection of human subjects and of the ethical codes of the relevant professional bodies.
- b) PIs should ensure the retention of all data, records and primary outputs according to local regulations so that subsequent inquiries can be properly addressed. Where local regulations or practices do not specify a duration, we recommend that all materials should be preserved for at least seven years from the date of the last published output. Where appropriate with regard to the confidentiality of informants, material should then be considered for deposit in a suitable archive for the benefit of other scholars.
- c) PIs should consider whether they have any conflicts of interest that might compromise publications from those for whom they are responsible, whether they are credited as an author or not. It may be appropriate to disclose these to editors alongside the disclosures of authors.



Responsibilities of Referees (Reviewers)

1) Who is a Referee?

Referees are external experts chosen by editors to provide written opinions on submissions, with the aim of improving them. Self-nominations to the pool of referees are welcomed but there is no obligation on editors to adopt these. The referees' role is to advise the editors. The final responsibility for decisions on what is and is not published rests with the editors, who may reach a different conclusion from referees, based on their wider view of the pool of submissions and the pressures on journal space. Sociology of Health and Illness treats peer review as a confidential process, although referees are free to sign their advice and disclose their identity to authors if they choose to.

2) What are the responsibilities of referees?

- a) Referees should provide constructive, speedy, accurate, courteous, unbiased and justifiable reports.
- b) Referees must not make any use of data, arguments or interpretations in papers they are invited to review, unless they have the author's permission.
- c) Referees must maintain the confidentiality of the manuscripts that they are asked to assess. This extends to referees' colleagues who may be asked (with the editors' permission) to give opinions on specific sections.
- d) Referees must declare relevant interests and possible conflicts to editors when they are invited to review a manuscript.
- e) If referees suspect that research misconduct has occurred, they should first draw this to the attention of the editors in confidence.
- f) Referees have a particular obligation to consider possible plagiarism in papers that they are evaluating and to draw the editors' attention in confidence to any material that they consider to be problematic.

3) Complaints

If authors are dissatisfied with the quality of peer review for Sociology of Health and

Illness, they must first draw their concerns to the attention of the editors. If their concerns are not satisfactorily resolved, they may then ask for them to be reviewed by the Chair of the Editorial Board, or such independent person as the Chair may nominate. The decision of the Chair, or the independent person, shall be final and binding on all parties.

Responsibilities of Editors

1) Role of Editors

a) Under the constitution of Sociology of Health and Illness, the editors direct the journal, with the support and guidance of the Editorial Board and the Trustees of the Foundation. They must consider and balance the interests of many constituents, including readers, authors, publishers, staff, board members, advertisers and the wider community. They have exclusive responsibility for decisions about whether to accept or reject papers. In matters of possible research misconduct, they will work closely with the Chair of the Editorial Board and the representatives of the publishers.

2) General Duties

- a) Editors' decisions to accept or reject a paper for publication will be based only on the paper's importance, originality and clarity and its relevance to the remit of the journal, relative to the pool of papers under consideration at the time and the space available in the journal.
- b) Editors will treat all submitted papers as confidential.
- c) Editors will not make any use of data, arguments or interpretations in papers submitted for publication, unless they have the author's permission.
- d) Editors will screen all papers submitted for publication to determine whether they are relevant to the remit of the journal and show sufficient potential importance, originality and clarity to justify forwarding them for peer review.
- e) All original studies passing the editorial screen will be peer-reviewed before publication, taking into account possible biases due to conflicting or related interests. Where papers have been commissioned, this will be clearly identified.
- f) Studies that challenge work previously published in the journal will be given sympathetic consideration.
- g) Studies that report negative results will not be excluded from consideration.
- h) If a published paper is subsequently found to contain major flaws, editors will ensure that the record is corrected prominently and promptly.
- i) Editors will disclose relevant interests to readers. Where conflicts of interest have implications for the review process, this will be led by another member of the editorial team or referred to the Chair of the Editorial Board. In particular, any submission by a member of the editorial team, a research fellow currently working on a grant held by a team member, a graduate student currently supervised by a team member or by a current collaborator of a team member will be referred to the Chair of the Editorial Board to conduct the review process.

3) Advertising

Advertising in Sociology of Health and Illness is a matter for the determination of the publishers.

- a) Editorial decisions will not be influenced by advertising revenue or reprint potential.

- b) The publishers will endeavour to ensure that all advertisements meet current UK regulatory requirements for truthfulness, taste and integrity.

Approach to Misconduct

1) Principles

Journals have a particular role in articulating the ethical standards of the research community and in ensuring that additions to knowledge are valid, accurate and obtained by legitimate means. In the pursuit of this goal, editors, reviewers and board members have a joint responsibility to identify cases of possible misconduct, to carry out a fair and transparent preliminary investigation to determine whether a prima facie case exists and to refer the matter, where appropriate, to a body with the authority to take disciplinary measures.

- a) Misconduct in publication is the intention to cause others to regard as true that which is not true. This is not solely a question of particular acts or omissions but of the mens rea, the objectives, interests and possible illegitimate gains, of the author, editor or reviewer.
- b) Deception may be intentional, the result of reckless disregard for possible consequences or negligent. Each of these circumstances may justify investigations and academic sanctions.

2) Investigating Misconduct

- a) The editors will not simply reject papers that raise questions of misconduct: they are ethically obliged to investigate these.
- b) Investigations must recognise the serious legal and professional implications of an allegation of misconduct and depend upon the strict observance of confidentiality by all those involved.
- c) It is not the responsibility of editors publicly to sanction those committing misconduct, recognising that they do not have the resources to conduct full investigations or the standing to take disciplinary measures. It is, however, their responsibility to co-operate fully with employers, professional associations or national regulatory bodies to ensure that a high standard of scholarly integrity is maintained.

3) Serious Misconduct

- a) This includes but is not restricted to evidence of fraud or fabrication in research results, complete or extensive plagiarism, major breaches of anonymity or confidentiality of data on research participants or other abuse of the rights of human subjects, as identified by reference to the Nuremberg Code or the current edition of the Declaration of Helsinki, or of the abuse of co-authorship, either to include those who have not contributed to the research or to exclude those who have.
- b) Editors, reviewers or readers may identify possible evidence of serious misconduct. In all cases, the first action must be to draw it to the attention of the editorial team in confidence. If the editorial team are compromised, the matter may be referred to the Chair of the Editorial Board.
- c) In consultation with the Chair of the Editorial Board, the editors will determine whether one of their number should be appointed to investigate the matter or whether an



independent person should be asked to undertake this in confidence. The investigator may obtain such confidential expert advice as she or he considers appropriate and will submit a full report in confidence to the editors and the Chair of the Editorial Board.

d) The investigator may conclude that there is no case to answer or that the case does not warrant treatment as serious misconduct and so recommend to the editors. The editors, in consultation with the Chair of the Editorial Board, shall not be bound by this recommendation but must record reasons for their dissent. If there is no case to answer, a paper will be handled in the usual way. If the case is not treated as serious misconduct, it will be dealt with through the process described at 4 below.

e) The investigator may conclude that there is a prima facie case of serious misconduct and so recommend to the editors. The editors, in consultation with the Chair of the Editorial Board, shall not be bound by this recommendation but must record reasons for their dissent.

f) If it is agreed that there is a prima facie case of serious misconduct, the available evidence will be disclosed in confidence to the person against whom the allegation is made, who will then be invited to submit a response. In the light of this response, the editors, in consultation with the Chair of the Editorial Board, will determine whether to forward the whole matter to the person's employer or professional association or to a relevant national regulatory body.

4) Less Serious Misconduct

a) This includes but is not restricted to redundant publication, minor plagiarism, failure to declare relevant conflicts of interest or inadequate acknowledgement of the contribution of others.

b) Editors, reviewers or readers may identify possible evidence of less serious misconduct. In all cases, the first action must be to draw it to the attention of the editorial team in confidence. If the editorial team are compromised, the matter may be referred to the Chair of the Editorial Board. Those dealing with the matter must remember that even minor allegations may have serious professional consequences.

c) In consultation with the Chair of the Editorial Board, the editors will determine whether one of their number should be appointed to investigate the matter or whether an independent person should be asked to undertake this in confidence. The investigator may obtain such confidential expert advice as she or he considers appropriate and will submit a full report in confidence to the editors and the Chair of the Editorial Board.

d) The investigator may conclude that there is no case to answer and so recommend to the editors. The editors, in consultation with the Chair of the Editorial Board, shall not be bound by this recommendation but must record reasons for their dissent. If there is no case to answer, a paper will be handled in the usual way.

e) If it is agreed that there is prima facie evidence of less serious misconduct, the available evidence will be disclosed in confidence to the person against whom the allegation is made, who will then be invited to submit a response. In the light of this response, the editors, in consultation with the Chair of the Editorial Board, will determine whether some internal sanction may be appropriate.

5) Sanctions

In view of the possible legal implications, sanctions d-h will not be invoked without reference to the publishers and to the Trustees of the Foundation.

- a) A confidential educational letter of explanation to the authors where there seems to be a genuine misunderstandings of the principles of publication ethics.
- b) A confidential letter of reprimand and formal warning about future submissions.
- c) A formal letter in confidence to the relevant head of institution or funding body.
- d) Publication of a notice of redundant publication or plagiarism.
- e) An editorial detailing the misconduct.
- f) Refusal to accept future submissions from an individual, team or institution for a specified period.
- g) Formal withdrawal or retraction of the paper, reported to other editors and indexing services.
- h) Report to an employer, professional association or national regulatory body.



Robert Dingwall

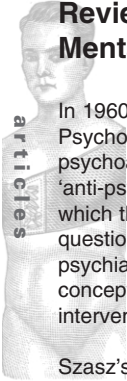
Elizabeth Murphy

Veronica James

Alison Pilnick

30 January 2002

This Statement will be reviewed in December 2004. Comments are welcomed and should be submitted by email to shi@nottingham.ac.uk



Review of a Classic Paper: Thomas Szasz 'The Myth of Mental Illness'

In 1960 the journal of the American Psychological Association, the *American Psychologist*, published 'The Myth of Mental Illness', written by a practising psychoanalyst and psychiatrist Thomas Szasz. His thesis was the opening salvo in an 'anti-psychiatric' bombardment which followed over the subsequent two decades in which the *raison d'être* and legitimacy of institutional psychiatry was fundamentally questioned. The essay opens with the statement, 'At the core of virtually all contemporary psychiatric theories lies the concept of mental illness. A critical examination of this concept is therefore indispensable for understanding the ideas, institutions and interventions of psychiatrists'.

Szasz's central proposition was that mental illness is a myth, 'a metaphor mistaken for a fact' the function of which is to 'disguise and thus render more palatable the bitter pill of moral conflicts in human relations'. Szasz problematises the medical construct of mental illness from within a framework of Cartesian dualism. He takes as a reference point the split between psyche and soma, when questioning the norms used for measuring mental illness and the epistemological assumptions underpinning the construct of mental illness.

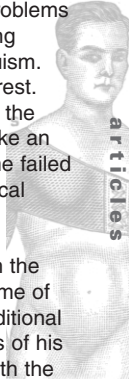
For Szasz, physical diseases, including those of the brain (neurological diseases), are properly identified by medical practitioners by visible or measurable physical disturbances (signs), alongside the patient's reported experience of physical changes (symptoms). By contrast, 'mental symptoms refer to patients communication about him or her self and the social worlds within which they live'. 'Problems in living' (troubles caused by conflicting personal needs, opinions, social aspirations and values) according to Szasz have been wrongly attributed to 'unspecified psycho-chemical processes and are regarded as similar to other diseases. "We call people physically ill when their body-functioning violates anatomical and physiological norms; ...we call people mentally ill when their personal conduct violates certain ethical, political and social norms". Mental illnesses are mainly 'communications expressing unacceptable ideas, often framed in an unusual idiom'.

In interpreting communications about the life-world of humans as symptoms of neurological functioning a category error is being made by psychiatrists in the organisation and expression of knowledge. For Szasz, whilst bodily symptoms should be tied correctly to 'an anatomical and genetic context' the notion of mental symptom are intrinsically bound to social and ethical contexts.

The term 'myth' in Szasz's proposition is conditional in so far as he recognises that 'personal unhappiness and socially deviant behaviour' actually exist. He objects though to the de-politisation and de-socialisation which occurs with the categorisation of such phenomena as disease or illness. Thus, the notion of 'myth' does not mean 'non-existent' but alludes instead to the erroneous classification of the deviant constituent acts and distressed or distressing experience reported by people as a form of illness. Thus, Szasz draws attention to a logical and epistemological error of reasoning on the part of orthodox psychiatry but suggests that this 'mistake' has a functional value for the profession, which brings us to another part of his thesis in the paper.

Szasz's second point of attack focused on the role and function of the profession of

psychiatry in responding to and promoting medical measures as the solution to 'problems in living'. In so doing, Szasz broke with the dominant tradition of providing flattering descriptions of health professionals as purveyors of specialist knowledge and altruism. Instead, the activities of psychiatrists, he suggested, were expressions of self-interest. This entailed a kind of 'psychiatric propaganda', the aim of which was 'to create in the popular mind a confident belief that mental illness is some sort of disease entity, like an infection or a malignancy.' In promulgating such a view, psychiatry at the same time failed to see and treat "difficulties in human relations" within their specific social and ethical contexts.

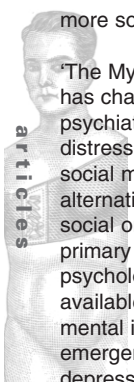


The essay provoked a number of well-rehearsed arguments and undoubtedly, with the benefit of hindsight, there are a number of weaknesses in his original analysis, some of which maybe attributable to the brevity imposed by the word length limit of the traditional academic paper. It is worth mentioning that Szasz presented only the bare bones of his arguments in this original paper, which were subsequently elaborated in a book with the same title. Nonetheless, some of the weaknesses should be mentioned. For example, the statement that in the case of psychiatric intervention what people seek out and receive depends more on the socio-economic status and beliefs of the person than on 'mental illnesses' is applicable to many physical illnesses. Critiques provided by those such as Peter Sedgwick pointed out the implications of conceptualising the patient as a political hero, a nascent idea presented in the essay and subsequently developed in other 'anti- psychiatric classics' (notably by Ronald Laing and David Cooper). Such a view of the patient was said to ignore the suffering of individuals and their families.

The failure to present a credible alternative to the existence of institutional psychiatry in managing 'problems in living' was viewed as nihilistic. The association of Szasz with the ideas and politics of the libertarian right also meant that his thesis was treated with suspicion by those on the left. At a conceptual level, the over drawn dualism demarcating physical from mental illness looks crude when compared to the genre of the social constructivism of physical illnesses which followed some two to three decades later.

Would the paper be accepted for publication today? It was written at a time when the inter-disciplinary exchange of ideas seemed to occur with seeming ease. (I found this particular version of the paper in a collection edited by Phil Brown entitled *Radical Psychology*, in a section headed 'Sociological Approach'). Whilst the rhetoric of inter-disciplinarity and trans-disciplinary knowledge has increased in recent years, a cynical reading of this is that this results more from the pressing pragmatics of gaining external funding for empirical research, rather than a desire for the enthusiastic exchange of theoretical ideas based on curiosity, political idealism and values.

Referees might not have viewed Szasz's offering as analytically robust enough or distinctively sociological or psychological enough to warrant publication in a first ranked unit-disciplinary journal today. But it is precisely because of its successful crossing of boundaries that I offer *The Myth of Mental Illness* as a classic. The undisputed strength of this paper lies with the impact that it had on the contemporary mental health field and its continuing relevance today. Love or hate the thesis it sowed the seeds of a major re-think about the taken-for granted nature of mental illness and the way in which society responds to psychological deviance. It forced medical orthodoxy to account for itself to a dissenting colleague and an onlooking world and it provoked a reform in psychiatric ideas. Witness, for example, Anthony Clare, in response to anti-psychiatry, offering a



more sophisticated eclectic model of psychiatric practice.

'The Myth of Mental Illness' has acted too as a barometer for how much and how little has changed in the mental health field. On the change side of the equation, the old psychiatric hospitals have closed and new paradigms and definitions of 'psycho-social' distress have emerged. The 'anti-psychiatry' movement has been followed by a thriving social movement of users of mental health services who have challenged and developed alternatives to the medical model of mental illness. There is greater recognition too of the social origins and context of mental health problems in official health policy and in primary care practice. However, despite the emergence of competing social, psychological and lay paradigms and the absence of any real further evidence than was available in 1960 from genetic and biological research into 'mental illness', the notion of mental illness as essentially a disease of the brain remains alive and well today. The emergence of more refined chemical compounds, the new 'anti-psychotics' and 'anti-depressants' and more sophisticated brain imaging technology, have been grist to the mill of traditional biological psychiatry. Forty years after its publication, Szasz's attack on the construct of mental illness still provides us with considerable food for thought.

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Book Reviews

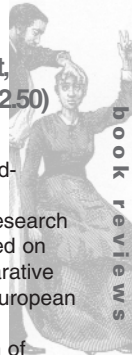
Mason S, Megone C. (eds.) (2001) *European Neonatal Research: Consent, ethics committees and law* Aldershot: Ashgate (ISBN 0754613011 Hbk £42.50)

This collection of papers reports a three year European Commission (EC) Bio-Med-funded study across 11 countries. The main themes are the practical problems encountered by neonatologists and parents concerning consent, and the role of research ethics committees (RECs) in regulating neonatal research. There are reports based on interviews and surveys with practitioners, parents and REC members, with comparative analysis of national laws and problems. Guidance from the USA (1996) and the European Council (1997) are contrasted to show how two ethics frameworks, principled or pragmatic, with either theoretical or empirical bases, underlie European regulation of medical research.

Some chapters have many authors, others present individual views. The key theme is how to balance the need to protect individual babies from the risks of taking part in research, versus the need to permit far more neonatal research, with its vital potential benefits to babies of expanding evidence based treatment. Far too few neonatal treatments have been adequately tested and refined through trials.

This is a useful, informative book on an important topic, though it does have limitations. Other EC Bio-Med projects, (for instance, one on 'contested futures' and techno-science, see MSN, 27, 1:48-50) illustrate how EC projects can deepen critical analysis and debate about the complexities and contradictions in current issues. Yet this book simply reports differences rather than analysing them. It concludes with a 'consensus statement' that, however, records 'majority' views and indicates many areas of uncertainty and disagreement. There are numerous complacent statements: 'In most countries within the EU it is thus today impossible to get approval for research which is ethically sub-standard, or to perform research without ethical approval' (p91-2). This comment was challenged, for example, by the Alder Hey Inquiry in Britain, which demonstrated how 'unethical' research may not arise through medical malice, ignorance or intentional negligence, but when well-intentioned doctors hold different values from those of many parents. 'Is parental "informed consent" always necessary?' asks one clinician (pp 237-248). She concludes that RECs should play a greater part in safeguarding the babies' interests as, too often, parents are unable to give sufficiently informed and considered consent, especially during emergencies, in which neonatal research decisions tend to arise. The frequent mention of RECs, as effective means to prevent unethical research, monitor projects and thereby ensure reasonable standards, ignores RECs' lack of expertise or resources to do so, which the project itself reports. The authors draw on main stream literature. They tend to ignore the critical questions raised mainly in the semi-published 'consumer' literature about problems in medical research, although these could have considerably sharpened and clarified the project debates.

The eight years or so, from inception of EC research plans to the published book, limit the contribution which EC projects can make in areas of rapid change, unless they probe more lasting, underlying issues instead of concentrating, as this report does, on attempting to influence EC-wide policies. The book has been overtaken by major



changes. For example, it constantly refers to 'direct benefit' to the child whose 'best interests' are served by taking part in research - although that makes it hard, even unethical, for parents to refuse or withdraw their baby from a project. Meanwhile, the Declaration of Helsinki (version 2000) has resolved this confusion, by separating research (investigation) firmly from therapy (intended benefit) and no longer using the misnomer 'therapeutic research'. Also, in Britain at least, the book has been outdated by new guidance from the Royal Colleges and British Medical Association on neonatal and paediatric research, and by big changes in REC structure, resources and members' training.

The main, implicit message of the book is of great diversity in views around Europe. Greek doctors tend to insist that the Greeks prefer medical paternalism. Whereas a Danish author calls for RECs to be more independent, socially representative, democratic, transparent and 'tough', in order to promote public confidence and willingness to support medical research. With such international diversity, will consensus ever be possible?

Priscilla Alderson, Institute of Education, University of London

Anionwu EN, and Atkin K. (2001) *The Politics of Sickle Cell and Thalassaemia* Buckingham: Open University Press (ISBN 0-335-19607-1 £18.99).

Sickle cell disorders (SCD) and thalassaemia are recessively inherited blood disorders. There are estimated to be over 10,000 people with a SCD and around 600 cases of thalassaemia in the UK. However, even though the prevalence of these inherited blood disorders is greater than that for cystic fibrosis and haemophilia it appears that policy makers and health and social care professionals still know very little about them. This book offers a comprehensive introduction for anyone interested in finding out more about haemoglobinopathies. In particular it provides an account of the social, historical, political and economic context which has shaped the UK provision of health and social care services for these disorders. A main theme throughout the book is how institutionalized and individualized racism impacts upon the experiences of affected individuals and their families. Indeed, the authors argue that although there appears to be an increasing interest in these disorders, together with moves to improve service provision, the haemoglobinopathies would have higher priority if they were not seen as 'black' conditions.

Given that there is widespread ignorance and a lack of understanding about SCD and thalassaemia the authors provide a clinical introduction in chapters two and three. This account covers the origins and geographic distribution of SCD and Thalassaemia, a description of the most common types of disorders, an outline of their patterns of inheritance and the different laboratory investigations that can be used for haemoglobinopathy screening and diagnosis. Chapter three gives an overview of the clinical features and strategies for managing SCD and Thalassaemia, particularly stressing different symptoms, life expectations and current treatments.

Although a main aim of the book is to provide a detailed examination and evaluation of

UK haemoglobinopathy provision there are also a number of other broader concerns. Indeed, the authors note (pg.3) that the haemoglobinopathies provide a case study for examining many of the wider problems that deny minority ethnic communities adequate health and social care.

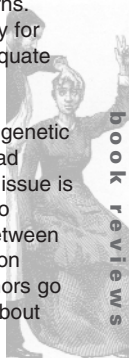
Chapter four discusses the practical and philosophical problems of screening and genetic counselling for SCD and thalassaemia. This chapter is also set within another broad theme, which highlights some of the debates surrounding the 'new genetics'. One issue is the degree to which truly informed choices are available in contemporary society to people at risk of having children with inherited disorders. The complex tensions between 'informed decision-making' versus disease prevention are explored and the question 'what is/are the objective(s) of screening for genetic conditions' is raised. The authors go on to demonstrate how different medical and public health discourses and ideas about humanism, eugenics, consumerism and citizenship all influence these tensions.

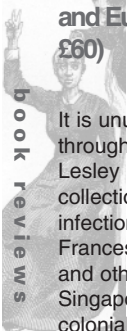
In chapter five the authors present an 'illness narrative' in order to reflect some of the experiences of the individuals and families affected by these disorders and how they are mediated by the broader social, economic and political context. Again, it is stressed that the experiences of the haemoglobinopathies can be linked with other debates and these centre on issues relating to chronic illness, disability rights, ethnicity, family obligations and caregiving. Perhaps, one criticism is that these more personal accounts could have been highlighted earlier, or been thread throughout the different chapters in order for the reader to get some sense of what it may be like to live with, or be in a family affected by, a haemoglobinopathy from the start of the book.

More specific issues relating to current and future health and social care provision are addressed in chapters six and seven. The authors document how a lack of flexibility, poor funding, cultural insensitivity, institutional and individual racism can all lead to poor quality care, inadequate information, an insensitivity to individuals and families worries and inappropriate provision. And they note, 'the chapter paints a bleak picture, with haemoglobinopathy provision appearing erratic, lacking in coordination and unable to meet the needs of individuals and their families' (pg. 109). However, the authors stress that there are examples of good practice and services which individuals and families do value. Thus, although the gaps in provisions are highlighted they also demonstrate the opportunities for improving these services. However, there is still a continuing need for community action and proactive engagement by statutory agencies because in the current political climate the neglect of haemoglobinopathies is always a possibility.

Overall, this book offers a comprehensive introduction to the clinical, political and social aspects of the haemoglobinopathies and should be read by academics, policy makers, social and health care practitioners who have an interest in this area and the broader concerns outlined above.

Karen Forrest, University of Aberdeen.





Davidson R, & Hall LA. (eds.) (2001) *Sex, Sin and Suffering: Venereal Disease and European Society since 1870* London: Routledge (ISBN 0415234441 Hbk £60)

It is unusual in edited collections to find a consistently high level of scholarship throughout, but this is certainly evidenced in this volume from Roger Davidson and Lesley Hall. With an impressive array of historians, from Europe and the US, the collection provides a social history of responses to the threat of sexually transmitted infections (STIs) over two centuries. 'European society' is appropriately inclusive here; Frances Bernstein's beautifully illustrated chapter is concerned with revolutionary Russia, and other contributors describe medical intervention in Shanghai, Hong Kong and Singapore (Kerrie Macpherson), Uganda (Michael Tuck) and the penetration of British colonial medicine and influence globally (Phillipa Levine). Such a range of perspectives might prove confusing or disorienting; once again, the rigour of the scholarship is matched by a fluency of theory and treatment of empirical material, and so this is never a problem.

Davidson and Hall summarise succinctly in their introduction why a history of responses to STIs should be of interest beyond the relatively small coterie of medical historians. 'Not only has it been significant in shaping and articulating perceptions of sexuality generally, it has also provided a rich field for the study of the state's response to perceived threats to public health occasioned by what were deemed to be inappropriate and dangerous forms of sexual and gender behaviour'. This robust opening is not empty rhetoric; throughout the volume different authors revisit this statement, giving it empirical support and theoretical development, often in surprising ways. My own interest lies primarily in responses to venereal disease in the UK, and this ethnocentric bias propitiously allows me to discuss the contributions of both of the editors, although special mention should be made of David Evans (often a regular to BSA MedSoc), whose chapter is concerned with post-war policy in relation to the STIs and is an extremely thorough and lively tour of UK policy up to HIV/AIDS: highly recommended.

But first to Lesley Hall, surely the doyenne of the social history of STIs in the UK. In starting with the Royal Commission on the Contagious Disease Acts, Hall's chapter just post-dates the 1870 of the book's title and ends 75 years later with the early days of the NHS. It charts the tension that existed (and to some extent continues) between medical moralists of various hues, and those who sought to introduce - however misguidedly (cf the authors of the CD acts) - practical public health responses to the perceived threat posed by STIs to the health of the nation. Hall's sure sense of the complexities of contemporaneous social response means, however, that this is not a battle between 'good/liberal' and 'bad/repressive' doctors and campaigners, but a series of spats involving groups or individuals for whom STIs represented the expression of quite different social evils. From Josephine Butler's opposition to the CD acts' legitimisation of the double standard, permitting male sexuality to be expressed whilst women could be forcibly submitted to medical investigation ('speculum rape'), to its transformation a few decades later into Christabel Pankhurst's 'Votes for Women, Chastity for Men' campaign, control of STIs provided a ready-made vehicle for the expression of a range of ideological perspectives. Fighting this 'terrible peril to our Imperial race' was unsurprisingly a call to arms to eugenicists, as well as, in the Second World War, a means to regulate women's

sexuality (the 'easy amateur' being considered a greater threat to fighting men than the more experienced professionals who could 'take care of themselves').

In temporal terms, Roger Davidson starts where Hall ends, but also is mainly concerned with the specifically Scottish response. This is more explicitly concerned with gender and, to a lesser extent sexuality ('passive homosexuals' as 'reservoirs of infection'). The chapter also touches upon interesting ideas regarding the role of the Church, and the Calvinism still evident in Scottish public life, in discussing the medico-legal control mechanisms introduced to deal with the STIs in the latter years of the 20th century. Interestingly, 'sociological insights' were increasingly brought to bear on the problem, with female 'promiscuity' combining unproblematically with female juvenile delinquency, to construct 'the ever-willing teenage girl' as 'the female equivalent of the skinhead in his bover boots'.

Regardless of your interests, I would agree with Davidson and Hall's introduction which argues that responses to the STIs succeed in clearly defining boundaries and social mores which cogently précis ideologies and values. This is the most comprehensive account of European and European-influenced state control measures with regard to the STIs, from the past, for the foreseeable future.

Graham Hart, University of Glasgow

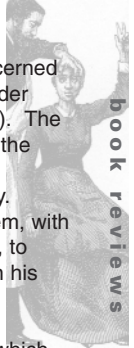
Smith DF, and Phillips J. (eds.) (2000) Food, Science, Policy and Regulation in the Twentieth Century: international and comparative perspectives London: Routledge (ISBN: 0415235324 Hbk £55)

A copper-bottomed investment for anyone interested in the subject. Arising from a conference in Aberdeen in 1999, and published in a well-respected series, its seventeen contributors, from UK, USA and Netherlands cover aspects of the entire century, from the pasteurisation of milk to the regulation of GM crops.

Among my favourites are Rima Apple's account of the vitamin boom in the US during the Second World War (consumption was promoted as a patriotic activity and vitamins added even to cigarettes and sweets); Margaret Barnett's chapter on how the People's League of Health, led by the wonderfully named Olga Nethersole, fought bovine TB in the inter-war years; and Peter Atkins on the struggle over milk pasteurisation - should milk be made 'unnatural' and no longer the drink of our forefathers ?

Not every chapter is an easy read. Summaries would have been useful. Acronyms abound. The struggles of committees and government departments take up much space. As Hugh Pennington wryly notes, a propensity to engage in boundary conflicts appears to be a built-in property of government departments; but as the century ages, pressure groups, the media - even individual sociologists - increasingly take to the stage.

The book ends with a very topical contribution, from David Barling, tracing the process of regulating GM crops. This also points the way forward. Our new century will feature



plenty of conflicts on these lines, as new concepts like E numbers and nvCJD appear. There are rich pickings already for sociologists, political scientists and contemporary historians. Reaching agreement on what new concepts mean can take time, and responses may differ from nation to nation. “Experts” cannot always be readily identified, and in government eyes may be a source of embarrassment as much as useful advice. To quote Pennington again, ensuring appropriate implementation may take even longer than agreeing on the science.

Bernard Ineichen, University of Surrey

Clarke A. (2001) *The Sociology of Healthcare* Harlow: Pearson Education (ISBN 0582369541 Pbk £18.99)

This introductory textbook begins with a discussion of the biomedical model and the need for a sociological perspective on both health and illness. Five distinct sociological perspectives are described: “structural functionalism”, stemming from the work of Talcott Parsons; “conflict perspectives”, often involving Marxist approaches; “interpretive perspectives”, associated with symbolic interactionism; “feminist perspectives” (liberal, radical and socialist feminism are all briefly discussed); and “social constructionism”, which has been profoundly influenced by the work of Michel Foucault. Chapter Two, “Experiences of Health and Illness”, is designed to help students understand the differences between disease, illness and health. It discusses both lay perspectives and academic definitions of these concepts. It also considers the experience of stigma, with particular reference to people with AIDS, epilepsy and mental illness.

In Chapter Three, “The Sociology of Mental Illness”, the complexities of defining mental illness and mental health are discussed. The emphasis is on the influence of social factors, such as gender, ethnicity and class, in the epidemiology of mental illness. These themes are also highlighted in Chapter Four, “Inequalities in Health”, which emphasises the very real influence of demographic and socio-economic position on British mortality and morbidity rates.

Chapters Five and Six consider various aspects of the life course: “Childhood and Adolescence” and “Later Life”. In Chapter Five, the social construction of childhood is emphasised, as is the importance of recognising the agency of children as active participants in their own healthcare. In Chapter Six, the emphasis is on the contribution which older people make to society, such as their role as informal carers of families and children. This perspective on old age is contrasted with disengagement theory, which suggests that older people are basically a burden on society because they are heavily reliant on social services. Such theory is linked to social practices which devalue older people and treat them like dependent children.

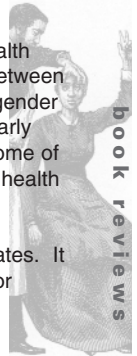
Chapter Seven discusses a range of debates around families and community care. The concept of physically “caring for” someone is contrasted with a broader emotional role of “caring about” a person. Caring is seen as “emotional labour”. The centrality of gender in the provision of care is highlighted and the provision of informal care by families is also examined. The ways in which changes in the nature of family life in Britain have

impacted upon the provision of care is also considered.

Chapter Eight outlines a range of factors associated with interactions between health care professionals and patients. Various sociological aspects of the relationship between doctors and patients, as well as nurses and patients, are discussed. The role of gender in the power dynamics which characterise the doctor-nurse relationship is particularly emphasised. The last Chapter, "Contemporary Issues in Healthcare" continues some of these themes as it outlines the role of professions in healthcare, the sociology of health promotion, and British health service reforms in the 1990s.

This book will be very useful for teaching medical sociology to British undergraduates. It is comprehensive, concise and easy to read. Also, it has summaries, questions for discussion and suggested readings at the end of each chapter, which enhance its effectiveness as a teaching tool.

Mark Sherry, Oregon Health Sciences University



Hancock P, Hughes B, Jagger E, Paterson K, Russell R, Tulle-Winton E, and Tyler M. (2000) *The Body, Culture and Society: an introduction* Buckingham: Open University Press (ISBN 0335204139 Pbk £14.99)

In recent years, the human body has emerged as a key problem in and across contemporary social thought. Divided into six individually authored chapters, this volume offers an up-to-date introduction to the place of the body within a range of sociological subdisciplines. The authors make no claim to present a definitive overview of the subject area, but instead review the literature relating to a series of 'typical' bodies: disabled, consuming, working, elderly, medical and ethical. Issues of interest to medical sociologists discussed within the text include organ transplant, health promotion, dieting, self-harm, sexuality, cosmetic surgery, disability, gerontology and reproduction. Each chapter contains a guide to further reading.

Drawing on post-structuralism, feminism and the philosophy of 'difference', the various authors show how competing conceptions of the body emerge within a specific, historical context. Kevin Paterson and Bill Hughes, for example, locate the emergence of the 'disabled body' in the transition from feudalism to capitalism, at which point disabled people became categorised as 'non-productive' and consequently found themselves increasingly under the jurisdiction of medical science. In a society demanding individual economic productivity, the (unproductive) disabled body is construed only in pejorative terms, as 'invalid', 'deficit' and hence in need of medical intervention.

The development and importance of the medical gaze is considered in Bill Hughes' chapter on medicalised bodies. Hughes draws on Foucault's 'dispersal of discipline' thesis to explain the extension of healthcare practise from diseased to healthy bodies. The medical conception of the body, he claims, is undergoing a major transformation due in part to significant changes in the pattern of disease, and also to the growth of alternative, more holistic conceptions of embodiment. The end result is a dispersal of

medical power: "As the social forces that act on the body and embodied behaviour itself are recognised as belonging to the 'regime of total health', new forms of therapeutic space and action can be continuously invented. Nothing, in theory, falls outside the orbit of the healthcare world because the healthy subject is ecologically situated" (p. 26). Hence contemporary medical practitioners are as likely to issue proscriptions for healthful living as they are to treat the diseased or cure the sick. What's more, the individual - by virtue of his or her embodiment - is capable of remaking his or herself by the utilisation of disciplinary practises that have emerged from medical science.

This is a theme developed by Elizabeth Jagger, who explores the consequences of 'consumer culture' for the body. Self-identity, she argues, is no longer derived from work and production but from consumption and leisure (p. 45). This is exemplified in the slogan 'You are what you eat', which emphatically links consumption to appearance and well being in a reflexive project of self-construction. In contrast with the scientific, universal, and indeed 'natural' biomedical body, the consuming body is malleable; a continuous and all-pervasive 'project' which should be worked at and accomplished as part of an individual's self-identity.

Overall I found this collection to be a highly enjoyable, thought provoking and challenging read. That said, I did find some of the terminology difficult to follow (e.g. alterity) and, despite being described as an introduction suitable for undergraduates, the text did not include clear definitions of key terms (notably 'embodiment'). There was also an implicit assumption that the reader was already familiar with recent developments in social theory, such as post-structuralism, feminism and the philosophy of 'difference'. Consequently, I probably wouldn't recommend the book as a first port of call for readers that are new to the field (in my view Williams and Bendelow's *The Lived Body* offers a more accessible and comprehensive introduction), but it has much to offer more confident scholars who are grappling with the complexities and nuances of the sociological study of the body.

Susan Batchelor, University of Glasgow

Leon D, and Walt G. (eds.) (2001) *Poverty, Inequality and Health: An International Perspective* Oxford: Oxford University Press (ISBN 0192631969 Pbk £29.50)

This book brings together papers which were originally presented at the London School of Hygiene and Tropical Medicine's ninth Public Health Forum which was held in London in April 1999. There are seventeen chapters in all. These cover a diverse range of topics, among them issues relating to health and health inequalities within both developing and developed countries, as well as comparisons of indicators of health, illness and mortality among countries. The book thus brings a welcome international perspective to the study of health inequalities, with contributions on the implications for health of transition in the former Soviet Union (Martin McKee), the effectiveness of interventions on inequalities in infant and child health in Brazil (Cesar Victoria, Fernando Barros and J. Patrick Vaughan), and the health impact of poverty reduction programmes in Bangladesh (A. Mushtaque R. Chowdhury and Abbas Bhuiya) among others. Further chapters focus child health and mental health in developing countries. The common themes which the editors

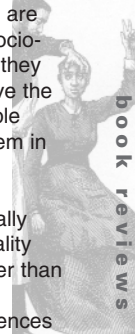
identify as emerging from this internationally-oriented collection include an increasing focus on poverty within countries, the issue of 'focus', that is, whether inequalities are primarily a matter of inequitable access to health services or of determinants of socio-economic differences in health status and disease. The most important point that they make is that studies which transcend a single geographic or historical setting have the capacity to underline the fact that health inequalities are neither static nor inevitable phenomena. Health inequalities do not have the fixity that is often attributed to them in familiar and stable political and economic settings.

One discussion of the situational specificity of health differences is provided by Sally MacIntyre's discussion of the way in which sex differences in mortality, or in mortality gradients by class, have varied in different contexts. Her point, briefly, is that rather than assuming the existence of a 'true' underlying gender difference in health, and in consequence writing off variations in gender difference as artefacts, gender differences can be understood to vary, since gender is differentially enacted in different contexts. A good example of historically variable gender difference is the greater increase in mortality among men than among women in parts of the former Soviet Union after the end of state socialism. - It is worth noting in passing that a recent UNDP report referred to the region's millions of 'missing men', in tacit comparison with the 'missing women' of South East Asia that had been previously identified by Amartya Sen.

I welcomed the inclusion of a chapter by Stephen Kunitz, which offers a critique of the concept of social capital as it has been used in health discourses. This is an area which stands in need of much more consideration and conceptual analysis. I also enjoyed Maureen Mackintosh's chapter entitled: 'Do Health Care Systems contribute to Inequalities?' This is a good example of what international health research and thinking can achieve. She defines health care as a core element of social inequalities in any society, and at the same time a site for the contestation of that inequality. Her 'social settlement' approach to health care argues that health care is relational and that recent health care reform has been an integral part of broader social changes, including economic liberalisation, which have had an explicitly unequalizing intent.

Amartya Sen rounds off the volume with a short piece which considers two perspectives to the relationship between wealth and health, one which concentrates exclusively on economic progress, and one which involves a broader focus on 'the lives that we can lead'. He shows that people in wealthier countries do not always have lower overall mortality than those in poorer countries; explicit 'support' policies, are part of the picture of relatively low mortality in relatively poor countries such as China or Sri Lanka, or his much quoted example of the Indian state of Kerala. In advocating an approach that does not categorically oppose 'economy' and 'policy', Sen closes the book with an aphorism: 'There may be no wisdom in seeking permanence, but there is some permanence in seeking wisdom.'

Peggy Watson, University of Cambridge



Parker H, Aldridge J and Egginton R. (Eds) (2001) UK Drugs Unlimited. New research and policy lessons on illicit drug use: Palgrave (ISBN 0-333-91817-7 Hbk £42.50)

Young Britons consume more illicit drugs than their peers anywhere in Europe. How and why this has happened, frank discussions of the theoretical debate surrounding the UK's current drugs policy and several detailed descriptions of contemporary studies which attempt to gauge the extent of drug taking behaviour among young people await the reader.

The book boasts eight varied chapters entitled: Unbelievable? The UK's drug present; Unenforceable? How young Britons obtain their drugs; Unconventional? Adolescent drug triers and users in England; Unpreventable? How young people make and remake drug taking decisions; Unstoppable? Dance drug use in the UK Club scene; Unreachable? The new young heroin users; Untreatable? Hidden crack cocaine and poly drug users; and Unpredictable? Britain's drug futures.

From the outset the reader is asked to engage in covering a range of interesting topics, beginning, fittingly, with an overview of recent drug policy events in the UK. The opening chapter sets the stage well for an informative look at how young people purchase drugs and make drug-taking decisions. Discussion of drug acquisition and differences between sensible recreational drug use and problematic dependent use are focused and reflected in procurement strategies. The authors conclude that the vast bulk of young drug takers keep to self-imposed rules of engagement protecting them from both sides of the war on drugs, that is, both official enforcement and the shady criminal world!

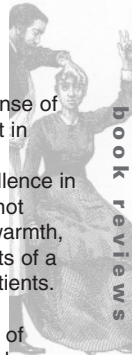
Are young Britons who take drugs unconventional? Chapter 3 details the Northern Regions Longitudinal Study - which is cited as the only ongoing large sample longitudinal study of adolescent drug trying and use in the UK. The value of this applied example in the book is in helping to understand the complexity and dynamics of drugs pathways through adolescence and how sensitive prevalence data can be generated and interpreted. The study shows that in relation to previous generations today's drug using youth may be unconventional, but in terms of their own cohort (1990's youth) they distinctly are not!

Each of the chapters sits well on its own and the combined effect of the book is to challenge many conventionally held assumptions about young people and drug taking behaviour. The final chapter outlines some perceptions about the difficulties in attempting to predict the future for the both likely scale and type of drug use among Britain's youth. Interestingly from a research perspective, current government monitoring systems are criticized and the likely implications for future projects outlined.

Overall I enjoyed reading the book and particularly warmed to the informal style of its presentation. I would recommend the book to fellow drug researchers and policy makers in the field who work with young people. The book, however, is engaging and accessible to a wider audience who wish to gain insight into some of the current issues and implications of addressing drug use by young people and more importantly understand why current policies and legislation can not hope to be effective.

Patrick Branigan, London School of Hygiene & Tropical Medicine, University of London

Reynolds W.J. (2000) *The Measurement and Development of Empathy in Nursing* Aldershot: Ashgate (ISBN 0754612643 Hbk £37.50)



Empathy is central to helping relationships. For nurses, being able to convey a sense of empathy may mean that they are able to provide patients with appropriate support in times of acute distress. Previous studies have documented the positive effects of empathy on the health of patients. Empathy is therefore essential for clinical excellence in nursing. Unfortunately, however, many studies of nursing suggest that nurses do not convey such empathy. This book suggests that nurses can be trained to convey warmth, respect, trust, understanding and genuineness in their work, and reports the results of a training course aimed to improve the ways nurses demonstrated empathy with patients.

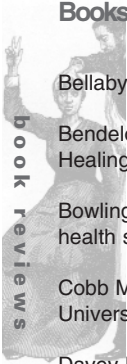
Empathy is often considered a difficult concept to define, as it combines elements of feelings, understanding and behaviour. Accordingly, the measurement of empathy has rarely been considered an appropriate area of investigation for quantitative studies. However in this book, Reynolds attempts to develop a measurable “empathy scale”. Reynolds suggests that when patients describe nurses who demonstrate empathy, they seem to be indicating that they want nurses to attempt to listen, to be sensitive to their feelings, to seek clarification of confused messages, to sound warm and genuine, and to help them focus on solutions to their problems. Similarly, they did not want nurses to manipulate them, to fail to listen to their conversation, to interrupt or sound judgemental, or to sound unfriendly. Reynolds uses this information to develop his “empathy scale” which can be used to evaluate communications between nurses and patients.

Because Reynolds feels that existing courses have not enabled nurses to show empathy in their clinical work, he developed an empathy education course which involved a self-directed study kit, a literature review, meetings between student nurses and their supervisors, a two-day workshop and supervised clinical work. Students who undertook this course mostly viewed the course positively, and many reported that they were more aware of opinionated behaviour and avoidance of the patient’s concerns. Some nurses reported that barriers to the demonstration of clinical empathy included a lack of time, lack of support from unsympathetic colleagues and interruptions to clinical work. Reynolds accordingly concluded that “nurses’ clinical environments may impede their ability to offer empathy” (p.95).

Reynolds suggests that an effective and empathically supportive supervisory relationship is central to the effectiveness of the course. Supervisors needed to be visible, available, approachable and skilled in demonstrating empathy in order for the course to achieve the best possible results. Unfortunately, for both patients and nurses, many student nurses complained that their supervisory relationships were not “empathically supportive”.

I think this book has tackled an important issue, clinical empathy, in a fairly novel way by using a quantitative approach. The results of the course seem to indicate potential for improvements in nursing practice. My main criticism of the book is that the literature review seems somewhat out of date (there is only one reference dated after 1995). I would have liked to have seen comparisons between this approach and other, more recent, literature on empathy in helping relationships.

Mark Sherry, Oregon Health Sciences University



Books available for review

- Bellaby P. 1999 Sick From Work: the body in employment Aldershot: Ashgate
- Bendelow G, Carpenter M, Vautier C, Williams S. (eds.) 2001 Gender, Health and Healing: the public and private divide London: Routledge
- Bowling A. 2002 (2nd edition) Research Methods in Health: investigating health and health services Buckingham: Open University Press
- Cobb M. 2001 The Dying Soul: Spiritual Care at the End of Life Buckingham: Open University Press
- Davey B, Gray A, Seale C. 2002 (3rd edition) Health and Disease: A Reader Buckingham: Open University Press
- Dennis A. 2001 Making Decisions About People: the organisational contingencies of illness Aldershot: Ashgate
- Devries R, Benoit C, Van Teijlingen ER, Wrede S. (eds.) 2001 Birth By Design: Pregnancy, maternity care, and midwifery in North America and Europe London: Routledge
- Ettorre E. (ed.) 2001 Before Birth: understanding prenatal screening Aldershot: Ashgate
- Gilbert N. (ed.) 2001 (2nd edition) Researching Social Life London: Sage
- Gwyn R. 2002 Communicating Health and Illness London: Sage
- Higginbotham N, Briceno-Leon R, Johnson N. 2001 Applying Health Social Science: Best practice in the developing world London: ZED Books
- Higgs J, Titchen A.(eds.) 2001 Professional Practice in Health, Education and the Creative Arts Oxford: Blackwell Science
- Hughes D, Light D. (eds.) 2002 Rationing: Constructed Realities and Professional Practices Oxford: Blackwell
- Klein R. 2001 (4th edition) The New Politics of the NHS London: Prentice Hall
- Komaromy C. (ed.) 2001 (3rd edition) Dilemmas in UK Health Care Buckingham: Open University
- McNamara B. 2001 Fragile lives: death, dying and care Buckingham: Open University Press
- Meyers RJ, Miller WR. (Eds.) 2001 A community Reinforcement Approach to Addiction Treatment Cambridge: Cambridge University Press

Moreno JD. 2001 *Undue Risk: Secret State Experiments on Humans* London: Routledge

Nottingham C. (ed.) 2000 *The NHS in Scotland: the legacy of the past and the prospect of the future* Aldershot: Ashgate

Scambler G. (ed.) 2001 *Habermas, Critical Theory and Health* London: Routledge

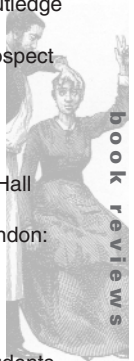
Shaw M, Dorling D, Mitchell R. 2002 *Health, Place and Society* London: Prentice Hall

Shildrick M. 2002 *Embodying the Monster: Encounters with the vulnerable self* London: Sage

Shilling C, Mellor PA. 2001 *The Sociological Ambition* London: Sage

Watson NA, Wilkinson C. (eds.) 2001 *Nursing in Primary Care: a handbook for students* Hampshire: Palgrave

If you would like to review any of the above books, please contact Geraldine Barrett via email (geraldine.barrett@lshtm.ac.uk), telephone (020-7927 2268) or post (HPRU, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT



Marge's JobSpot: should I stay or should I go?

In these uncertain times in which we all now live you may find yourself wondering about whether it may be worth the stress of applying for a new job, sitting tight where you are for a few more years or checking out that mini-cab firm advertising for drivers at the end of your street. Use this simple questionnaire to find out if your organisation/department/workplace (or your position in it!) is doomed.



Answer the following questions and keep a tally of your score:

1. Has your Department/Institution/Workplace changed its name in the last 5 years (score 10 points)? Are discussions currently taking place about changing the name of your Department/Institution/Workplace (score 15 points)? (If you answered yes to both these questions add another 10 points)
2. Has your Department/Institution/Workplace merged with another Department/Institution/Workplace in the last five years (score 20 points)? Did this merger coincide with a change of name (add 15 bonus points)?
3. Are people moving office/desks with a frequency that makes it difficult to find where they are or even IF they still work in your Department/Institution/Workplace (score 10 points)? Have you recently turned up to work to find someone else sitting at your desk and people smiling nervously when you ask where your things are (score 15 points, add another 15 bonus points if this involved security being called, add 30 bonus points if the police were called)?
4. Are people inventing or being given meaningless job titles (e.g. any combination of deputy/assistant/director/co-ordinator, anything with the word 'centre' in it) that are used in letterheads, emails or on their doors (score 10 points)? Do you have/use a title like this (add 15 bonus points)?
5. Have you ever said the word 'RAE-ABLE' and meant it (score 15 points)
6. Does your Department/Institution/Workplace have a mission statement (score 15 points)? Has your boss/Head of Department ever quoted any part of it (add 5 bonus

points)

7. Do you find yourself in meetings that you do not know the point of more than once a month (score 15 points for each meeting)? Do any of these meetings have the word 'advisory' in their title (add 15 bonus points for each)?
8. At your last staff meeting how many people did you fail to recognise (score 5 points for each person)? At your last staff meeting did your boss/Head of Department fail to recognise you (add 20 bonus points) or call security (add 30 bonus points)? (If you no longer attend staff meetings then subtract 10 points from your overall score.)
9. Has someone in authority recently suggested a way of reorganising your Department/Institution/Workplace that is so bizarre that no one actually understands it and when asked to explain it they change the subject (score 15 points)? Was the suggestion put into practice (add 30 bonus points)?
10. Has your Department/Institution/Workplace recently appointed a Professor with the words 'health' and 'economic(s)' in close proximity in their job title (score 10 points for each instance)?
11. Do you know how many cups of coffee are too many (score 15 points)?

Score Under 70: You have either retired from work, recently won the lottery or are so out of contact with reality that it does not matter anymore. Sit back, pour another drink from that secret stash you keep in your desk and enjoy yourself.

Score 70-200: You should probably make sure your CV is up to date and maybe buy the Guardian on Tuesdays (or check out that mini-cab firm advertising for drivers at the end of your street). You should also put any potentially offensive weapons out of your reach. Maybe think about setting up a secret drink (or drug) stash in your desk.

Score over 200: Once you have finished reading this get up and leave the building. Once outside start running and don't look back, keep running...

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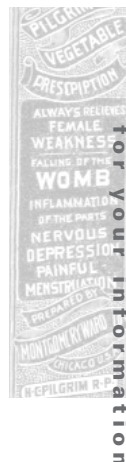
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