

**Medical Sociology News**  
**Vol 30 No 3**  
**Winter 2004**







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**EDITORIAL: WELCOME TO OUR WINTER EDITION**

We could not resist opening our editorial with a recent quote about sociology from *The Lancet*, which the editors of that esteemed organ found so interesting (funny?) that they put it on the front cover:

*“The days when medics cut up dogfish have long gone (and many no longer even cut up Homo sapiens, so anxious are they to get to their sociology course).”*

S. Jones (2004) A pilgrimage from Pliny to Powell via platypus (book review), *The Lancet*, **364**: 1117-8.

**Professor Meg Stacey**

People who knew Meg Stacey have spoken warmly of the last edition of MSN. We would like to say thank you to Gillian Bendelow for being guest editor of that edition and also to all those who sent in contributions. We apologise for the omission of the piece from the Centre for Research in Health, Medicine and Society and the Department of Sociology, University of Warwick, but are pleased to include it in this edition.

**A Bumper Issue!!**

There are five very interesting articles in this edition. Judith Green has kindly submitted her plenary from the recent Medsoc conference in York, which is good news for those of us who were unable to attend. In this paper, *‘Professions and Community’* she raises a number of interesting questions about the nature of ‘professionals’ and ‘professionalism’ and examines two discourses in the context of ‘community’ and ‘community development’ as well the historically changing nature of expert knowledge.

We are also pleased to have Margaret Reid and David Armstrong’s much sought after and requested article ‘Guidelines on evaluating qualitative research proposals in health services research’. This should hopefully meet the demand created by many people asking for a reprint of Mildred Blaxter’s article on this topic which was published in MSN 22:1 and which we referred to in edition 30:2. Clearly there is a pressing need for guidelines on how to write and evaluate qualitative research even among the experts!

We have a very topical essay on incapacity benefits and pensions from Patricia de Wolfe. We also have a more light-hearted piece by Edwin van Teijlingen on the competing demands on the medical sociologist's time, making it difficult to write anything, let alone top quality articles in highly rated journals. The usual crop of PhD abstracts and book reviews are included, as are a few problems intended for Marge. There are conference reports, news and notices which we hope you will also find of interest.

Due to the large and welcome deluge of material received, the last edition of MSN was longer than usual! Though excellent news, this stretched our finances somewhat. To make life a little easier and to keep our budget in check, it would be appreciated if future articles submitted for inclusion could be no more than 2500 words and should be suitable for a general medical sociology audience. Please try to avoid footnotes and send copy in as an email attachment. Anything submitted will be peer-reviewed by members of the editorial team.

### **A Division of Labour!**

We are all very busy and have had to reorganise our lives to accommodate the production of MSN on a tight budget and with the usual time restraints. We therefore request that for the Spring 2005 issue anyone with queries or copy for submission contacts members of the editorial team as follows:

Maureen Porter	<a href="mailto:m.a.porter@abdn.ac.uk">m.a.porter@abdn.ac.uk</a>	subscriptions
Fiona French	<a href="mailto:fiona.french@nes.scot.nhs.uk">fiona.french@nes.scot.nhs.uk</a>	PhD abstracts
Karen Forrest	<a href="mailto:k.forrest@abdn.ac.uk">k.forrest@abdn.ac.uk</a>	book reviews
Chris Yuill	<a href="mailto:c.yuill@rgu.ac.uk">c.yuill@rgu.ac.uk</a>	articles/advertising
Edwin van Teijlingen	<a href="mailto:van.teijlingen@abdn.ac.uk">van.teijlingen@abdn.ac.uk</a>	Aunt Marge
Lydia Lewis	<a href="mailto:l.lewis@abdn.ac.uk">l.lewis@abdn.ac.uk</a>	regional & study group events
Steve Brindle	<a href="mailto:s.j.brindle@abdn.ac.uk">s.j.brindle@abdn.ac.uk</a>	other forthcoming events & conference reports

**We look forward to receiving contributions for the April issue by the end of February 2005 (on time please!)**

As with everything else costs of producing MSN are increasing. Reluctantly, and after much soul searching, we've had to raise the subscription fee for 2005. We hope that you will feel that MSN still represents good value for money. So now is the time to buy yourself that Christmas present you really deserve and take out your 2005 subscription! Details are at the back of this edition, but please note we need subscriptions soon otherwise 2005 may be an MSN-less year!

Lastly, we wish all our readers a Merry Christmas and a Happy New Year. Here's to a well-earned rest over the festive season!

*Nollaig Chridheil* (as they say in Scotland)!

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

### TRIBUTE TO PROFESSOR MARGARET (MEG) STACEY

Meg, Emerita Professor of Sociology, came to our department in 1974 and remained academically active, despite retiring in 1989, until very recently. For over 25 years she was an integral member of our department and was included in our RAE entry in 2001. We pay tribute to her scholarship, leadership and warmth. She was the first woman professor at Warwick and she successfully chaired the Department between 1974 and 1979.

Meg was a woman of compassion and conviction who put into practice her inclusive vision of society. She was a pioneer in the feminist movement, an eminent scholar of gender, health and healing, and an inspirational teacher.

Her research and publications span many important social issues, from her studies of *Tradition and Change* in Branbury and the welfare of children in hospitals, to the book that won the Fawcett prize on *Women, Power and Politics*, and other works on the regulation of British medicine and the legal and ethical dilemmas of the new reproductive technologies. A guiding theme in all Meg's work was 'to make a difference' and to mitigate intended and unintended suffering in medicine, health care and beyond. Meg led by example, challenging oppression and opening up new ways of seeing things in the best traditions of sociological and feminist scholarship.

She opened the eyes of both medicine and academe to the hidden, unpaid work of women and children in the health care division of labour and to the reliance of the public world of production on the private world of reproduction. This was a case, as Meg wryly put it, of 'overcoming the two Adams' in which Adam Smith's formal division of labour and Adam and Eve's informal division of care subordinated women's work. She pioneered a dialogue between the voice of medicine and the voice of the lay-world. This was an important precursor of the contribution of social science to medical curricula, including that of the Leicester-Warwick Medical School.

Meg was a founder member of the Centre for Women and Gender Studies and the Centre for Research in Health, Medicine and Society at Warwick (now absorbed into the new Institute of Health). She also served as a lay member on the General Medical Council from 1976-1984, and was Executive Chair of the Human Values in Health Care Forum. In April 1999 an international gender, health and healing conference, hosted by the Centre for Research in Health, Medicine and Society, was held to celebrate Meg's life and work. It was a truly memorable and momentous occasion and a testimony to the affection as well

as respect that Meg enjoyed across the public / private divide.

Meg died on 10<sup>th</sup> February 2004. She will be sorely missed as a colleague and a friend, an advocate and ally, a mother and companion. Perhaps, most of all, she will be remembered for the warmth of her smile, the twinkle in her eye and the wisdom of her words, leaving us all to pick up where she left off. We will do our best, Meg, promise...

**Centre for Research in Health, Medicine and Society and Department of Sociology, University of Warwick**

## NEWS AND NOTICES

### Regional and Study Groups

#### London Medical Sociology Group: 2005 Programme

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

Time: 6pm – 7pm

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

12 Jan	Patient Advice and Liaison Services: Life in the Frontierland of NHS Culture	Julienne Meyer City University & Anne Lanceley University College, London
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9 Feb	“It is not a cat and mouse game. It’s communication”: Participation in consultations	Fiona Stevenson University College, London
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9 Mar	Risk and uncertainty: Analysing stroke survivors narratives	Andy Alaszewski University of Kent
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13 Apr	“In defence of self” reactions to stigma among dyslexic students in German higher education	Miranda Leontowitsch English and University College, London
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For further copies of this programme please contact Paul Godin 020 7040 5933. To receive details of all LMSG meetings visit the BSA website: [britsoc.co.uk/](http://britsoc.co.uk/) Joint LMSG Organisers: Richard Compton, Jacqueline Davies, Paul Godin (Convenor), Miranda Leontowitsch and Susan Robinson (Treasurer)

**Scottish Medical Sociology Group**

In 2005 we are planning two meetings:

- Roundtable on recent developments on ethics & the work of ethics committees
- Health policy and practice implications of violence in families

Details will be circulated through the usual channels, including seminar news in December.



**West Midlands Medical Sociology Group - Call for Abstracts**

Postgraduate Forum: Social Aspects of Health, Illness and Medicine  
Venue: University of Warwick, Wednesday 25<sup>th</sup> May 2005, 10am – 4.30pm.

With a keynote address by Dr Simon Williams, University of Warwick

Following the success of the event last year, the West Midlands Medical Sociology Group and the Forum for Health, Medicine and Society would like to invite you to participate in a postgraduate forum that explores social aspects of health, illness and medicine. The postgraduate forum provides a supportive, informal and constructive venue for research students to share ideas, discuss work in progress and explore different research approaches.

We have organised a full day event that includes lunch, coffee and tea and there is no charge for this meeting. There are some limited funds to contribute towards some participants' travel costs. The number of places is limited. We are now looking for research students who are willing to present their research, so please do send a 150 word outline of your presentation by 25<sup>th</sup> March 2005 if you would like to participate in this exciting new forum. If you wish to send an abstract or attend this forum please contact [Cecilia.Olivet@warwick.ac.uk](mailto:Cecilia.Olivet@warwick.ac.uk). We look forward to hearing from you.

**West Midlands Medical Sociology Group – Meetings in 2005**

**Venue: R3.41 University of Warwick** (Level 3, Ramphal Building, Central Campus)

The West Midlands Medical Sociology group would like to invite you to the following meetings. The meetings include a presentation by a speaker followed by a discussion of their research from 5.30 to 6.30 pm. Refreshments are available from 5 pm. Directions and campus map can be found at <http://www2.warwick.ac.uk/about/visiting/>. Everyone is welcome, especially research students and those new to the field.

23 Feb	'Making Sense of Motherhood: A Narrative Approach'	Tina Miller, Oxford Brookes University
4 May	'Caregiving, Mental Health and Ethnicity: an Irish dimension	Stephen Handsley, The Open University

Co-convenors: Wendy Martin, Stephen Handsley and Alan Bradley.  
For further information please contact Wendy Martin,  
[W.P.Martin@warwick.ac.uk](mailto:W.P.Martin@warwick.ac.uk).

**THE BRITISH SOCIOLOGICAL ASSOCIATION  
ANNUAL CONFERENCE**

**THE LIFE COURSE: FRAGMENTATION, DIVERSITY AND RISK**

*Monday 21st - Wednesday 23rd March 2005  
at the University of York*

**Plenary Speakers will be:**

**Professor Liz Stanley (University of Newcastle Upon Tyne)**

**Professor Jenny Hockey (University of Sheffield)**

The new social demands and complexities of life in 'late modern' or 'postmodern' global societies are transforming the life course. In an age of 'flexible' working practices and shifting family arrangements, the fundamental co-ordinates of social life are becoming ever more transitory and uncertain. At the same time, increasing social pressures towards individualisation and a common (mediatized) knowledge of 'panics', 'crises' and 'catastrophe', leave the majority with a heightened sense of personal insecurity and social unease. Under such circumstances it appears that we are made increasingly conscious of the fact that social life is characterised above all by experiences of fragmentation, diversity and risk. People are being made to question the prevailing ideas of who they are and what they should get out of life. Moreover, it can be argued that the cultural pluralism and reflexivity of society at large is mirrored in the extent to which western sociology has become a repository for expressions of personal discontent and a 'celebration' of ideologies of difference. It is no longer possible to identify sociology with a common set of intellectual practices and disciplinary concerns; the sociological enterprise is as fragmented and uncertain as the societies it seeks to explain. How should we respond to this state of affairs? What is the 'promise' of sociology for our times?

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

*The Fragmentation of Youth  
Work, Family and Negotiation  
Caring Across the Life Course  
Social Identities and the Life Course  
Gender, Race and Sexuality  
The Lived Experience of Class  
Making Sense of Life Trajectories  
Methodological Approaches  
Individualisation and Risk*

Further information available from:

The BSA Website: [www.britsoc.co.uk/conference](http://www.britsoc.co.uk/conference)

E-mail: [Conference2005@britsoc.org.uk](mailto:Conference2005@britsoc.org.uk)

Conference organising team and stream convenors

Miri Song, Sarah Vickerstaff, Azrini Wahidin and Iain Wilkinson (University of Kent).

**REGIONAL AND STUDY GROUP ANNUAL REPORTS**

**Wales Study Group**

**Convenors: Dr Lesley Griffiths and Dr. Susan Philpin**

This group continues to present research seminars roughly four times a year. These are well attended and provide opportunities for networking as well as lively discussions. Our programme this year has been as follows:

**24 September 2003 Cardiff**

Professor Laurence Moore, Director, Institute for Society, Health & Ethics, Cardiff University, School of Social Sciences

**Can a schools-based, peer-led intervention reduce the uptake of smoking by adolescents?**

Dr Edward Coyle, Director, Wales Centre for Health

**From Beveridge to Wanless: A modern framework for public health action in Wales**

**30 October 2003 Swansea**

Dr. Cecilia Rohrbach Viadas, Health Department, Puebla, Mexico

**Another perspective on ageing: a comparison between a traditional village and a peasant community**

Dr. David Greaves, School of Health of Science, University of Wales, Swansea

**A commentary on an essay by Virginia Woolf – “On Being Ill” (1926)**

**29 January 2004 Swansea**

Dr. Sarah Li, Social and Behavioural Sciences, Faculty of Health and Social Care Sciences, Kingston University & St. George’s Hospital Medical School, Surrey

**Doing criticism in symbiotic niceness**

Tessa Watts, School of Health of Science, University of Wales, Swansea

**Being there – some reflections on the emotional dimensions of fieldwork in specialist palliative care**

### **30 June 2004**

Dr Frances Rapport, Primary Care Group, Swansea Clinical School, University of Wales, Swansea

### **Using phenomenology to explore decision making in Assisted Reproductive Technology**

Professor Lindsay Prior, School of Social Sciences, Cardiff University

### **A virtuous circle? Combining quantitative with qualitative methods in HSR - the case of an outcome measure.**

Next year's programme is currently at the planning stage but will include presentations by Maureen Deacon on her ethnographic work in an acute mental health ward and Sue Philpin's work on an intensive care unit.



### **BSA London Medical Sociology Group**

Organising committee: Richard Compton, Jacqueline Davies, Paul Godin (convenor), Miranda Leontowitsch and Susan Robinson (Treasurer)

The London group has had a very successful year. We have had an excellent set of presentations from established medical sociologists and those who have recently completed their PhD. Whether about genetics, ageing, complementary medicine or bodybuilding, we try to bring to you the most interesting and thought provoking speakers we can. If you would like to present a paper or know someone else who might, we would be delighted to hear from you for future programmes.

Once again, our Xmas quiz night was a huge success, with people coming from within and outside London to take part. Our combination of 'match the medical sociologist to her/his person to the first degree', current events, book titles and music rounds meant that all the teams had a chance to drink their way through two fun filled hours while still (if only gently) working their sociological muscles. We are already planning this year's and think it will become the London social event of the festive season.

We are looking forward to the year 2004-5. We would like to remind everyone that people of all stages of their careers or education are welcome at our

meetings, as are people from clinical backgrounds and other academic disciplines. We always go out for a drink and a meal after the presentations and everyone is invited to come along, join in, buy a round and just enjoy medical sociology for the evening. Hope to see more of you in 2004-5.



**West Midlands Group**

**Convenor Hannah Bradby, University of Warwick**

The West Midlands Group has co-sponsored three lively and well attended events this year all held at the University of Warwick and attended by scholars from as far afield as Canada, Portugal and Scotland. Admittedly these people may not have been primarily drawn to the Coventry area because of the BSA West Midlands Medical Sociology Group activity, but we hope to have promoted their speedy return to the locality.

During May (19<sup>th</sup> and 26<sup>th</sup>) we held two half-day meetings at which a total of nine postgraduates presented their research. The idea was to provide constructive and friendly criticism of ongoing research which might provide a staging post for presentations to a wider audience. This suggestion clearly met a need, since the level of interest was high, with a total of 45 people participating over the two days from six different Universities. Presentations ranged from the lived experience of Cystic Fibrosis to hunger and food insecurity in Portugal and the social determinants of child health in Malaysia. Theoretical approaches drew on feminism, Heidegger and phenomenology and quantitative and qualitative methods were represented, including some lovely visual aids to qualitative interviewing older people. The standard of presentation was high and certainly comparable to any mainstream research meeting, which bodes well for the future of health research in sociology. Informal networking was promoted by the provision of lunch. For further details see:

[http://www2.warwick.ac.uk/fac/cross\\_fac/healthatwarwick/past\\_events/postgraduate\\_forum/](http://www2.warwick.ac.uk/fac/cross_fac/healthatwarwick/past_events/postgraduate_forum/)

On June 16<sup>th</sup> a colloquium entitled ‘Social Aspects of Ethnicity and Health: Research and Service Provision’ attracted over one hundred registrations. Representatives from the worlds of policy-making, funding, service provision, service use, academic research and the voluntary sector made for a day in

## Regional and Study Group Annual Reports

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which the politics of inequality was never far from the top of the agenda. The fraught issue of the role that research should play in redressing the well-documented inequities along lines of class, ethnicity and gender was the main focus of discussion.

Professor James Nazroo (University College London) opened the day with a paper on health inequalities, using familiar census ethnic group categories and empirical data as a spring board to thinking more deeply about the complex inter-relations of gender, generation, racism and class that make up ethnicity and the circumstances that influence when it comes into play as an identity. This was followed by the launch of the National Centre for Research into Ethnicity and Mental Health with presentations from Professors Sashi Sashidharan and Scott Weich of the University of Warwick and Professor Clair Chilvers of the Department of Health, each followed by general discussion. After lunch presentations on current research were given by Dr Tarani Chandola of University College London (on researching health inequalities), Dr Lorraine Culley of De Montfort University (on infertility services and ethnicity) and Dr Hannah Bradby of the University of Warwick (on mental health services and institutional racism). Using different approaches and methodologies these papers analysed and evaluated the contribution to differential and poorer outcomes for minority ethnic groups of pathways through and perceptions of care. The day closed with Dr Maria Stuttaford of the University of Warwick reminding the conference of the significance of June 16<sup>th</sup> as Soweto Day, and giving timely consideration to the possibilities of emancipatory research. She urged researchers to ask who will be emancipated by the next piece of work undertaken and to consider how this might be measured.

For further details and the power point slides shown see: [http://www2.warwick.ac.uk/fac/cross\\_fac/healthatwarwick/past\\_events/ethnicity\\_and\\_health/](http://www2.warwick.ac.uk/fac/cross_fac/healthatwarwick/past_events/ethnicity_and_health/)

The convenorship of West Midlands Group passes to Wendy Martin and Stephen Handsley, both of the Department of Sociology at the University of Warwick.

The **Scottish Medical Sociology Group for 2003 - 2004** focussed on two subjects which were '*Families, Violence and Health Care*' and '*Research Ethics*.'

In March 2003, we held a joint meeting of the Scottish Medical Sociology Group and Centre for Research on Families and Relationships. *Marsha Scott & Fran Wasoff* spoke on the subject of - '*Scottish domestic abuse policy in context: a new era of welfare feminism?*' They suggested that Scottish domestic abuse policy is structured around the "3 Ps": prevention, protection and provision. How service provision is privileged within that framework, particularly services for women with children, and how the unified phrase "women and children" dominates the policy discourse, raises some interesting questions about the direction of current policy. This session explored those questions and the wider implications of policy that constructs women's rights and needs chiefly through their role as mothers in the family. *Ann Ferguson*, Elder Abuse Project Leader Age Concern spoke on the subject of Scotland '*Breaking the Silence on Elder Abuse*.' This presentation drew on UK and other research with a view to establishing the prevalence of abuse of older people in Scotland, the types of abuse, where abuse occurs and who the perpetrators are likely to be. Anne also illustrated the impact abuse can have on an older victim, particularly when family members are involved and how older victims can respond is a range of abusive situations. The availability of support services, legal remedies and other solutions was outlined as were the gaps, which currently existed.

In October a seminar was held on the subject of '*Child Protection: International and Interprofessional Aspects*'. *Malcolm Hill* began by outlining key features of the *Scottish Review of Child Protection*, which culminated in the Report of 2002 and a 3-year strategy for improving relevant services. This was placed in the context of shifting approaches to the ill-treatment of children in the UK over the last 30 years, which includes a change from a predominantly medical model in the 1960s to a legal/social work led approach currently. The Review included consideration of different approaches to child protection in certain other counties. Malcolm highlighted some of the key differences in assumptions, policies and practices, with respect to British-North American models and continental European models. Again, attention was given to the roles and status of different kinds of profession and agencies.

The Scottish review was instigated following the death of a young child in Dumfries and Galloway. In addition to this national review, individual agencies have also been involved in evaluating child protection systems. The Greater Glasgow Health Board is one of these. *Pam Green Lister* was the second speaker and she presented the findings of her research which was conducted with the Greater Glasgow Primary Care NHS Trust on nursing and child

protection. This research examined the involvement of community nurses in the Trust in the field of child protection, focussing on their support, supervision and training needs. The findings are based on a survey of nurses and interviews with a range of key stakeholders in the Trust. The importance of clinical supervision for health professionals has been emphasised in a range of governmental and professional policy documents. Yet, a review of the literature suggests that there are considerable variations in how clinical supervision is understood by health professionals. The focus of her presentation was on the understanding and experience of Trust staff clinical supervision in child protection work.

In June 2004 the Scottish Medical Sociology Group hosted a further seminar on the topic of Families, Violence and Health Care. *Debbie Hindle*, Senior Tutor at the Scottish Institute of Human Relations in Edinburgh and Glasgow talked on the topic of *'The Emotional Abuse of Children'* and *Sarah Nelson*, Research Fellow in Sociology, University of Edinburgh talked on the topic of *'The Physical Health Consequences of Childhood Sexual Abuse: "The Body Keeps the Score."*

A recurring theme for the Scottish Medical Sociology Group is research ethics. In February 2003 we organised a seminar with the Socio-Legal Studies Association on *'Research Ethics, Research Governance, the law and you.'* *Ursula Huws* presented the work of the RESPECT project, funded by the European Commission to develop professional and ethical guidelines for the conduct of socio-economic research in the information society (<http://www.respectproject.org/code>). *Moira Nolan* from the Scottish Executive Health Department Chief Scientist Office provided an overview of the aims, key roles and responsibilities of the Research Governance Framework and outlined the process for achieving compliance (<http://www.show.scot.nhs.uk/cso/>). *Michael Adler*, Professor of Socio-Legal Studies at Edinburgh University, outlined the response of professional associations and higher education institutions to growing concern with the legal and ethical aspects of social research. He paid particular attention to problems associated with secondary analysis, data protection and research involving children and vulnerable adults.

**Sociology of Mental Health Study Group**

**Convenors: Lydia Lewis and Louise Woodward**

We are pleased to announce that this group was launched this year. A call for interest that appeared in the Spring issue of MSN received a vast number of responses and led to Louise Woodward agreeing to co-convene the group. A first meeting was held at the Med Soc conference in September and was well attended, giving the convenors the opportunity to discuss group aims and activities with those present. The group is presently in the process of establishing its web site within the BSA Medical Sociology Group web site and hopes to hold its first event in June next year.



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### CONFERENCE & EVENT REPORTS

#### ***Your Disco Needs You!* Some reflections on this year's Med Soc Conference at York**

Another excellent conference this year bore witness to the vitality and depth of medical sociology, boasting a wide range of contributions touching on a variety of methodological, theoretical and substantive concerns. The two plenary speeches by Peter Conrad and Judith Green gave a good thought-provoking lift to the conference with delegates particularly appreciating Peter timing his talk to neatly coincide with a free wine reception! Most delegates this year were very upbeat and enjoyed the quality of papers and the seamless wonderful organisation.

There was some controversy however. Due to the increasing instabilities of Med Soc's finances various trimmings and belt-tightenings have been necessary. One of which was the cancelling of a Med Soc staple – the last night disco. Over the years this has provided the emotional effervescence that keeps us all hyped up and committed to charting new regions of medical sociology during the dark days between conferences. Over the years, especially, at York we've boogied, though with varying degrees of rhythmic accomplishment, till after midnight, often partying on till way after people of a certain status and responsibility should boogie and party. Obviously though, this has nothing to do with the occasional subdued attendances and participation in the morning sessions the day after! The news, then, that there would be no disco this year was met with a combination of disbelief and anger. Would this mean that the last night would just fizzle and whimper out with a few civil drinks in the bar over routine and polite conversation? Would we be deprived of witnessing sagacious grey bearded professors and eager young postgrads sharing the same dance floor? Surely not! At one point there was even mutinous whisperings of forming a 'Save the Disco Campaign'.

Everything was looking bleak and forlorn– but in that darkest of nights one star shone brightly and that was the jukebox in the bar. Digging out as much small change as possible, delegates sifted through the catalogue punching in any and everything that one could shake one's PhD to! Disco, indie, punk and pop classic floor fillers boomed out and the dance floor was more packed than ever! Though there must be an immediate Med Soc committee investigation as to who it was that selected the sequence of mournful dirge-rock of Radiohead and Coldplay that interrupted the happy discofest.

Overall, a superb improvised and spontaneous evening with the jukebox disco perhaps becoming set to be a future highlight?

**Dr E Waugh Brideshead College.**



**Sociology of Mental Health Study Group**

**Report of first meeting held at BSA Medical Sociology Group Conference, Friday 18<sup>th</sup> September 2004, 12.30-1.15pm  
Convenors: Lydia Lewis and Louise Woodward**

We were extremely pleased to see a total of 16 delegates attend this first meeting of the Sociology of Mental Health Study Group, the proceedings of which were most encouraging for the future of the Group.

The meeting began with the convenors and others present introducing themselves. Referring back to a call for interest posted in the Spring issue of Med Soc News this year, Lydia then explained how Louise had expressed an interest in co-convening the Group and how between them they had arrived at the first workshop. The reasons for setting up the group were explained as follows:

- **Heightening the profile of the area of study.** It was felt that the Sociology of Mental Health is still somewhat marginalized within Medical Sociology as a whole, and although there seems to be a lot of activity in the area, there currently lacks a forum for bringing this together.
- **Networking and information-sharing.** It was also felt that the Group could serve this function, particularly by enabling connections between people working in different kinds of environments (eg. Sociology Departments, Medical Schools, NHS Trusts, etc.)
- **Support.** There was a general feeling speaking to colleagues working in this area that it can be very challenging, especially if one's work is challenging to the dominant psychiatric paradigm, and so the Group could also serve a support function by helping to bring together individuals with similar interests or perspectives.

Discussion began around the following agenda items:

- **Aims, objectives of the Group.** To those outlined above, the following ideas were added:

- information-sharing could include circulating references and cross-fertilisation of papers;
- networking would serve the important function of enabling the sharing of ideas and facilitating collaboration.
- **Scope of the Group.** Discussion here centred on the 'boundaries' of Sociology of Mental Health, the political nature of decisions about substantive focus and who the Group should aim to include.
  - **Substantive focus.** Possible overlaps with other study groups, such as the Emotion Study Group within the BSA, were noted. It was decided that the Group should not be too narrowly focused and should encompass more peripheral areas, keeping its boundaries 'elastic', particularly as barriers between Sociology of mental health and other area of study are breaking down. However it was also acknowledged that the Group should be careful not to overlook issues of exclusion relating to mental health and should retain a user focus. A short discussion ensued about whether the Group should be named 'Sociology of Mental Health and Distress Study Group' but it was decided that the shorter version of the name should be retained for brevity, whilst ensuring that the Group's statement of intent makes clear that 'mental health' also encompasses mental distress/illness in analytical terms.
  - **Group membership.** It was decided that the Group should be open to and encourage the joining of anyone with an interest and should not be confined to academics working in the field.
- **Group Activities.**
  - **Web site.** A Group web site within the BSA Medical Group web page should be set up by the end of the year. It was stated by LL and LW that the above discussion would be used to formulate an introduction and aims/objectives of the Group for the site. Draft of these to be circulated to members for comment before being posted on the site. LL and LW suggested that a link within the site to members' details with associated areas of interest could serve a networking function. All members to be contacted about this. It was also suggested that the web site could also be used to post papers. LL and LW to look into the practical feasibility of this and to report back.
  - **E-mail discussion list.** A number of people expressed the view that members would not necessarily find this helpful as people often

don't have time for such 'on-line discussing'. LL gave details of an on-line discussion group named Qualimentalhealth initiated by Janet Stoppard at the University of New Brunswick, Canada, that seems like it could be aiming to serve this function for qualitative researchers in mental health. Members to contact LL if they would like details about this.

- **Activism.** Suggestion that the Group could serve an activist function or at least help facilitate this. Discussion of whether the Group would want to comment on Government policy documents, for example. Decision that if members want to collaborate to do this, the best way would be through the Mental Health Alliance.

- **Seminars.** Decision to hold a day or half-day seminar in June next year. Venue tba but Edinburgh or Nottingham would be possibilities, as would be Bradford, home of 'Critical Psychiatry', or other centres of relevant activity. Offers of help with organising a venue were received from members present. Decision that the event should have a theme but this should be kept broad enough so as not to be too exclusive. The point was made that applications for funding (eg from ESRC) might help decide this. Inviting speakers as well as putting out a call for papers would be a good idea. The holding of more local seminars was also discussed as a good idea and although outside the scope of what the convenors could arrange in the next year, others would be welcome to use the group to organise such events. The website may be used, via the convenors, to notify the group of any forthcoming seminars which may be of interest. Other 'outputs' in the form of publications from the Study Group's events would also need to be kept in mind.

- **Funding.** LL/LW to apply for funding for the June event from the SHI Foundation and also to look into other possibilities such as British Academy and ESRC (although it was felt that the latter would be more achievable in the second year of running). Possibility that LW could get some financial support from her employer. Paul Godin, BSA Medical Sociology study-group co-ordinator, stated that there is £150 available to each study group on an annual basis but groups are encouraged to self-fund eg. by charging a fee for attendance at events or to find alternative sources of funding as discussed.

The meeting ended with the convenors thanking everyone for attending (and with attendees thanking us for initiating the Group!). It was decided that a

similar meeting will be held at Med Soc next year when the Group's development and activities will be reviewed.

### **Convenors' contact details:**

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### **Scottish Medical Sociology Group**

#### **October Workshop: User Involvement and Creating Public Value in Health Care: Questioning Arnstein's Ladder**

**Jonathan Q Tritter, University of Warwick**  
**Alison McCallum, STAKES, Finland**

The Scottish Group hosted a workshop run by Jonathan Tritter and chaired by Lydia Lewis (University of Aberdeen) and Linda McKie (Glasgow Caledonian University). This was based around a paper jointly authored by Jonathan and Alison. The workshop opened with Jonathan outlining debates on user participation, in particular defining the term and processes therein. Participants reviewed their own experiences and these informed subsequent discussions. Later that afternoon Jonathan presented the paper (see abstract below).

#### **Abstract:**

User involvement or public and patient participation has emerged as a key health policy theme over the last five years not only in the UK but also internationally. All such policy statements reference Sherry Arnstein's seminal article 'A ladder of citizen participation' published in 1969, but do so uncritically. The paper outlined the evolution of user involvement in English health policy, examined some international examples and identified different kinds of involvement and the distinction between involvement and empowerment. A discussion of participants' experiences of user involvement led to the second half of the presentation which focused on the factors that Arnstein's model does not take into account, referred to as missing rungs and the adverse effects, or snakes, on Arnstein's ladder. The final section of the paper discussed a way of understanding user involvement within a broader public value theoretical framework.

### **International Joint Congress: European Perspectives on Changing Health Systems**

European Society for Health and Medical Sociology [ESHMS] and la Societa Italiana di Sociologia della Salute [SISS] Bologna Sept. 2004

Who could resist Bologna in September? After all, Italy has everything - history, culture, music, art, architecture and cuisine. Surely many saw it as a holiday opportunity when news first filtered through of this conference. We both certainly weren't slow in deciding to tack some extra days onto our conference bookings!

And Bologna didn't disappoint, revealing itself (for the second time for one of us) as a truly beautiful city with an easy-going atmosphere often lacking in tourist centres such as Rome and Florence. The 'red city' (named to reflect both the colour of its buildings and its political history), small enough to stroll around - and in the comfort of the shade due to its colonnade-lined streets - proved to be the perfect conference retreat.

We registered in the magnificent Aula Magna which seemed to be a church converted into a conference hall. The first part of the afternoon was given over to speeches by various dignitaries, welcoming us to Bologna and wishing us "fruitful discussions" (as the translator put it on each occasion!). There followed several scene-setting papers on shifts in health-service financing and health-care reforms in Eastern, Southern, and Northern Europe. Some were interesting but did not lend themselves to the opening of a 'debate' as programmed. We fell exhausted upon the little cakes which accompanied coffee, and left before the end.

The evening meal in a local restaurant followed by musical entertainment was a chance for us to meet old friends and make new acquaintances. Held in a lovely partially open-air setting, the 'social dinner' had to be the highlight of the event. I (MP) was delighted to find myself next to some Italian ladies who spoke little or no English. It was great practice for my halting Italiano. Although they had not been on the menu, the chef prepared course after course of delicious vegetarian dishes for those who requested them. We all ate and drank incredibly well.

The second day saw us in the university buildings. Bologna claims to be the oldest university in Europe; it is certainly one of the most beautiful, with every room classically proportioned with frescoed walls and ceilings and stained glass windows. This was the scheduled day for 'submitted' papers and the talks were the usual mixture of polished and thought-provoking presentations.

However the timetabling (of 9 parallel sessions with up to 9 presentations in each, with 20 minutes per talk and question-period) meant that it was not possible to attend everything one might have wished. In addition, this left very little time for discussion and the poor chairing of some sessions meant that presentations weren't kept to time or the amount of questions allowed varied unaccountably. The linguistic challenges presented by international conferences such as these were also inevitably present.

Lunch was excellent and served and eaten *al fresco* in the University's Winter Garden. Perhaps it was the wine which accompanied it, or the warm Bologna air, but the place seemed to empty after the meal. This did, nevertheless, provide a good (and extended!) opportunity for networking and discussion.

We presented our papers in the afternoon session. Extra papers had been slotted into mine (MP) with the result I eventually gave my paper an hour late to an audience of other speakers and perhaps two others. The last paper of this session was interrupted several times by people wanting to use the room! I (LL) also had my paper interrupted by an announcement allowing no time for questions! The event concluded the next day with plenary sessions back in the Aula Magna. Unfortunately these were not well attended with many delegates slipping out before the end. However it did provide a very interesting glimpse into the development of medical sociology in the Italian context.

Overall, the event was enjoyed by both, but we have to say the organisation did let it down occasionally. Obviously the organisers cannot be held responsible for delegates not attending sessions and this may be a consequence of the exotic venue. (Certainly this also happens at medical conferences in foreign locations.) However, it was difficult to ascertain in advance where the conference venue was and where sessions were taking place on the two days! We did manage to find them through our own ingenuity but not without a lot of investigation and walking. It seemed, though, that a good time was had by all and we do congratulate the organisers for initiating this European-wide event, a follow-up to which is already planned.

**Lydia Lewis & Maureen Porter, University of Aberdeen**

## **ARTICLES**

### **Professions and community**

**Judith Green**

**London School of Hygiene & Tropical Medicine**

Like many social scientists, we have recently been involved in a number of projects aimed at evaluating or informing policies that address inequalities. In our case these include a Food Standards Agency (FSA) funded study of ways to include hard to reach groups in policy consultations (with Jessica Mitchell, Alizon Draper, Ulla Gustaffson and Nicki Thorogood); a study for Thames Chase Community Forest that was prompted by concerns about 'barriers' to the use of green space (with Ruth Pinder) and some work on current policies to address inequalities in accidental injury rates. In thinking about how to research particular communities, and on the usual things commissioners are interested in, such things as barriers to using services, or enabling disadvantaged communities to have a voice, we have, inevitably, ended up having to think about not the nature of the communities themselves, but the relationship of policy implementers to the groups that are the 'targets' of such interventions.

This has raised a number of questions about what it is to provide or design a service for users. How should professionals relate to the communities that they serve or organise services for, and what effects might different models of relationship have on the outcomes of services provided? There has been recently considerable debate about what it means to be a professional in modern society, about how professionals should be organised (Allsop et al 2004), and on what kinds of public input there should be on professional governance. The concept of 'community' has also of course had a resurgence as a referent of policy recently, with sociological ideas entering the mainstream through public discourse on social capital as a route for redressing social inequality.

This paper is a tentative exploration of the possible connections between these twin concerns of professionalism and community, and why they might have some implications for the potential success of contemporary health policy initiatives aiming to redress inequality. To start, I'd like to flag one image of the relationship of professionals and communities that many will be familiar with, from the popular TV serial *Eastenders*. In the fictional world of Albert Square, we regularly see one professional – the local doctor – interacting with the rest

of the community in spaces such as the local market and pub, the Queen Vic. Characters such as Dr Trueman were seen in their professional capacity, but also as having social ties to the community in which they worked. Now there are two key things that might suggest these kinds of scenes are part of a fictional rather than documentary image of urban life in the UK.

First, this kind of social mixing of professionals and the (largely working class) communities they serve, actually rarely happens in urban areas - few working class people would have the kind of exchanges we saw between Dr Trueman and his patients. Indeed, most professionals (other than religious leaders) live apart from the geographical community they work with, and certainly rarely interact within the same social leisure spaces as their clients. Second, there is perhaps an obvious figure missing from the television images of the Queen Vic – that of the contract researcher in the corner, desperately trying to recruit participants for a focus group on Sure Start, Urban Renewal, or one of the many other complex social policies that are currently targeting the real life equivalent of communities such as that of Albert Square. These markers of fictionality are, I think, related. I'll start with the role of the professional within the community.

### **Narratives of profession**

In the classic Parsonian sense, the 'good professional' is affectively neutral: he or she does not let the emotions of social relationships impinge on decision making in the professional sphere. To 'be professional' implies a certain distance from the mess of emotional and social entanglements. But of course this has not necessarily meant that professionals have not been enmeshed in social networks and traditionally, it has been argued, doctors would perhaps have had the kind of cross-cutting ties across the communities they worked with that are suggested in images from *Eastenders*. Here for instance, in a piece reflecting on changes to health service from 1948, when he bought a partnership in Nottinghamshire just as the NHS was being established, one GP recalls the 1950s. Back then, he remembers:

*...we still lived 'above the shop' and great importance was still attached to belonging to the community. It was rare for the doctor to live outside the practice area. He might well be on the Parish or District Council, act as a school governor, and would certainly be active in organising the local fete or gala each year (McLaren 1999: 16-17)*

To a large extent this idea of a professional commitment beyond that of service provision has perhaps disappeared in urban Britain: and not just in terms of

health care. Dale Southerton (2002), for instance, in his study of three social groups in an English new town, found a sharp geographical as well as cultural separation of the professional and other classes there, reproduced in a finely divided housing market, in which each class knew exactly where they belonged spatially within the town. Southerton discusses the ways in which each group marked its boundaries through talk about the kind of people they were, compared with the other groups: what sorts of consumption patterns they had, what sorts of moral values and so on. The specific places they lived in located these cultural patterns. In the most affluent group, the most salient reference point for group identity was that of the 'professional': those in this area saw themselves, in distinction to the other two groups, as 'successful professionals'. (Southerton 2002:184). For the most long-established affluent residents 'community ties' referred to close social networks with other professionals. Community action (such as coming together on some voluntary project) involved working with others from the same tightly circumscribed neighbourhood, not others across the town from the other social groups. This is a very different notion of community from that painted above by the Nottingham GP.

I started getting interested in this spatial and cultural separation, and its association with another, more nostalgic vision of community, about ten years ago, when I was involved with a small project with GPs in south London (Green 1993, 1996). This project was commissioned by what was then the FHSA to address a 'problem' that they had identified; that of the comparatively large number of single-handed GPs still working in the area. These practitioners had small practices, often with no other staff other than perhaps reception help, often provided by family labour. They were regarded as a 'problem' because they did not fit well with the ideals of modern health service provision. They did not, it was argued, behave like modern professionals, in that they were relatively isolated from other doctors, with little access to ongoing medical education, and they had difficulties in providing the ever growing range of technical services that were expected from modern primary care. Single-handed GPs were, in short, apparently 'leftovers' of an old-fashioned kind of practice that really shouldn't still exist within the health care system of a modern city.

For the project, we carried out interviews with 25 of these single-handed GPs, and 25 GPs in partnerships (matched by age and gender) working in the same geographical areas. At the time, what struck me most was the very different ways that community was constructed in the two sets of interviews. For single-handed GPs, 'community' referred primarily to the practice population

that they both served and felt part of. For example, one described the catchment area of his practice as:

*My little parish here ... the little local population has its own particular problems, and I see my way forward as, if I'm going to remain single handed, as fitting in more with the local population with its peculiar problems, rather than anything else (Single handed GP)*

Another, on describing the satisfactions of his job, said:

*What I would call 'colloquial intimacy', little jokes, stories, being present in pivotal periods of people's lives, and playing some kind of practical role in that. Having people wave to me in the street when I ride my bike around. Er, having, being part of a community (Single handed GP)*

Now the partners, who worked in the same sorts of places, talked about them in very different terms:

*It's not nice for people walking in the middle of this estate (Partner)*

*Well, you see, there's the Axminster estate where they have riots, the Borrowdale estate where they have murders and the Chartwell estate where you find heads in dustbins ... On the walkways of the Axminster estate you're on your own. You might as well be on the North Pole. (Partner)*

Now it is perhaps unfair to make too much of the contrast, and there are some good reasons why the single-handers might want to stress the positives about their locale, and the partners the stresses. However, the imagery of 'my little parish' compared with 'the north pole' as ways of describing the geographical community within which you work was nonetheless striking. One describes a geographical space in which you belong, as a professional, and have a particular and ongoing, if rather patrician, relationship with; the other is an alien space, which you visit at your peril. The single-handers still talked very much of being part of the community within which they practised. In general they did all their own on call work, with responsibility for their list of patients 24 hours a day, seven days a week. This was not perceived as a particular burden; in fact there was considerable pride in managing this, and in knowing the patients so well that first, they rarely called out of hours, and second, if

they did, much of the work could be managed by phone.

The partners, working in modern, larger practices, talked instead about a clientele they came in to deal with, then left at the end of the day, often never covering evenings and weekends, except if on the rota. If not a place of danger, as in the quotes above, 'the community' (those people who constituted the practice list) were certainly 'work' and potentially troublesome work at that, creating excessive and ever growing demands. Indeed, when asked whether they would consider working as solo practitioners, most of the partners said that the demands from patients would be unbearable on your own.

When it came to describing professional colleagues, the tone of imagery was reversed. Partners identified with what could be called a 'professional community' describing their colleagues in warm and positive terms, and as a source of social as well as clinical support:

*I get a lot of support from the partners, sharing ideas, responsibility, concerns (partner, south London)*

Indeed one's colleagues were a bulwark against the stresses of this rather burdensome local community:

*I think the worst problem that single handers have ... is the inability to explode about patients to one another (partner, south London)*

In contrast, the single-handers talked about partners they had once had as a frequent source of stress and dispute, and breaches with fellow professionals were a common reason given for the decision to work solo. Professional community was not, in general, something they identified with, or expressed any regret at not having – indeed the very *idea* of a professional community was largely absent from their accounts of working life. For single-handers, providing a quality service lay not in the honing of technical skills through continuing education or discussions with colleagues, but in the relationships they had with patients, over time, often over generations. The rhetorics of the single-handed GPs constructed an idealised clinical relationship of a healer to both their individual clients, nurtured through continuity over time, and to the collectivity of the local community, nurtured through this notion of belonging. This relationship was therapeutic in itself, in that healing lay in the relationship, rather than in the provision of a certain set of professionally defined services. In contrast, the services provided for clients of the larger group practices were

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probably technically superior and provided in an affectively neutral way, with professional community being the referent for service quality.

There are, then, two rather different discourses of professionalism at work here. One derives primarily from a set of relationships with clients and the other derives primarily from a set of relationships with other professionals; the former is framed as rather anachronistic, and the latter as modern.

Now these interviews were carried out over 10 years ago and of course since then the organisation and workforce of primary care in the UK has changed radically. First, even more GPs are now working for large partnerships of six or more partners, with a drop in single-handed and smaller practices. Second, and perhaps more significantly, far more GPs now work as non-principals (41% in 2003, compared with 2% in 1983), often in salaried positions or as part-time GPs (DOH 2004). A new breed of GP has emerged, unlikely to be working full time, not wanting the pressures of principal status, and perhaps choosing only to do the kind of work they enjoy. Lorelei Cooke (2004) carried out a small study of these non-principal GPs and found that they self-consciously contrasted themselves with 'old fashioned GPs'. Old fashioned GPs were perceived to have had a professional life that was bound up in the community, with the GP role as a master status, describing the whole of their life and their relationship to others. In contrast, the 'new' GP valued a work-life balance, the teamwork of the primary care clinic and the ability to select what they called 'nice' work, as the specialisation of the new clinic allowed them to be much choosier about which problems and which kinds of primary care clients to see:

*I think the old fashioned general practice, it was your life, you were on call 24 hours a day, your patients knew where you lived ... your life was not your own until you retired ... you were part of the community, almost part of their family ... whereas the new general practice I feel is people are doing a job ... at the end of the day, it's not a life really anymore (Non-principal, quoted by Cooke, 2004)*

Cooke's claim that we are seeing a shift in the notion of what professional work is all about is reflected in evidence from a BMA survey, which suggested that younger doctors are less likely to choose medicine as a vocation, and more likely to see it as 'a job like any other'.<sup>[1]</sup>

### **The narrative of a loss of community**

Now I certainly don't want to romanticise the services provided by the 'old fashioned' single-handers. There are of course downsides to any community, apart from the limitations in technical expertise and range of services. Like any community, that of the single-handers' patients is as circumscribed by those excluded as those included, and indeed many single-handers were rather choosy about whom they registered, in contrast to the large practices which would take any patient so long as their list was not closed. But all this does imply a rather seductive argument about loss. Changes in the provision of primary care, reflecting broader social changes in the division of labour in industrialised countries, have, it seems, both separated professionals from the communities they work with, and somehow eroded those relationships between professionals and local communities that were once part of the fabric of the social order.

The first caveat to being wholly seduced by this argument, and rather nostalgically looking for a way back to some more idyllic notion of community, is that this was not inevitable. Indeed the health centre or large group practice was once seen as a radical force in primary care provision. Tudor Hart, for instance, contrasted his experience of overworked GPs in squalid shop front surgeries from his early days as a London GP with the development of health centres which would, he said provide 'an outpost of popular science ... (and a) centre of participative democracy' (Tudor Hart 1988: 335). David Armstrong (1985) argued that it was the health centre itself which configured space and time to actually produce the 'community' as the new site for which primary care uniquely provided a service. The health centre was the physical manifestation of this new referent in health: the community. Ironically, though, the health centre, through its contrast with earlier forms of primary care, has apparently brought into being an entity which exists primarily and most graphically in the nostalgic images of a past general practice

A second reason to be a little sceptical of arguments that modernisation and bureaucracy have eroded the ties of vertical social capital that might have endured in earlier ages, with GPs opening local fetes and riding around waving to their patients, is that the old-fashioned notion of the professional whose status and role in the community was bound up in their professional identity is perhaps rather rhetorical – what Shuval and Bernstein called the 'basis of a functional mythology' of medicine as a calling, which probably characterised very few real doctors, either in the 1950s or now (Shuval and Bernstein 1996). Certainly if we are looking for the GPs who identify with a local community, and have primary obligations to the families who live there, they seem to exist primarily in some rather mythical settings - in the rhetorical, and possibly

romanticised accounts of the few 'old fashioned' single-handed GPs left, in the retrospective accounts of retired GPs, and in fictionalised accounts of East end communities.

So we don't have to accept that in the old days professionalism was somehow more functional for the social order, but simply to note that there is at least a *perceived* loss here, in more modern discourses of professionalism. The geographical and cultural separation of professionals from the communities they work in has emerged as a problem, and one that has perhaps some implications for social divisions more generally in society.

### **Skocpol and the move from 'membership' to 'advocacy' civic society**

In the US, this 'loss' of the ties of vertical social capital is a phenomenon analysed by Theda Skocpol (1996, 1999), who has linked it to the erosion of civic society. As Skocpol notes, the rise of a large and educated middle class of expert professionals has changed the ways in which communities interact there as well. She talks about an earlier age '[w]hen US professionals were a tiny, geographically dispersed stratum':

*Working closely with and for non-professional fellow citizens in thousands of towns and cities, lawyers, doctors, ministers and teachers once found it natural to join – and eventually help to lead – locally rooted, cross-class voluntary associations. But today's professionals are more likely to see themselves as expert individuals who can best contribute to national well-being by working with other specialists to tackle complex technical or social problems (Skocpol 1999)*

Skocpol describes the decline of large membership civic organisations in the States, such as the National Congress of Parents and Teachers, or the Masons, which drew membership from across the social classes and, crucially, also acted as significant contributors to national policy debate. Between the 1960s and 1980s these were replaced by a growing number of more centralised and professionalized associations, which were more orientated towards advocacy and political lobbying. Large membership organisations foundered, and no longer acted as locally rooted participant groups. The only ones to survive and prosper, she argues, are those such as the National Rifle Association and National Right to Life Committee, which are overtly partisan activist organisations. Skocpol summarises these changes as shifting American civic society from a membership to an advocacy society.

Old-style mass membership organisation drew from the professional, business and working classes, but (the downside, as always is with community) often, of course, exclusively by gender or ethnicity. New associations are less reliant on building grass roots activism and membership as a route to funding, and more likely to draw on wealthy individual donors. They are therefore less democratic, in that they are less likely to involve local branch meetings and representative democracy and more likely to rely on mail shots and executive professional organisers for communication through the organisation. The new membership groups disproportionately exclude involvement of working class people. They are tilted towards the wealthy and the advantaged 'doing things for' others rather than doing things with them. In short, she suggests that 'community' itself has been professionalized, with membership organisations likely to be led and organised by professional organisers reliant on technical expertise in media presentation, lobbying, recruitment and fund raising. What they don't provide any more is local level social support; the kinds of vertical, or what Putnam calls 'bridging', social capital that provides both ties across social groups and a voice for local communities through local branch-structure participative democracy. Indeed, one might go one step further than Skocpol, and argue that even 'doing things **for** others' has been superseded by not doing things, but rather facilitating other people doing things. Increasingly, the provision of professional expertise is defined as the organisation of others' efforts, rather than actually providing a service. Society thus becomes more polarised. There is an ever larger expert cadre, whose labour is increasingly the provision of expertise directed primarily at other professionals, or semi-professionals, and ever more segregated communities, with fewer ties across the social fabric and restricted access to a democratic voice. The problems of inequality, and the communities who suffer them, are then the targets of much contemporary social policy.

### **Polarisation: the problem for contemporary policy**

Contemporary social policy in the UK in recent years has been framed to a large extent by this triple problem. First is the problem of polarisation itself, with enduring inequalities (and associated health effects) posed as an affront to the supposed meritocracy of modernity. Second is restricted access to voice for certain groups, with a consequent concern about involving the public in decision making both as a liberal good in itself and as a route to legitimacy. Third is the apparent declining stock of social capital, with the 'loss' of community identified as both a cause and a consequence of polarisation.

If we think about either national policies such as the DOH's *Tackling Inequalities*, or the Accidental Injury Task Force's (DOH 2002) *Preventing Accidental Injury*, or more local, circumscribed initiatives such as the FSA's commitment to

developing methodologies to consult with hard to reach consumers, or Thames Chase Community Forests' evaluation of how to widen access to green spaces - these all attempt to address, from different angles, the problems of community voice and polarisation, and utilise a discourse of redressing inequality as a policy aim.

In general terms, policy, in health and other social arenas, might be characterised as increasingly complex: setting broad brush national headline targets based on evidence for both prioritisation and programme implementation, but facilitating, rather than directing, local action, often through second tier local organisations that don't even themselves deliver services, but facilitate others in delivering services. These organisations are typically complex partnerships of both governmental and non-governmental agencies. There are often obligations on providers and policy planners to involve the public (O'Neill and Williams 2004), and there is often an explicit aim of targeting the most deprived communities, or the most at-risk social groups.

I'll just illustrate these features briefly with one national example, that of the current Accidental Injury Task Forces' prevention policy – which of course addresses a cause of morbidity and mortality with steep social class gradients. DOH priorities for action on preventing accidental injury are based on **reviews of the evidence** that identify promising interventions based on research, including referral to falls prevention programmes for older people, and installation of smoke alarms by the fire brigade. Such interventions should be **targeted** at areas of health inequality (AITF/DOH 2002: xi). However, the delivery of accidental injury programmes should be organised through **Local Strategic Partnerships**, including Local Authorities, PCTs and other stakeholders

In terms of addressing inequalities, the DOH's approach is one of directing action at particular communities. Thus, it advocates looking at particular social groups to see where and why interventions are and aren't successful, and to gather evidence about why there is, for instance, differential access to injury reduction advice by social group (AITF/DOH 2002: 46). There is also the usual obligation to involve the public. One aim is for instance to 'gather input from individuals in deprived areas and from ethnic minorities to ascertain how goals and objectives might reflect their views' - but within, of course, the constraints of a professionally defined set of solutions. The problem, therefore, is located within particular communities, whose responses to programmes are somehow inadequate. Now it is not surprising that there is nothing here about addressing the social structural determinants of inequalities – the focus

is on shaping interventions to target those social groups that have been identified as of high risk.

This targeting is to be done by professionals who will become what the document calls a 'well trained workforce', front line staff who, it is suggested, should have a 'common base line of information and understanding to underpin their joint working and initiatives' (p43). So part of the programme explicitly involves developing a professionalized canon of information and knowledge that is shared. It also constructs a new professional grouping or community – that of the accidental injury specialists – which now has a growing infrastructure to support it, such as the emergent MSc programmes in injury reduction.

There are a number of potential problems with these kinds of policy aims. There have been, for example, well documented specific problems in trying to deliver locally through multi-disciplinary partnerships which include representatives from different organisations with different agendas and very different evidence bases (see eg Green 2000). Here, I want to just flag up three ways in which policies like this possibly reinforce the social segregation of the professional expert from the community which is targeted, and certainly fail to deal with segregation as a factor that contributes to inequality.

First, the starting point of a professionally-defined, and rather narrow evidence base as the framework for both the headline targets and, increasingly, the programmes chosen for implementation to achieve those targets. This inevitably shapes the aims and processes of policy in ways that are potentially rather alienating for the communities that are the subjects of those policies. At one level evidence-based policy implementation is perfectly reasonable – indeed it would be irrational to resist calls for scarce resources to be spent on interventions for which there is evidence for success. But of course this evidence base has been generated through answers to rather specific questions already mired in professional value systems. Questions such as 'How can we get children to eat five portions of fruit and veg a day?' or 'How can we prevent hip fractures in the elderly?' take little note of the competing priorities parents, children or older citizens might have, in addition to optimum nutrition or not tripping over. So if we then try to include public voices in planning, they are usually asked not to shape the priorities of food policy, or how to improve their quality of life, but simply how we professionals can best get you to adopt what we've already decided is in your best interests.

Now policy interventions have presumably always recreated the social and cultural values of the elite, but what the tenor of contemporary policy does is

make this increasingly irresistible through the twin appeals to both an apparently politically neutral evidence base and to public involvement. In short, the public are being asked to contribute to thinking through how they can best be shaped and governed.

To take just one small example from the Thames Chase Community Forest (TCCF) project. Now this is a typical complex, if fairly local policy, involving the usual mix of partnership working, second tier organisation (TCCF doesn't actually do anything like plant trees - or even own any land – but it facilitates landowners doing things) and involving public voices. One of the aims is to increase access to the green space to targeted population groups - but not, of course, on their terms. One public suggestion about popular uses of the green space such as building a theme park or a wild animal park was treated with absolute derision by the steering committee – instead, the public must be taught to use the green space 'properly', in an approved way which involved such proper orderly deportment while using the forest, proper appreciation of 'native' flora and fauna, and healthful and purposeful activity. One approved activity is going for walks, and there are a number of leaflets available from TCCF to help plan a walk. However, it is not just any old walking, but walking with a self-consciousness as described by one Sports Development Manager:

*You should be slightly puffed, not out of breath, so you can carry on a conversation, and slightly warm. That's the whole idea (Pinder et al, forthcoming)*

So the very physiology of the body, as well as its deportment in space and time, are to be governed by this policy. An evidence base on the therapeutic uses of the environment overrides any other moral values the public might have had – such as fun or excitement, or simply lazily enjoying the space – and the public are invited to give voice only to those questions posed by experts.

A second contribution to the hardening of the boundaries between professionals and the communities targeted by these policies is the focus on inter-professional teamwork and multi-agency working to deliver ever more complex interventions. Again, the aims here are perhaps rational ones of pulling down barriers between the professions and trying to integrate policy aims so that different agencies are not pulling in different directions. However, these tendencies have two other effects. First they reinforce the primary orientation of professionals to other professionals – now not only within their own fields, but across the professional classes. They also create a new tier of expertise – what we might call meta-knowledge. It is no longer enough merely to have acquired a

canon of esoteric professional knowledge; the good professional must now engage in continuing education to constantly update that knowledge, and reflect on the methodological and epistemological base of that knowledge in order to engage meaningfully in multi-professional working. Knowledge for policy is increasingly complex – meta-analysis, systematic reviews, and integrated reviews which ideally draw on knowledge bases across a number of discipline. At the point where ‘traditional’ professional expertise, those discrete canons of esoteric knowledge acquired through formal training and informal acculturation, were almost at the point of democratisation, and accessible (in principle at least) to all, they of course no longer serve to separate the expert from the lay person. The erosion of discretion through the drive to protocol-driven practice, and the increasing accessibility of ‘facts’ through IT, means, in theory at least, that the lay public could access it. Now what distinguishes the expert from the lay person is meta-knowledge - a knowledge about knowledge, embodied in such skills as access to constant updates of professional knowledge through professional networks, and increasingly multi-professionals networks, and skills in assessing meta-reviews of knowledge, in for instance systematic reviews and ever more complex methodological debates about the status of knowledge.

Third, and perhaps most corrosively, what the imagery and the practice of much contemporary policy does is contribute to the erosion of respect between professionals and communities. Richard Sennett (2004) has written at length about the scarcity of respect in modernity. In his argument, this arises from a number of facets of modern society. One is our discomfort with the rituals that might facilitate communication across social divides. Second, we have difficulties with admitting just claims of adult dependency. Third there are limited ways in which people can participate with self-respect in the conditions of their own care or earn self-respect through giving back to the community. Without an exchange, people cannot enter into the mutually bonding ties of gift relationships – and these are what perhaps build social capital. Although offering a critique of modern welfare policies, Sennett pulls away from policy dictates. ‘Treating people with respect’ he says ‘cannot occur by simply commanding that it should happen’ (Sennett 2004: 260). And we can’t – but we can perhaps identify aspects of modern policies that are more or less likely to facilitate respect. I’d argue that the unintentional effects of the characteristics of contemporary social policy that I’ve outlined are likely to decrease respect.

A first step in respect is what Sennett calls the ‘error’ of recognition (2004:44), in which we imagine we see ourselves in others – the point of connection across difference. Second is the acknowledgement of that difference – that

the other is legitimate, even if not like us. In the TV show *Faking It*, the idea is that two people from across a social divide meet so that one can learn to pass themselves off convincingly as a member of the other's sub-culture – such as a middle-class classical musician and an urban DJ. When the show works, the person 'faking it' both experiences this error of recognition – this person who seemed like my polar opposite is actually like me – and then, often from learning some craft skills from the other, learns to appreciate their values and accomplishments for what they are. This is perhaps the essence of the kind of respect Sennett is talking about<sup>[2]</sup>. Separating particular groups as 'targets' for interventions does not facilitate this kind of respect. First, it serves to deftly turn clients into 'others', for whom it becomes more difficult to make that error of recognition. Instead of experiencing a shared humanity (however mistaken) in the 'other' who is in need of a service, we feel primarily the otherness of the targeted. Second, it makes almost impossible the recognition of legitimate difference. In delineating more and more carefully the population groups most in 'need' of interventions (the geographical communities with highest teenage pregnancy rates, or the ethnic communities with highest rates of diabetes) we construct identity groups that may or may not have any consciousness of themselves as a group, and then demand from them a representative 'voice' – of young people, of ethnic community, of diabetes patients.

Of course this is to some extent the usual liberal dilemma about dealing with difference, in that in discursively delineating the boundaries, noticing difference, we at the same time reproduce it. But, what contemporary policy does, is not just *notice* the difference, name it and thus reify it, but then 'targets' the other. This targeting is not done to explore difference or come to understand different values, but to request a voice to assist in self-governance. Now targeting again sounds like a rational use of resources, but it is not a neutral verb, and it carries I think certain rather unpleasant connotations. To target is to mark *in order to aim at*, and perhaps the only rational response to being targeted is to duck. And then to feel rather resentful. Indeed many projects reliant on community development have found exactly this response. Martin O'Neill and Gareth Williams (2004) report, for instance, on the frustration and hostility of residents of one south Wales community after years of targeting that has resulted in little discernable benefit – professional researchers came in, prepared their reports, then retreated back to the more affluent areas from which they came, serving only to reinforce the labelling of a disadvantaged community. As the young people in one school involved in the FSA project wrote on a poster they were asked to design to illustrate their ideas about school dinners, 'Walworth kids have got a chip on their shoulder'. Having a chip on your shoulder is an absolutely rational response perhaps to being

asked to contribute to the governance of your own diet in a social situation (the school) in which your autonomy is denied in every other way. And so disrespect is reciprocated, with front line professionals increasingly reporting a 'lack of respect' from clients.

### Conclusion

I've suggested that the ideology of modern professionalism is rooted no longer in the mythology of vocation and service orientation but primarily in professional networks – hardened through the evidence based commitments of much contemporary policy, and perversely, perhaps, from the obligations to build multi-disciplinary partnerships. Esoteric knowledge and specific expertise are no longer enough to separate the professional classes from the laity, and instead there has been a drive towards what we might call 'meta-knowledge', located not in the canon of say medical knowledge or in academic disciplines but in the networks of professionals, increasingly inaccessible to lay people.

The most disadvantaged communities, increasingly separated from all potential ties of vertical social capital, are now the targets of social policy. Whilst the verb 'target' might suggest merely focusing resources to where they are most needed, I suggest that this also constructs a particular relationship between professionals and communities on the receiving end of this targeting and it is a relationship that fundamentally speaks of disrespect and separateness. In essence, both discourses of professionalism and the shape of health policy are increasingly hardening the boundaries between professionals and the communities they once served, making the amelioration of inequality less, not more, likely.

Thirty years ago David Werner (1978) made a radical call for health professionals to come from the rural communities in which they practiced. In the modern city, with cross cutting and rather amorphous community boundaries, this call would be inappropriate – which communities would we mean? Do we really want our police forces, health services and teaching staff to mirror exactly the constellations of social, cultural and religious identities of the local population? It is not possible, or even necessarily desirable, for professionals to represent exactly the multiple communities they serve. Neither is it possible or desirable to return to the patrician relationships professionals had with communities of the past, even if they ever existed. But if we are serious about addressing social inequality, and its effects on health, a first step, following Sennett, has to be a search for a more respectful relationship between professionals and communities, and on an individual level a recognition that, as Arthur Frank has noted, 'the wounded healer and the

wounded storyteller are not separate, but are different aspects of the same figure' (Frank 1995:xii).

### Notes

[1] Of those under 30, 0.9% of doctors said 'medicine is a vocation'; 52.1% said 'must be organised to balance family and career'. Of those aged 55 and over, 17.9% said 'vocation' and 17.9% 'must be organised to balance career and family'.

[2] Many thanks to Ulla Gustafsson for this.

### Acknowledgements

This paper is the result of a number of discussions about policy with colleagues, and I'm grateful in particular to the following: Nicki Thorogood, Ulla Gustafsson, Alizon Draper and Ruth Pinder, whose ideas have been either plagiarised or travestied, and to Lorelei Cooke for her expertise on primary care.

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### **Guidelines on evaluating qualitative research proposals in health services research**

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The use of quantitative methods in health services research is well established, and grant applicants, funding committees, and referees are conversant with the criteria with which proposals will be judged. In contrast, qualitative research has in the past been 'viewed with scepticism' <sup>1</sup>; it is now becoming more acceptable as a valid approach in health services research <sup>2</sup>, with funding bodies more willing to finance qualitative projects.

The introduction of qualitative research into health services research has not been straightforward, and others have documented the difficulties in publishing qualitative research in medical journals <sup>3</sup>. Problems also remain at the point of funding, where a panel of individuals usually drawn from a range of specialties are asked to make a judgement about the quality of the proposal. At this point some understanding is required of qualitative methodologies, including the nature and framing of the research question, the anticipated outputs, the validity and appropriateness of the various approaches, not to mention sampling, sample sizes and so on. Unless those in judgement of the proposals can have some appreciation of these issues then qualitative proposals are unlikely to receive proper consideration. A similar problem is faced by ethical committees where the value and purpose of the different methods are often poorly understood.

There is as yet little documented advice on writing and evaluating qualitative research proposals. These brief guidelines are intended to suggest evaluative criteria that might be of value to grant-giving bodies, ethics committees, referees and, not least, research applicants anxious to secure a favourable assessment of their proposal. None of these criteria are offered as definitive, as with any research proposal excellence is a combination of many factors and the same applies with equal force to proposals in this relatively new area.

### Section 1: General comments

#### 1. What is qualitative research?

Qualitative research is not a variant of quantitative research. It has different origins, incorporates different methods and has different justifications. In this sense it is inappropriate to employ many of the criteria used to judge a quantitative study to evaluate a qualitative one.

Qualitative research is mainly concerned with understanding events, processes, views, etc, from the perspective of the individual and group(s); qualitative methodologies capture ways in which people perceive and interpret events, experiences and relationships. This means that qualitative methods are sometimes used to 'explore' problem areas before generating hypotheses that can be tested using traditional quantitative methods ('What are the problems associated with bed management in this hospital?'). Thus researchers can incorporate both qualitative and quantitative methods into the same study in which case they may have a complementary function.

Qualitative methods are also used when the most important question is how people view a particular situation, such as their health or the health services ('How do patients with diabetes cope with their illness?'). They are sometimes used when interactions are the centre of the study, for example, interactions between professions (studying team-work in general practice) or between consumers and professionals.

There is sometimes confusion with the term 'qualitative' itself. In this document qualitative data refers to text (often derived from interviews or observations). Qualitative data in its turn can be analysed either qualitatively or quantitatively; this document only deals with qualitative data analysed qualitatively. (To add to the confusion, in statistics the term 'qualitative' is often used to refer to categorical data as opposed to ordinal or interval data.)

#### 2. What forms does it take?

Qualitative research does not involve stating specific hypotheses that will be tested in the study; on the contrary, the reason for doing the research in the first place is often to generate hypotheses. The research question is therefore more 'open' than in quantitative research.

There are several specific data collection methods used under the umbrella title of 'qualitative methods'; interviews and focus groups (group interviews) are two commonly used methods; observation (whether the researcher is a

participant or not), oral histories and historical research are other less commonly used methods.

Essentially, analysis of qualitative data is carried out on words rather than numbers, thus analysis is very different from the statistical analysis routinely found in quantitative research. This has implications for both providing evidence of a proper analysis and also presenting results in a succinct and coherent way. (In addition, some projects might try to convert words into numbers, such as in content analysis, and carry out an analysis along more traditional quantitative lines.)

### **3. What are its strengths?**

In the traditional quantitative survey, the researcher approaches the respondent with a predetermined question and response set ('Were you satisfied with the consultation?' yes/no). The more open approach of qualitative research ('How did you find the consultation?') elicits people's experiences and views in their own words. The expressions that they use, the way they talk about issues and the explanations and inferences they make can be very revealing.

By asking people to talk about their interpretations of experiences and events the qualitative approach emphasises the reasons why things happen, why people believe what they do rather than simply recording which general category their beliefs fit into. This tends to produce a different sort of explanation to quantitative research. It can also mean that although the researchers have a hunch about that the key issues of the project, the subjects themselves may define them very differently.

Qualitative methods, notably interviews and focus groups, may be used to extend studies which have collected data from individuals through closed questions (eg. yes/no) by asking them to elaborate on their views. This often produces a more complex set of explanations, for example, reasons why people do not always follow professional advice or examples of why they fail to use a particular service.

Observational studies add an important dimension by analysing people's behaviour in 'real-life' situations, rather than studying what they say they do. Although observational studies are not always easy to conduct the findings from good studies have contributed to our understanding of people's behaviour. A project might combine a period of observation with another qualitative method (eg a series of interviews), or, less commonly, with quantitative methods.

A good qualitative research project can give a powerful insight into an issue/ research problem in a way that a table of figures never can. The findings of qualitative research, being grounded in everyday experiences, can also have a deep intuitive appeal for the reader.

#### **4. What are its weaknesses?**

Qualitative research is inappropriate for gathering some types of objective data - such as travel times and prescribing rates, or data from official statistics. Although qualitative research can be used for comparative purposes ('What are the differences of views about antenatal care between middle and working class women?') it is not the best method for more complex comparisons ('What are the differences in views of middle and working class in three age groups?').

Unlike quantitative data there are no 'objective' statistical tests that can be applied to the data to establish whether findings are the result of chance or are 'significant', indeed these concepts are alien to qualitative researchers. Qualitative research relies on the researcher's analysis and interpretation of relatively unstructured data and therefore places a greater burden on the expertise of the researcher particularly in terms of judging whether something is a valid inference. Validity is a serious issue for qualitative researchers who have developed a number of ways of checking on the validity of a study (for example, checking on researcher effects, triangulation, looking for negative evidence). A good proposal would recognise these potential problems of qualitative method and comment on ways in which the issue of validity would be tackled.

Because qualitative studies are usually based on 'unrepresentative' samples it is important that the researchers do not make unwarranted claims about the generalisability of the study. Indeed the researchers should be aware of the limitations of their study and note ways in which they can help reduce these limitations.

### Section 2: What details should I look for in a proposal?

In quantitative research the range of possible answers can be pre-specified. However, in qualitative research which tends to explore people's views or experiences there may be few indications of the nature of the findings in advance - although sometimes related studies might give some indication. This makes the business of writing research proposals more difficult since the study's outcome cannot be anticipated. Nevertheless it is important that the methods are clearly laid out and have been thought through.

#### **5. What is the research question?**

For reasons described above this is likely to be general and open rather than specific and closed. Even so, the question should imply that a qualitative approach is more appropriate; too often the method is chosen before the question is properly posed and with hindsight it could better be answered using more traditional quantitative methods. For this reason the use of qualitative methods needs to be justified.

#### **6. Background literature cited?**

Usual standards apply to presentation of the background literature on the justification for the study. The rationale for using qualitative research should be more than simply the absence of other studies using these methods. The applicants should say why - and in what way(s) - research using qualitative methods could add to existing knowledge.

#### **7. What methods of data collection are proposed?**

i) Are the proposed methods appropriate to the research question? Some questions, for example, might be more easily answered through a questionnaire study. (Reasons why a questionnaire study would be inappropriate might be helpful.)

ii) Are the methods of data collection described in detail? Are they justified? Are alternatives considered? Are the proposed procedures practicable in that particular setting?

#### **8. How is the sample to be selected?**

It is unusual for a qualitative study to use a representative or random sample of a population. There are a variety of different sampling strategies which may be appropriate depending upon the subject and context of the research. However, researchers should explain and justify how they propose to select their sample and the implications for the research outcome of their sampling

method. Sometimes a sample is chosen that makes sense in terms of the underlying theoretical model that is being developed and therefore the sampling may change as the study progresses; nevertheless, this procedure should be described and justified in the methods section of the research application.

### **9. What numbers of interviews/focus groups are proposed?**

Obviously the sample size depends upon the funding requested, the time scale and so on. However, as with quantitative studies, the sample size can be too small to generate valid findings or too large to be efficient. Many qualitative researchers have found that results tend to repeat themselves as they analyse progressively larger numbers of data responses so as a rough 'rule of thumb' a figure of 20-30 interviews is acceptable within a limited time frame. If the researcher wishes to consider two different groups (e.g.. by age, gender etc.) then 40-60 interviews is acceptable (though may take quite a long time to collect). Numbers of 100 and beyond are usually questionably large and would be viewed with concern - can this number be justified?

With focus groups, 1-3 is rather small, unless a pilot study, 15-20 focus groups becoming rather large. With focus groups, the aim is to cover different 'categories' of individual through group work (e.g. different ethnic groups, different ages) and to capture their views.

### **10. What data are to be collected in the study?**

While qualitative research does not use structured schedules such as survey questionnaires but a more open range of questions, it is still helpful to have sight of the kind of topics to be covered and/or questions that will be asked. A claim simply to study 'experiences' or 'meanings' is insufficient.

### **11. Who is to carry out the research?**

Carrying out interviews is a skilled task and should not simply be delegated to any researcher, or even to someone with experience of interviewing in another context (such as clinical or other professional work). A social science background and /or training is of value and previous experience of interviewing is a clear advantage.

### **12. Who is to analyse the research? Have they previous experience?**

In quantitative research a well-designed protocol is often sufficient to offer very specific guidance on how the analysis is to be carried out; in qualitative research, on the other hand, the protocol is necessarily more limited and the 'creative' element emerges in the analysis. For this reason it may be realistic

and sensible to fund a researcher with experience or a track-record of qualitative analyses for at least part of the study.

However, it is more difficult to 'drop in and out of' a qualitative project to help with the analysis. Becoming familiar with the data essentially means reading through the transcripts a number of times before thinking about, or being able to comment on, the analysis, and the corollary is that the time to be given the study by more senior/experienced proposal applicants needs to be more than token.

### **13. How is the analysis to be carried out?**

It is now common to use a computer package for data analysis. However, the programme only facilitates data management and requires a specific analysis strategy by the researchers. It is not sufficient just to state the name of the computer package being used (e.g. 'analysis will be carried out using NUDIST'). There are a number of approaches to choose from and one needs to be stated and described in the research application. The essence of qualitative analysis is to extract from the data not simply common responses to questions but broader 'themes' at a more conceptual level, such as shared uses of ideas and meanings (e.g. one might look for underlying similarities with the experience of illness from individuals suffering from quite different conditions). Good qualitative analysis develops more abstract comparisons (and differences) by classifying the data into meanings and then grouping sets of meanings into perhaps further patterns.

Data analysis is a slow process; it is important that the researchers have time to do a full rather than a superficial analysis of the data. This will involve an iterative process of identifying classification 'codes' and ascribing relevant text to that code; these codes can then be used creatively to construct a more over-arching statement/interpretation of the data. Clearly the greater the familiarity with the data the more likely that the best set of codes emerge and the overview has wider relevance and usefulness (e.g. findings on doctor-patient relations in a general practice context may be relevant for a far wider range of doctor-patient interactions in other contexts).

### **14. What is the timescale for data collection and analysis?**

While a single interview may only last an hour it may take a day to arrange, visit, and carry out. The interview is usually transcribed and the transcription checked: a one hour interview therefore probably takes another day to prepare for analysis. This means that interviews with 20 people may take a minimum of two months to collect and prepare for analysis. Data analysis is a slow and

laborious process as transcripts need to be carefully scrutinised and every few phrases considered for coding. Six months for this process is not excessive. This produces a rough 'rule of thumb' of about one year/eighteen months as the timetable for a qualitative study with a small sample, easy access, etc, if preparation, piloting, writing up, etc, are also included.

### 15. Costings

These would normally include salaries (are the proposed staff of sufficient seniority?), travel costs, costs of equipment (a high quality tape recorder, microphone and playback machine are all justified), transcription costs, purchase of computer software, and other incidental costs.

### 16. Implications and dissemination

The clinical/service implications of research need to be drawn out and plans for dissemination described. This is often particularly difficult for qualitative research as specific hypotheses are not being tested and the general shape of the results is unknown at the beginning of the research. Nevertheless, the applicants need to discuss why the area is important and why the findings may shed light on a health service problem. Equally they need to describe how they will disseminate the findings to health care providers and other researchers who might want to use quantitative methods to explore further particular facets of the findings.

Acknowledgments. For helpful comments on earlier drafts: Members of the Scottish Office, Chief Scientist Office, Health Services Research Committee, Dr Patrick West, Prof Marie Johnson, Prof Ray Fitzpatrick, Dr Elizabeth Murphy

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## The Sick Finance the Aged? Incapacity Benefit (again) and Pensions

**Patricia de Wolfe**  
London

Three years ago, I published an article on incapacity benefit (IB) in *Medical Sociology News* (de Wolfe 2001). It was written in the wake of allegations by Alistair Darling, the then Work and Pensions Secretary, that large numbers of people were claiming the benefit illegitimately, unchecked, for an indefinite period. In noting the absence of benefits-related issues from medical sociology and in arguing for the inclusion of these issues, I pointed to the demoralising and stigmatising effects of such pronouncements on claimants who were chronically ill and unable to work.

Well, here we go again. The policy statements this time come from Tony Blair, in the light of Adair Turner's report on pensions. The pensions shortfall, Blair claims, is to be resolved not by raising taxes, but by 'reconfiguring the welfare system' (Guardian 2004a) and freeing people from a 'culture of dependency' (Guardian 2004b). His remarks make it clear that he has the 2.4 million claimants of IB,<sup>1</sup> 'languishing on benefits', in his sights (Guardian 2004b). The extension of existing pilot schemes (interviews, financial incentives) to encourage IB claimants back to work appears not to be enough for Blair. Writing in the *Guardian* (2004c), Patrick Wintour speculates that time limits might be placed on IB for at least some claimants. This article questions whether Blair's proposals make sense in economic and political terms, and points, yet again, to the effects of comments such as Blair's on the morale of long-term claimants of IB.

In examining the practicalities of Blair's proposals, it is first important to consider how the IB count came to be so high, and whether it is likely to remain so. Research indicates that sickness-related benefits claims were swelled in the 1980s and 1990s by large numbers of redundant workers (mainly men) in traditional industrial areas where employment opportunities were scarce. Many had suffered injuries or ill-health, and they were allowed or indeed encouraged to register as sick, keeping unemployment figures low. And many have remained as long-term claimants of IB (Beatty and Fothergill 1999; Alcock *et al.* 2003).

However, the events which generated this surge in numbers seem unlikely to recur. The industries (coal, steel and heavy engineering) which haemorrhaged workers in the 1980s and 1990s are too depleted to do so again. Even in the event of large-scale redundancies elsewhere in the economy, access to

sickness-related benefits for the unemployed is plainly not going to be allowed in the current political climate. A further issue in considering the future of the IB count is the advanced age of a large section of the IB claimant population, 48% of whom are over 50 (Department for Work and Pensions 2004a). Unless pension age is suddenly raised for those shortly to reach it (surely politically and administratively impossible), these claimants will be pensioners in a maximum of 15 years' time. (Entitlement to IB ceases at pension age.) Admittedly, this leaves many claimants – amongst them long-term claimants – who are currently in the lower age ranges; and some new claimants will inevitably join their ranks despite more restricted access.<sup>2</sup> It seems, however, that the IB count may have peaked. Thus, Blair may have lighted on a relatively short-term phenomenon as a solution to the very long-term problem of funding pensions.

The notion that reductions in the IB count can solve the pensions crisis seems even more questionable in view of the limited possibilities for, and potential repercussions of, returning many of these claimants to work. Two – related - issues arise: the health of the claimants, and the state of the labour market.

All IB claimants (except for the very severely ill or impaired) are subject to a medical appraisal (known as the personal capability assessment) by the Department for Work and Pensions (DWP) after 28 weeks. DWP medical tests are repeated at intervals, so that long-term claimants in particular will have undergone repeated assessments of their capacity for work. Inevitably, there will be some fraud, and no doubt some inertia. It seems unlikely, however, that more than a fairly small proportion could be fit for full-time employment requiring a normal degree of vigour – although, as noted below, what counts as 'normal vigour' for the purposes of work may vary over time.

The second matter, the demand for labour, is sometimes overlooked in the discussion about both pensions and IB. It is too often assumed that supply is all: that if people were forced or persuaded to retire later, or to cease claiming benefits, overall participation in the labour force would increase. But this can happen only if vacancies exist. Widespread early retirement and a high IB claimant count may be masking considerable unemployment. Thus, even if IB claimants were to return to work in significant numbers, they would simply be ousting other workers.

The issues of claimant health and hidden unemployment are interlinked. Where demand for labour is low in relation to supply, employers become more selective, excluding potentially less productive applicants: the relatively old as well as the less able-bodied. Berthoud (1998), examining the reasons for the

trebling of claimants of sickness-related benefits between 1975 and 1995, argues that the employment threshold has gradually moved down the severity scale, so that people with impairments who would have been employed in the 1970s are no longer readily employable. Further, increased competitiveness has reduced the availability of 'light duties' for long-standing employees in poor health. Thus, while some IB claimants are unfit for work of any nature, an unknown number might be in employment under different economic circumstances

Writing at a time when it seemed that the government would confine itself to reducing the IB claimant count by restricting inflow, Beatty and Fothergill (1999: 54-56) question whether the government is aware of the full extent of hidden unemployment in certain local British labour markets, especially where the official unemployment count is already highest. Given the scarcity of jobs in these areas, most IB claimants, if forced off IB, would remain out of work. If they were transferred onto jobseeker's allowance (paid at a lower rate than long-term IB, and means-tested after six months), expenditure on benefits would fall; but this measure might unleash a political storm as the true degree of unemployment became manifest. One wonders whether Blair is conscious of this risk, and, if so, whether he is incurring it for financial reasons alone.

In my previous article (de Wolfe 2001: 45) I speculated on government motives for their attack on the legitimacy of the sick, querying whether this attack was purely cost-led, or whether it was part of an ideological agenda. The latter explanation might perhaps account for what might otherwise appear an anomaly: the strange silence, at least at the time of writing this, surrounding the rocketing cost of another benefit, disability living allowance (DLA).

### **DLA: A WORKING BENEFIT?**

DLA is payable – at a number of different rates - to people who have become disabled before the age of 65 (although it may continue to be paid to existing claimants past this age), and who need help with mobility and/or personal care. It is not means-tested, contribution-related or taxable, and it does not normally count as income for the purpose of additional means-tested benefits. It is available to those who work as well as those who do not, so that the latter may also be claiming IB (Greaves 2004: 117-136).

In 1995, there were about 1.5 million claimants of DLA. At 31st May 2004, this number had risen steadily to 2.6 million. Of these, nearly 1.8 million were below pension age (Department for Work and Pensions 2004b; 2004c). Expenditure on DLA appears to equal, or even perhaps exceed that on IB.<sup>3</sup>

It is possible that the disorders or impairments for which DLA is awarded are on the whole less likely to remit than those suffered by IB claimants, so that claimants are bound to accumulate as the years go by. As already seen, however, IB claimants also accumulate. Further, many people are routinely reassessed for DLA, and some move off it. DLA has in practice become harder to obtain since its introduction in 1992 (personal communication from benefits adviser). But it has not been the subject of persistent negative public discourse in the same way as IB.

I am not, of course, advocating a crackdown on DLA claimants. I am simply noting that a source of expenditure which seems to be on a sharply rising trend attracts little opprobrium, or indeed attention, while one which seems set to fall is so much in the public eye. Is this perhaps because DLA is available to those who work - and indeed, probably enables some people to access work? Or because the term 'disability', as opposed to 'illness', has connotations of a problem that can, in principle, be solved by the straightforward construction of ramps and rails - at least from the point of view of enabling those affected to access employment? For participation in the labour force (at least for those with no private means of support) seems increasingly to be construed by the government as a precondition for true citizenship.

### **THE DEMORALISATION OF CLAIMANTS**

My previous article noted the effects of being an IB claimant, and of government attacks on the integrity of claimants, on the subjects of my own research (people with M.E.): persistent fear of being reclassified as fit for work, and of impoverishment; a persistent sense of being under suspicion, and niggling doubts about their own *bona fides*, sometimes despite drastically limited capacity for activity. Lives already spoiled by illness are thus further impaired by financial worries and a profound feeling of stigmatisation.

Suggestions that the pension age should be raised threaten to remove one exit route from this sense of stigma - albeit a distant one for those who are relatively young. Long-term IB claimants eventually become pensioners. The term 'pensioner', until now, has carried connotations of worthiness, albeit perhaps with slightly patronising overtones. But this is doubtless set to change. A pensioner will henceforth be somebody under suspicion of having retired too soon and thereby placed an unwarrantable burden on the state.

So what future for those trapped in this unenviable identity and this precarious financial position? Incentives exist to encourage sick people back into work, as do linking provisions aimed at ensuring that those who attempt to return to work and fail are treated as continuing claimants. Many IB claimants express

a desire to return to the workforce, whether or not they are fit to do so (Beatty and Fothergill 1999: 39; personal communications); and charities seeking to move people from IB to work complain of inadequate government funding to meet demand (Guardian 2004d). But there are many very sick people to whom these schemes are of no help.

Since 2001, the government has been piloting a major initiative for the chronically sick: the Expert Patient Programme, intended to both draw on and enhance patient expertise, and due to be mainstreamed throughout the NHS over the next three years. Trained lay volunteers will lead a series of six structured weekly sessions, covering topics which include relaxation, cognitive symptom management, exercise, nutrition, problem solving, and communication with health care professionals (Department of Health 2001: 23). The stated aims of this programme include enabling patients to minimise the physical and emotional effects of their disorder; to reduce their use of medical services; and to improve take-up of education and training courses and of employment opportunities (*ibid.*: 14).<sup>4</sup>

There is nothing intrinsically wrong with helping people to help themselves. But writings advocating the scheme (Department of Health 2001; Donaldson 2003) abound with language constructing the chronic patient as newly endowed with confidence and motivation, with self-efficacy, with coping skills, control and independence. Given that the government's healthcare buzzword is currently 'choice', there is no counterbalancing official discourse of care for the long-term sick, recognising their need for practical and emotional support; or of social responsibility for people who are frail and vulnerable – beyond the responsibility to teach them to take responsibility for themselves. Nor is there any acknowledgement of the fact that illness is not managed in a void, and that confidence and coping skills might be more easily promoted in a situation of reasonable financial security and comfort. Self-efficacy becomes difficult if you cannot afford to turn the heating on in winter. It also becomes difficult where integrity is under repeated attack.

It is unclear whether the government will go as far as to set a time limit on IB for certain claimants, forcing them onto means-tested benefits; and, if so, how these claimants would be selected. Any such measure would, of course, impoverish the long-term sick and their families, many of whom are already suffering loss of earnings and the additional costs of illness. But even if the IB rules remain unchanged, Blair's comments will have negative effects.

It is in any case extremely hard for those permanently unfit for work to sustain a sense of self-worth and of membership of the social world. Joblessness

may be tantamount to social death in a society where occupational status is central to identity (Herzlich and Pierret 1984: 222-223). Further, illness is frequently conceived of as controllable, whether through medical intervention or through conscientious self-care (Herzlich and Pierret 1984: 283-288; Duff: 1994: 39-41; de Wolfe 2002: 261-262); so that the long-term sick are open to aspersions of being complicit in their own plight. Persistent public accusations of malingering exacerbate the isolation of the chronically ill, and undermine their view of themselves and their relationships with others.

The issue of adequate support for the elderly is a complex one on which I cannot comment here, except to say that it seems to me both impractical and unethical to provide for them at the expense of the sick. The issue of support for sick and disabled people is also complex. It involves a consideration of the demand for labour and the nature of work available; and the danger of marginalising increasing numbers of people as work becomes more pressurised. It also involves attention to the financial position and the morale of those unfit for work, and to the effect of both practical measures regarding, and discourse surrounding, sickness-related benefits. Stigmatising the non-working sick, or promoting positive thinking without practical help, will not solve these problems, for which there are no quick fixes. The government shows little sign of understanding this.

### NOTES

1. The figure of £2.7 million which sometimes appears in the press includes some 300,000 claimants of severe disablement allowance, abolished for all except existing claimants in 2001. I have used the figure of £2.4 million since it forms the basis of DWP statistics on length of claim, age of claimants, etc. 'Beneficiaries' of IB receive the benefit on the basis of national insurance (NI) contributions, but the wider category of 'claimants' also includes recipients of other benefits on the basis of the same medical test. For beneficiaries, IB is not, with certain exceptions, affected by other income, although long-term IB is taxable. For other claimants, it is means-tested. Over 900,000 IB claimants receive NI credits only (Department for Work and Pensions 2004a).

2. There have been suggestions that new categories of claimants are being created, notably women workers suffering from stress (Observer 2004), but the statistical evidence for this is as yet unclear.

3. The nominal annual cost of incapacity benefit for the year 2002-2003 is stated to be £6.8 billion (House of Commons 2004). (Severe disablement allowance cost almost a further billion.) Disability living allowance is stated to be paid to 2.6 million people at an average rate of £58 per week, thus totalling

£7.8 billion per year (Department for Work and Pensions 2004b). However, it is very difficult to compare the true cost of different benefits. IB, for example, is taxable, whereas DLA is not. But recipients of DLA may be working, so that revenue from taxation of their earnings is not lost.

4. While the Department of Health document (2001: 31) explicitly notes the need to make the programme available to those who have difficulty accessing services, their list of such groups does not include those who are too ill to cope with a weekly session of 2 ½ hours. So far, it appears that severely affected people with M.E. have requested fortnightly sessions, and/or sessions which include a break, in vain (personal communications).

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### **Why I can't get any academic writing done?**

#### **Edwin van Teijlingen, University of Aberdeen**

My previous head of department, Professor Elizabeth Russell, used to say that we prioritise the urgent, but not necessarily the important issues in our everyday academic life. As a consequence of this we never had time to sit down and think before we started writing academic papers. One of the important parts of academic life (not just in the eyes of RAE assessors) thus always came last. I have tried to list all the urgent things that have stopped me over the years from writing in the table below.

	Days used	Days left
One year		<b>365</b>
Holidays	38	<b>327</b>
Weekend days	104	<b>223</b>
Attending conferences (plus travel)	6	<b>217</b>
Invigilating exams:	3	<b>214</b>
PhD / MSc examining	2	<b>212</b>
Face-to-face teaching	20	<b>192</b>
Supervision of students	20	<b>172</b>
External examining (plus travel)	11	<b>161</b>
Preparation for teaching	25	<b>136</b>
Marking (double marking)	10	<b>126</b>
Writing exam questions	3	<b>123</b>
Staff meetings	4	<b>119</b>
Advising meetings	1	<b>118</b>
Course meetings	5	<b>113</b>
Staff student liaison meetings	1	<b>112</b>
Postgraduate committee meetings	2	<b>110</b>
Other committees	7	<b>103</b>
Advising students	15	<b>88</b>
Admissions	10	<b>78</b>
Away Days	2	<b>76</b>
Writing research grant proposals	20	<b>56</b>
Review articles/ books/ proposals	5	<b>51</b>
References for students/staff	3	<b>48</b>
Update handbooks	2	<b>46</b>
Correspondence	10	<b>36</b>
Invited guest presentations	2	<b>34</b>
Emails	10	<b>24</b>
Library orders	2	<b>22</b>
Write course evaluation reports	4	<b>18</b>
Student support (non-acad.)	5	<b>13</b>
Courses professional development	4	<b>9</b>
Other academic committees	3	<b>6</b>
BSA Medical Sociology Group	4	<b>2</b>
Work with outside agencies	2	<b>0</b>
Attend seminars	5	<b>-5</b>
Interviewing/ new staff	4	<b>-9</b>
Supervision/support staff	5	<b>-14</b>
Travel between university sites	2	<b>-16</b>
Searching library	1	<b>-17</b>
Graduation ceremonies	2	<b>-19</b>
Trade Union meetings	1	<b>-20</b>
Common cold etc.	2	<b>-22</b>
Any other unpredicted events	?	
Days left for writing papers????	?	

**PhD ABSTRACTS**

**Building reputation: the significance of pain talk in hospice and palliative care team meetings**

The broad aim of my research is to understand from a sociological perspective how palliative care professionals talk about pain. I discuss the development of pain medicine and the concept of 'total pain' within the hospice and palliative care movement. I focus on two main areas within the thesis: pain talk and the negotiation of professional boundaries. I develop a theory of reputation, which links these two analytic ideas and enables one to understand how different types of reputation are constructed. I focus in particular on how specialist nurses in hospice and palliative care develop a reputation in the medical space through talk about pain. Through talk-in-action that focuses on pain, a space is opened up that enables the palliative care team to develop a unique identity around expertise related to pain and other symptoms, and in this way they build a reputation for themselves and for palliative care. Reputation is achieved through the use of rhetorical and linguistic resources. The rules of pain work are made visible in the talk and this enables both competent work and professional identity to be displayed and explored. By use of linguistic and rhetorical resources palliative care professionals' construct their competence by comparison with those who do not have this expertise. Analysis of pain talk enables an understanding of how expertise and identity is negotiated. The expertise that is made visible in the talk is primarily biomedical expertise, but other forms of expertise are also made visible through psychosocial talk. The thesis therefore offers a linguistic analysis of how pain talk enables the members of the palliative care team to build a team reputation as experts in managing pain in the body. Talk about pain shapes the boundaries of professional work with patients in pain.

My findings suggest three substantive conclusions. Firstly that the palliative care team accomplish their reputation through pain talk, and that reputation is threatened when pain is difficult to relieve. Thus reputation is primarily achieved by a discourse that shapes pain and symptoms in the body as the primary mode of intervention. Secondly the palliative care team use rhetorical forms of speech to position themselves and their expertise in contrast to non-specialist practitioners and this establishes the collegial positioning of specialist nurses in such settings and achieves reputation for the specialist nurse as an expert in pain work. Thirdly specialist nurses in palliative care use specific linguistic strategies such as telling mystery stories, asking questions and the use of footing to keep a neutralistic positioning to enter into medical discourse and to

shape the agenda of talk. These strategies enable interprofessional work in the context of the team. In conclusion 'total pain' is linked with two types of reputation. Firstly the discourse of 'total pain' establishes the reputation of the palliative care movement within a holistic and humanistic framework. Secondly it enables the palliative care movement to construct its medical reputation as a successful speciality in relation to pain and symptom management. These two types of reputation are in tension.

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### **The whole and the parts: spiritual aspects of care in a West of Scotland hospice**

This thesis is an exploration of the spiritual aspects of hospice care, from the perspective of my understanding of the theory of the social construction of knowledge, and my particular interest in how people implement theories, beliefs and knowledges, especially excluded knowledges, in practice. The study examines the relationship between the dominant understandings and structures of allopathic medicine, the claim that hospices provide "total" or "holistic" care (which includes spiritual care) for dying people, and workers' practices in a particular hospice. It also considers the relevance for my own research practice of feminist research methodologies and the attempt to integrate ways of knowing which are considered, on the one hand, "emotional" and/or "subjective," and, on the other hand, "rational" and/or "objective."

The thesis begins with a chapter which considers the theory of the social construction of knowledge, focusing predominantly on Thomas Kuhn's concept of the "disciplinary matrix," and discussing the relationship of this concept to new, particularly challenging theories, such as the theory of social construction of knowledge itself and Cicely Saunders' theory of "total pain" and "total care." The thesis proceeds to outline my methodological approach, using feminist ethnographic methods, and to discuss my approach to analysing the data I collected through my fieldwork. The following two chapters discuss my empirical findings. The first of these, drawing predominantly on material gathered through participant observation, reflects upon general aspects of care in the hospice, and notes the difficulties of observing spiritual aspects of care. The second empirical chapter considers workers' perceptions and talk about these particular aspects of care, primarily through the material I gathered through one-to-one interviews.

I argue that the particular hospice I studied was not a uniform place, but rather an assembly of distinct spaces, and workers' practices differed both between these different parts of the hospice and between workers within each area. Thus, there was not a uniform approach to care in the hospice, and it varied depending on which particular workers were involved with a particular patient. Most workers were nevertheless aware of, and often claimed to adhere to, the hospice philosophy of holistic or total care, and many identified the spiritual aspects of care as the most important aspects of hospice care. Yet these particular aspects of care were those which, it seemed to me, were most frequently absent; in part owing to the variation in workers' perceptions and practices. Few workers in the hospice identified a spiritual aspect to the care which they personally gave, feeling that spiritual aspects of care were part of "somebody else's job." Of those few workers who identified a spiritual aspect to the care which they gave, most located this in their attitude towards the patients. However, a few workers in this small group considered that spiritual care involved both a particular attitude on the part of the carer and also a particular content: explicit engagement with questions which may be termed spiritual, metaphysical, existential and/or religious, an understanding of spiritual care which is, I suggest, closest to that of Cicely Saunders.

Thus, although workers were aware of the philosophy of total care, they generally perceived total care as being the outcome of all the activities performed by all members of the multi-disciplinary team. Workers' practices were shaped more by their disciplinary backgrounds, and the associated structures of professional health care, than by the philosophy of total care. The net result was that spiritual care was often absent, since few workers identified providing this care as part of their role, but assigned it to an indefinite other member of the multi-disciplinary team. I conclude by referring back to the situatedness of knowledges and practices, and the complex relation between these, and by pointing to the difficulties of implementing radically new or challenging theories, beliefs and knowledges in practice, both for workers in the hospice which I studied and also for myself.

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**Lay attitudes towards cardiovascular risk in the context of screening, prevention, and trial participation**

This study aimed to explore lay attitudes towards, and perceptions of, cardiovascular risk in the context of screening and prevention. Participants were members of a healthy population (50-79 years) invited to attend screening for asymptomatic atherosclerosis, some of whom were subsequently invited to participate in a randomised control trial assessing the efficacy of aspirin in preventing cardiovascular events. The study sample included screening non-attenders, individuals who declined to participate in the trial, as well as trial participants. Semi-structured qualitative interviews and focus groups were conducted and transcribed verbatim. Transcripts were analysed inductively and interpretatively for emergent themes.

**Findings:**

**Screening attendance:** Salient explanations of barriers included fatalism, optimistic bias, denial, disinterest and perceived lack of necessity; “what’s not broken, you don’t fix” emphasised low risk perception regarding asymptomatic conditions. Conversely participants who spoke highly of screening attendance implied individual responsibility, but often in hindsight. Participants often distinguished their own attitudes from those of others.

**Screening experience:** ‘At risk’ results often mismatched pre-screening beliefs and expectations, provoking some participants to reinterpret these, whilst others maintained them and sought alternative explanations. Key influences on participants’ reactions included the nurse-participant dialogue, understanding, and perceptions of the novel screening measurement (ankle-arm blood pressure ratio).

**Preventive medicine:** Despite positive attitudes towards preventive behaviour and aspirin, preference for avoiding medication prevailed, particularly until the condition was symptomatic and/or medication deemed “necessary”

**Trial Participation:** Influences on trial participation ranged from feelings about personal gain or loss to altruistic attitudes, and the trial tablet was central to many participants’ attitudes. Common misunderstandings concerned the RCT’s purpose, concept, procedure and the selection criteria. Preference for the active drug was overwhelming; discontent focused on commitment and being a ‘guinea pig’. Perceptions of personal susceptibility to cardiovascular risk seemed to dominate participation decisions.

### **Conclusion:**

The present study demonstrates the ubiquity of low cardiovascular risk perception in members of a general public population, and how this underlay attitudes towards screening, prevention, and participation in a preventive research trial. The asymptomatic nature of atherosclerosis, and lack of awareness of the screening measure emerged as particularly important contributors to low perceived risk, amidst the complex context of personal and situational factors in which people make decisions about their health. The findings have implications for, and can inform, the promotion of preventive health for asymptomatic conditions. Furthermore, the findings about attitudes towards, and understanding of, trial participation have implications for those conducting research trials particularly regarding informed consent.

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### **Stigma, agency and mental health: a discourse analysis of service users' talk**

This thesis is a social constructionist analysis of talk produced in research interviews with people with a psychiatric diagnosis. In total ten interviews were included in an analysis of different ways of talking about the social situations experienced by people with such a psychiatric diagnosis. The main methods employed were semi-structured interviews utilised for the collection of research data and discourse analysis utilised for the analysis of this interview data. The main findings were as follows. Firstly, it was found that there are empirically observable ways of talking about being a person with a psychiatric diagnosis and social reactions towards this possession of a psychiatric diagnosis (both by the incumbents and broader society). Secondly, in a methodological context, it was found that these different ways of talking were used interchangeably by the research participants depending upon the social context they used to describe their social situations. Thirdly, it was found that the impact of these different ways of talking could be empirically demonstrated to impact upon the incumbent person's agency (or more specifically, that person's talk about what they are able (and unable) to do. Fourthly, the study identifies (and empirically validates) the impact of these different ways of talking about action on the social stigmatisation of people with a psychiatric diagnosis. Finally, the thesis addresses the roles of different mental health social movement organisations in relation to these social processes of stigma.

The study is a consideration of the social situation of people with a psychiatric diagnosis and moves towards an understanding of this social situation through a combination of an application of empirically derived analysis and the application of sociological theory. It asserts that it is a fundamental ascription of an inherent lack of rationality in the 'mentally ill' that leads to the consequent broad ranging stigmatisation of people with a psychiatric diagnosis. This thesis offers an insight into these stigmatising social processes and it is hoped that the findings and conclusions contained herein can be applied to these processes with the aim of positively impacting upon a social situation that is all too founded upon much fear and ignorance.

**Ewen Speed**

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## BOOK REVIEWS

**Curtis S. (2004) *Health and Inequality (Geographical Perspectives)*. London: Sage [ISBN 0-7619-6823-7 pbk £21.99]**

**This has to be one of the best books relating to Health and Inequality. The title gives a good indicator that Curtis is intending to explore Health entirely from geographical perspectives rather than the medical approach. This is a refreshing change—and Curtis works extremely hard at analyzing health inequalities within the framework of geographical patterns, and then attempts to develop strategies for reducing these. Curtis uses comparative work to highlight this country with international health issues.**

**Throughout the book, Curtis illustrates her arguments with sound examples. A minor point however, she does tend to interchange terminology here, between travellers, gypsies and the Romany populations, without identifying the difference between these groups.**

The book is full of supporting references to justify Curtis' approach to Health and Inequality. She argues that Health Inequality does not reflect the medical approach but is due to geographical issues (including income etc). The chapter "Landscapes of Consumption: care and commodification" discusses the introduction of the NHS Reforms (1997) but doesn't hint whether these have actually been successful at reducing inequalities.

**The cover of the book is an interesting concept: it looks like a carton for a prescription drug (rifampicin), but focuses on diet. Initially, I thought that this was a medical textbook – the spine just reads "health and inequality". My only criticism of the book is the cover!**

I definitely recommend this book—it is well written, researched and will be a valuable resource. It will complement all the material available which tends to focus on the medicalization of health inequalities. Curtis deserves to be highly recommended for this brilliant book.

**Timothy Simon Faltermeyer**  
Thames Valley University

Green J, Thorogood N. (Eds) 2004 *Qualitative Methods for Health Research*. London: Sage. [ISBN 0 7619 4771 X pbk £19.99]

This book provides a good introduction to the field of qualitative research as the principles and approaches in qualitative health research are well explained. It serves as a timely reminder that the term 'health research' includes two broad strands of work: critical studies of health from social sciences perspectives and studies for health, from the disciplines of public health, health promotion or health services research.

**One of the aims of the book is to provide an introduction to qualitative methods that uses examples of health research from a number of different settings, so that they can demonstrate how key methodological issues may have different implications in different contexts. Secondly, it seeks to bridge the gap between theoretical perspectives and the policy-oriented field guides, thus stressing the importance of well designed theoretically informed policy-oriented research. Finally, the book aims to explore how an understanding of health and health behaviour can be gained through qualitative methods.**

At first glance, the book is obviously clearly set out although the font size is noticeably small which readers might find frustrating! The book has three distinct parts. Part 1, 'Principles and Approaches in Qualitative Health Research' has three chapters. The introductory chapter sets the scene for health research by highlighting the contributions of sociology, social anthropology, and the history of medicine in understanding human health. Chapter two outlines the number of tasks associated with research design, and the key principles of good design and conduct in qualitative research are discussed. Ethical research practice has been considered in greater depth than in other textbooks on qualitative research (for example, responsibilities to research participants), and draws attention to the kind of decisions qualitative health researchers have to make in research design.

Part 2, 'Generating and analysing data' has five chapters which cover four dominant strategies for data collection: in-depth interviews, group interviews, observation and documentary research. A final chapter focuses on how to improve rigour using three approaches (thematic content analysis, grounded theory, framework analysis).

The final part of this book, 'Doing Qualitative Work for Health' is devoted to the practical issues identified in qualitative health research, and these include writing and reading qualitative work. Its final chapter 'Reading and appraising qualitative work' highlights the challenge of critically appraising the research output of others.

Given that we already have several useful textbooks on qualitative research, one might ask what another book on qualitative research has to offer? In essence, Green and Thorogood have taken an almost different stance to focus on health research. The chapters are packed with useful information and tips for a novice researcher, such as key points for each chapter, and 'exercises'. The inclusion of selected case studies from a number of settings throughout the book provides good references to published research and an alternative way of learning. A reading list can be found at the end of each chapter allowing the reader to further explore any of the aspects related to qualitative health research. Overall, many of the points discussed throughout the text have a much wider relevance. Hence, the book would appeal to those who work in public health, primary care, health promotion, nursing and management. In particular those who have little experience of social science theory would be able to learn how the researchers went about their research inquiries from the various projects. It would also appeal to postgraduate students interested in learning how to do qualitative health research.

**Khim Horton**

University of Surrey

**Saks M. (2003) *Orthodox and Alternative Medicine: Politics, Professionalization and Health Care*.** London: Sage Publications [ISBN 1-4129-0153-7 pbk £19.99]

This is an excellent book that applies insights derived from the professions' literature to a comparative case study of orthodox and alternative medicine in Britain and the United States from the pre-industrial to the modern era. In particular, Saks bases his analysis on a neo-Weberian (i.e. social closure) reading of the professionalization of bio-medicine. He argues that the socio-historical consequences of medical professionalization were the legal entrenchment of a link between biomedicine and orthodoxy, accompanied by the institutionalization of a distinction between orthodox and alternative medicine (this latter category comprised of marginalized therapies and systems of healing). Saks highlights the political dimension of this distinction, arguing that it is not a product of any intrinsic characteristics, but rather, is a product of the exercise of professional self-interest by biomedical practitioners in the attainment of power, status and income. This being said, he does not suggest that professional self-interest is necessarily opposed to the public interest, but rather, that it represents a distinct empirical phenomenon.

In the first chapter Saks characterizes the state of health care from the sixteenth to nineteenth centuries within both nations in terms of pluralism, self-help and folk-based practices. Widespread and effective professional mobilization was still lacking, hence the continued existence of blurred boundaries between orthodox and alternative medicine in the largely competitive markets of the time.

In chapter two, Saks emphasizes the centrality of regulation as a “watershed” in the enactment of social closure and successful attainment of medical dominance. He then reviews the predominant theories of professionalization, concluding, expectedly, that neo-Weberian closure explanations best account for the attainment of legal monopoly. He argues that by the mid-twentieth century, medical dominance was well established legally within both nation-states in the delivery of health services as well as in the health care division of labour.

The third chapter focuses on the fate of alternative medicine. Notably, Saks documents the significant decline in numbers of its practitioners in both nation-states by the twentieth century as a consequence of exclusionary strategies undertaken by the medical profession.

Saks brings us to the latter twentieth century in chapter four, tracing the rise of a medical counter-culture that, albeit always in existence, grew substantially in size and strength during this time period. Initially defensive, the medical profession increasingly articulated a more receptive position in the latter part of the 1990s, albeit only in so far as medical dominance was not jeopardized.

In chapter five, Saks examines the challenges to the medical profession that have been posed by other health professions, and by increasing state, corporate and public involvement in health care. He concludes that resultant changes in health care delivery may represent more of a reconstitution of existing relationships than a decline of medicine’s autonomy and control within those relationships, and thus, that the “deprofessionalization” thesis is still open to debate. In the final section of this chapter he notes the propensity towards professionalization among alternative practitioners, which is increasingly resulting in the passage of licensing legislation.

Saks concludes by extolling the benefits of a cautious integration of alternative medicine and its practitioners, including potentials in the area of chronic illness and health promotion, the realization of cost-savings, and the provision of comparatively safer remedies. To this end, he highlights the critical role of the

state, documenting recent regulatory developments in both countries. At the same time, he warns against the ills of a system that serves the interests of alternative and orthodox professions alike.

Despite his breadth, Saks' work is missing one key element. Specifically, his book would have been enhanced with greater attention given to the racial element of social closure that was effected in the U.S. context, particularly given the ubiquity of indigenous practices in the pre-industrial era (as he notes), and the hostility towards, and virtual exclusion of Indigenous peoples, African Americans and Jews, in addition to women, from medical training, markedly in the aftermath of the Flexner report of 1910 (as others, including P. Starr remark).

This aside, what Saks has accomplished is an inclusive and timely overview of the history of medicine, medical dominance and professionalization, based on several decades of research. Further, while charting similar professional trajectories, Saks has provided a rich documentation of how differing socio-political contexts – for example, the more decentralized character of the U.S. political system - have played out in the relationship between orthodox and alternative medicine. Few works have so effectively synthesized this substantial volume of historical and theoretical material. As such, this book represents a significant contribution to these intersecting areas of study.

**Kristine A. Hirschhorn,**

Department of Sociology, McMaster University

**Devries, Raymond, Cecilia Benoit, Edwin Van Teijlingen, Sirpa Wrede. (Eds) (2001) *Birth by Design: Pregnancy, Maternity Care, and Midwifery in North America and Europe* London: Routledge (ISBN 0415923387 pbk £17.99]**

*Birth by Design: Pregnancy, Maternity Care, and Midwifery in North America and Europe* is a powerful book. Its approach is multi-disciplinary – including sociology, anthropology, history, political science, medicine and midwifery – and its scope broad – providing as it does a comparison of childbirth in Finland, Norway, Sweden, Germany, the Netherlands, France, the United Kingdom, the United States and Canada. As Robbie Davis-Floyd notes in the Foreword the overwhelming message of the book is that birth does not 'just happen' but is subject to sociocultural design. Edited by Devries, Benoit, Van Teijlingen and Wrede the book has many contributors – including practitioners as well

as academics - who working across cultures and continents (within and between chapters and sections) provide a rich and varied analysis.

The book is divided into three main sections: 'The Politics of Maternity Care', 'Providing Care' and 'Society, Technology and Practice'. In each of these sections important political questions – about political systems, State intervention, the organization of professions, educational systems, stratification and inequality, and attitudes about the use of technology - are raised. This overt political approach, which highlights the perspective of the midwife and the birthing woman, adds to the detailed, often sophisticated academic analysis. In sum the book is groundbreaking in its analysis and scope and original in its design and construction. *Birth by Design* is an essential read for any scholar or practitioner who wants to better understand the management and experience of reproduction and birth across the world.

**Gayle Letherby,**  
Coventry University

**Hunink M, Glasziou P, Siegel J, Weeks J, Pliskin J, Elstein A, and Weinstein M. (2001) *Decision making in health and medicine: Integrating evidence and values.* Cambridge: Cambridge University Press [ISBN 0521770297 pbk £38.00]**

This update of the Weinstein text (Weinstein M.C., Fineberg, H.V., Elstein, A.S., et al (1980) *Clinical Decision Analysis*) presents a series of tools that are available to clinicians, medical students, patients, policy makers and the payers of health care to aid clinical decision-making.

Decision-making is presented as a complex process. Medical decision-making is thought to be increasingly complex, as the outcome of each decision may have substantial consequences. As the number of diagnostic, management and treatment options available continue to rise rapidly, the ability to practice evidence based medicine becomes increasingly difficult. In addition, available evidence has to be considered in line with personal, patient, governmental preferences and recommendations under resource constraints. This text provides tools to aid decision making in clinical practice. It also provides suggestions on how to improve communication between the parties involved in decision-making (patients, clinicians and policy makers).

The tools presented are based around the PROACTIVE approach (problem – reframe – objectives – alternatives – consequences and chances – trade-offs

– integrate – value – explore and evaluate). This is a modification of the PrOACTIVE approach proposed by Hammond *et al* (Hammond, J.S., Keeney, R.L. & Raiffa, H. (1999) *Smart Choices: A practical guide to making better decisions*. Boston, MA: Harvard Business School Press.).

The text deals with a number of different categories of decision-making. It identifies the wide range of factors that need to be taken into consideration in a manageable way. The text has good summaries and definitions of complex terms that are clearly visible throughout the text. Throughout the text decision-making is presented as a non-linear process. Other chapters in the book provide advice on choosing between treatment options, how to manage uncertainty, deciding when to use diagnostic tests and how to interpret their outcomes and how to use existing evidence in practice.

Although presented as a text for medics and non-medics, as the text progresses a series of more complex tools are presented primarily for clinicians. This book would be useful for those experienced in health services research, non-clinicians may find the book focuses too much on clinical practice for their requirements. A series of exercises are included for you to check your understanding of the various techniques outlined in the text. Answers to exercises and a collection of additional resources are also included in the accompanying CD-ROM.

**Liz Shirran,**  
University of Aberdeen

**Glasziou P, Irwig L, Bain C, and Colditz G. (2001) *Systematic reviews in health care: A practical guide*.** Cambridge University Press [ISBN 0521799627 pbk £20.99]

This text is described as a “user friendly introduction” to a “difficult subject”. Indeed the title and the description are apt. This text would be suitable for anyone who is new to undertaking or interpreting systematic reviews. Glasziou and colleagues present definitions of complex terms in a way that enables the reader to conduct their own systematic review, from formulating a question to disseminating the results. The authors suggest useful resources for researchers working independently and detail further sources of expertise that may be sought when conducting a systematic review. Follow-up reading for those looking for more detailed information is also provided in the text.

In a world of ever increasing publications that are found in a wide range of sources, good quality systematic reviews can be a useful starting point. This

text is not only recommended if you are considering starting to conduct systematic reviews of your own, it is also a valuable text for learning how to evaluate and interpret systematic reviews.

Glasziou *et al* show how the methodology of systematic reviewing can be applied to a wide range of question types depending on the population, intervention, comparison and outcomes of interest. Throughout the book they outline how to progress through all processes from question construction, identifying the literature, appraisal and synthesis of applicable studies to writing-up and disseminating the systematic review. Separate chapters indicate how to conduct each stage of the review process depending on the type of question you are asking e.g. the effectiveness of an intervention, diagnostic test etc. Although these steps are written in a clear and practical way, the authors also caution that undertaking a systematic review can be a timely and resource consuming enterprise. A comprehensive glossary and list of abbreviations are supplied for those not familiar with systematic review terminology.

Throughout the text there is strong emphasis that a quantitative synthesis in the form of a forest plot and summary estimate of overall effect is neither necessary nor sufficient to make a review systematic. This text provides a structured and easy to follow introduction to systematic reviews for those of us who do not have an in-depth knowledge of statistics.

### **Liz Shirran**

University of Aberdeen

**Nottingham C [Ed] (2000) The NHS in Scotland. The legacy of the past and the prospect of the future. Ashgate, Aldershot**  
[ISBN: 0754612767; hardback £50.50]

This book covers a wide spectrum of health care issues in Scotland from the beginning of the 20<sup>th</sup> century to the present day whilst attempting to look to the future. As such, it can only skim the surface of the many topics covered.

Chapter 1 provides a brief history: from the creation of a Scottish Health Board in 1919, to the introduction of the NHS, and, more recently, the impact of Scottish devolution. Chapters 2 and 3 document the history of the nursing profession. Interviews with retired district nurses revealed that they did not particularly remember the introduction of the NHS except as one among many developments in health care. Relationships with patients were remembered most. The introduction of the NHS resulted in heavier workloads for GPs and nurses alike as patients sought the care they felt they were entitled to. During

the 1960s, health centres emerged and, as a result, nurses lost some of their professional autonomy. At UK level, nurses' pay and conditions were inadequate and, in 1948, 600 student nurses at St Mary's, London, threatened to resign over a pay cut from £3 16s 2d per month to £3 3s 4d. This resulted from their new liability to pay National Insurance contributions. By the end of 1948, the Whitley Council had agreed to increase nurses' pay by £5 a week. Chapter 4 considers the impact of Scottish devolution on the nursing profession, suggesting that nursing leaders in Scotland are more fully integrated into key professional and administrative networks compared to their counterparts in England. The author cautions that the nursing profession must remain united if it is to avoid fragmentation as a result of devolution. The impact of European legislation on nurses is also considered: the European Working Time Directive has reduced the working hours of doctors-in-training, accelerating the need for enhanced and extended roles for nurses.

The book places particular emphasis on the importance of public health, the need to address poverty and health care inequalities. Chapter 5 contains an interview with Dr David Player who commissioned "The Health Divide" by Margaret Whitehead.

Chapter 6 provides an account of the asbestos tragedy on Clydeside, drawing attention to the negative impact of occupational health services lying outside the NHS. Chapter 8 discusses the particular problems of providing health care in remote communities and describes some recent developments in telemedicine. These are being used to assist remote health care practitioners in their day-to-day practice. Chapter 11 compares health care reforms in Britain and the Netherlands after the Second World War, pointing to the fact that both countries built on existing pre-War policy.

The book concludes with a chapter on the implications of devolution for health care policy and cautions policymakers to tread carefully. Whilst devolution offers opportunities to make Scottish health care distinctive, it will only maintain electoral support if it continues to deliver the same level of patient care as in the rest of the UK. Overall, this book contains an interesting variety of topics ranging from the start of the 20<sup>th</sup> century through to the present day and should be of interest to anyone interested in health care provision in Scotland. It would be a useful text for undergraduate students interested in the development of the NHS in Scotland or the history of the nursing profession.

Fiona French  
NHS Education for Scotland  
Aberdeen

**BOOKS AVAILABLE FOR REVIEW**

Arber S, Davidson K, Ginn J. (Eds) 2003 *Gender and Ageing: Changing Roles and Relationships*. Maidenhead: Open University Press

Baggott R. (2004) *Health and Health Care in Britain*. Basingstoke: Palgrave Macmillan.

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**If you would like to review any of these books, please get in touch with:**

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**Please send copy for April issue to the appropriate person by:**

**Friday 26<sup>th</sup> February 2005**

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**AGONY AUNT**

**Dear Aunt Marge,**

I have just completed my PhD at a very old university, and I am looking forward to graduating this summer. I was based in a medical department where I was asked to contribute to the cost of the printing of my PhD thesis on the departmental printer. I am interested to know if this is common practice. Do other PhD students have a similar experience, or am I an exception?

A poor ex-student from Milton Keynes.

**Dear poor doctor,**

First, and foremost, my congratulations on successfully defending your PhD thesis. Do not let minor hiccups like the one you describe, spoil your celebrations! It seems a bit steep for your department to ask you to contribute to the production of the thesis, especially, as your department is probably benefiting from your presence in other ways. I'm sure that you, like many other postgraduate students, have helped your department by doing some teaching, marking (at short notice) or assisting of a research assistant with a research problem. However, in defence of all poor university departments, there seems to be less money available at the level where the academic work takes place as more and more is siphoned off through top-slicing. I know that is not your problem, but it is unfair on hard-working academics who bring in the money through grant income and their contribution to teaching, not to receive the benefits of their work.

Having said all that, I should point out that in my day we had to pay a typist to produce an original and several carbon copies of our theses. The third copy was virtually illegible. Presumably you have been spared that expense and disappointment by doing it yourself on a word processor.

Best wishes,  
Aunt Marge

**Dear Aunt Marge,**

I notice that your column has become a place where dissatisfied sociologists vent their spleen about the conditions/pay/environment in which they work, and I should like to add my own contribution.

Why oh why is research these days so under-funded? I am employed on a two year grant from a major funding body where corners have been cut to such an extent that there is insufficient funding for travel to research interviews, let alone conferences and meetings. There is little money to pay for tapes to be transcribed, data to be entered on computer and even postage is a problem. I understand the funders even balked at a few inter-library loans!

I do not earn very much and I bitterly resent having to subsidise the university and/or department by paying these things out of my own pocket.

Yours,  
Very weary and long suffering researcher

**Dear Weary,**

I agree it is shocking, and not to be countenanced by someone in the university's employ. Refuse to do it and perhaps the money will be found. I have seen it happen.

As a sociologist we all know that this is the glorious strength of the market, that is departments put in bids in a process of competitive tendering. The 'best', often the 'lowest bid' will get the prize, i.e. will get the funding. As many grant applications are under-funded anyway, there is little leeway for departments to put in competitive bids. The universities cannot compete on staff time and little on salary (thank God for that!), or the proportion of university overheads, so they cut corners on stationery, travel, and other little items, to keep the cost of their research bid down.

This whole competitive tendering process is also an enormous waste of time and money. You get all these departments across the country bidding against each other, each spending weeks of staff time to get a grant proposal written, travelling to meetings to present the application.

I am particularly upset about this process as over the past year we have come second in bid for a research project at a national level. Three times my colleagues and I spent a lot of time and effort in preparing the grant application, travelled to Edinburgh or London to present our case only to be told that we were very good, but not good enough!

Good luck  
Marge

### More little gems from the internet

Have you ever wondered what the Apgar score was all about? It is used by health professionals and parents alike, to calculate the health status of the newborn baby at one and five minutes after birth.

Well I learned from one Dr Howard Rodenberg writing in JEMS, the on-line journal of emergency medical services, that it was invented by an American woman doctor, Virginia Apgar in 1953. Infants are rated (0-2) on the basis of each of the following components giving a maximum score of 10:

**A**ppearance  
**P**ulse Rate  
**G**rimace (reflex irritability)  
**A**ctivity (muscle tone)  
**R**espiration

I can't help wondering what would have happened if the good doctor's name had been Yuill or van Teijlingen!

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**Medical Sociology News** is published three times a year by the Medical Sociology Group of the British Sociological Association.

Subscription rates for 2005 are:

Overseas subscription:	£20
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