

Medical Sociology News
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Summer 2005



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EDITORIAL: WELCOME TO OUR SUMMER EDITION

Call for Feedback

By the time you read this, the summer term will be behind you, examinations and graduation ceremonies over and the holidays in prospect. You may even be reading this whilst lying on a pleasant beach somewhere, soaking up the sun, sea and sangria. Well let's hope not! However, there is no excuse for not responding to us. We often get emails saying what a good job we are doing and how the world needs MSN but we rarely get material for publication. And we need it to keep going. Moreover, we will soon be coming to the end of our three year term as editors, and so we have included below an item on 'the future of MSN' asking whether there is any team or group of individuals out there who would like to take over from us after this year. Please do think about putting yourselves forward – there are many benefits to the role as outlined below (and additionally including free places at MedSoc each year). It would also be a shame in many ways to see the publication go given its history and unique role within the Medical Sociology community of the BSA.

Despite these concerns, the team has been busy as usual gathering material for this edition. We have quite a large number of notices of forthcoming events and a healthy collection of conference reports. In addition, there is an extremely good crop of book reviews, PhD abstracts and, of course, Dear Marge. Included as well are two short articles. In the first, Maureen Porter summarises the situation for infertility patients in Italy where recent legislation has drastically limited the availability of In-Vitro Fertilisation and inadvertently put women's lives at risk. In the second, John Brewer, in a piece reproduced from the electronic newsletter produced by the Department of Sociology at the University of Aberdeen, pleads for would-be authors to take more care about anonymising their submissions to academic journals. Often trying to anonymise your submission (beyond providing a removable title page) can seem too tedious and time consuming to contemplate after getting the layout right, the references in the correct format and the lines counted before even tackling the electronic nightmare that is supposed to be making submission easier. At the same time many medical journals, in which medical sociologists publish, do not use a system of anonymous refereeing at all. Not only are papers sent out for review

with authors' names attached, but referee reports come back to the authors with the reviewers' names on it. Given the ethical issues, the increasing pressure to publish and also to act as referee for submitted papers, this is an important issue and MSN would value your feedback.

Further news from Aberdeen is that Edwin van Teijlingen and Maureen Porter interviewed Professor Sally Macintyre on the occasion of her receiving an honorary Doctor of Science from Aberdeen University in July 2005. Sally reflected on the main influences on her career to date and on the position of medical sociology in the spectrum of social sciences. The full text of that interview will appear in the next edition of MSN.

Meanwhile, happy reading (whether you are on the beach or elsewhere!) and we look forward to receiving your copy and reflections on, or offers to take forward, the future of MSN over the coming few months.



Prof. Sally Macintyre's receiving her honorary degree from the Chancellor of the University of Aberdeen (July 2005)

Photo courtesy of the University Press Office

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NEWS AND NOTICES

The future of Medical Sociology News

This is the seventh edition of MSN which the Aberdeen team has produced. It has been a learning curve, the production of each issue becoming easier and more streamlined than the last, as well as a learning experience for us all. Editing the newsletter has provided valuable experience of editing and producing a newsletter for several members of the team. We have all honed our skills in team-working, as it became evident that the key to successful production of the newsletter was effective sharing and co-ordination of tasks. The activity has additionally facilitated networking between members based in three different departments/institutions, and there have been the social benefits of some pleasant evenings planning and editing over a pint or a cappuccino. There have been moments when we have struggled through lack of time, bouts of ill health and changes in the make-up of the editorial team. Yet on the whole it has been a good experience and we are glad we took it on. Now, however, it is time to pass the editorship to a new team as our three years are coming to an end (our last issue will be December of this year).

We would be delighted to hear from any group out there who would like to take over the editorship and production of MSN from the beginning of next year. We would be happy to discuss this with any interested parties, as well as to provide guidance and practical help during the early transition period.

A note of caution though. With money always so tight within the BSA and MSN not always breaking even, there have sometimes been questions over whether the newsletter should continue. Numbers of individual and institutional subscribers have dropped steadily over the last ten years and we have at times been disappointed by a lack of response to requests for articles or problems for Aunt Marge. As the forthcoming events we mention are also circulated through the jiscmail list, we have also wondered whether this renders this section of MSN obsolete. Yet there is no other outlet for conference reports, PhD abstracts and your medical sociology-related agonies! The newsletter

also provides an ideal outlet for short articles and 'think pieces', including medical sociologists' reflections on their work.

So the question remains: DO YOU THINK THERE IS A FUTURE FOR MSN OR IS IT ANOTHER VICTIM OF THE RAE AND SIMILAR EXERCISES? We need to hear from you! If you want it to continue then please do think of getting a team together to produce it in the future.

Yours in anticipation,

The Editorial Team

**Deadline for copy for December issue:
Monday 31st October 2005**

FORTHCOMING EVENTS - National and International

The BSA Annual Conference 2006

Call for Paper/Poster Presentations

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

**Friday 21st - Sunday 23rd April 2006
Harrogate International Centre**

Plenary Speakers

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

Geoff Payne (BSA President)

Angela McRobbie (Goldsmiths College, University of London)

The conference theme is open to wide interpretation and we invite papers addressed to the following stream headings:

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

There will also be an 'Open stream'.

Abstract submission form available from:

E-mail: Conference2006@britsoc.org.uk

or visit the BSA Website: www.britsoc.co.uk/conference

Abstracts must reach the BSA Office by 30th September 2005.

BSA Medical Sociology Group Annual Conference 2005

**Thursday 15th - Saturday 17th September
University of York**

Plenary Speakers will be:

**Ellen Annandale, Department of Sociology,
University of Leicester** who will speak on:

'Missing Connections: Medical Sociology and Feminism'

**Graham Scambler, Professor of Medical Sociology,
University College London** who will speak on:

'Social structure and health: A narrative of neglect?'

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

Cancer; Complementary and Alternative Medicine; Ethics; Ethnicity; Experiences of Health and Illness; Gender; Genetics; Health Policy; Health Service Delivery and Organisation; Health Technologies; Inequalities; International Health; Lay/Professional Interface; Lifecourse; Mental Health; Methods; Primary Care; Reproduction; Risk; Teaching Health Professions; Theory.

There will be a publishing workshop, a teaching medical sociology workshop, a publishers' exhibition, a newcomers' reception and a conference dinner.

The Cancer Study Group, the Mental Health Study Group and the Human Reproduction Study Group will hold a session at the conference.

Booking form, outline programme and further information available from:

The British Sociological Association, Bailey Suite, Palatine House
Belmont Business Park, Belmont, Durham DH1 1TW
Tel: [+44] (0) 191 383 0839 Fax: [+44] (0) 191 383 0782

**e-mail: bsamedsoc@britsoc.org.uk or visit our website
www.britsoc.co.uk/msconf**

FOUNDATION FOR THE SOCIOLOGY OF HEALTH AND ILLNESS

Call for Proposals for Symposia/ Workshops

The Foundation for the Sociology of Health and Illness wishes to support symposia and workshops dealing with important issues in the field. These may be on any topic, but the Foundation is particularly keen to support dissemination, discussion and debate on interdisciplinary themes with wide public relevance.

It is expected that the symposia/workshops will typically be one-day events, although the case for a two-day meeting will be considered. While it is expected that in some instances speakers will be by invitation, attendance should generally be open to anyone with an interest in the workshop theme.

A maximum of £2000 will be available per event for expenses related to speakers' travel, hiring a venue and hospitality. The Foundation will welcome bids that include other sources of funding to which the Foundation grant could be a contribution.

Proposals of no more than two pages, containing a detailed description of the content of the symposia/workshop and an outline budget should be sent to the Chair of the Foundation, Professor Roisin Pill, for consideration by the Trustees:

**Professor Roisin Pill
9 Westbourne Crescent
Whitchurch
Cardiff
CF14 2BL**

email roisin.pill@btinternet.com

Applications should be received by 28 February 2006

Applicants will be notified of the Trustees' Decision by 28 March 2006

XVI ISA World Congress of Sociology
Durban, South Africa, 23-29 July 2006
The Quality of Social Existence in a Globalising World.



CALL FOR PAPERS:
Social science and bioethics

Submission Deadline: 1 November 2005

At the next **International Sociological Association World Congress (Durban, South Africa, 23-29 July 2006)**, for the ***first time***, an entire session will be devoted to ***Bioethics***. This is a unique opportunity for those doing research in the field of bioethics to reach an international community of social scientists, a community concerned with societies in transition and with the role of social science in reconstruction and development.

Academics and researchers who wish to join - and contribute to - an international conversation about bioethics are strongly encouraged to submit their proposals.

Abstracts (2 pages maximum) should be submitted to the session co-chairpersons on or before **1 November 2005**:

Kristina Orfali, Columbia University, USA, ko2145@columbia.edu and
Raymond DeVries, University of Minnesota, USA, devries@umn.edu

Information about the XVI ISA world conference can be found at:
<http://www.ucm.es/info/isa/congress2006>

**An international conference to be held at
Ministère de la Recherche, Paris, France**

Call for Abstracts

Wednesday, September 7th - Saturday 10th, 2005

As a joint venture of the European Association for the History of
Medicine and Health (its VIIth meeting) and the Society for the Social
History of Medicine

Any proposal of papers or posters should be accompanied by an abstract clearly describing the contents, one A4 page, no more. The abstract will be submitted as an e-mail attachment. It should be prepared very carefully, as it will be circulated among the organisers and serve as the basis for acceptance, inclusion in a relevant session, suggestions for amendments, etc.

The abstract should clearly state the problem or questions that will be addressed in the study, the material on which it relies, the methods used, the results emerging, and there should be some lines discussing the originality and scientific relevance.

Sessions which foster cross-national themes and perspectives are being encouraged. Research networks of the EAHMH and Erasmus Networks are also welcome to propose sessions.

The official languages of the international sessions are English and French.

Abstracts and correspondence dealing with scientific presentations (papers or posters) should be directed to the conference organiser, Prof Patrice Bourdelais - **Patrice.Bourdelais@ehess.fr**.

**Society for the Social History of Medicine
Annual Conference 2006**

Practices and Representations of Health: Historical Perspectives

28-30 June 2006
University of Warwick
Coventry, UK

Call for Papers

The SSHM Conference is organised jointly by the Centres for the History of Medicine at the Universities of Birmingham and Warwick.

Keynote speakers include:

Susan E. Lederer (Yale University),
Sir Geoffrey Lloyd (Cambridge),
Charles E. Rosenberg (Harvard University).

The Programme Committee welcomes offers of papers on a wide range of topics that link to the theme of the conference, but particularly encourage papers on the following themes: alternative and complementary health movements; airs, waters and places; medicine and emotions; theatre, music and medicine; child health; old age and death; body shape and image; disability; race, post-colonialism and health; health and the workplace; the historiography of the history of medicine. The Programme Committee also seeks proposals for panel sessions. All papers should ideally present original work not yet published or in press.

Deadline for submission of abstracts
15 September 2005.

Please send abstracts to Molly Rogers (**molly.rogers@warwick.ac.uk**). If you are unable to submit electronically, please send eight copies of your abstract to **Molly Rogers, Centre for the History of Medicine, University of Warwick, Coventry CV4 7AL, UK**. Abstracts should be limited to one page and must include your mailing and email addresses, telephone number, and affiliation.

**Medicalisation of Spaces, Spaces of Medicalisation:
New Debates in the History of Medicine and Science**

University of Kent, Canterbury

12th November 2005

Call for Papers

300 Word Abstracts for Papers due on the **1st August 2005**

This conference aims to address spaces of medicine and science: geographic, physical, imagined or other. Spaces can be both physical and imagined, and yet significant to the understanding of the history of medicine and science through time. For example, the physical environment of a hospital could dictate the level/type of care provided, Equally the setting itself could influence the actual practice of medicine. Moreover, by following how the chosen setting adapts and develops, something of the social, cultural and philosophical influence upon medicine and science can be discerned. By understanding how different societies in the past visualised their spatial arrangements we can learn something about how they thought and how social and symbolic relations were maintained.

We invite papers focusing on spaces in the history of medicine and science to facilitate an interdisciplinary discussion between scholars in diverse fields and we warmly welcome abstracts from postgraduates and scholars working in areas such as Anthropology, Archaeology, History and Sociology, although this is by no means exclusive. By remaining intentionally broad, we aim to facilitate discussions to consider the role, influence and importance of the physical, geographic and bodily settings in which medicine and science has been conducted.

Please contact Dr. Patty Baker (P.A.Baker-3@kent.ac.uk) and Tal Bolton (tb40@kent.ac.uk) for further information.

Abstracts should either be sent to Patty Baker at the School of European Culture and Languages, Cornwallis NW, University of Kent, Canterbury CT2 7NF or Tal Bolton at the School of History, Rutherford College, University of Kent, Canterbury CT2 7NX.

Ethnicity, health and health care: understanding diversity, tackling disadvantage - Call for papers

Proposals are invited for contributions to the 13th monograph in the series to be published by Sociology of Health and Illness in conjunction with Blackwell Publishers. The monograph will explore the sociology of ethnicity, 'race' and religion in relation to health, health care and illness. Contributions could address the following themes:

- ❑ Continuity and change in debates on ethnicity, health and health care
- ❑ The implications of national and international political and economic realities for health and health care provision to minority ethnic groups
- ❑ The relevance of demographic changes, social mobility, cultural change and regional and international migratory flows for health and health care
- ❑ Quantitative and qualitative explorations of health and health care beyond simple inter-ethnic comparisons, including the experiences of settled and new minority ethnic groups, refugees, asylum seekers and trafficked people

The monograph will appear both as a regular issue of the journal and in book form. We anticipate that most papers will report original empirical research, although we also welcome innovative theoretical and conceptual work. We are keen to receive contributions from an international range of researchers.

Potential contributors should send an outline proposal of up to 800 words by **November 30th 2005** to Waqar Ahmad, Middlesex University, Trent Park, Bramley Rd, London, N14 4YZ, UK, e-mail: **w.ahmad@mdx.ac.uk**, or fax (+44 (0)20-8449-0798). The outline should provide a realistic indication of the content of the proposed article in a structured form and, if reporting an empirical study, include (1) major hypothesis or research question (2) methods (3) data source (4) findings and (5) conclusions. Proposals will be reviewed and the outcome notified by January 14th 2006. Authors whose outlines are shortlisted will be invited to submit an article of 6000 to 7000 words by July 1st 2006. All submissions will be refereed in the usual way and should follow the journal's style guidelines:

(<http://www.blackwellpublishing.com/submit.asp?ref=0141-9889>).

The planned publication date is September 2007.

FORTHCOMING EVENTS – Regional and Study Groups

London Medical Sociology Group

Venue: King’s College London, Room 1.16, Franklin Wilkins Building, Stamford Street, London SE1 8WA (**Nearest tube and rail:** Waterloo)

MEETINGS: 6pm – 7pm

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

12 Oct	Globalisation and health	Martin Hyde University College London
9 Nov	Variation in asthma care for ethnic minorities	Jane Gregory King’s College London
14 Dec	Christmas quiz night (everybody welcome: arrangements will be circulated later)	

To receive details of all LMSG meeting, please contact Miranda Leontowitsch: m.leontowitsch@pcps.ucl.ac.uk or visit the BSA website: britsoc.co.uk/

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Death, Dying and Bereavement Study Group

The Group will be holding a meeting on 28th November at the Quaker Meeting House in Sheffield. The plenary speaker is Liz Lloyd and the theme of the meeting is **ageing and death**. Abstracts of 250 words are invited by the end of September. Please contact Karen Kitchen on k.kitchen@sheffield.ac.uk or tel. 0114 222 8303 for further details.

Convenors: Jane Seymour, Sheila Payne and Jenny Hockey.

Sociology of Mental Health Study Group

Following a highly successful event at the end of June this year in Nottingham, the Group will be holding its AGM at the BSA Medical Sociology Conference in York on **Friday 16th September between 12.30-1.30pm**. The meeting will provide an opportunity to reflect on the Group's activities and to provide input into the development of these. New members are welcome to come and join.

Convenors: Lydia Lewis and Louise Woodward.

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Subscription rates for 2005 are:

Overseas subscription:	£20
Institutions:	£20
National subscriptions (waged)	£15
National subscriptions (unwaged)	£10

Please make cheques payable to: **BSA Medical Sociology Group**
and send to

Maureen Porter, Department of Obstetrics & Gynaecology,
University of Aberdeen, Foresterhill, Aberdeen, AB25 2ZD
m.a.porter@abdn.ac.uk

CONFERENCE AND EVENT REPORTS

British Sociological Association Annual Conference 2005

Admittedly, the prospect of presenting my PhD research findings at the annual BSA conference 2005 instilled strong feelings of both anticipation as well as trepidation. Whilst I had attended various conferences and presented my research at local or small-scale conferences, this would be my first experience of presenting at the BSA Annual Conference.

Back in November 2004, when I learnt that my proposed paper had been accepted for presentation, I was excited and somewhat grateful to be bestowed the opportunity to share my thesis with the wider research community of sociologists and considered the three day conference an excellent chance to 'network'. However, as the weeks passed and "P Day" (presentation day) drew closer, that early zeal was gradually replaced by sheer panic!

On reflection, this panic was undoubtedly fuelled by a range of fears relating to both the probable and improbable on both practical and personal levels: *"What if the OHP packs in during my presentation?"*; *"What if I'm so nervous I can't speak?"*

Nevertheless, good preparation and a 'dry run' performance prior to "P Day" provided as much reassurance as possible and thus, my maiden voyage to York to my first BSA conference was made.

On arrival at The University of York campus on Monday morning for registration, I was immediately struck by the atmospheric buzz created by the enthused delegates, conference organisers and the multitude of bookstall holders and publishers present for the duration of the conference. Following registration, an hour was spent in the surroundings of my basic, yet liveable on-campus accommodation perusing the comprehensive conference programme and abstracts, deciding how the next few days would be filled.

Indeed, investing time at an early stage of the conference, planning which papers to attend undoubtedly served to maximise my conference experience. Indeed, the programme was so comprehensive that several of relevant papers that I had wished to attend, ran concurrently.

The conference was organised around various areas of interest or 'streams', within which the papers presented were related. As my paper was in the caring stream, I attended as many other caring related papers as practicable, in order to learn of other related research activity.

Whilst my own paper related to informal caring, I was struck by the diverse range of papers presented in the 'caring' stream, perhaps due to the wide and somewhat ambiguous interpretation of 'care'. Thus, in addition to papers on informal caring in the context of illness or disability, caring was interpreted in terms of the normative caring within familial relationships as well as professional caring. Although initially unsure whether to go to those presentations which appeared to deviate from my specific interpretation of caring, attendance actually proved worthwhile and a useful means of extending my knowledge and potential research interests. Moreover, in terms of my personal development, this facilitated observation and critical analysis of a range of presentation styles.

In addition to papers in the caring stream, I attended several others including various postgraduate workshops, which were ultimately aimed at PhD students at various stages of their research. Of particular personal benefit was a session on managing the final stages of the PhD journey, which considered both practical issues and personal feelings and concerns. I felt that this discussion session offered an almost therapeutic element for PhD students negotiating the final hurdles of their research, particularly those like myself who have minimal opportunity to share their experiences with a postgraduate community within their universities. Moreover, this session was facilitated by an individual who recently completed her own PhD and thus, who could truly empathise with both the feelings of concern and excitement shared.

In terms of sharing my own research "P' day" landed on the second day of the conference. Realistically, I knew from prior attendance at other papers in the caring stream that there was likely to be no more than ten attendees. However, the prospect of a small (and previously supportive) audience did not serve to allay my nerves. Following a morning of frenetic last minute rehearsals, coupled with the full range of classic manifestations of stress "P' hour" finally arrived.

The majority of the actual presentation slots were for one-hour periods, during which two papers were given. As my paper was allocated the second slot of the hour, I had an anxious thirty-minute wait. Finally “P minute” arrived. Thankfully, the nerves soon subsided, there were no technical hitches, I felt that I was relatively articulate and the audience appeared interested, supportive and raised a multitude of provocative and interesting issues. Indeed I felt that the questions and discussion provoked by my presentation served as good preparation for my forthcoming oral ‘Viva’ examination.

Following the presentation, and indeed throughout the entire conference I was amazed at how utterly exhausted I felt – a sentiment shared by fellow presenters and delegates. The consensus was that the combination of active listening, processing and absorbing information is indeed mentally demanding. Thus, planning adequate breaks throughout the day and working on the basis of the ‘quality not quantity’ principle when setting personal itineraries, proved critical in ensuring maximum benefit from the conference experience. Moreover, leisure time was actively encouraged in the evenings with relaxed dinners and social events which also provided excellent networking opportunities.

However, the conference ‘buzz’ evident in the first two days seemed to ‘die a death’ on the third and final day as delegates departed in mass, leaving a relatively small number of individuals who required to stay overnight largely due to long distance travel. However, perhaps an organised event such as a dinner on the last evening may have provided fitting closure to the conference and enticed a greater number of individuals to attend the final presentation on the third day, by one of the two plenary speakers.

Nevertheless, the personal gains achieved from preparing for, attending and presenting at the conference were both significant and diverse and included: establishing a network of pertinent national and international professional contacts; broadening my areas of knowledge and research interest in relation to both caring and wider domains such as health and the family; as well as exploring my strengths, weaknesses, concerns and aspirations in relation to managing the remainder of my PhD ‘apprenticeship’ and future research career. Overall, an excellent experience hopefully to be repeated next year!

Emma Christie, The Robert Gordon University

North East Scotland Medical Sociology Conference

This year's biennial North East Medical Sociology (NEMS) conference held in Aberdeen on June 3rd at the Robert Gordon University drew together a wide range of academics, practitioners and researchers, with fifty people in attendance and eight people presenting throughout the day. Once again, the conference demonstrated the continuing strength of medical sociology in its 'intellectual birthplace' in the North East of Scotland.

The conference began with three papers concerning young people and their well-being. John Love's work on the consequences of parental drug misuse for young people drew attention to the considerable drug problem that faces the North East of Scotland, while Edwin van Teijlingen mapped out the problems facing educators dealing with young people and sexual health. An ethnographic approach was used by Chris Yuill to locate some of the influences on young people's emotional well-being in a dormitory town near Aberdeen.

The early afternoon session examined issues concerning fertility and death. Maureen Porter discussed the ways in which men and women managed the passage of time whilst seeking and undergoing infertility investigations. A reflective piece of research by Fiona Work examined the gendered complexities of a woman researching men and their grieving. Anar Arnason rounded off this session with an anthropological account of Icelandic nurses' practices on presenting and managing the recently deceased.

The later afternoon open session involved an international perspective from Cathy Di Dominico who discussed how structural changes in the Nigerian economy were having a negative impact on the health of Nigerian women. Finally, occupational therapist, Stephanie Morrison, demonstrated ways in which purposeful occupation can lead to health improvement.

Each paper was warmly received and followed by interesting debate and questioning. A publication of the papers will follow later in the year. The event concluded with cheese and wine on the terrace of this architecturally interesting university, on what turned out to be the warmest day of the early summer in the north east of Scotland. The

event was co-organised and sponsored by the Institute of Applied Health Sciences at Aberdeen University and the School of Applied Social Studies and the School of Nursing and Midwifery at the Robert Gordon University.

Chris Yuill
Robert Gordon University

Subscription rates for 2005 are:

Overseas subscription:	£20
Institutions:	£20
National subscriptions (waged)	£15
National subscriptions (unwaged)	£10

Please make cheques payable to: **BSA Medical Sociology Group**
and send to

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m.a.porter@abdn.ac.uk

**British Sociological Association (BSA) Medical Sociology Group
Sociology of Mental Health Study Group report of inaugural
symposium**

Sociology of Mental Health: Rethinking the Boundaries

Nottinghamshire Healthcare NHS Trust, Thursday, 30th June 2005

We were extremely pleased to welcome over 75 delegates to this first symposium of the study group, including those from mental health organisations (including service user groups) and health care professionals as well as those working within academic contexts. This diversity of delegates was particularly pleasing as one of the aims of the event was to help both 'broaden the boundaries of the academic study area and 'bridge' this with other areas of activity in the mental health sphere.

The day began with a welcome address from the convenors, Lydia Lewis and Louise Woodward. The focus and aims of the study group were laid out and it was explained that one way of meeting these (including networking, support and sharing of ideas and information) was to hold an annual event at which members could present and discuss their work. It was explained that the theme of the symposium arose from discussion at the Group's first annual meeting at the BSA Medical Sociology Group conference in September last year at which the issue of defining the sociology of mental health as a study area, including whether and how it was desirable to do so, was discussed. LL went on to describe how she and LW had been extremely pleased with the response to the initial call for papers – in terms of the quantity, range and quality of abstracts received – and that they had decided to include all abstracts submitted in this year's event. This meant that there would be a packed programme and the introduction of a parallel session. The themes to be addressed by presentations during the day were then laid out as follows:

- Boundaries between psychiatry and the sociology of mental health.

- Links between the study area and forms of activism and organising within the mental health sphere. (This, it was explained, had been something of particular concern to group members at the annual meeting and it was noted that the convenors were especially pleased to be welcoming presenters from a number of service user organisations, including Active Involvement in Mental Health [A.I.M.] (High Peak region) (delegates were urged to view a poster presentation from this group during the breaks), Edinburgh Users Forum and Aberdeen Mental Health Service User Network.)
- Conceptualisations of mental health and distress.
- The field of mental health services from a sociological perspective.
- Sociology of mental health as a study area (a theme to be returned to during the closing discussion).

Acknowledgements were given to the Sociology of Health and Illness Foundation for providing financial support for the event, the BSA for supporting the event and the study group, particularly Lesleyann Pinkerton for managing the Group's finances and Nicky Gibson for helping with publicity through the web site, Lorna Viikna for helping manage administration of the event, and Anne Rogers for her support through looking into a publishing opportunity arising from the event (further details were announced later in the day). Delegates were encouraged to complete and return evaluation forms as it was explained that the convenors were hoping to make this an annual event. A number of 'housekeeping' issues followed.

LL then introduced the first session of the day entitled ***Lay, medical and sociological understandings of mental health and distress.*** Presentations in this session were as follows:

- Christine Nugent, Department of Sociology, University of Essex, 'The duck and the rabbit? The maiden and the crone? A comparison of lay and psychiatric narratives of depression in older women';
- Richenda Power, The Open University and The British School of Osteopathy, "Body learning": a practical challenge to the boundaries of definition of 'mental health';

- Robert Chidlaw, School of Nursing and Midwifery, University of Sheffield, 'Young People Discussing Life – Challenges and Troubles: hearing the voices of young people';
- Sean Stitt, University of Bolton, 'When Irish Eyes Aren't Smiling: Mental Health Issues Among the Irish Living in Britain'.

These four papers made for an exciting opening session in which the key issue of conceptualising mental distress, including in relation to processes of mental and emotional healing, and to ethnic inequalities in mental health, was raised. All presentations were extremely well received with delegate questions and comments following each but unfortunately having to be limited due to time availability.

Following a short coffee break the day resumed with a short announcement from Anne Rogers inviting abstracts for a special issue of the *Journal of Mental Health* on the theme of the Sociology of Mental Health (please contact anne.rogers@man.ac.uk for further details). The second paper session chaired by Mark Freestone of University of Nottingham and Nottinghamshire Healthcare NHS Trust and entitled ***Conceptualising mental distress: the limits of psychiatry and the contributions of sociology***, then ensued. Presentations were received as follows:

- Hugh Middleton, Nottinghamshire Healthcare NHS Trust, 'Mental Health; Some Boundaries with Medicine';
- Marcus Redley, Department of Psychiatry, University of Cambridge, 'The psychiatric assessment of non-psychotic patients who self-harm: how psychiatry can become sociology';
- Anne Rogers, University of Manchester and David Pilgrim, University of Liverpool, 'Mental health inequalities, social psychiatry and critical realism?'.

The papers in this session made for another stimulating session, raising again important issues surrounding the epistemological basis of psychiatry, the position in Britain of what is known as 'social psychiatry', and the relationship between competing perspectives on the nature of 'mental illness' and the British political landscape.

The lunch break provided an important opportunity for networking and discussion among delegates – evident from the lively nature of this during

the entire time available. A number of delegates also took the opportunity to view poster presentations and to discuss these with contributors. They included a creative display giving insight into the work of A.I.M. and a poster outlining 'An Exploration of the Social Identity of Mental Health In-patient Service Users' by L. Jackson, J. Today, D. Giles, & J. Smith.

After lunch, presentations resumed with two parallel sessions as follows:
Sociological perspectives on the position of mental health service users (chaired by Suzanne Hodge, University of Liverpool)

- Ross Graham, 'The Modern Service User';
- Ewen Speed, Department of Health and Human Sciences, University of Essex, 'Discourses of consumption or consumed by discourse? A consideration of what 'consumer' means to the service user';
- Anne O'Donnell, 'User involvement – some questions, some answers'.

Sociological perspectives on the field of mental health services
(chaired by Louise Woodward)

- Mark Freestone, 'The Field of Psychiatric Care: Contextualising High-Secure Mental Health Research';
- John Aggergaard Larsen, European Institute of Health and Medical Sciences, University of Surrey, 'Addressing the 'how does it work?' question in complex mental health intervention';
- Anthony Page, Dane Garth Mental Health Unit, Furness General Hospital, 'Schizophrenia – rethinking the boundaries'.

Again in both of these sessions, presentations ensued with lively discussion and debate. In the former, consideration was given to the advances of 'user involvement' in mental health services, including comparisons between the Scottish and English scenes, and debates surrounding 'buddying' schemes within mental health services. In the latter, discussion centred around the contribution of ethnographic work to the field of psychiatric care and debate upon how to systematically conceptualise the wider social and political context within which psychiatric care is situated. Consideration of how mental health services

bring about change to the way service users experience their illness, and the contribution of qualitative research to understanding here, was also a topic of debate, as was the positioning of those with a diagnosis of schizophrenia, both in society and in relation to the professional identity of the psychiatrist.

After another short (but lively) break, the final session, chaired by Michelle Day of the University of Nottingham and entitled ***Conceptual issues in the sociology of mental health***, included the following presentations:

- Samuel Leze, A.T.E.R Université Claude Bernard Lyon I, Laboratoire de Sciences Sociales, ENS, Paris, 'A Sociological perspective on mental health: what is at stake?';
- Dan Oneill, 'The marginalisation of learning disability';
- Joanne Warner, 'Rethinking epistemological positions in the sociology of mental health';
- Darin Weinberg, Department of Sociology, University of Cambridge, 'On the boundaries of subjectivity: Some conceptual issues in the sociology of mental health and illness'.

Making for a varied session that addressed the sociology of mental health as a study area: in France; in relationship to and incorporating the study of learning disability; and its ontological and epistemological underpinnings, including as found in 'critical realism' and the sociological concept of subjectivity, this transpired to provide both challenging and thought-provoking material that addressed the overall theme of the day.

Following the thanking of all presenters and delegates by LW and LL, and their urging of delegates to attend the study group's AGM at the BSA Med Soc conference in September, the convenors initiated a discussion around the theme of the symposium. LL began the discussion by suggesting that the day's proceedings seemed to signal that it was not only possible but also of considerable value and worth to define and work within the sociology of mental health as a study area. Further, presentations delivered seemed to fall within the three themes of the study area identified by Busfield (2000): conceptualising mental distress, the field of mental health services and mental health inequalities, and it is perhaps the relationships between these three themes that require further scrutiny and elaboration, as well as conceptualisation and theorising.

Delegates' comments were then invited. One issue raised was that of medicalisation in the field of mental health and distress and the role of sociology in challenging this, including through looking at the interests served by medical conceptualisations and trying to put the brakes on processes of both medicalisation and 'therapeutisation'. One delegate questioned why we feel it necessary to maintain boundaries around the categories 'mental distress' and 'mental disorder' and what we think we may lose through dispensing with these. It was noted that sociology and anthropology can offer the field an approach in which the local is understood in relation to the social and cultural and that the benefits of this are a critical approach which does not necessarily place blame on particular groups or individuals.

A number of comments were received about sociological research as an evidence base for policy and practice in the mental health sphere. One delegate urged sociologists to be more strident with their knowledge claims here as we evidently have a lot to offer! The valuable insights gained from ethnographic research and qualitative research more generally were noted (although one delegate expressed the need for critical appraisal of this kind of research as with any other). That qualitative research and patient-centred reviews are now being taken seriously as evidence for policy and practice in mental health services was noted.

Lastly, discussion centred around how sociology may be making inroads into established mental health services, including through its incorporation into medical training (although the degree to which sociology features in clinical psychology programmes at present was questioned). It was noted that the two positions available to medical sociologists to date have been as either a subsidiary to medicine or a polemicist and so the advancement of 'applied' medical sociology would perhaps require the carving out of new roles for its practitioners. The availability of a career structure for sociologists in the Health Service and the role of the BSA in assisting processes of professionalisation for sociologists was questioned. It was noted that changes in the current political and policy climate may be opening the way to further address these issues.

All presenters and delegates were thanked once again for their attendance and contributions. Christine Nugent of the University of Essex also thanked the convenors for organising the event.

A full report of delegate feedback from the event is included in the report on the study group's web site at:

http://www.britsoc.co.uk/new_site/index.php?area=specialisms&id=237.

Once again the convenors would like to thank all of those who came along and made the event such a success. We hope to see you again soon!

**Lydia Lewis and Louise Woodward
Sociology of Mental Health Study Group Convenors
July 2005**

Deadline for copy for December issue:

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**Please send all copy to the editors by
email as a Word document attachment**

ARTICLES

The current state of infertility treatment in Italy

Maureen Porter, University of Aberdeen

This short article is intended to draw medical sociologists' attention to the situation in Italy with regard to Assisted Reproductive Technologies (ART). Here Politicians and Popes have contrived – for what they probably see as the best of motives - to restrict people's access to fertility treatment, and in the process have inadvertently risked women's lives. I have summarised the information available in British and Italian newspapers and various web-based newsletters. These are my own views, informed by liberal feminist politics and not informed by any religious conviction, but motivated by a sense of injustice and my love of Italy.

How many now remember the heady days of 2002-2003 when Italy's In-vitro Fertilisation (IVF) programme was one of the most successful in Europe? Maverick doctor Severino Antinori shocked the world by helping women as old as 63 to become pregnant through IVF. (Since then, Adriana Iliescu aged 66 has given birth to a 3lb baby in Romania as a result of donated sperm and donated eggs.) Antinori also regularly hit the headlines with his claims that he was well on the way to cloning the first human being. At that time, Health Minister of this strongly Roman Catholic country Girolamo Sirchia said, "Research should be carried out on animals, not Christians" (Arie 2004). Also since then, Hwang Woo-Suk in South Korea has claimed to have created the world's first cloned human embryo.

Largely as a result of Dr Antinori and his colleagues' activities, Italy was labelled the 'Wild West' of infertility treatment, a place where anything goes and women flocked to obtain controversial treatments not available in their own countries. In 2004 politicians reacted to the situation by passing draconian laws regulating assisted reproductive technology. The embryo was given the status of 'full human being' and provision of fertility treatment was severely limited. The main features of the legislation were:

- Available only to 'stable heterosexual couples' who were shown to be clinically infertile, cohabiting and of childbearing age.

- A maximum of three oocytes (eggs) to be fertilised in any one IVF cycle.
- All embryos resulting from this fertilisation were to be transferred to the uterus at the same time, thereby increasing the risk of multiple pregnancy.
- Embryo freezing was banned, though the less successful oocyte freezing was not, and pre-existing embryos already in cryostorage (frozen), were to be 'put up for adoption' if left unclaimed.
- Pre-implantation genetic diagnosis and prenatal screening for genetic disorders were banned.
- Gamete donation – eggs and sperm – were banned.
- Research into human embryos was completely prohibited.
- Surrogacy arrangements were banned. (Source: Boggio 2005)

Violations of the new laws were to be severely punished, with jail sentences of 10-20 years for those caught investigating or cloning human embryos and fines of 300,000-600,000 euros for those helping single or homosexual women, or using donated gametes to achieve pregnancy.

Opponents of the legislative changes rightly predicted that they would have a deleterious effect on the success rate of Italy's IVF clinics. There is now less chance for clinics to obtain good quality embryos (because they do not have a 'pool' of embryos from which to select), and no opportunity to discard those with little likelihood of implanting or the potential for carrying a genetic disease. Seven clinics have recently pooled their results covering the first four months of the new regime and published them in the journal *Human Reproduction*. Using data only on fresh embryo transfers, 900 cycles carried out after the new law came into effect were compared with 961 carried out a year earlier. The pregnancy rate fell from 27.0% to 24.2% per oocyte retrieval but the prohibition on freezing embryos produced a marked effect on cumulative success rates (Ragni *et al.* 2005). The Italian press has reported on a number of medical meetings and conferences where the estimates of various other centres were presented. These have suggested that the stringent laws forbidding the storage and transfer of frozen embryos has resulted in a fall in pregnancy rates from 33% to 20% on average (Costa 2005).

The fact that all three embryos now have to be returned to the uterus has increased the chances of multiple pregnancy, and the concomitant risks to the mother's health and well being. During this period, the incidence of twins has risen from 14.2% to 18.6% and the rate of abortion from 17.1% to 23.1% (Costa 2005). *BioNews*, an on-line ethical journal reported that one exceptionally small woman had to obtain a court order to be allowed to terminate a triplet pregnancy of 11 weeks gestation. Another was apparently told that she must transfer all her IVF embryos although they had not been tested for the beta-thalassaemia gene mutation of which both she and her partner were carriers (Horsey 2005).

In an attempt to allow Italian women fairer access to ART, a few Italian doctors have moved their clinics to just outside the country's borders. Italian couples have voted with their feet and the number of couples treated since the new law came into effect dropped from 2,418 in 2003 to 1,746 in 2004 (Costa 2005). Italian women are now attending clinics all over eastern and western Europe and as far afield as the Ukraine. Suzy Leather, chairman of Britain's Human Fertilisation and Embryology Authority (HFEA) recently warned that 'IVF tourism', though understandable was ill-advised, as clinics in eastern European countries were not subject to the same health and safety regulations, and regularly transfer three or four embryos in an attempt to improve their success rates (Derbyshire 2004). (The success rate in Slovenia in 2001 is quoted as 32.2% compared with 28.4% in Britain, although individual clinics vary greatly – see the latest *HFEA Guide*, 2005.)

Italian law provides that a referendum may be held with a view to changing any law which 500,000 signatories to a petition indicate they are unhappy with. The required number of signatures was obtained by the country's Radical Party with the result that Italians were asked to vote on four aspects of the law over the weekend of 12-13th June 2005. These were: the full human rights ascribed to the embryo; the three embryo limit; rules governing embryo research and gamete donation. These aspects would be repealed if the vote went in favour of the resolution and there was a 50% turn out. Feelings were running high: on the anti-legislation side more than 100 Italian scientists asked people in an open letter to go out and vote; 30 infertility specialists went on hunger strike (a huge sacrifice in a country like Italy) and famous Italian actresses added their voices to the campaign. The new Pope was said to favour the law which 'protects life' and to believe that lifting restrictions

would 'pose a threat to life and the family'. Perhaps most significantly the Roman Catholic Church urged people not to vote, with the highly contentious but successful slogan: 'Life cannot be put to the vote: don't vote'. Doubtless this contributed to the poor turn out at the referendum in which only 25.9% of registered voters participated. Of the 12 million Italians who did vote, 75% wanted to repeal the law.

This means that Italy's exceptionally restrictive laws stay in place although the Ministry has recently issued up-dated guidelines on their application. All but the most conventional couples will still be denied the opportunity to improve their chances of conceiving. Women's health and welfare will continue to be put at risk as the rights of the 'full human embryo' take precedence over the rights of their fully adult mothers. Benagiano and Gianaroli (2004) point out that this legislation is "in total opposition" to a liberal abortion law passed over 25 years ago. "This means that today Italy has a law that protects every early, pre-implantation embryo and another that allows the 'suppression' of every post-implantation one" (p.117). (For suppression read abortion.) They suggest, but do not advocate that the only way to properly enforce the law is to ban IVF altogether but others, particularly those who campaigned against the law, are worried that this result may have 'opened the door' to the repeal of the country's abortion law.

It seems only right that the last word should come from someone directly affected by the situation. The Italian actress Monica Bellucci who played Mary Magdalene in Mel Gibson's film *The Passion of Christ* was quoted in *The Observer* recently as saying:

"If I asked a priest or a politician what my body is like, what my ovaries consist of, how my ova work, they wouldn't know what I was talking about. Politicians and priests should stay out of this.... When I travel, people abroad laugh at me when I describe the Italian law to them. It's a law against women which is worthy of the Inquisition." (Follain 2005)

To me it seems ironic that this should have happened in Italy, a country where I have always found children especially welcome, and which as recently as 2003 proposed financial rewards intended to encourage women to have more children and thereby raise an alarmingly low national fertility rate (Kennedy 2003). As far as can be gauged, Italian

women who choose to have children are still choosing to have only one child. Let us hope that those who have difficulties conceiving are not forced by this restrictive legislation to have more children than they want or to undergo more distressing IVF treatment cycles.

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“As I have argued elsewhere (Brewer, 2004)” *

John Brewer, Sociology Department, University of Aberdeen

Well, actually I haven't written it before but I've certainly complained to colleagues at length and to editors about it. As someone who referees a great deal for several different journals on quite diverse topics, I have come across many authors recently who deliberately, blatantly, self-identify in the text. Inasmuch as they tell referees who they are, it is apparent that senior sociologists as much as new entrants into the profession are doing this. It's something I've only lately become aware of and why it's happening now is interesting.

Anonymity is a principle that has long been central to editorial practice; it's part of the universalism that characterises modern notions of professionalism. It avoids conflicts of interest and all the particularistic considerations that mark nepotism and favouritism. It also allows for friendly relations to continue with people whose work has on this occasion been rejected, panned or otherwise disliked. The top US journals in sociology require all identity markers be deleted from the text and return submissions if this is breached. The *American Journal of Sociology* and *American Sociological Review* give advice on how authors can cite themselves anonymously.

Of course, astute (or devious) authors left subtle cues in the past. Excessive citation to one author was a possible give away of absorption with one's self. Citations to forthcoming works, or to unpublished conference presentations, could be clues to self-referencing. Subtlety gave no guarantees of recognition and it was never clear to the author whether self-identifying wrought any benefits. These days, a sizeable proportion of authors have abandoned all hesitancy.

Papers sometimes note the name and institutional affiliation of authors at the back and are thus missed by editorial checking, footnotes are often revealing about identities and co-workers, and many authors place personal pronouns in the text before citing works that then become obvious as their own. Why?

It might be the outbreak of RAE disease, which leads normally sensible people to make strategic calculations of self-advantage and to promote

themselves relentlessly. Part of the epidemiology of RAE disease is inflated concentration on – and in some badly affected people – inflated assessments of self. Sufferers can be led into thinking that if referees know it's them, they'll be sympathetic ("I'm a recently completed PhD") or sycophantic ("I'm famous"). Some authors are led by RAE disease to submit as articles unedited work originally written in another format – conference papers, chapters in edited collections, encyclopaedia entries – which have no insistence on anonymity. But RAE disease is a moral panic amongst academics and far fewer people are affected badly than is commonly perceived. The RAE is like medieval witchcraft: too easy an explanation.

It is professionalism itself that partly explains this trend. The nature of research is changing. The rise of multi-disciplinary research teams, the increase in external funding from sponsors, and the proliferation of multi-authored papers all increase the range of colleagues, bodies and previous co-authors who properly need acknowledgement. Done sloppily – or calculatingly – acknowledgement of intellectual debts merges into self-identifying. Editorial guidelines are needed now that take account of these changes in research and writing practice while maintaining the principle of anonymity. As I have argued before, in a profound and well-researched study, that is only £16.95 and would make a wonderful stocking filler, that I hope may be made into a film and was short listed for the Bernard Mathews Turkey Award and is essential reading in Level 1 Posh Spice Studies at University-like College Willesden.... golly, what was the point I was making?

* This piece was first published in 2005 in *Sociology e-Bulletin*, the electronic newsletter of the Department of Sociology, University of Aberdeen (web address: <http://www.abdn.ac.uk/sociology/bulletin/index.shtml>).

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PhD ABSTRACTS

Mother Knows Best: Gastrostomy feeding in disabled children - professional and parental discourses

This thesis explores professional and parental discourses in relation to gastrostomy feeding technologies. Drawing on resources from feminist poststructuralism as a rationale for interpreting women's accounts, it examines how these ideas can lend themselves to the study of parenting and feeding. Current clinical and research arenas bring health care providers, children and their families to make decisions about children's feeding. A prevalent medical discourse in feeding disabled children revolves around malnourishment and poor growth, prompting a perception of the need for a gastrostomy feeding tube.

Interviews with 22 mothers, between 1998 and 2001, formed part of an externally funded evaluation of gastrostomy feeding which the author was employed to co-ordinate. The author presents a deconstruction of the research study to explore how researchers mediate between different clinical and research discourses, and analyses how the subsequent political and ethical issues impact on children and their families.

Women's accounts are analysed as constructing tube feeding as an intervention that either transforms their child by rendering her as 'other', or transforms their way of relating to the child, represented through oral feeding. Tube feeding was also constructed as an infringement of the child's rights to be involved and participate in social arenas, also associated with oral feeding. Both parents and clinicians constructed feeding decisions in terms of the child's best interests but, informed by competing and contradictory discourses, arrived at different conclusions about children's care. Parental accounts are analysed in terms of complex cultural-political overdeterminations between discourses of mothering, children's rights and normative child development.

This analysis suggests that the clinical focus on weight-gain may underestimate women's concerns and has implications for how services support families. Drawing on reflexive methodological debates, the author highlights the needs and responses of researchers and clinicians, and indicates how these could be better addressed.

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Social capital, social exclusion and understandings of community in an urban and a rural context

This thesis is concerned with lay perceptions and experiences of place of residence and community in the specific contexts of an urban and a rural environment. The starting point for the research was the growth of interest in the 1990s in the concept of social capital as a possible mechanism linking the social characteristics of a community with inequalities in health. This fuelled theoretical debate about the nature of social capital and methodological questions concerning the meaning and validity of proposed indicators. Four issues were of particular concern to this study: debates about social capital as an individual or collective resource; the applicability of social capital to geographical communities; claims that social capital operated as a public good benefiting even the most socially isolated individuals; and the problems of measuring community level characteristics on the basis of individual level data. A central interest was in the impact of personal context on interviewee accounts of the same place.

The study comprised of in-depth interviews involving 69 women and men living in two localities in North Kent: a village and an urban ward that had been a village within the lifetime of older residents. The study design allowed for comparison of interviewee accounts of the same locality and between accounts of the two localities. The research findings confirmed the significance of place of residence to interviewees as a physical and social environment, a representation of 'society', and an extension of and contributor to personal identity. Interviewees exhibited sophisticated understanding of social changes affecting the locality and complex internalised social rules governing relations with neighbours and asking for help. Community involvement and leadership were undermined by negative attitudes towards those who were 'too involved' or self-promoting. The research raised questions about the validity of common indicators of social capital and supported individual and structural understandings of that concept rather than one based on collective norms and values. Finally, the occurrence of individual and collective stories in interviewees' accounts provided rich insights into reflexive and cultural dimensions of community.

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In search of wellbeing: Reflecting on the use of alternative and complementary health practices

This thesis outlines and analyses how alternative and complementary health practices work *beyond* physiological health or efficacy that can be established through science. I thus explore the use of alternative and complementary medicines in contemporary Britain in relation to wider societal conceptualisations of health, illness, the self and the body. I also discuss how both users and practitioners conceptualise health, and consider how people using alternative and complementary medicines establish their involvement as legitimate. In addition, I analyse the empowering and agency-giving facets of alternative and complementary health practices.

In this thesis, I draw on 31 in-depth interviews with both users and practitioners of various alternative and complementary medicines. The focus is on women's experiences. I argue that the position of alternative and complementary health practices is paradoxical in that these forms of health care are strongly aligned with important cultural understandings about the self and the body, yet also marginal in the context of the continuing institutionalised dominance of biomedicine.

However, rather than addressing physiological health, alternative and complementary medicines are shown to remedy subjective experiences of *wellbeing*. I argue that the experiences of healing reached through alternative and complementary health practices pertain – not only to the physiological body - but also to the client's sense of the self as an active, empowered and knowledgeable agent. Alternative and complementary health practices offer empowerment through different kinds of *recognition* emergent in good therapeutic encounters. The possibilities for healing afforded by alternative and complementary medicines are also shown to relate to the character of these practices as *embodied*. Importantly, the way in which the self and body are conceptualised in alternative and complementary medicines enables women to produce themselves as capable of self-fulfilment and control – qualities traditionally ascribed to masculinity.

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Genetically Exceptional? Women's Experiences Of Being At-Risk Of Hereditary Breast and Ovarian Cancer.

This thesis questions whether the experiences of women at-risk of hereditary breast and ovarian cancer (HBOC) might be genetically exceptional. Using a combination of retrospective in-depth interviews with women at-risk and observations of consultations carried out at a regional specialist centre, this research questions the genetic exceptionalism thesis and the argument that the experiences and decisions that women at-risk of HBOC make, are unique and thus different compared to those of women diagnosed with non-genetic, sporadically developing breast or ovarian cancer.

In examining the arguments for and against genetic exceptionalism, this thesis revisits the medical sociological literature on the doctor-patient relationship and discusses the difficulty in establishing who should be recognised to be the patient within the genetic consultation, the decision to undergo genetic testing and the decision to have risk-reducing, prophylactic surgery. The resulting analysis recognises the data to be moral accounts, constructed by research participants so that their utterances would be perceived in a particular manner. For example, while justifying their reported actions, participants were attempting to portray themselves as moral, responsible citizens, mothers, patients and women.

In addressing these four aspects of women's HBOC experiences, this thesis concludes that there is little unfamiliar to medical sociologists about the experiences described and the rationales given by the participants. Such data lends itself to the position where the notion of genetic exceptionalism cannot be supported. Consequently, the thesis concludes that the experiences of women at-risk of HBOC seem to be little different from other, non-genetic health experiences.

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A Search for the 'public' in UK Government's public health initiatives: the case of the North Cumbria Health Action Zone

This thesis explores the subject of community involvement in health promotion and the understanding of health that lay people have compared to professionals. It is a case study based on an empirical investigation of the development and practices of a Health Action Zone. The thesis focuses on Health Activists and investigates the process of their involvement in health promotion activities, and through this, the relationship between lay and professional understanding of and approach to health, health outcomes and health outcome indicators, and how these become legitimate and influence the prioritisation of public health interventions.

The methodology is informed by the author's own history and draws on participatory action research techniques, underpinned by the work of Paulo Freire. The empirical research is contextualised in a review of literature on the development of public health and community involvement in the UK, the national Health Action Zone evaluation, and conceptualisations of health and illness. The policy and political context is that of the 'New Labour Government's 'third way', a perspective associated with the concept of social capital as a means of deepening democracy and reversing social decline by government acting in partnership with civil society to engender community renewal and development. The thesis explores how, in practice, through the government's idea of 'modernisation', a top down approach was introduced which prioritised professional concepts of health and community, thereby marginalising lay knowledge, community participation, and the opportunity to utilise place-related factors as incentives for lay participation. The thesis recommends frameworks that could be used to explore health perspectives when planning collaborative interventions. It also proposes a more dynamic model for the analysis of elements of social capital in partnerships involving professionals and the community, in order to contribute to a more inclusive and effective public health practice.

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Working with the Body in the Medical Curriculum

Medical students learn the knowledge and skills required to undertake the practice of medicine and how to operate within its culture or cultures, through the medical curriculum. Since the 1950s, an extensive literature on the professional socialisation of medical students has explored how students are socialised into becoming doctors and how their attitudes to patients are developed over time.

My research focuses on the ontological status of the bodies that students encounter in the medical curriculum: dead and dissected, unconscious and conscious. It uses the two constructs of the medical body - passive and object - and the everyday body - active and social - to explore the relationships between students and these bodies, in an attempt to find an approach which recognises the complexity of these interactions. I would contend that the curriculum serves to support the notion of the medical body in various ways and certain normalised educational practices reinforce this. However, the everyday body is present for students in various situations: e.g. when they connect socially with a patient.

Attention to the ontological status of the bodies that students interact with is important because it influences the way that the body is treated. If a student needs to negotiate access to a patient's body, how they go about this will be affected by the status they accord the body: negotiating access with a person whose body is considered to be passive is likely to take a different form from a negotiation with someone whose body is viewed as active and interacting. The introduction of policies and procedures which aim to improve interactions between patients and students, need, therefore, to be understood in the wider context of the status of body in educational encounters and in medicine.

Students must find their way through an uncomfortable and complex tension between using bodies for their own ends and, at the same time, respecting these bodies. I propose that this tension be openly discussed and that the contingent nature of both students' and patients' bodies needs to be acknowledged. Encouraging a view of the patient's body as everyday- as a social 'educating' body - through more active involvement of patients in students' education, might be one way to counter, or interrupt, the unnecessary transformations to the medical body.

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Reassessing the 'gift relationship': the meaning and ethics of blood donation for genetic research in the UK

This thesis is based on a critical re-appraisal of Richard Titmuss' classic formulation of gift relationships, which has long been a point of reference for thinking about blood donation in Britain. It argues that Titmuss' interest in the intersections of social systems and health care, together with his concern with mutuality, has been lost in the characterisation of blood donation as a uniquely altruistic activity. This argument is applied to some key assumptions about blood donation in Britain in the thesis, which considers their historical and political contours, and interrogates them in the light of the development of large biobanks which require blood samples for genetic research.

In examining the revival of this 'mobilising metaphor' for genetic biobanks, interview data from UK National Blood Service donors and with others donating blood for a genetic research project is generated and analysed. This reveals that the notion of gifted blood has considerable acuity in summoning up social allegiances based on a sense of community. It is suggested however that mutuality (not one-dimensional altruism) is the model implied by these participants' stance to blood donation or participation in research. This resonates with the re-evaluation of Titmuss' work, in which debates about practical mutual provision and social insurance are more prominent than is generally acknowledged.

Biobanks, as with blood banks of a traditional kind, are bound up with an assertion of common interests. The tacit use of notions of gifted blood and solidarity in the context of contemporary policies on biobanks are revealed as problematic. The thesis concludes by underlining the importance of having an explicit political debate about the UK Biobank, and of developing mechanisms to negotiate and protect the collective interests to which it refers.

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Never say die: A study of Cardiopulmonary Resuscitation and the National Health Service: an ethnographic enquiry

The focus of this anthropologically informed enquiry is the 'life-saving' intervention known as cardiopulmonary resuscitation (CPR). This is a relatively common practice within modern, (technologically rich) Western medicine and is a measure employed for the management of sudden death. The concern here is with the *practice* itself and not with other related issues such as 'the body' or the 'personhood' of the body in question.

Thus the conceptual core of the thesis is the boundary between life and death and how this has come increasingly to be mediated by the act of CPR. It explores, via the process of ethnographic fieldwork conducted in two hospitals in the UK between 1999 and 2002, the everyday world of how this practice is sustained and performed despite its limited success rate in terms of effective clinical outcomes.

How CPR as a procedure has developed and how it is constructed as a rational, 'normal' intervention at the point of death, is examined as is the role and occupational positioning, in relation to medicine and nursing, of a cadre of health care personnel called Resuscitation Training Officers (RTO) whose job is to teach CPR skills to the health care workforce (and beyond). It is they who acted as the key informants for the enquiry.

The identifying of significant political and professional forces operating at a macroscopic level, notably the legal system, is intended to illuminate actions taken and behaviours adopted at the 'micro' level of health care delivery; the interface between practitioner and patient, between practitioner and practitioner and, in this case, between life and death. Here the notion of an objective notion of 'risk management' as a key driver and shaper of clinical practice, particularly at the end of life, is considered alongside Douglas' (1992) notion of risk as a culturally mediated entity.

Goffman's (1961) notion of performance is drawn upon briefly to examine the 'social display' that occurs during a CPR event and how social roles are 'pulled off' by 'actors' engaged in 'on stage' performances which may take place in either 'front' or 'back' regions. The classroom teaching by RTO's of life saving skills is considered as a 'back stage' preparation for

the 'front stage' performance by the resuscitation team of an actual emergency clinical event. Despite the advantages of this theoretical thread in drawing attention to some elements of the CPR performance it did not provide a neat explanatory 'fit' to address the shifting identities and roles and 'audiences' that were noted in the CPR arena and this is documented. The 'display' that was observed appeared to have both a manifest function; that of saving life and also an additional more symbolic function as a 'marker' between life and death. This interplay between the technical rationale and ritual aspects of the intervention is examined and places death as a symbolic 'border crossing' marked out by significant social and cultural processes, in this context, mediated by medicine.

It is suggested that CPR provides a symbolic, quasi-ritualistic, contemporary death management practice which provides a 'solution', for health care professionals and the public, to the 'problem' of what to do in the face of death. Simultaneously, it offers the possibility of survival and, for health care organisations and services, addresses the risk-management/ medico-legal agendas of current health care practice.

Policy implications are considered as well as the contribution of ethnographic research to health care practice and the potential limitations on this with the advent of Research Governance initiatives now operating in the National Health Services (DoH 2001).

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Obesity: Epidemiology, Consequences and Interventions

Obesity is a worldwide epidemic, creating important medical and social problems. It is one of the ten top health risks in developing countries and one of the top five in developed countries according to the WHO, affecting women and men of all ages and all socioeconomic groups .

This PhD research had four objectives:

- To describe distribution of obesity and its trend by socio-demographic (age, gender, region) and socio-economic status (education level, social class) in England and Scotland.
- To review the relationship between obesity and all causes, coronary heart disease, stroke, hypertension, cancer, asthma, diabetes, osteoarthritis and thyroid disorders.
- To assess the economic consequences of obesity.
- To evaluate the cost-effectiveness of interventions for prevention of obesity in adults.

A series of systematic reviews was conducted as well as statistical analysis of the UK Archive and Grampian Health Board data. Health Surveys for England, Scottish Health Surveys and Grampian Lifestyle Surveys show that obesity and being overweight are increasing across all socio-economic and demographic groups.

The nature of the relationships between obesity and CHD, stroke, hypertension, cancer, diabetes, osteoarthritis, thyroid disorders, asthma and excess of all causes mortality are analysed and discussed. The huge economic burden of obesity (up to 8% of total health expenditure in different countries) is presented although apart from the USA few countries have assessed the economic consequences.

There is insufficient evidence of effectiveness of strategies to prevent obesity in adults and there is a need to develop comprehensive and multi-component strategies. Intersectoral policy and environmental initiatives in addition to behavioural change approaches on a national and international scale should be considered.

This thesis showed that obesity is an important public health, medical, social and economic problem and should be considered from many perspectives by individuals, communities, policy makers, researchers, health providers and health managers.

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BOOK REVIEWS

Stanworth, R. 2004. *Recognizing Spiritual Needs in People who are Dying*. Oxford: Oxford University Press.

ISBN 0-19-852511-7

This book is about how terminally ill people talk about their experiences in terms of personal meaning and identity. Rachel Stanworth talked to 25 patients in a hospice and asked them to tell their personal story about 'what's it like for you'. Stanworth demonstrates how terminally ill people use a non-religious 'language of spirit', which emphasises metaphor and symbolism. She describes her approach as a theological anthropology and explains how theology handles spiritual awareness in terms of the experience and language of grace. The graced experience, according to Stanworth, is as much a question as an answer and comes to people via the concrete experiences of their lives such as 'the light breaking into darkness'. Thus to be graced is not of our own making but can break unexpectedly into consciousness and we are given many examples of this in the book.

The book has four parts. Part 1 outlines the theoretical support for the spiritual interpretation of patient's words. In a theological sense the story and its telling are examples of 'grand moments' and has the quality of a gift because it enables the unanticipated finding of somewhere 'safe to stand' through the telling of the story to someone who is attentive. Part 2 explores how terminally ill people make spiritually significant statements using the 'tools' of symbol and metaphor. An aspect of the 'language of spirit' is the use of archaic language. One of the metaphors invoked by patients was 'reaping what one sows'. For example one woman explained how she thought that occupational stress had contributed to her cancer. Using archaic language and humour enabled frightening thoughts and feelings to be approached and expressed safely and to be disarmed. Stanworth explains how the use of archaic language is not linked with education or literacy and emerges at a point where everyday language breaks down because too much is expected of it. The difficulty with such archaic language is that it may remain unheard or ignored, as carers may not know how to respond to it.

Part 3 presents nine metaphors, which mediate spirituality in the 'here and now'. In this part of the book Stanworth moves from how the

language of spirit works to focus on what terminally ill people use it to say. She seems to use the term metaphor in conjunction with archetype. She draws on psychoanalytic discourse in particular the work of Jung, in relation to the archetype of stranger, for example. Stanworth discusses how little attention is paid in palliative literature to the stranger. She found two themes in patients' narratives: non-recognition of one's own self and non-recognition of oneself by others. To be facing death results in acute tension and there may be difficulty in maintaining one's personal security. For example one woman described, 'I resent being sick because I don't feel this is me'. Although there is effort made by patients toward 'putting up a front' and to 'be reasonably pleasant', this is not always possible and one man describes how 'the mask definitely slips'. In these utterances Stanworth describes how patients were facing new and unrecognisable aspects of self and they were expressing a desire to be accepted, recognised and heard, as this overcomes the feeling of estrangement sometimes evident in their talk. She says that the language of spirit conveys dimensions of personhood that are both deeply personal but also timeless and universal.

Part 4 discusses the implications for spiritual care. Although short this section provides pointers to ways that such care may be given. For example paying attention to the illogical line or gesture and to offer companionship rather than interpretation. Thus by refining one's moral perception we may be able to see things from another's perspective and Stanworth demonstrates how to do this in her carefully documented reactions to patients' symbolic language. This book is essential reading for all those who work with terminally ill people. There are so many perceptive insights and practical observations that I believe it may also be helpful to people who are supporting a loved one who is very ill and dying. The book will also be of interest to social scientists interested in culture, identity, emotions and psychosocial care and to therapists and chaplains involved with dying people.

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Prilleltensky, O. 2004. *Motherhood and disability: children and choices*. Basingstoke: Palgrave. ISBN 1-4039-0495-2. £47.50

Motherhood is a sensitive subject. All mothers worry that they may not be good enough. Motherhood for disabled women, who are often seen as dependent themselves, is a particularly difficult issue, which has been handled delicately in this book, written by a disabled mother/academic from a feminist and disability rights perspective. The book begins with a moving personal story about the author, who has muscular dystrophy, and her three-year-old son. She has fallen in the snow outside his nursery school, is unable to get up, and her son becomes frustrated by his inability to help. Eventually, a teacher from the school comes by. She ends the story by saying that the incident happened 13 years ago and her son "has since had many opportunities to fulfil his childhood dream of helping mommy up." (p 3) This story alone provides much to think about mothering in general and what balance should be fostered in children between freedom and responsibility.

Based on a qualitative study involving physically disabled women, and consisting of four focus groups and in-depth interviews with 13 women, with and without children, the aim was to identify disabled mothers' general concerns and problems with services. The first three chapters address the background literature about disabled women, sexuality and motherhood. These are followed by a chapter on the research process. An acknowledged problem in the study was anonymity, as most of the participants belonged to one local disability group, and this led to the author limiting quotations and not describing full narratives. The next four chapters cover the experiences of the interviewees, from childhood to the present time. The final chapter concentrates on resilience, specifying risks, protective factors and possible interventions for different life stages, which might increase the well-being of disabled mothers.

One possible weakness of the study is that all the participants came from disability groups and had similar viewpoints. It would also have been interesting for links to be made between the mothers' childhood and adult experiences, but this would have necessitated more complete narratives. To create more of a balance, I would have liked to have heard from the children, some of whom were teenagers or adults. A concern expressed about disabled mothers is that the children may become their mothers' carers, and the mothers in this study tried to avoid this. The author also

makes the point that disabled mothering "stretches the boundaries of what we consider inappropriate parent-child relationship and speaks to the diversity of acceptable parenting practices" (p 79). An important message of this book is that disabled women are extremely resilient (although this resilience can be over-romanticised by heroic stories) and with appropriate support have a great deal to give to children. There are detailed recommendations in the last chapter about the kinds of support and interventions that create the confidence for disabled girls and women to be able to form relationships more easily and make informed decisions about having children.

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Shaw, I. and Kauppinen, K. (Eds) 2004. *Constructions of Health and Illness: European Perspectives*. Aldershot: Ashgate. ISBN 0754632768.

Shaw and Kauppinen have edited a varied but delectable collection of essays addressing a valued contribution of medical sociology, that of social constructions of health and illness. I have always found the 'constructionist debate' to be an exciting field and certainly my students have really engaged with the critiques of medicine, in particular, its relation the medicalisation thesis. At the core of social constructivism is the claim that the biomedical model is not an objective or value free way of understanding illness. However, the field is quite dispersed with a large number of voices and preoccupations ranging from the problematization of reality to the social creation of 'facts' and from the application of technical knowledge by clinicians to how medical knowledge mediates social relations. At times, social constructivism is rather daunting to comprehend. Here Shaw and Kauppinen have gathered timely pieces of work to capture the field at the turn of the 21st century. Most of the chapters have originated from presentations made at the 2001 European Sociological Association's biannual conference in Helsinki. Perhaps because of this, the chapters are a delight to read, each simplifying complex issues into handy comprehensive bite-sizes of information.

The book starts off with a solid introduction to the social constructionist debate. Shaw and Kauppinen explicitly identify four strands within the constructionist debate: (1) how medical knowledge and facts become socially constructed; (2) how disease entities cannot be divorced from their social context; (3) how social relations are mediated by medical knowledge and medical labelling and (4) medicalisation, i.e. the way medicine makes claim over areas previously thought of as 'natural' rather than 'medical'. They also look at the criticisms of social constructivism, raising the issue of biological reality. Although brief, it is a suitable means to familiarize undergraduate students with constructivist approaches.

The lay person's health beliefs dominate in the collection. In Chapter 2, Shaw and Woodward investigate lay constructions of risk, where medical rumours perpetuated in the media lead to increased fears and subsequent visits by patients to GPs. Later in the book, Chau and Yu look at the factors that affect Chinese people's decisions when choosing methods of promoting health and seeking social inclusion. There are chapters on self-rated health in Moscow and Helsinki, how lay understandings of health impact upon lifestyle practices in Louth, Ireland, views of depression and construction of lay resistance to vaccination.

In Chapter 8, Allsop, Jones and Baggott argue that the way in which pain, injury and loss is defined will affect how people come to terms with these events and how they take collective action as health consumer groups in the public arena. It is interesting to look at how lay people construct their perceptions of health and illness as often the focus is on the positivist versions of disease as held by clinicians. However, the book could have benefited from more contributions on the consequences of medicine's dominance in modern society. Only one chapter looked at medicalisation (the final chapter's discussion on 'unhappiness' being reconstructed as a medical problem), whilst Chapter 1 examined the visualisation of disease by pathologists. Perhaps this criticism is a little picky given that, with edited collections, it can depend upon contributions offered. Also, looking at lay people's constructions is an interesting direction, particularly at how medical knowledge is constructed by both 'experts' and 'lay people', and has implications for the doctor-patient relationship. Overall, this book was an enjoyable read and a good account of some of the research currently being undertaken in the field.

Dr Catherine Heffernan, University of Oxford.

Heyman, B. and Henriksen, M. 2001, *Risk, Age and Pregnancy: A Case Study of Prenatal Genetic Screening*. Basingstoke: Palgrave. ISBN 0-333-73940-X

Since the late 20th century, the British health care system is increasingly being organised around the management of risk in populations. Arguably, this move is symptomatic of the UK being a risk society, as sanctions are continually being imposed to reduce risk to citizens, from the mandatory wearing of safety belts to the safer production of food. Within this climate, public health initiatives have gained increasing importance, in particular, that of disease prevention. Screening is a specific form of secondary disease prevention that is aimed at detecting disease in its pre-symptomatic phase. This ideally leads to early diagnosis followed by prompt effective treatment whereby patients' quality of life or survival is improved. As the health care system became more focused on the importance and cost-effectiveness of public health promotion and disease prevention, there was a shift to screening populations. Screening programmes have now been developed for a wide range of conditions including breast, cervical and colon-rectal cancers, coronary heart disease, hypertension, neonatal hearing disorders and antenatal genetic disorders.

Heyman and Henriksen's book is part of the growing body of research literature on the phenomenon of screening in the UK. However, whilst most studies are preoccupied with the formal design and operation of screening systems, Heyman and Henriksen aim to address the organisational complexity of their operation. In particular, they are interested in the shift from the care of individuals in the health and social care systems to the management of risks in populations. They maintain that this shift is most advanced in the field of maternity care, with pregnant women and their babies being offered a wide range of screening tests. Entitled *Risk, Age and Pregnancy*, this book is a case study on genetic screening and testing for Down's syndrome and other chromosomal abnormalities within a maternity hospital in North-east England. It looks at women's experiences of decision-making regarding genetic tests and their outcomes and the viewpoints of hospital doctors and midwives on risks of genetic screening or testing. The focus is on risk management not ethical issues surrounding genetic screening for Down's syndrome. The methodology consisted of fieldwork done between 1995 and 1997 whereby 35 women were interviewed and

analysed using a grounded theory approach. Six further interviews were conducted with pregnant midwives, 11 interviews with hospital doctors and 5 interviews with midwives. A survey of 1552 pregnant women was also undertaken alongside 16 hospital consultations and 10 follow up interviews after hospital consultations. The authors make no claims about the typicality of the screening system under examination and argue that in the absence of national or international standardisation, every screening system takes on its own organisational form.

I did approach this book tepidly. The fact that the fieldwork was undertaken about 10 years ago did not endear itself to me. However, once I started reading, I found that the study was full of gems in regard to how women view antenatal genetic screening, many of which could be explored in greater detail in other studies. For example, use of genetic technology defining pregnant women over the age of 34 as being biologically old and the implications this has on women amidst the social trend of women delaying childbirth. As with all case studies, it provides a snapshot of social process on a micro level. It is a starting point in relation to a sociological investigation of the rise of genetic screening and testing. Genetics is growing in dominance in health care and it is open to social scientific scrutiny on its effects on people's attitudes and behaviours. Heyman and Henriksen's final chapter 'Conclusions' offers an easy- to-read listing of the individual chapter's findings. These findings act as pointers to further studies – e.g. the incorporation of service user choice into screening system design may give rise to social inequalities with more affluent women being more likely to be screened. Heyman and Henriksen have provided a book that would be of use to people studying or researching screening programmes.

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Baggott, R. 2004. *Health and Health Care in Britain* 3rd Ed. Basingstoke: Palgrave Macmillan. ISBN 0 333 96159 5 pbk. £20.99

Although the second edition was published as recently as February 1998 this new 2004 edition is welcomed as it attempts to cover 'the torrent of government initiatives' (p. xii). In a climate where the media focus on health issues is often controversial, it is helpful to have such a book that provides both a historical and critical approach. For someone who finds it difficult to be up-to-date with health policies this book provides the answer.

The book has drawn on advice and information from various eminent academics in the field as well as contacts in the NHS. As a standard reading on many health policies and management courses, this book can benefit others who wish to know more about the evolution of the British Health Care system and the critical perspectives on health care.

The book has fourteen chapters. Its introductory chapter offers an overview of recent trends, an analysis of key factors affecting health and illness in the UK, and a discussion of variations between different population groups. The concept of 'medical hegemony' is explored in Chapter 2, which includes a discussion of orthodox and alternative medicine, as well as lay models of health and illness. Chapter 3 discusses a number of broader critical perspectives of health care encompassing New Right, Managerialist and Rational-Economic Critiques; Marxist, socialist, communitarian and Third Way perspectives; and feminism, Green critiques and the medicalisation thesis. In Chapter 4 we are offered an understanding of how the British health care system evolved to place recent developments in context. The way in which health care in Britain is funded (including the Wanless review) is examined in Chapter 6 while an analysis of the relationship between the organisational structures, networks and processes that underpin policy development and planning are explored in Chapter 7. This highlights the difficulty of matching the concept of access in health care with issues of policy-setting and rationing, which is explored in Chapter 8.

Issues surrounding the quality of health care in the UK are included; Chapter 9 focuses mainly on hospital care and Chapter 10 on primary care. The book is up-to-date in discussion on 'managed care' organisations. The debate on Health and Social Care in Chapter 11

explores how health and social services have developed to improve care and treatment of older people, children, people with mental illness, people with learning disabilities and those with chronic illness. Chapter 12 examines the development of policies on patient and public involvement, complaints and advocacy, and patient choice. A more consistent approach to public involvement is advocated. The challenge of public health is highlighted in the penultimate chapter of this book. Public health policies in the UK are historically to do with the promotion of health of the whole community; Baggott outlines them in relation to postwar period, the Thatcher and Major Governments, and the Blair Government. A broader perspective is offered to include the European Union and International Strategies such as the World Health Organisation. In Chapter 14 Baggott concludes that 'each health care system generates its own particular configuration of issues' (p. 357).

The underlying argument presented in this book is convincing, that policy developments are often unpredictable. Issues raised are well backed up by relevant research, reports and statistics. Each chapter finishes with a conclusion and recommendations for further reading. This is a book that has much to offer to many health care professionals and those undertaking courses related to health care provision and management. It has valuable and surprisingly, easy to read information to provide the reader with up-to-date information about health and social care in Britain.

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Murphy, E. and Dingwall, R. 2002. *Qualitative Methods and Health Policy Research*. New York: Aldine de Gruyter. ISBN 0 202 30710 7 (Pbk). £24.95.

Lets face it there should be a quota on the number of methods/methodology books publishers can produce. Everybody who has lectured on the subject seems to produce a version of their course in a 'methods/methodology text' format. Just how do they look at

themselves in the morning'? I for one can hardly see over the pile of methods/methodology books in the way. Use your imagination for why they are in the bathroom in the first place! The authors of this book, aware of sourpusses like myself, apologise for producing another methodology book, but believe they are doing something different - and they are, sort of.

The origins of this book are different (from the methods course ones above), it stems from a report on qualitative methods for the UK National Health Service Health Technology Assessment Programme - and a useful report it was too. On some of the various booksellers' web sites this text has the sub-titled: 'A Consumers Guide', but my copy does not state this on the cover! Lets face it, a snappy title it is not, but it does try to do what it says on the tin, er, cover! Or would, if the cover had the sub-title!

Confused? Don't worry, the book isn't, it is a clearly written and authoritative text by people who know what they are talking about, and know how to say it. Admittedly, I had hoped that this book would be one which I could give to my potential research sponsors and say "read". In practice, as I detail below, it is probably more useful as a book to remind us that we are accountable for our research (in many ways), and therefore useful to refer to when 'Slipping up our own arses again' (to paraphrase Heraclitus) - and do not under-estimate the importance of such a tool!

The Introduction says it is aiming at "commissioners and consumers of health care research, those who have to plan, make policy, manage, and deliver services to, and for, sick people" (p1) Again, don't be put off, the book is doing more than that - which is just as well because personally, I can't see the above having the time or inclination to read such a text. Exceptions to this may be when they are on formal courses, such as MBAs with health service research components - indeed I have recommended it to a colleague just for this reason. Generally though, I think the intended audience will just ask the researcher to explain the issues involved, and this is partially why it could be a useful text for researchers themselves: it reminds us what the consumers concerns and knowledge needs may be (hence my Heraclitus 'reference').

The book is in three sections: 'The Contribution of Qualitative Research'; 'The Practice of Qualitative research'; and, 'Evaluating Qualitative

Research'. It is informative, and illustrated throughout by interesting examples, which are discussed usefully (not in the usual fashion of methodology books, i.e., a case study box, a format that brings despair gnawing at ones heart). The text covers most areas of qualitative research, from a health policy research angle: describing the pros and cons of various approaches (and differences from quantitative studies, advantages and disadvantages, uses in combinations, practicalities in practice, the ethical dimensions, and that old chestnut - issues of quality.

The book works as a really good handbook for researchers themselves, stressing that we have to bear in mind that we have an audience paying for our wares who have practical problems and issues to be facilitated by our investigations: which can only be facilitated by quality research. An audience who perhaps are not too concerned by the intricacies of relativist arguments, hence this book's adopted perspective of "subtle realism" and the appliance of some sort of 'scientific' rigor - an approach some will see as too conservative.

One Caution: This book is aimed at an American (USA) audience, even though the authors are British. Thus, the majority of the examples are from USA studies. I however, did not find this detracted from the applicability and potential uses of the book. Another oddity was that my paperback ISBN number was stated on the various web sites as the hardback version (so be careful with the details ISBN details). I point this out as you may actually want to read/purchase this book.

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Karen Throsby (2004) *When IVF Fails: feminism, infertility and the negotiation of normality*. London: Palgrave MacMillan. ISBN 1-4039-3554-8.

'**When IVF Fails**' contains widely cited text of social research into the background of 'biological childlessness'. Such research has been lacking in particular around questions such as: 'How and why do people conceptualise reproductive technologies?' and 'Why is behaviour affected when faced with the decision to end IVF treatment?'

Throsby highlights that *'the "post IVF body" is marked by IVF and its failure, and that "the after picture of IVF" is less prominent in the dominant representations of the technology'* (p.3) – one of the primary concerns of this book. The book questions legitimacy of the status of IVF and is disapproving of the technology, capable of generating 'novel family structures' such as the licensed treatment of lesbian couples, and peri-menopausal women who have decided to put their 'fertility on hold', which have become a 'tabloid staple'. Genetic manipulation and cloning techniques receive equally short shrift. The Human Fertilisation & Embryology Authority (HFEA) insist that it is illegal to 'sex-select' for social reasons in the UK, and in my experience, pre-implantation genetic diagnosis (PGD) has been available to couples where there exists the possibility that embryos will be affected by certain chromosomal problems or a sex-linked disorder.

Closure of treatment is viewed in the context as 'regaining control' through having 'a choice'. How women locate themselves within the domain of 'normality' after IVF failure constitutes a primary focus of this book. Throsby adopts a feminist approach to centralising women's experiences with reference to the lack of female voice in debates surrounding the legislative framework for fertility treatment in the UK, with the embryo positioned firmly at centre stage. Gender and technology have redefined infertility (in relation to IVF) as a necessity, rather than a matter of choice, and essential to female identity. Nonetheless, the author ascertains that, assisted reproductive techniques are associated with an element of physical and emotional risk to those women who experience them.

Chapter 2 reports on the decision to end treatment after failed IVF. Throsby reveals to the respondents that she has chosen to live without children, and that she has the pre-existing condition, endometriosis (causing infertility). In my opinion, this is a dangerous engagement, which may be interpreted as 'research as therapy' and as such, introduces bias. Chapter 2 also acknowledges the attributes, skills and often confident, successful lives individuals assume outside IVF treatment.

Chapter 3 examines the discourses of nature and technology, and describes powerful emotions of interviewees, and addresses a key issue – not *whether* or not the couples engage with technology for reproduction, but *why*. Women described how age may have denied them the chance of '*new revolutionary treatment*' with many '*still hopeful*' of a spontaneous conception. The state-of-the-art reputation of IVF can serve as 'demonstrative shorthand' for having tried everything (p.57), as social and family pressure, not to mention the consumer culture is immense.

Chapter 4 highlights the 'post-code lottery' system with regards to NHS funding for IVF. Throsby sums this up exquisitely: '*the naturalising presence of a baby is absent to counterbalance the discomfort that exists around the transaction itself*' (p.83). Financial constraints and age also influenced the final decision to end treatment.

Couples interviewed by Throsby attributed NHS prioritisation as unfair and 'weak'. '*Consequently, many of the women were extremely sensitive to the issue of legitimacy of their claim on scarce NHS resources*' (p.102), in particular where services for abortion were given 'unlimited' funding.

Chapter 5 explains 'managing visibility' where having treatment became known to 'others', and '*the gender-normative social and emotional labour that this knowledge produces*', and finally examines a number of direct silencing strategies exhibited by the participants '*in an attempt to manage the (hyper)visibility of their IVF and it's failure*' (p.110). The development of new reproductive technologies can minimise the sense of control for many women who, under normal circumstances lead very successful, professional lives. Managing self-injection at certain times of the day, whilst experiencing emotional (hormonal) upheaval '*draw on the*

familiar discourse of women's vulnerability to hormones' (p.118), –a vulnerability many found incompatible with their career.

Chapter 6 describes how partners take responsibility for their 'sub-fertility' and in cases of male factor infertility, the association between fertility, virility and masculinity. Throsby acknowledges that the gender dynamic between her self and the male participants may have acted as a constraint. Where male infertility existed, *'women experienced isolation and felt unsupported, and the male partners were unable to express support beyond a show of emotional strength or their own grief and distress'*. Finally, the author reveals an enduring construction of the 'normal' body as unpredictable and liable to fail, *'whilst finding alternative ways of understanding the female body, which move away from insufficiency and blame'* (p. 161).

The final Chapter describes 'Seeking Resolution', where the failure of what eventually turns out to be the final cycle does not always coincide with the decision to end treatment, which may come months or even years later. How couples negotiated 'normality' is aptly described as *'laying claim to the normatively determined attributes of motherhood; and the redefinition of what constitutes having or being, a family'* (p.171). Although written from a purely feminist perspective, the author acknowledges the fragility of the male psyche and the urgent need for a new vocabulary which facilitates the development of different ways (and visualising) both male and female bodies. Throsby concludes with an important point; *'resolution of childlessness or living child free, is in no way exclusive of the desire to have a biological child (or more children). In fact, the resolution which is sought is precisely one which can accommodate both the desire to have a child, and also the possibility of a positive present and future that is not negatively defined by that desire'* (p. 185).

Val Peddie. Research Midwife, University of Aberdeen

Phillipson, C., Allen, A., and Morgan, D. (Eds) 2004. *Social Networks and Social Exclusion*. Aldershot: Ashgate. ISBN 0 7546 3429 9 hbk. £50.

This is a delightful book. The product of seminar meetings such as this can become a pastiche of disparate papers 'congealed' with an efficacious commentary. This book is seamless; each chapter resonant with the dominant theme. New Labour's exclusion policy, conveniently ditching redistribution of wealth, has given further impetus to networks. The Barclay Report (1982), also romancing the community, promoted social workers' 'transcendental' skills for harnessing caring networks.

The circuitous history of networks is noted in the opening section. As an established part of the anthropological tradition this was projected on community studies via, e.g., Bott and Frankenberg; Barnes also used networks in a Norwegian 'parish'. Medical sociology also invested effort in networks. Surprisingly, McKinlay's (1972 and 73) work is mislaid; distinguishing utilizers of health/welfare.

Historically Tonnies is worth a nod. In the 1970s networks promised to bridge the 'two sociologies' and be the foundation of mathematical sociology. The government's interest in care pathways will be a further impetus.

Lubben and Girona catalyse well the key sources of networks and health and critique the Lubben Social Networks Scale's (LSNS) original design-retesting it with different samples and settings. Initially the factor matrix was applied to elderly populations. A six-item scale being useful for screening 'isolation'.

Networkers are now deploying Bourdieu's forms of capital to buttress analyses. Networks are either a positive or negative resource. Southerton's case study of Spare Time Practices in a New Town illustrates this well; those with little cultural capital had fewer spare time happenings and used more public and private space. Networks are also a mechanism for increasing cultural capital, especially knowledge. Cattell's discussion of poverty and exclusion exposes the simplicity of government assumptions on a better networking strategy. The dynamics of poverty are often complex. As she shows the explication of social capital for connecting networks to wider ideologies is not always

possible. Networks tend to offer closed systems, or expanding zones of activity as Boissevain's 'Friends of Friends' do. Networks always have an invisible one impinging on it; often obvious to the researcher after concluding the study.

Older people are now a popular theme for networks, because of their increasing relevance for the exclusivity debate; with their greater risk of social isolation (fear of crime etc.) poverty and ill health, as Scharf and Smith succinctly note. Those in deprived areas are especially vulnerable. One fifth of the elderly here were socially isolated. The government may be able to develop new economic structures in deprived areas, but whether it can (re) engineer neighbourhood social attachments is open to debate. Whether Dykstra from her large Dutch elderly population is entitled to conclude that there is a diversity in partnership histories when about three percent were engaged in new relationships, needs further discussion.

Concluding, I have only been able to pick and peck at this thought provoking book. Those engaged in medical sociology and social policy will gain much. Multiple copies are well worth recommending for the library.

Joel Richman, Ex Manchester Metropolitan University.

Rogers A. and Pilgrim D. 2003. *Mental Health and Inequality*. Basingstoke: Palgrave MacMillan. ISBN 0 333 78657 2 pbk.

As someone with interests in mental illness, inequalities in health, public health and sociology I have been waiting for this book for years. And I can think of no one I would rather write it than Rogers and Pilgrim. And I liked the book immensely. So why am I having so much difficulty writing a review of it? Why am I struggling to know what to say that isn't simply a synopsis? I think it's because, and I hope I'm wrong, I'm worried *Mental Health and Inequality* will have a very small audience (interestingly and unusually, neither the Introduction nor the back cover provide an indication of the intended readership). I know the currently practising

mental health (illness!) professionals won't read it and I'm worried that it won't make it onto the recommended reading lists for many students in the health professions, sociology or public health. This is a tremendous shame because the multidisciplinary, theoretically and socially critical yet realist (madness and distress do exist) approach taken by Rogers and Pilgrim makes for a stimulating and informative text. Indeed, *Mental Health and Inequality* could be read as an introductory sociology of health and illness textbook using mental illness as a case study, or even as a complete re-write of the authors' excellent *A Sociology of Mental Health and Illness*, rather than a specialist addition to the literature on inequalities in health.

Rogers and Pilgrim perform a very difficult balancing act: they try to do justice to the perspectives provided by clinical psychiatry, psychiatric epidemiology, social psychiatry, sociology and history; they attempt to provide breadth but not superficiality; they ensure that lay knowledge is included; and they apply a critical realist lens to all they see. It's a bit like juggling grapes and cannon balls simultaneously on a high-wire while jets buzz you and you engage all the different groups in the audience in concurrent conversations about G/god. And to add an additional degree of difficulty, our intrepid authors examine at least three different sorts of inequalities: inequalities in the presentation of mental illness in different social groups; inequalities in the way people with mental illness are treated in society and in the health care system compared with people with physical problems; and inequalities in the funding and management of mental health services compared with other health services. Generally speaking, the pictures painted are not pretty ones from human rights, equity, compassionate or health outcomes viewpoints. Although the authors do make the valid point that if the treatment is of uncertain efficacy and/or limits the freedom of the individual, both of which are undoubtedly true for mental illness, not getting it, albeit for all the wrong reasons, may not be such a bad thing.

Individual chapters focus on the distribution of mental illness in the community, mental health services, primary care, inequalities through the life course, violence and discrimination, professional and lay knowledge, drug treatment and 'talking treatments'. All are well written, predominantly from a UK perspective, and excellently referenced. However, while the authors often discuss serious mental illness (madness), predominantly schizophrenia, and anxiety/depression

(misery) separately, they also frequently refer simply to mental illness, which is far from satisfactory for readers who may not have a good knowledge of the different sorts of mental illness – one size most certainly does not fit all when talking about mental illness. I know it's petty, and I am sure it is not the authors' fault, but I also cannot resist highlighting the amusing error on page 34 where the iconic act of removing the Broad Street pump handle in 1854 is attributed to 'TV reporter John Snow'.

I hope I am mistaken and that many read *Mental Health and Inequality*. Public health generalists, those with an interest in health inequalities or mental illness, and social and health policy makers will enjoy and gain much from it. Indeed, because the authors set the whole discussion within the context of the politics of mental illness, the coercive and socially controlling nature of therapy over the last 200 years, the unbreakable link between attributions about mental illness and the whole self (as opposed to merely a part of the body when one has, say, a broken leg) and the rights of people with a mental illness to citizenship not just treatment, the book inevitably, but explicitly, sheds much light on society at large and is potentially of interest to any sociologist.

Peter Sainsbury, Sydney South West Area Health Service. Australia.

BOOKS AVAILABLE FOR REVIEW

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

Steve Brindle

Email: s.j.brindle@abdn.ac.uk

Maximum word limit = 500 words

AUNT MARGE

Dear Aunt Marge,

Re: co-incidence

I wonder if your readers have had similar academic coincidences as the one I had recently. I was sitting in Dullas International Airport, Washington DC on my way back from a review meeting at the National Institute of Health, waiting for my plane to be announced. I was reading a Ph.D. thesis I was about to examine. The thesis involved interviews with drug-users in a treatment centre, and the student relied heavily on Lefebvre's spatial theory.

The chapter setting out the theoretical framework mentioned a number of sociologists who had written theoretical pieces on space. One of those theorists mentioned was Augé's work on non-places. According to the student, Augé suggests that these non-spaces, such as international hotels, international airport lounges and international modes of transport, lack definition. They are known, not lived. What identifies these non-places as such is their sameness, regardless of location. The student goes on for a while in more detail.

It seems odd that I was reading this theoretical analysis, which is fairly new to me, whilst I was sitting in exactly such a non-space. It then struck me that many scholars must have had similar experiences, reading about a theoretical or analytical piece of work, on a topic area in which one is situated at that very moment of reading about it.

Dr Edwin van Teijlingen
University of Aberdeen

Dear Aunt Marge

I read Edwin van Teijlingen's piece on providing references in the previous issue (*Medical Sociology News* 31: 1) with a smile on my face. Just two days ago my partner met one of my ex-students in the city centre in Wolverhampton. My partner asked her how she was getting on. The ex-student started a long story about how she had applied for a nursing course and how she had to ask me for two different references—one paper copy for the funding body and a different electronic one for the university. Of course, this had all been at the last moment meeting a deadline.

When the request for this ex-student's references arrived on my desk I did not really have the time to write them. But I always feel a moral obligation to write references, because it can affect someone's future. So I had gone to my office one weekend, under protest from my partner, to write them both. However, the student proceeded in telling my partner that she decided in the end not to continue with the application, as it was not quite right for her. I did not know any of this. As students hardly ever thank you for writing a reference, I only usually know that they had not got the job or place on a course when the next request comes in! I thought I would recount this story as demonstration of how one can become even more fed up and disenchanted by the thankless task of reference-writing.

Tired principal lecturer (medical sociology) from Wolverhampton

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