



# Medical Sociology News

Issue 29  
Summer 2003



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## What's in this issue

**BSA Medical Sociology Committee** ..... 4

**Editorial** ..... 6

**Letter to the Editors** ..... 9

### News and Notices

Elections for the Editorial Board of Sociology of Health & Illness ..... 10

BSA Annual Conference 2004 ..... 11

Forthcoming Conferences ..... 13

### Conference Reports

BSA Annual Conference ..... 25

Regional and Study Group Reports: ..... 26

### Articles

What medical sociology do we teach to health professional students? ..... 33

Interview: Mike Hepworth ..... 34

PhD Reports ..... 40

Hidden Jewels of the Internet: Social update ..... 46

Phil Strong Memorial Prize Essay ..... 47

Prizes ..... 50

Sits Vac - Agony Aunt ..... 55

**Book Reviews** ..... 60

Books available for review ..... 77

**Questions and Answers** ..... 79

**Subscriptions** ..... 80



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## EDITORIAL

### **Greetings from the frozen North, home of the new Editorial team**

This is the first issue of *Medical Sociology News* produced by the new editorial team based in Aberdeen. We are a group of medical sociologists with a range of interests and varying experience. Most of us work for one of the two universities in Aberdeen (the University of Aberdeen and The Robert Gordon University). One is employed by NHS Education for Scotland. Whilst it is a big advantage to be all in one place, we hope to reflect the diversity of medical sociology in the UK on the pages of *MSN*.

Scotland is now regarded as the sick man (or woman) of Europe, with mortality and morbidity rates second to none. It seems appropriate, therefore, that *MSN* should be edited from here, at least for the foreseeable future. We would like to thank the outgoing editors, Geraldine Barrett, Simon Carter, Judith Green, Geraldine Leydon, Nicki Thorogood and Michael Traynor for the excellent job they have done these last few years. We are delighted to say that Kelly Lawless of the London School of Hygiene and Tropical Medicine is staying on as administrator with responsibility for getting the newsletter printed and sent out. We are very pleased to have Liz Grant providing admin and secretarial support in Aberdeen. Michael Traynor has kindly offered to continue putting the *MSN* on the web for us. Recent past editions can be viewed at <http://www.lshtm.ac.uk/php/msn/index.html>.

Aberdeen has a fairly long history in medical sociology, which is mentioned by Professor Mildred Blaxter in her thoughtful letter to the editors. In 1951, Raymond Illsley came to Aberdeen, becoming the first Director of the Aberdeen MRC Medical Sociology Unit, which remained in the City from 1965 to 1985. The single most important influence on its establishment in Aberdeen was Sir Dugald Baird. Baird was Regius Professor of Obstetrics and Gynaecology<sup>1</sup> in the University of Aberdeen from 1937 until his retirement in 1965. He promoted the study of non-medical influences on stillbirth and maternal health, such as housing, nutrition, and psychological and social factors and successfully delivered one of the editors!! Baird's experience 'as a medical student attending home confinements of women in the Glasgow slums in the 1920s was fundamental in shaping his career'<sup>2</sup>, and he became interested in social class differences in the field of

reproduction when he observed ‘the contrast between childbearing in the upper social classes and in the slum dwellers....’<sup>3</sup>. As a result of his observations, the Aberdeen Maternity and Neonatal Databank, came into being in 1951 and continues to this day. It keeps a record of all women delivering babies at Aberdeen Maternity Hospital and now has data on three generations of women in some families. It has provided a unique resource for epidemiological studies of the local (largely unchanging) population. The first Social Science Research Council (SSRC) programme grant in the early 1970s employed people who are now well-known names in medical sociology such as Phil Strong, Sally Macintyre, Alan Davis and Tony Walter.<sup>4</sup>

Since the MRC Medical Sociology Unit moved to Glasgow in 1985, the discipline has been pursued by individuals in a number of diverse departments. Needless to say, we are pleased to be promoting Medical Sociology in Aberdeen once more through our new role as editors of *MSN*. We were pleasantly surprised by the words of encouragement we received for taking on the task and hope that, along with our annual North East Medical Sociology conference, it will help us heighten the profile of the discipline here in Aberdeen. We also realise of course that it is getting harder and harder to persuade people to take on important tasks in promoting medical sociology which do not fit into the very limited, if not downright stupid, RAE thinking in this country. We thus weren’t too surprised by the sighs of relief up and down the country when we put ourselves forward! We should however acknowledge other teams who came forward to edit *MSN* (like us at the 11<sup>th</sup> hour) and who were equally keen to carry forward the work of previous editorial teams and to continue to promote and support the work of the international sociological community.

This issue of *MSN* has the usual mix of conference reports, announcements of forthcoming meetings, calls for papers, PhD abstracts, regional reports and a bumper crop of book reviews. Please don’t be shy of coming forward to review one of the many books on offer. Sadly we have said goodbye to ‘Dear Marge’ but have Uncle Edwin standing in until a new problem page editor has been appointed. We have an excellent article from Emma Pitchforth, recent winner of the Phil Strong Memorial Prize and also a new section involving an interview with a prominent personality in medical sociology. For this edition Chris Yuill, aided by Lydia Lewis, interviewed Mike Hepworth, well known for his work in the sociology of the body. In future we would like to see other, perhaps young or less experienced sociologists interviewing prominent sociologists with whom they come into

contact. It is also nice to see new blood entering the profession, having recently completed their doctoral theses. There has been something of a dearth of articles to include in this edition, **so expect to be accosted at the conference and asked for a contribution!**

We hope that you enjoy reading this first issue from the new team as much as we have enjoyed putting it together. We would welcome any comments and suggestions you would like to send in. **And we would especially welcome some more material!**

The Editors

Maureen Porter

Lydia Lewis

Karen Forrest

Fiona French

Chris Yuill

Edwin van Teijlingen

<sup>1</sup> At the time of Dugald Baird's appointment the chair was still called Regius Chair of Midwifery.

<sup>2</sup> B. Thompson, 'Foreword', in: B. Thompson, C. Fraser, A. Hewitt and D. Skipper, *Having a first baby: Experiences in 1951 and 1985 compared*, Aberdeen, 1989, p. v.

<sup>3</sup> D. Baird, 'Social Research and Obstetric Practice', *Question*, 1969, (January), pp. 3-4.

<sup>4</sup> Teijlingen van, E. & Barbour, R. (1996) The MRC Medical Sociology Unit in Aberdeen: its development & legacy, In: Adams, A., Smith, D. & Watson, F. (Eds.) *To the Greit Support and Advancement of Helth. Papers on the History of Medicine in Aberdeen, arising from a Conference held during the Quincentenary Year of Aberdeen University*, Aberdeen History of Medicine Publications, 54-63.

**Please send copy for the December issue of MSN to the Editors by:**

**FRIDAY 31 OCTOBER 2003**

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## Letter to the Editors

Dear Editors

It was with pleasure that I noted that MedSocNews is to be edited from Aberdeen. It seems very suitable that it is coming back to what is in some sense its “home”. Of course, Aberdeen cannot claim all the credit for the great upsurge of British medical sociology in the late 1960s (though it is probably the only University where a riot took place in 1970 by students trying to get *in* to a medical sociology lecture – the historic battle of the Nat.Phil. Lecture Theatre) but it will always have a special relevance for the subdiscipline. The original MRC Medical Sociology Unit, whose alumni are now spread so widely, certainly had a hand in the birth of the Medical Sociology Group, and its first small conference in York, and in due course its Newsletter. Much is owed to Raymond Illsley, the Unit’s Director, and perhaps even to Dugald Baird whom my respondents in research more than 30 years ago used to remember as “the Professor himself, the hie heidyin!”) who first brought Raymond to Aberdeen. The address of the new Editors seems to complete a circle. This is just to wish the new team very well – may the Newsletter continue to grow ever more substantial and interesting, continuing the work of previous editors.

**Mildred Blaxter**

**School of Medicine, University of East Anglia and  
Department of Social Medicine, University of Bristol**

## NEWS AND NOTICES

### Elections for the Editorial Board of *Sociology of Health and Illness*

Two places on the Editorial Board of the journal *Sociology of Health and Illness* will be filled by election at the Annual General Meeting of the BSA Medical Sociology group at the BSA Medical Sociology conference in York on 27 September 2003.

The Editorial Board meets twice a year, usually once at the Medical Sociology Conference and once in London. We expect all Editorial Board members to take an active role on the Board. This includes refereeing articles throughout the year and contributing to the Board meetings, which advise the Editors. Elected members serve a three year term, after which they are eligible for re-election for one further term.

If you would like to stand for election, please complete the nomination form enclosed with this issue of *Medical Sociology News*, and return to me by 12 September 2003 or, if you are attending the conference, to the convenors (Davina Allen or Cath Exley) before 12 noon on 27 September 2003.

**Judith Green, LSHTM**

Judith.green@lshtm.ac.uk

*Where chaos begins, classical science stops. For as long as the world has had physicists enquiring into the laws of nature, it has suffered a special ignorance about disorder in the atmosphere, in the turbulent sea, in the fluctuations of worldwide populations, in the oscillations of the heart and the brain. The irregular side of nature, the discontinuous and erratic side - these have been puzzles to science, or worse, monstrosities.*

*James Gleick. Chaos: Making a new science*

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## BSA ANNUAL CONFERENCE

### Sociological Challenges: Conflict, Anxiety and Discontent

**Monday 22 – Wednesday 24 March 2004 at the University of York**

#### Call for Presentations/Posters

The task of sociology is significantly defined by the social conflicts that take place in modern societies. While modernity affords more pleasures and opportunities to more people than ever before in human history, the sociological imagination is animated by issues of social division, economic hardship, cultural disadvantage and political oppression.

It is under these circumstances that our discipline is in constant debate, defining its social role and value. More recently such debate has taken place in relation to the impending ecological crisis, the negative consequences of neo-liberal capitalism, the extreme inequalities between the developed and developing world and the aggravated uncertainties associated with an intensifying experience of rapid social and technological change.

This conference provides an opportunity for delegates to debate the sociological challenges that continue to define our discipline, as well as those that are emerging as the core concerns for social life in the twenty-first century. On these grounds, how might sociology venture to identify its purpose and identity in the world it seeks to explain? We invite papers addressed to the following themes:

- **Embodied expressions and oppression**
- **Politics, responsibility and neglect**
- **Intimacy, work and family life**
- **Culture, conflict and everyday life**
- **The challenge to sociological theory**

All BSA study groups are offered the opportunity of organising separate streams at the conference, are actively encouraged to be an organised part of the conference and where possible, to participate in one or more of the above themes. The conference organising team also encourage papers for an **open stream** and **teaching and learning stream**.

**ABSTRACT submission form available from:**

The British Sociological Association, Unit 3F/G, Mountjoy Research Centre, Stockton Road, DURHAM DH1 3UR, or by **E-mail:** [Conference2004@britsoc.org.uk](mailto:Conference2004@britsoc.org.uk)

*Abstracts must reach the BSA Office by **30 September 2003**. Late submissions, faxed submissions or hard copy submissions will not be considered.*

For more information on Abstract Submissions and Poster Presentations, visit the BSA's website: [www.britsoc.org.uk/events.htm](http://www.britsoc.org.uk/events.htm)

**IMPORTANT DATES:**

<b>30 September 2003</b>	Last date for submission of abstracts
<b>17 January 2004</b>	Last date for registration by paper presenters
<b>24 March 2004</b>	Last date for presenters to provide a disk copy of paper

**Conference Organising Team and Stream Convenors:**

Gill Dunne, Elizabeth Ettorre, Kevin Meethan and Iain Wilkinson  
University of Plymouth

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## BSA MEDICAL SOCIOLOGY GROUP

### Annual Conference 2003

**The 35th Annual Conference of the BSA Medical Sociology Group will be held from 26–28 September at the University of York**

Plenary Speakers will be:

**Professor Elianne Riska**,  
Department of Sociology,  
Åbo Akademi University, Finland

who will speak on:

*'Bringing the "mind" back in?: The relationship between health and society'*

**Professor Raymond De Vries**, Center for Bioethics, University of Minnesota, and the Department of Sociology and Anthropology, St. Olaf College, Minnesota who will speak on:

*'Protecting our virtue(s): Medical sociology at 50'*

**Booking Form and Programme available from:**

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

The BSA Medical Sociology Group website:  
<http://www.britsoc.co.uk/msconf>

## The Social Organisation of Healthcare Work Call for Papers

Davina Allen (University of Wales College of Medicine)

Alison Pilnick (University of Nottingham).

Carolyn Wiener (University of California, San Francisco)

Outline proposals for contributions are invited for the eleventh monograph in the series published by **Sociology of Health and Illness**, in conjunction with Blackwell Publishers, in the year 2005. The monograph aims to build on the strong tradition of studies of health care organisation in medical sociology and develop further the links with the sociology of the professions, health policy, and division of labour; organisational sociology, health services management; language and communication studies and studies of technically mediated collaborative work. Possible areas for contributions are:

- Healthcare organisations (public/private/voluntary, virtual) and their inter-relationships
- Divisions of labour (occupations, professions, unwaged caregivers, healthcare labour markets)
- Service delivery and organisation (teamwork, patient/professional interaction, temporal/spatial dimensions, human/machine interaction, e-health developments)
- Consumerism and new models of patienthood.
- The impact of policy developments on the social organisation of healthcare work in national and international contexts.

Potential contributors should send an outline proposal for papers (up to 800 words) to co-editor of the monograph, Davina Allen, Nursing, Health and Social Care Research Centre, East Gate House, 35-43 Newport Road, Cardiff, CF24 0AB by **28 November 2003**. Email submission is encouraged (allenda@cf.ac.uk) and all eventual paper submissions must also be in electronic form. International submissions are particularly encouraged. The monograph will appear both as a regular issue of the journal and in book form.

All proposals will be reviewed and notifications of the outcome will be given by **16 January 2004**. Those invited to contribute to the monograph will be asked to submit articles of between 6,000-7,000 words by **30 June 2004**, following the journal's stylistic guidelines, so that they can be refereed in the usual way. It is planned to publish the monograph in **September 2005**.

## 2003 Building Bridges Conference

The University of East Anglia, Social Services and the NHS have collaborated to host the CHaS Conference Series.

The purpose of these multiprofessional conferences is to explore the evidence of innovation in partnerships between professions, services, and higher education institutions that are striving to deliver enhanced health and social care. The focus of the 2003 Conference will be to examine how professional and service divides are now being bridged.

**Conference Theme** - There are four themes running through this year's conference:-

***Innovative Clinical Practice*** – Evidence of innovative service developments, good practice, collaboration between primary and secondary care and between health and social care sectors in response to the perceived increase in demand in primary care.

***The Challenge of Demand*** – Exploration of perceived increases in patients' expectations and demands for health and social care. Examination of factors influencing this and indications of how practitioners and services could/should respond.

***Continuing Professional Development*** – Evaluation of undergraduate and postgraduate education as a tool for future success in interprofessional working and working across service and sector divides.

***Challenge of Team and Partnership Working*** – Examples of team and partnership challenges within and between services and evidence of how these have been overcome.

Keynote speakers are:

Kay East (Department of Health)

Prof Amanda Howe (University of East Anglia)

Prof Mildred Blaxter (Bristol University)

Prof Mike Nolan (University of Sheffield)

Nigel Appleton (for DH on older peoples housing needs)

Carol Haydon (Audit Commission)

Further information available on the website:

<http://www.ueachas.org.uk/Default.asp?Section=Event>

## **3rd Annual Sociology of Cancer Study Group Conference - POSTPONED UNTIL MARCH 2004 University of Warwick**

This conference seeks to explore research that focuses on peoples' experience of cancer, the ways they – patients, carers, families and friends – make sense of the illness and strategies that they adopt to live with cancer. We welcome submissions from researchers that work on any aspect of cancer and from wide array of disciplines and institutional contexts.

The conference includes both formal refereed papers as well as workshops discussing pre-circulated articles and papers. These workshops are intended to promote informed debate, shared experiences and the development of conceptual and theoretical ideas. One workshop will focus on user involvement in cancer research.

### **Submitting an Abstract**

Please submit an abstract of no more than 250 words and include the following information:

1. Title, Forename, Surname
2. Affiliation
3. Contact Address
4. Contact Email
5. Title
6. Abstract (no more than 250 words)
7. Would you be willing to present a poster rather than a paper?
8. Do you have a proposal for a workshop session (together with specific articles)

There is a form available for submitting a proposal or feel free to simply provide the relevant information. Please submit to [J.tritter@warwick.ac.uk](mailto:J.tritter@warwick.ac.uk). If you do not wish to submit by email please mail your submission to:  
Dr Jonathan Tritter, Department of Sociology, University of Warwick, Coventry CV4 7AL UK

We aim to accept as many papers as possible and have the facility to run two parallel papers streams. Paper presenters are asked to speak for **15** minutes and allow 15 minutes for discussion.

All submissions will be reviewed by the committee: Jonathan Tritter, Geraldine Leydon and Clare Moynihan.

### Registration Fees

We aim to only meet our actual costs. Participant fees are £15 with students and unemployed being asked to pay £5. Fees include conference materials, lunch and refreshments.

If you wish to attend the conference but not provide a paper please send a cheque made out to the British Sociological Association together with your Title, Name, Mailing address and affiliation.

### Accommodation

Enquiries about accommodation should be made on an individual basis. Please contact Jonathan Tritter at [J.tritter@warwick.ac.uk](mailto:J.tritter@warwick.ac.uk)



## Society for Social Medicine

### 47<sup>th</sup> Annual Scientific Meeting, 17-19 September 2003, The University of Edinburgh

Five workshops are planned to take place on Thursday afternoon (subject to demand).

1. Accountability in health and health care
2. Evaluation of complex policy interventions to improve health
3. Primary care research – national data as a platform for research
4. Families, relationships and health
5. Complexity science: new ground or hot air?

Further information can be found on the website [www.sspc.uk.com/conference/SSM2003](http://www.sspc.uk.com/conference/SSM2003)



## London Medical Sociology Group 2003 Programme (Sept-Dec)

### 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.

#### 10 September:

Mandatory Reflection? The constitution of the competent nurse  
*Sioban Nelson University of Melbourne*

#### 8 October:

'Happy, healthy and here'. Constructing responsibility for employee health.  
*Russell Jackson Sheffield Hallam University*

#### 12 November:

The social construction of telemedicine  
*Carl May, University of Newcastle*

#### 10 December:

Christmas special event (everybody welcome)

For further copies of this programme please contact Paul Godin 020 7040 5933.

To receive details of all LMSG meetings by e-mail contact Mark Newman, [m.newman@mdx.ac.uk](mailto:m.newman@mdx.ac.uk) or visit the BSA website:

[http://www.britsoc.co.uk/bsaweb.php?area=item2&link\\_id=94](http://www.britsoc.co.uk/bsaweb.php?area=item2&link_id=94)

*Joint LMSG Organisers: Richard Compton, Paul Godin (Convenor), Rachel Grellier (Ents. Officer), Chris McCourt, Mark Newman, Susan Robinson (Treasurer) & Margaret Rogers.*

## Scottish Medical Sociology Group: Autumn Meeting

Friday 31 October 2003:

Adam Smith Building, University of Glasgow

### Child Protection: International and Interprofessional Aspects

Malcolm Hill will begin by outlining key features of the **Scottish Review of Child Protection**, which culminated in the Report of 2002 and a 3-year strategy for improving relevant services. This will be placed in the context of shifting approaches to the ill-treatment of children in the UK over the last 30 years, which includes a change from a predominantly medical model in the 1960s to a legal/social work led approach currently.

The Review included consideration of different approaches to child protection in certain other countries. Malcolm will highlight some of the key differences in assumptions, policies and practices with respect to British-North American models and continental European models. Again, attention will be given to the roles and status of different kinds of profession and agencies.

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

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

The session will run from 1.30 to 4pm. Tea and coffee will be provided from 1pm and again during the break between papers. If you would like to attend please contact Gill Hubbard (gh77c@clinmed.gla.ac.uk) or Linda McKie (l.mckie@gcal.ac.uk) by **Wednesday 29 October 2003**.

## **Forthcoming seminars on randomised controlled trials**

**15 October 2003**

### **Randomised Controlled Trials (RCTs) in Public Health: Impact on Evidence Based Policy and Practice**

Prof Keith Tones

Leeds Metropolitan University

### **“Beyond the RCT: a new gold standard for health promotion”**

Dr Jane Hutton

University of Warwick

### **“Statistics is essential in RCT ethics”**

Clare Snowdon

Cambridge University

Prof Doug Altman

University of Oxford

### **“Levels of evidence, quality scores, and checklists: the seduction of simplicity”**

Chair

Prof Margaret Thorogood, University of Warwick

Convenor

Dr Maria Stuttaford, Research Fellow, Institute of Health

Institute of Health, Room 17a, Physical Sciences Building, University of Warwick

For further details please contact **Cecilia Olivet**

E-mail: [cecilia.olivet@warwick.ac.uk](mailto:cecilia.olivet@warwick.ac.uk)

Tel: +44 (0) 24 765 23164

## North East Midlands Sociology of Health and Illness Group Meeting

**5 November 2003**

The next meeting will be held at the Trent Palliative Care Centre in Sheffield. Three papers will be presented.

\* Josie Tetley, Lecturer, School of Nursing Sheffield - Research with Elders from African Caribbean Community

\* Katie Ward, Research Associate, Institute of General Practice and Primary Care, Sheffield - The Relationship between the internet and access to pharmaceutical drugs and health related information

\* Dr Paul Ward, Senior Lecturer in Sociology, Hallam University, Sheffield - Inequalities in health care provision (esp GP prescribing) and lay and professional ideas about medicine health and risk

Please contact **Jane Seymour** at Trent Palliative Care Centre, Sykes House, Little Common Lane, Abbey Lane, Sheffield S11 9NE Tel 0114 2620174 fax 0116 2362916 or email [j.e.seymour@sheffield.ac.uk](mailto:j.e.seymour@sheffield.ac.uk) if you would like to attend.

*“We keep passing unseen through little moments of other people’s lives”*

*Robert M Pirsig  
Zen & the Art of  
Motorcycle Maintenance*



## St Bartholomew School of Nursing & Midwifery

You are invited to attend St Bartholomew School of Nursing & Midwifery's sixth Inaugural Professorial Lecture:

"The Harvest that lies before us" Sister-nurses and their hospitals in the nineteenth-century United States '

By Dr Siobhan Nelson

Dr Siobhan Nelson is Associate Professor at the School of Nursing, University of Melbourne and Visiting Professor within the Department of Applied Psychosocial Sciences at St Bartholomew School of Nursing & Midwifery.

Date: 17 September 2003, 5.30pm

Venue:

Lecture Theatre

St Bartholomew School of Nursing & Midwifery

Philpot Street

Whitechapel

Tea & Coffee from 5.30pm, refreshments served after the lecture.

For further information or to book a place please contact Helen Reid at [H.E.Reid@city.ac.uk](mailto:H.E.Reid@city.ac.uk)

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## 2nd International Shared Decision Making Conference

### **New Conversations with Patients**

Swansea Clinical School  
Singleton Park  
Swansea SA2 8PP  
Wales United Kingdom

**2-4 September 2003**

### **Professor Annette O'Connor**

Canada Research Chair in Health Care Consumer Decisions Support  
Professor, University of Ottawa

### **Professor Albert G. Mulley, Jr. M.D., M.P.P.**

Chief, General Medicine Division  
Director, Medical Practices Evaluation Center  
Massachusetts General Hospital

For more information contact:

Gwennan Thomas  
Swansea Clinical School

### **Themes**

- Developing communication skills
- Involving consumers in care process
- Populations or individuals: who comes first?
- Developing or evaluating decision aids into the clinical workplace

### **Organisers**

- Glyn Elwyn - University of Wales Swansea
- Angela Coulter - Picker Institute Europe
- Adrian Edwards - University of Wales Swansea
- Theo Schofield - Ethox, University of Oxford
- David Pink - Long Term Medical Conditions Alliance

## **The International Institute for Qualitative Methodology**

The institute hosts 2 international conferences per year: the Qualitative Health Research series and the Advances in Qualitative Methods series, alternating between the Canadian and international sites.

### **Qualitative Health Research Series**

IIQM, University of Alberta  
Banff, Alberta

**30 April -4 May 2004.**

### **11th Annual Qualitative Health Research Conference**

IIQM Europe, Universiteit Utrecht

**Spring, 2005**



## **The 6<sup>th</sup> Conference of the European Sociological Association**

The Sociology of Sexuality Network  
23-26 September 2003  
Murcia, Spain

Further details available at: [www.um.es/ESA](http://www.um.es/ESA)



## **18th World Conference on Health Promotion and Health Education**

**26-30 April 2004 - Melbourne, Australia**

Health2004 is the 18th World Conference on Health Promotion and Health Education. More than 2000 delegates are expected, representing governments, major international organisations and foundations, community groups, public health organisations, medical professionals and many others. The conference is auspiced by the International Union for Health Promotion and Education (IUHPE), based in Paris, and the conference will also host the triennial General Assembly of the IUHPE members.

Further information is available on the conference website:  
<http://www.health2004.com.au/default.asp>

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## REPORTS ON CONFERENCES, MEETINGS AND EVENTS

### BSA ANNUAL CONFERENCE

#### **Social Futures: Desire, Excess and Waste** **11-13 April 2003, University of York**

This year's conference went off with a bang once again, with an exciting variety of papers being presented, plenary sessions from Beverley Skeggs, George Ritzer and B. S. Bariskar of the Indian Sociological Society, and the chance to meet colleagues and friends, both old and new.

Papers falling within the realms of medical sociology were wide-ranging, although interestingly many of them were presented within the 'technological dystopias' stream. Topics here included health technologies aimed at mid-life women, sexual pharmacology, epidemiologies of breast cancer, the medical presentation of cervical screening, parental and professional talk about MMR, the practice of high-technology medicine, the 'consumption' of genes, and blood donation and 'bioidentity'. There were also a number of medical sociological papers presented within the stream of 'consumption and waste', including on the subjects of cosmetic surgery, caring and media representation of debates about abortion and substance abuse. Other papers (including my own) were presented about user involvement and consumer choice in health services, and there were interesting contributions from those speaking about the experience of older people in care settings. Needless to say it made for an exhausting few days as delegates attempted to cram in and 'consume' as many papers as is possible in the space of a weekend!

There was also the usual late-night banter in the bar including, among my own crowd, some passionate discussions about the sociology of mental health (or psychiatry and its discontents!). The other highlight for me was my brief interview with Laurie Taylor, although regrettably my contribution did not make it onto *Thinking Aloud*.

Overall, it was a stimulating and thoroughly enjoyable few days as always, and I came away feeling inspired, invigorated and reminded of why I chose to study the truly fascinating discipline that is Sociology. My thanks to all the organisers and I very much look forward to attending again next year.

**Lydia Lewis, University of Aberdeen**

## **Scottish Medical Sociology Group**

### **Report from March Meeting: Policy Responses to Violence in Families**

This was a joint meeting with the Centre for Research on Families and Relationships on the topic of health and social policy developments and responses on violence in families. It was well attended with the audience that included researchers, practitioners and policy-makers. There were two presentations followed by a lively debate on research and policy issues. A brief resume of the presentations is provided below:

#### **Scottish domestic abuse policy in context: a new era of welfare feminism?**

Marsha Scott & Fran Wasoff, Centre for Research on Families and Relationships, University of Edinburgh.

Scottish domestic abuse policy is structured around the “3 Ps”: prevention, protection and provision. How service provision is privileged within that framework, particularly services for women with children, and how the phrase “women and children” dominates the policy discourse, raises some interesting questions about the direction of current policy. This session explored those questions and the wider implications of policy that constructs women’s rights and needs chiefly through their role as mothers in the family. Are children the “innocent” victims of domestic abuse, and do they therefore represent a less contested focus for resources and public attention? Participants discussed the short- and long-term implications of social policy that treats women and children as a unit and renders women without dependent children virtually invisible.

#### **Breaking the Silence on Elder Abuse**

Ann Ferguson, Elder Abuse Project Leader, Age Concern Scotland

This presentation drew on UK and other research with a view to establishing the prevalence of abuse of older people in Scotland, the types of abuse, where abuse occurs and who the perpetrators are likely to be. It illustrated the impact abuse can have on an older victim, particularly when family members are involved and how older victims can respond in a range of abusive situations. The availability of support services, legal remedies and other solutions were outlined as were the gaps which currently exist.

## The North East of Scotland Medical Sociology Conference - March 2003

With contributors from Aberdeen University, The Robert Gordon University and the NHS, this year's North East Medical Sociology (NEMS) offered a variety of topics and contributions. This well attended event provided a dynamic overview of the research interests of nine local academics, Post Doctoral Students and researchers. The focus of contributions displayed a wealth of variety ranging from in-depth applied empirical research to theoretical discussions concerning areas of potential future research. The event also clearly indicated how collaborative work could occur between two universities and how future cooperation could take place. This is important given the strong emphasis that both institutions have in training medics, nurses, Allied Health Professionals, and social workers.

Though no particular theme was set in advance the issue of culture rose in several papers. Culture here in its widest sense, for example: street culture affecting the health of homeless people, the culture of sexism and its influence on men and women doctors, the culture of a local community and how it relates to health; or the lessons that can be learned from studying elder care in India.

Chris Yuill	The city: health, place and being
John Love	Homelessness and health
Mike Lyon	Evaluating health in custody: a sociological reflection
Fiona French	Female doctors, constraint and job satisfaction
Emma Cowie/ Paul Dempster	Identity, caring and young people Death
Bernice West	The culture of old age, health and care
Edwin van Teijlingen	Wider culture and health care organisation
Lydia Lewis	User Involvement in Mental Health Services: A feminist social constructionist analysis
Maureen Porter	Relevance of having operative delivery to women's decisions about child number
Mark Ebert	Seeing through the 'natives' eyes: imposing categories

## **Symposium of the Social Aspects of Death, Dying and Bereavement Study Group**

The twelfth one-day symposium on social aspects of death, dying and bereavement was for the final time - prior to its projected move to the Trent Palliative Care Centre at the University of Sheffield - held at the University of Leicester on Thursday 27 March 2003. The symposium continues to function as an effective forum for both new and established academics to present and discuss their research in a friendly and supportive environment.

Following a few words of welcome by the outgoing chair of the organising committee, Dr Cath Exley, the day began with morning plenary speaker, Gordon Riches, whose paper entitled "Unexpected outcomes in death education" focused on ways in which academic study and personal learning can be legitimately integrated and some of the possible ethical dilemmas such opportunities might present. Speaking of his experience in developing curricula devoted to the study of death, dying, disposal and bereavement, Riches gave a poignant account of the way that students often use their programme of study as a vehicle for re-visiting personal losses and unresolved grief issues; a situation which highlights the general absence of bereavement support for bereaved adults and young people. For Riches, this particular 'narrative space' allows the personal experience to ground the learning experience without intruding on the grieving process. In the next paper, "Bereavement, Loss and Young People: Tracing Some Contours", Jane Ribbens McCarthy gave a summary of literature relevant to the topic of bereavement and young people before offering an interim discussion of work to date. Ribbens McCarthy highlighted what she believes is a disparity in the contours between academic disciplines and theoretical debates surrounding bereavement in young people, and how we need to 'pull together' the different disparate strands to form a satisfactory and overall understanding of the problem.

David Reid in his paper, "Mentioning dementia: how identities of people with dementia are negotiated in day care", drew on research data collected as part of his doctoral study to explore the ways that dementia has historically been constructed inside a 'biomedical' framework; one which sees memory loss, progressive confusion and physical incapacity as a form of involuntary social death in which sufferers are largely seen as 'invisible' and incapable of 'normal' communication. Using current literature to support his claims, along with his own analyses, Reid suggested that the concept of dementia was itself embedded with stigmatised and stereotypical connotations and

required a reevaluation. His findings suggest that care-workers must 'think on their feet' by actively (re)negotiating the identities of dementia sufferers to create an impression which satisfies those people with the condition. Following a short break for coffee, Anne Arber presented a paper entitled "Constructing the boundaries of palliative care work" which traced the way palliative care teams construct interprofessional work in their talk and how the specialist nurse, in particular, contributes to this talk. Arber used examples of linguistic analysis to demonstrate how the boundaries of palliative care are 'jointly' constructed by use of questions, gate keeping, challenges to non-specialist practitioners and explicit and implicit negotiations. She concluded by suggesting that all members of the care team construct the presence of bodily problems and symptoms associated with advanced disease as a priority for access to specialist palliative care. The final paper of the morning came from Stephen Handsley and drew on work in progress that looks at Irish Catholic death and morning rituals in Britain. Entitled "Kinship networks, ethnicity, death and mourning: an Irish Catholic dimension", this paper drew its inspiration from the work of Philip Abrams on neighbourliness and neighbourhoodism, and on the way that the requirements of death and mourning are based on kinship networks and are used as a set of complex unifying devices that simultaneously serve to bind the social body while celebrating and confirming the groups cultural and collective identity. Handsley concluded his discussion by suggesting that these categorical mourning rituals as a series of cultural credentials help smooth the journey of death by facilitating expressions of grief and by creating a collection of authentic and distinctive meanings for participants which are instrumental in expressing a sense of cohesiveness for the group.

The afternoon session began with plenary speaker Jenny Hockey whose paper, 'A new ritual process', looked at the growing practice of removing ashes from crematoria for private disposal or storage. Hockey argues that, despite today's greater openness' about death, dying and bereavement, ashes are still invested with something of a 'taboo' nature and are purposely being located in space which is separated from the everyday world. Nonetheless, she believes that these actions create the conditions for a 'new ritual process' by offering the bereft an optional, less rigid rite-of-passage which, in contrast to the controlling influence of local authority crematoria, can take place under the control of families and friends of the deceased; a phenomenon which she argues represents a return to a series of memorialising options which draw from people's material, imaginative and spiritual repertoires. It is in the spatiality between the living and the dead that Hockey believes these new ritual processes of disposal create

reconstituted environments for memory and meaning. In an equally inspiring paper entitled "Life After Eighty: understanding the relationship between ageing and dying", Liz Lloyd introduced some of the key findings of a pilot study which uses an innovative combination of quantitative and qualitative methods to uncover how life events such as bereavement, moving house and admission to hospital are strongly associated with deaths among older people aged 80 or over. She also reported on the methodological and ethical challenges faced by research teams in this sphere of enquiry and how.

Kate Lillie followed with a paper entitled "Lourdes: A Pilgrimage for the dying?" in which she charted the spiritual cum religious activity of pilgrimage available to the terminally ill. For Lillie, this practice has generally been overlooked both in palliative care literature and by palliative care staff and she drew on Victor Turner's notion of liminality and *communitas* to conceptualise the way that there is a definite, but minor collective and communal discourse on death at Lourdes which is apparent through symbol and ritual. The latter part of the afternoon session contained a fascinating paper by Caroline Oliver entitled "When the sun goes Down: Death and Burial in Leisure Migration to Spain", in which she explored how older Northern-European migrants deal with death and disposal in a different cultural context to that of their own. Based upon ethnographic research amongst British migrants, who have migrated to Southern Spain following retirement, the paper focused on how choice of disposal is often limited by perceived barriers of linguistic and cultural differences, which sees many migrants choose cremation rather than burial. For Oliver, these 'choices' are due to the alien system of above-ground niche burials used in Spain, which are in contrast to traditional and familiar images of deceased loved-ones 'merging with nature' inherent in the symbolism of British burial. Oliver argued that in migration cemeteries often provide a 'cultural space' in which to (re)affirm one's self-identity. She concluded by suggesting that we need to be more sensitive to cultural beliefs about disposal given the rise in globalisation and diasporic mass movements and that rather than relying on parochial forms of death, dying and disposal we need to commemorating death in a more 'hybridised' fashion.

The final paper of the day, "Money Matters for Bereaved Parents", came from Anne Corden and featured evidence from a recent study highlighting the financial implications of the death of child. Difficulties included loss of benefits and allowances, problems in returning to paid work, funeral expenses and dealing with accumulated debt. The study raised a series of questions about whether and how practical matters to do with money and employment should be dealt with in bereavement counselling. Corden found

that many bereaved parents would value the input and assistance of 'trained and trusted counsellors' who understood and empathised with their situation during the period before and after their child's death. The findings appear to indicate that economic and financial perspectives may often be shielded by issues of grief and yet are of key importance when dealing with aspects of death, dying and disposal.

The day was brought to a close by Dr Cath Exley who extended her thanks to all those who gave papers and to everyone for attending what was a very enjoyable day. Finally, Exley extended her thanks to her co-conspirators on the organising committee before passing on her warm wishes to those who will replace them sometime in the near future.

Next year's symposium will take place on 27 March 2004 at the Trent Palliative Care Centre at the University of Sheffield. The outgoing organising committee are: Catherine Exley, Stephen Handsley and Carol Komaromy. Further details of the new committee members will be available shortly.

Stephen Handsley, Dept. of Sociology, University of Warwick  
S.Handsley@warwick.ac.uk

## **North West Medical Sociology Post-graduate Forum**

Wednesday 14 May 2003 saw a number of students, academics and practitioners present their ongoing research at the annual Post Graduate Research Forum held at Manchester Metropolitan University. The North West British Sociological Association (Greater Manchester) Medical Sociology Study Group, based in the Department of Health Care Studies, has been hosting the Forum for five years, and the traditional emphasis on support and accessibility was certainly evident at this year's event. The ten papers represented a diverse range of methodologies (from narrative research, biography and case study, to ethnography, questionnaires and interviews) and analysis, traversing a broad spectrum of clinical settings (for example radiography; mother/baby clinics; schools; general nursing) and medico-sociological discourses. Feedback confirmed that the Post Graduate Research Forum continues to be a constructive and supportive space for students/practitioners/academics working in multi and trans-disciplinary areas. For information about the 2003-04 North West programme of events, please contact:

Emma Hayter: [emma@echayter.freeserve.co.uk](mailto:emma@echayter.freeserve.co.uk)

Katherine Watson: [k.watson@mmu.ac.uk](mailto:k.watson@mmu.ac.uk)

Department of Health Care Studies, Manchester Metropolitan University

## London Medical Sociology Study Group

After almost a decade long vacation from Medical Sociology, I gave a presentation to the London Medical Sociology study group at King's College London on 21 May. I spoke about the continuing trauma of the Innu people of the Labrador-Quebec peninsula, with whom I have been working since 1994. Until the Canadian government and missionaries forced the Innu into European-style village settlements in the 1960s, they were permanent nomadic hunters, regarded as one of the most self-reliant peoples on the continent. Since then, they have suffered some of the highest suicide rates in the world, mass heavy drinking, epidemics of gas sniffing among children, and a host of relatively new diseases such as diabetes and heart disease. However, as a result of the very late colonisation of then Innu territories, the links between the Innu and the land have not been totally destroyed. Many Innu families spend up to four months a year in 'the country' in hunting camps. To visualise the contrast between the country and the villages, I showed a selection of slides.

While the medical professionals and the Canadian state are largely blind to the political content of Innu afflictions, the Innu themselves attribute their decline to the loss of meaning and purpose occasioned by settlement. In my presentation, I contrasted Innu and medical professional views of Innu suffering, ending with an advocacy of cultural continuity. Recent studies in Canada, as well as experiments among the Innu, have shown that young people who speak their own language, and are able to function in the way of life of their people are generally stronger physically and psychologically than those who remain rooted in the imposed settlement world.

My book on the Innu, entitled, *A Way of Life That Does Not Exist: Canada and the Extinguishment of the Innu* has just been published by Verso.

The event was followed by a very convivial evening with medical sociologists based in London. My thanks to Paul Godin for making it all possible.

**Colin Sampson**  
**Professor of Sociology and Director of American Studies**  
**University of Essex in Colchester**

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## ARTICLES

### What medical sociology do we teach to health professional students?

For the third year running the organisers of the annual BSA Medical Sociology Group Conference have provided us with a slot to discuss issues related to teaching medical sociology. After last year's interesting debate on assessments, we propose to discuss issues around the content of what we teach the students training for the health professions.

Some of the questions we would like to raise are:

- What is core and what are interesting extras?
- How does medical sociology fit in with an integrated curriculum?
- How do we teach our core elements in a problem-based curriculum?
- Who decides what students in the health professions need to know?
- What is the influence of national guidelines, policy documents, etc. such as, for example, the General Medical Council's *Tomorrow's Doctors* influence on what we teach undergraduate medical students.
- Are there differences in the kind and amount of sociology taught to nursing students, midwifery students, dentistry students, etc., etc.?

To start the discussion Andrea Litva and Sarah Peters from the University of Liverpool will present the findings of their postal survey of social and behavioural sciences taught in UK medical schools. The discussion will also include some of the feedback on the questionnaire results received at the second National Conference for Behavioural and Social Science Teachers in Medicine held in July in Liverpool

We invite everybody with an interest in teaching medical sociology to health professionals to come and join the discussion at the York conference!

**Edwin van Teijlingen**  
**Andrea Litva**  
**Sarah Peters**  
**Andrew Russell**

## Interview with Mike Hepworth, Reader in Sociology at the University of Aberdeen

The body and charting the life course have been long standing areas of interest for Mike Hepworth. Many of his ideas and writings have influenced mainstream sociology within the UK, providing insights into how the physical and the social interact. In the following interview Mike discusses how his interests in the body and ageing began, and how in the early days, spontaneous conversations, developing a distinctive teaching programme for second year sociology and various writings around the emerging issue of change in mid life helped to prepare the foundations of what is now called the 'sociology of the body'. He also reflects on the significance of growing older himself for his teaching and research practices.



### ***How did your involvement in what we now refer to as the sociology of the body begin?***

My interest began collaboratively when I started working with Mike Featherstone on changing images of mid life during the late 1960's at Teesside Polytechnic. In 1982 we published *Surviving Middle Age* which was the first book-length sociological study of images of middle age and marked our continuing interest in the role of images in the social construction of the life course. In 1982 Mike published his now famous paper on *The Body in Consumer Culture* that also had its roots in our joint investigations and discussions. This paper became, of course, a milestone in the sociology of the body in relation to developments in consumer culture. Another important turning point for me was collaboration with Bryan Turner whilst he was here in Aberdeen when we introduced sociological questions about the body into our second year teaching. During that period we had several discussions about the body (I used to give two lectures under the title 'Seven points About The Body') and issues of consumer culture and the ageing process and Bryan added an analytical framework derived from his reading of Foucault and medical sociology. Whilst my approach, via research and

teaching the sociology of deviance, was strongly influenced by symbolic interactionism. Bryan and Mike were grounded more centrally in sociological theory. We discovered a number of issues in common and simply pursued our interest in separate and joint publications and other sociologists also began to work in similar fields. Within the discipline you are part of an emerging collective sensitivity to issues which gradually takes on increasing momentum.

Another significant milestone was the development of the journal *Theory, Culture and Society* the first issue of which appeared in 1982. We have just celebrated our twenty first birthday! Over the years we have published a number of papers about the sociology of the body including Bryan's work, first researched in Aberdeen, on the discourse of diet and Mike's *The Body in Consumer Culture*. Several of these papers from TCS were later published in 1991 as *The Body*, the first reader on the sociology of the body which we edited for Sage and which is still in print.

***What's quite interesting there is that it all seems to begin with loose conversations and a few publications all leading to a series of books. How do you feel now seeing sociology of the body as being part of the 'mainstream' of sociology?***

It's been strange really. I don't remember that we thought at the time we were involved in creating a new subject area so to speak but simply that we were enthused by the work and believed that the body was neglected in mainstream sociology. As I mentioned, I'd been interested for a long time in the body as a sociological issue which is why I included the lectures about seven points about the body in our second year programme. I think the very fact of being a sociologist makes it difficult to claim ownership of a subject: knowledge is collectively produced and you are inevitably part of a more widely shared cultural climate.

***What helped you form your ideas about the body?***

I was always interested in references to the body in a wide variety of different sources - I was feeding into my interest bits of history, bits of literature, bits of social psychology, and art history. Because I was very much influenced by symbolic interactionism which is concerned with the ways we make sense of life and experience, I suppose it was a ready made one for me, really. For me symbolic interactionism provided a sort of skeletal framework on which to hang information and data gathered from a wide variety of sources. A book that influenced me a lot in the early days was Steven Kern's *Anatomy and Destiny*, which is probably the first cultural history of

the human body. At the time Mike and I were looking at images of ageing bodies with particular reference to middle age and were exploring books like Kern's and works by art historians such as Ann Hollander. In those days there wasn't a coherent sociology of the body to draw upon; we were working eclectically putting together an assembly of evidence from a variety of sources including the popular press, and Mike was adding a theoretical take on consumer culture. At that point we saw consumer culture as a very significant influence on body and age consciousness in western society as indeed it still is.

***What do you see happening next for the sociology of the body?***

I think there is an issue in sociology generally, which is where do we go from here? Sociology has been enormously successful and very influential and much of sociological awareness has become our present-day common sense. In the world of academic disciplines sociology has become an integral aspect of teaching. Medics, for example, have taken on many of the ideas and the sociology of the body is now incorporated into social gerontology and life course studies. So rather than whether there will be a sociology of the body as a separate area, it seems to me that the question is more one of where sociology in general goes in the future. And I think the way ahead for the sociology of the body in particular is through detailed empirical inquiry into variations of experience of the body within increasingly complex social arrangements; in other words, what is actually going on out there on the streets. For example, we can talk forever about the post-modern body in a highly speculative manner, and yet such theorisation may only apply empirically to select groups of people. At the moment this seems to be the case as far as older people are concerned. Some of the most privileged undoubtedly experiment with what may be called postmodern lifestyles but there are many who are excluded from the avant-garde through lack of resources and alternative cultural loyalties. It's not yet a general experience, although we cannot be completely certain because there's a need for a lot more research into how people experience the body and how it may be different in the future from what perhaps it was in the past. At the same time it is also important to develop cultural histories and accounts of the body as imagined, represented and idealised in visual and verbal imagery. Such work is a vital complement to empirical investigation.

As sociologists perhaps we now need to be thinking about ways to reinvent our disciplinary identity because literature's got in, geography's got in, art historians have got in, and a student can now take sociology on all sorts of courses that aren't called sociology.

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***Do you feel that we are entering a post-modern world where we are free to age how we desire?***

Mike and I became associated, certainly in social gerontology, with the idea of a postmodernist life course, but we never ever said, as I've already suggested, that it's happening to everybody. At the time of writing our first article about the impact of post modernity on conceptions of the life course we were reading Bourdieu and warned that the postmodern model should be qualified with reference to variations in material and cultural resources among differently placed social groups. In addition we have always argued that we can't, for example, explain away the facticity of the human body as if it can be seen only as a cultural construct the meanings of which can be endlessly negotiated and reinvented. There are things that happen to ageing bodies which are biological, for example arthritis, joints seize up and other changes. So at the moment, I think the future of ageing is going to be more complex than in the past: the old ideas will continue to exist alongside an extraordinary future for the privileged few who can afford bodily modifications such as cosmetic surgery and to experiment with richly innovative post-modern lifestyles and age identities. In other words the present social divisions will not disappear with postmodernity and will continue to influence the experience of growing older.

***And do you think that these post-modern ideas can actually create problems for people?***

Yes I think they can add to the anxieties of ageing. For example, Margaret Gulleto argues that consumer culture is actually saddling people with extra problems. The belief that we can buy a cure for growing older reinforces the concept of ageing as decline, because all you're doing is simply pushing back the boundaries of old age not eliminating the final problem of biological ageing. You're not getting away from ageing and death, you're simply pushing it further away, distancing yourself from it, and eventually it catches up with you. But it is also true that the increasing diversity of social and cultural life which is part of postmodern change does offer new opportunities (at least in theory) for older people to explore new experiences and identities. In that sense the movement away from more fixed or traditional images of ageing is very positive.

***So how do you see ageing becoming a more 'positive' experience for us in the future, considering, as you say, that there are biological aspects of the body that cannot be avoided?***

I think through challenging, as Gulleto argues in her book *Declining to Decline*, the concept of decline as a social construct. That is by challenging

the idea that because we inevitably grow older biologically we necessarily decline as social and individual beings. If you radically engage with fixed ideas of ageing as personal and social decline, then you might have a chance of allaying some of the anxieties that people feel and laying a more positive foundation to ageing which is grounded in wisdom, knowledge, education and even spirituality. So I'd go along with that because there are things that happen to your body that you can't control, even nowadays. And I'm not sure that I would personally want to either. But I think that you can make an argument for the positive aspects of ageing by drawing on the encouraging fact that many of the unsung older people throughout the world lead productive and vigorous social, personal and mental lives and make an enormous contribution to the well-being of their societies. The changing role of grandparents is only one example. And I think that's why education and courses for people in later life are important. Whatever happens to the body, most people remain mentally active and still have a lot going for them. So I think that's one way that sociology can contribute, by looking at different ways of understanding the ageing body.

***How do you feel about teaching about ageing as you yourself grow older? Does it change how you teach or approach the subject?***

It does, it's this issue of reflexivity. Whatever else is going on in reflexivity, ageing is sure as hell reflexive! Mike and I starting hypothesising about middle age as an emerging social problem in the 1970's when I was in my thirties, and looking at those issues then is quite different from looking at them now. What's happened, of course, is that I have moved through mid-life as lived experience rather than a largely intellectual exercise!

Teaching the Honours option, Ageing in Society, I often tell students that, unlike in some other subject areas, we are not just studying ageing in a detached manner (although we try to do this), but we are actually producing ageing, because in our exchanges and discussions we are exploring the direction ageing may take in the future. As younger people they are already involved and are probably going to be exposed to ageing of a sort which I haven't had and probably won't have. Whatever happens to the 'postmodern turn' ageing in the future is going to be different; students are going to be growing older in a world in which attitudes to pensions and job security, and so called global and post-modern change will affect the ageing process. And the models that exist now may no longer be relevant. I think we are in a transitional phase where traditional models of ageing which I was brought up with and which still exist, are really being questioned. That's another area for research: the extent to which contemporary images of ageing are

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changing and what evidence we can find of this change.

So twenty or thirty years on I'm inevitably looking at ageing through different eyes. And the irony of it is, of course, that I am aware of living it. A number of years ago Mike and I introduced the idea of the mask of ageing into the sociology of ageing – the idea, of course, that people's experience of growing older is of a younger self continuing to live on in an ageing body. I think a long experience of teaching the sociology of ageing may help to reinforce that experience! And with ageing you become aware that you're talking to people who are a lot younger who didn't know you before. So, talking to them nowadays I inevitably see myself as a person with a long history of teaching in this subject; when I was younger that was less likely because I didn't have that narrative behind me, that experience. But I think with social gerontology and the sociology of the body as well, that it's a good thing that there are people working in the disciplines who have grown older in the history of the subjects because, certainly where ageing is concerned, you are able to talk to groups of people reflectively about it, and I think that you do have a richer perspective on ageing than younger people just entering the area.

Research has shown that older people often feel obliged to make reference to time passing, it's an aspect of conversational practice – people think that because you've been around for a while, you're probably going to have to say something about time! But I have always been interested in time and time passing. When I was a kid, I used to love looking through family photograph albums and I used to insist on asking my grandmother who all these people were. I've always been fascinated by the changes that time displays on people's faces, and I've always been interested in memory, place, and the personal possessions that identify individuals– I like going to museums, looking at old clothes, that sort of thing. I'm fascinated by all that, I always have been. So I was a sort of 'natural' for the sociology of the body and ageing.

***Well thanks very much Mike. It was a pleasure talking to you and we very much hope you'll continue to contribute your insights into ageing and the sociology of the body for many years to come.***

**Interview by:**

**Chris Yuill, The Robert Gordon University**

**Lydia Lewis, University of Aberdeen**

## PHD REPORTS

### **Non - legitimate illness, embodied experience and the moral career: the case of ME/CFS**

**Tracey Jane Collett, Plymouth University**

The condition known as myalgic encephalomyelitis or chronic fatigue syndrome (ME/CFS) is an illness of unknown aetiology which affects over 150 000 persons in the UK. Whilst the cause of the condition is the subject of intense medical debate, the official view is that it is a form of atypical depression or somatisation disorder. This view is at odds with the views of many sufferers who claim that ME/CFS is a pathological disease that renders them severely incapacitated. Sufferers maintain that, because their condition is regarded as a minor, psychological illness, its severity is not recognised. Thus, rather than being granted assistance, their appeals for help are often met with accusations of malingering or hypochondriasis.

This, they argue, results in significant marginalisation. In short, sufferers' state that they experience bodily change that is profound and disabling, however, their claims to be 'really ill', are ignored.

ME/CFS is one of a number of conditions whose meanings are contested. Other such conditions include Gulf war syndrome, repetitive strain injury, organophosphate poisoning, and multiple chemical sensitivity. These conditions are worthy of sociological study because they 'make visible' the way that social definitions of illness impact on the experience of illness.

The data for this thesis is derived from an empirical study of sufferers' experiences of ME/CFS. Using both qualitative and quantitative research methods, the study explores the embodied experience of ME/CFS and the illness careers of sufferers. The findings of the study are analysed in the light of the sociological literature on 'the cultural expectations surrounding illness', 'embodiment' and 'the experience of illness'. Whilst the past literature has either focused on 'the cultural expectations surrounding illness' or 'the experience of illness', this thesis brings together the two areas and uncovers the complex set of relations and pathways that emerge when ideas about illness clash. The findings have implications for the sociological understanding of the illness experience. They are particularly relevant because, as the chronically ill population expands, there is an increasing

emphasis on individual responsibility for illness. Thus, whilst contested illnesses are a blatant example of what happens when sufferers are held accountable for being ill, the findings have implications for the experience of all chronic illness.

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## **Symbiotic Niceness: A Study of Psychosocial Care in Palliative Care Settings**

**Sarah Li**

**Kingshaw University and St George's Hospital Medical School**

The present thesis investigates how palliative care nurses enact psychosocial care in their natural settings (two hospices and one general hospital), particularly with reference to their talk. The aim of this thesis is to relate the doing of psychosocial care to broader notions of nursing as a form of emotional labour. The thesis offers an ethnomethodological-ethnographical perspective on psychosocial care and advances a theory that psychosocial care is enacted in emotional labour through the doing of 'symbiotic niceness'. It demonstrates that 'symbiotic niceness' is co-produced and co-performed in interaction by participants. This process of interactional co-production of 'symbiotic niceness' serves as a means of managing relations between palliative care nurses and dying patients.

I put forward the argument that enactment of psychosocial care through emotional labour in care of the dying is a project for the construction of therapeutic interaction in nurses' talk. In such occasions, moral identities are constituted and displayed, the nurse-nurse and nurse-patient relationships are constructed as reciprocal and symbiotic. Emotional labour represents more than the management of emotions in nurses' talk. Most significantly, through the enactment of psychosocial care, emotional labour is co-constructed by nurses and patients as a key strategy for the production of symbiotic niceness in interaction. Symbiotic niceness represents a core component of professional and patient identity. Impression management (character work) is thus a key strategic aspect of emotional labour which works to maintain social orderliness as well as to advance personal, professional and organisational aspirations. Emotional labour also works to make patients' experiences of illness more tolerable and manageable.

Exploration of the concept of ‘symbiotic niceness’ suggests that the ‘niceness’ of patients has implications for the nurses’ own performance of ‘niceness’, which is in turn a key component of the emotional labour that contributes to psychosocial care. This thesis also advances the argument that psychosocial care, mediated through ‘symbiotic niceness’, may be used by nursing professionals as a way to demonstrate good care and the nature of their expertise which in turn serves to preserve their professional integrity.

The concept of psychosocial care is thus demystified by the work I present. It relates to being nice to each other (nurses and patients). It also relates to competence, knowledgeableability and skills. My thesis acknowledges that patients’ dying experience has physical and psychosocial elements. It must be said that enactment of psychosocial care is an important skilled behaviour not to be demeaned. However, I argue that psychosocial care is not a specialist project even though it is dressed up in the technical language of psychology, psychiatry and medicine. I argue that symbiotic niceness can be analysed as a skill common to all humanity. It is available for everyone in ordinary everyday interaction. Nevertheless, symbiotic niceness may be objectified as a skill for certain groups of professionals to learn to do better, in particular, in situations in which they may have to deal with interactional problems.

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## **The spatialities of facial disfigurement: the case of acne**

**Marian Hawkesworth**

**The School of Economic and Social Studies, University of East Anglia**

For an apparently common skin problem, contemporary discourses about acne are reminiscent of those from previous centuries when, in the age of smallpox, leprosy and other visible diseases, it became a social duty to display a face that fitted in to everyday life. In the context of intercorporeality, where judgements are made about visible form, there are people who blame sufferers for having acne. References to eating the wrong food, sexual activity, overactive hormones, a lack of cleanliness and neglect are stereotypical representations that have become strongly linked to popular

perceptions of acne. For some, getting acne is a normal life course or a rite of passage that people have to deal with often through joking relationships. In their minds, acne, usually called spots in the beginning, is not going to be there forever. There are others, like the novelist and poet Charles Bukowski, who perceive their subjective experience of “disfiguring acne” as a primary influence on their identities and occupation of social space.

This thesis investigates the more general problem of the everyday presentation of the body and self over space and time. In particular, the research seeks to understand the everyday geographies of people marked out by their perceived facial differences, specifically those defined as having acne. The objectives of the research are threefold: (1). To document the diverse ways in which the lives of people with facial acne are bounded and barriered by social and attitudinal contexts; (2). To describe and evaluate the contrasting ways in which people with acne seek to negotiate, manage and cope with the boundaries and barriers of everyday life; and (3). To discuss the relevance and importance of interconnecting an understanding of facial disfigurement with theories of disability and impairment.

The research used qualitative methods searching out networks of volunteers through the Acne Support Group and a snowball sample of personal contacts. Finding participants proved demanding as some people try to keep quiet about their acne. Encounters with largely adult sufferers in the form of interviews, e-mails, letters and telephone conversations were often sensitive and difficult. In addition, two focus groups drawn among adolescents at school were carried out, combined with liaison and interviews of key professionals in organisations such as hospitals and schools, participant observation and a discourse analysis of journals.

My findings indicate the importance of focusing on the corporeality of the body, and the psychical and physical processes that help to compose it in specific moments of time and space. Moreover, the institutionalisation of acne in medical discourses and support groups is problematic, as it upholds and reproduces, rather than challenges existing normative standards of facial appearance.

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## Organ donation and transplantation - the paradox of gifting and dis/embodiment

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In the UK, since the 1950s, obtaining solid, cadaveric organs for transplantation has been encouraged through a “gift of life” discourse; an individual can choose to “opt-in” after their death, via carrying a donor card/notification on a driving licence/registration on the NHS Organ Donor Register (ODR). Yet regardless of whether and how the decedent recorded their wishes, their next-of-kin’s “lack of objection” is always ascertained prior to organ removal. The family refusal rate (approximately 30%) is considered a contributory factor to the continuing shortage of organs although little is known about why families’ refuse, or for that matter, agree. Hence, an empirical aim of the PhD research was to ascertain the circumstances in which an organ donation request was more likely to be accepted or refused by the family of a brain stem dead individual. Ethical approval was gained from three NHS ethics committees, and eighteen semi-structured interviews were subsequently carried out with donor (n=15) and non-donor relatives (n=3). The data demonstrated that *wider cultural beliefs embedded in society about the value of gifting, death and the body are brought to the specific context of an organ donation request. It is the interactions between these elements and others, such as familial dynamics and hospital support, in conjunction with the perceived benefit from organ donation, effects whether families will donate or not.* Both donor and non-donor families appeared to face the same difficulties, for example, around the “living appearance” of the dead body, understanding a diagnosis of brain stem death, fear about body mutilation, and inter- and intra-family conflict about the decision. Donor families donated, however, because they said they felt an “obligation” to carry out the deceased’s wishes. Despite, the small number of non-donor families interviewed, this duty was significantly absent and donation did not occur. This data has important policy implications around 1) how the present “opt-in” system can be improved and 2) can also contribute to debates regarding the merit of introducing alternative organ procurement systems.

Theoretically, an attempt was made to gain a better understanding about the definition and role of altruism and obligation and the social basis for modern, Western gifting systems: a “moral economy” was identified. The social construction of death as both a biological event/process was found

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to be important as was examining the emphasis away from a traditional death (cardiac cessation) to a brain orientated one. Lastly, a link between personal, social and corporeal identity was explored, demonstrating how meanings are constructed onto dead bodies/parts by different groups, dependent on differing social beliefs and needs. The nature of “embodiment” specifically a medical, Cartesianism legacy separating person/body, in contrast with a holistic, lay perspective was a significant finding. The PhD concluded with a suggestion that although the donation/gift of organs respects the sacredness of the dead body, this same sacredness can be perceived to be transgressed by the removal procedures that is required for organ transplantation to occur. Therein, lies the inherent paradox of organ donation and transplantation.

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*I have discovered that alcohol taken in sufficient quantity, produces all the effects of drunkenness.*

*Oscar Wilde*

## Hidden jewels of the INTERNET

### *Social Research Update*

There are a number of real hidden jewels on the Internet for medical sociologists. In my opinion one of these is *Social Research Update* edited by Nigel Gilbert and published by the Department of Sociology at the University of Surrey. To date *Social Research Update* contains 37 four-page spreads covering a wide-range of social science research methods. Topic range from 'The Importance of Pilot studies' to 'Ethnographic Writing' and from 'Longitudinal Research in the Social Sciences' to 'Paying Respondents and Informants'. The spreads are a real jewel for researchers, teachers and students alike.

#### **An introduction to Social Research Update (*copied from the webpages*)**

Methods of doing social research are continually advancing. New developments in information technology enable complex analyses to be carried out on a personal computer. Laptop computers and computer assisted telephone interviewing change fundamentally the way in which surveys are done. New statistical techniques are being developed which are better suited to the kinds of data which social researchers generally deal with. New approaches to qualitative data raise new theoretical and ethical problems.

In face of all this change, social researchers, pressurised to produce results, often do not have time to keep up with the latest developments. It is to fill this gap that we are producing *Social Research Update*.

Subscriptions for the hardcopy version are free to researchers with addresses in the UK. You can apply to SRU subscriptions by email: [sru@soc.surrey.ac.uk](mailto:sru@soc.surrey.ac.uk). More importantly, the webpages are easily accessible at: <http://www.soc.surrey.ac.uk/sru/sru.html>.

Social Research Update welcomes contributions. Articles on social research method topics should be about 2,000 words in length and aimed at a general research audience. If you are thinking of contributing, guidelines on writing for Social Research Update can be obtained from Nigel Gilbert ([n.gilbert@soc.surrey.ac.uk](mailto:n.gilbert@soc.surrey.ac.uk)).

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

*If anyone else has any **internet gems** like this, or interesting web sites they have come across, please send them in to us by **31 October 2003** for the December issue of MSN.*

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## Phil Strong Memorial Prize: Fieldwork in Bangladesh

Emma Pitchforth, Ph.D Student, University of Aberdeen

### Background

Gaining the Phil Strong Memorial Prize in 2002 has enabled me to complete my fieldwork for my Ph.D. In March 2003 I returned from six months data collection in Bangladesh. The topic of my Ph.D. is: 'Emergency obstetric care in Bangladesh, focusing on the needs of the poorest women'.

Access for all women to emergency obstetric care is thought to be vital if the number of maternal deaths are to be reduced (Donnay 2000, Midhet *et al.* 1998, Nirupam & Yuster 1995). Every year, over half a million women die during pregnancy and childbirth, and many more are left with severe morbidities (WHO *et al.* 1999). Emergency obstetric care is particularly important in Bangladesh, a country where over ninety percent of deliveries are at home.

Thaddeus and Maine (1994) outline the main areas of delay where women can face barriers when trying to access emergency obstetric care in the event of a complication. Their three phases of delay model shows that delays may occur in the decision to go to a health facility, in getting to an appropriate health facility and in getting adequate treatment once at a health facility. Research to date has focused primarily on the first two areas of delay and has shown that women with least resources are at a greater disadvantage in accessing emergency obstetric care. This study focused on the third area of delay to explore whether the poorest women were also at a greater disadvantage in receiving necessary treatment once at a health facility.

The aims of the study were: to assess the needs of the poorest women from the perspective of the women themselves and from health care providers; to establish what mechanisms are in place (formal or informal) to provide support for the poorest women at health facilities, and to explore how women are classified as 'poor' and what effect this may have on the treatment received, for example whether poorer women faced greater delay in getting necessary treatment. The study focused on government provision of emergency obstetric care in Bangladesh. Treatment is supposed to be free at point of service but it is widely recognised that patients can face substantial costs in paying for supplies, drugs, blood and consumables.

There are also many opportunity costs for the woman and attendants spending time at the hospital.

### **Data Collection**

The data collection was split between a Government medical college hospital and the women's homes for follow up interviews following discharge from hospital.

A short questionnaire with women as they were admitted to hospital and a case note review allowed us to assign each woman with a 'poverty score', record the nature of their complication and also the treatment they had received. We also asked for a description of how to reach their homes so that we could follow-up a smaller subset of women. The follow-up was conducted approximately one month after discharge and the purpose was to explore in more depth about their whole 'journey to care'. In these semi-structured interviews we were able to ask questions concerning all three areas of delay and could explore the costs incurred by the family, how the money was raised and the consequences this was having for the family.

Within the hospital, interviews with staff, patients and observation allowed me to explore what mechanisms were in place to provide support for women most in need and the decisions around who was considered to be most in need. With the exception of the doctors, all the interviews were conducted in Bangla with the help of an interpreter.

### **Findings**

The analysis of both the quantitative and qualitative data are ongoing with the aim to complete my Ph.D. at the end of 2003.

The initial analysis highlights that compared to the wider population, the poorest women are not utilising emergency obstetric care. The costs incurred by families were often substantial, particularly if large quantities of blood were required. The majority of families had to borrow money, usually from friends or relatives, or sell any belongings or crops that they may have. Most families were therefore left in debt or without their primary source of income. Support from the extended family seemed to be vital in enabling women to get treatment and the staff would often identify those in greatest need as those with no or few attendants accompanying them to the hospital.

The formal social welfare organisation within the hospital had limited funds

and due to bureaucracy and standard opening hours was not suitable for emergency cases. The doctors within the hospital operated a 'poor fund' system that meant that the poorest women should not go without lifesaving treatment. The poor fund was a mixture of drugs, equipment and money. The drugs and equipment would be collected from wealthier patients or from medical representatives and the doctors donated the money.

The study has been primarily hospital-based rather than community based to include women's experiences of health care, identify potential barriers to receiving necessary care but also explore the support mechanisms, which enable women to receive the treatment that they require.

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## **BSA: Phil Strong Memorial Prizes**

The BSA Medical Sociology Group is pleased to announce the Phil Strong Memorial Prizes for the Academic year 2003-4. It is anticipated that there will be two prizes to the value of £1000 each. The purpose of the prizes is to contribute to the advancement of medical sociology by supporting post-graduate research in medical sociology leading to a higher degree.

Applicants must show that they are working in the field of Medical Sociology and that they are registered for a higher degree at a British University or other recognised British research institution, with a named supervisor who is a member of the BSA.

Applications must be submitted to arrive no later than **30 August 2003**. The draw and announcement of winners for this year's prizes will be made at the Medical Sociology Study Group's AGM at their Annual Conference to be held at the University of York from 26-28 September 2003.

For further details on how to apply please go to:  
[www.britsoc.co.uk/msconf](http://www.britsoc.co.uk/msconf) or contact the BSA office:

Phil Strong Prizes  
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## **SOCIOLOGY OF HEALTH AND ILLNESS 2003 BOOK PRIZE**

The Sociology of Health and Illness Book Prize is awarded annually for the book judged to have made an outstanding and unique contribution to medical sociology. The books listed below, with a paragraph by their nominator, have been shortlisted for the 2003 prize. The winner will be announced at the BSA Medical Sociology Conference, which takes place in York, 26-28 September.

We are now seeking nominations for the 2004 prize. You can find all details and the nomination form on the website [www.britsoc.org.uk](http://www.britsoc.org.uk) – it's a really quick and simple process, so get thinking and nominating!

**Clare Williams, on behalf of the BSA Medical Sociology Group**

**Busfield, J. *Health and Health Care in Modern Britain*. Oxford, Oxford University Press, 2000.**

A skilful summary of social, economic and political aspects of health, health needs and health care provision in Britain. In addition to digesting a range of research material and presenting it in an accessible form, the book considers future prospects and dilemmas for health care in Britain, thereby casting well-rehearsed arguments about health inequalities and their causes and possible cures in a new light. The book could be of interest to both the novice and the old hand because it is well written and because it achieves a combination of range and depth.

**Hannah Bradby**

**Horwitz, A. *Creating Mental Illness*. Chicago, University of Chicago Press, 2002.**

Allan Horwitz's *Creating Mental Illness* is the most important book in the sociology of mental health in a decade.

Horwitz's main argument is that modern psychiatry has become what he calls 'diagnostic psychiatry' and this has led to a proliferation of mental

illness diagnostic categories (especially after DSM-III). Horwitz argues that only symptoms that reflect (psychological) internal dysfunctions, which are deemed to be inappropriate and are universal categories of the human species, are true mental diseases. There are few disorders that meet this criterion, schizophrenia, bipolar illness and some clinical depression (most of which were previously termed psychoses). All other current psychiatric disorders are expectable responses to stress, social deviance or 'problems in living' (to resurrect an old phrase). Modern psychiatry has given these disorders medical diagnoses (PTSD, ADHD, dissociative disorder, OCD, etc.) although they are not mental diseases. Thus modern psychiatry and psychiatric epidemiology overstate the amount of mental illness in society.

This is an important and controversial argument. Horwitz impressively integrates findings from history, sociology, epidemiology, biology and psychology to support his argument. While some may not agree that it is possible to make the clear distinction between 'real' mental illness and 'extended' diagnostic disorders (my term), he is surely right about the proliferation of mental illness.

Horwitz suggests this expansion is both a result and reflection of the rise of diagnostic psychiatry, the latest incarnation of psychiatric advancement. Using specific cases (e.g., sexual dysfunction, depression, multiple personality disorder), Horwitz shows how the advocacy groups, clinicians and especially the pharmaceutical industry promote the new disorders and are able to get them institutionalized into the psychiatric diagnostic nomenclature.

What sets this book apart from many others is that Horwitz is able to present a social constructionist argument without undermining the notion that there can be real biomedical disorders. This is an ambitious and precarious task for a sociologist, but Horwitz navigates these waters with rigor, intellectual grace and uncommon good sociological sense. This book is both an integrative study of the first order and a provocative and incisive piece of scholarship; it is a landmark study of psychiatric conceptions at the millennium.

**Jon Gabe**

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**Klinenberg, E. *Heat Wave: a social autopsy of disaster in Chicago*. Chicago, University of Chicago Press, 2002**

In July 1995 more than 700 people perished in a heat wave, making it one of the greatest natural disasters of American history. Eric Klinenberg goes inside the anatomy of the metropolis to conduct a “social autopsy,” examining the social, political, and **institutional organs of the city that made this urban disaster** deadly. Starting with the question of why most victims died at home alone, Klinenberg investigates why some neighborhoods experienced greater mortality than others, how the city government responded to the crisis, and how journalists, scientists, and public officials reported on and explained these events. Through a combination of years of fieldwork, extensive interviews, and archival research - and writing with much of the verve on an investigative journalist, Klinenberg uncovers how a number of surprising and unsettling forms of social breakdown—including the isolation of seniors, the institutional abandonment of poor neighborhoods, and the retrenchment of public assistance programs—contributed to the high fatality rates. The heat wave mortality has as much social as natural origins. Working in the tradition of Emile Durkheim and Kai Erickson, Klinenberg’s truly exceptional, innovative study promises to launch a new sociological research tradition that unites the methods and theories of medical sociology with the epidemiological research on social determinants of health.

**Robert Dingwall**

**The, A-M. *Palliative Care and Communication: experiences in the clinic*. Buckingham, Open University Press, 2002**

Written in an engaging style with extensive use of narrative, *Palliative Care and Communication* seeks explanations for the sense of optimism found among patients with small-cell bronchial carcinoma or lung cancer. Over a period of five years the author used ethnographic research methods to monitor the illness processes of patients from the time of receiving bad news until their death, from the perspectives of the various people involved: the patient, family and relatives, the doctors and nursing staff. Based on narrative descriptions, interspersed with observations, the author demonstrates ‘why things happen the way they do in practice’. The book explores informal codes, ambiguous messages, the dilemma between professional detachment and personal involvement, patterns of information and communication during the phases of the illness, the latent realisation

of approaching death, and the ambivalence of patients with regard to 'knowing and not knowing'. A first in its field, the book provides important information on a difficult subject in a clear and accessible fashion.

**David Clark**

**Kerr, A., Shakespeare, T. *Genetic Politics: from eugenics to genome*. Cheltenham, New Clarion Press, 2002**

Firstly, this is one of the few books in the area that places current developments in genetics in a socio-historical context. To me, it does what sociology does best and unlike many other books in the genre, this book does place developments in a wider societal perspective. It is readable, challenging and erudite and it is a book I can recommend to students. It is a rare book that can speak to a wide range of audiences, including sociological and professional, and this is one of them.

**Jane Sandall**

*If everything seems under control, you're just not going fast enough.*

*Mario Andretti (Racing Driver)*

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## Sits. Vac : Agony Aunt

Many of you will remember 'Marge', MSN's resident agony aunt who used to answer all our queries so promptly and adeptly. From the grounded and negotiated price of organic broccoli to the best way to deconstruct the post-modern theme park experience, Marge would always supply an answer. Often this might be surprising, not what 'concerned of Newmarket' for instance, had expected. But always it was delivered with careful consideration and a certain je ne sais quoi.

Sadly Marge has disappeared with her long suffering family into the Springfield ether and we are now looking for a new agony aunt. The qualifications for this totally unremunerated post are few:

1. Familiarity with the whole caucus of medical sociological knowledge from the founding fathers (for they were men, were they not?) to the present day emergence of mothers and sisters.
2. Knowledge and belief in academia, empirical research and the meritocracy, or just a semi-permanent post somewhere nice.
3. Kind hearted and considerate person with no particular axe to grind.

Uncles will be considered if there are insufficient applications from aunts. Applicants wishing for guidance in the style of reply required, are directed to the answers below which were received in response to the query submitted by 'Disillusioned in HSR' (all names have been changed).

In the meantime Uncle Edwin, who is on secondment from Hello, Heat or possibly Bunty will be standing in for Marge. So if you have any queries relating to your professional life, do not hesitate to send them in to him.

The editors regret that Uncle Edwin cannot reply to letters personally.

*"Every woman knows that, regardless of all her other achievements, she is a failure if she is not beautiful. She also knows that whatever beauty she has is leaving her, stealthily, day by day..."*

*Germaine Greer, The Whole Woman*

*Dear Marge*

Why is it that it still seems so hard for feminist sociological approaches to be accepted (dare I say valued) within the realms of health-services research (HSR) and public health? I have recently had some very disturbing experiences whilst attempting to carry out a project focusing on gender issues and taking a feminist perspective within such an environment, that included senior staff telling me my work is unfitting and irrelevant within HSR. Yet from where I'm standing, 'gender' is a critical and neglected consideration within the area of health services with which my project is concerned, and I am sure that a feminist approach to the research can reveal important understandings and insights for service development (for both women and men, I should add).

To me it appears evident that feminist, and other critical perspectives that medical sociologists may wish to take, should be considered necessary and integral aspects of HSR. It thus seems unfair that those of us attempting to undertake such work are often faced with the choice of either 'battling it out' and struggling to make our voices heard, or moving to more conducive disciplinary environments (which often means that these important perspectives are lost from consideration within mainstream policy and service-oriented health research). Others may give up on such research aspirations, keeping their feminist interests and identities 'in the closet' for fear of reprisal.

I must say it is hard enough to get an academic career off the ground these days without having to struggle against the grain in this way. But I feel my work is important and stimulating, and I would not like my ideas to lose their critical edge.

What is a feminist medical sociologist to do?

### **Disillusioned in HSR**

*Dear Ms or Mr Disillusioned*

Having read your letter I am sorry but not surprised to hear about your 'disturbing' experiences as a 'feminist sociologist' trying to carve out a career in the realms of HSR/Public Health research. I empathise with your position,

as I felt similarly disheartened for the first few years working as an RA with a sociological background on a multidisciplinary team based primarily in the Medical Faculty. I share a lot of your anxieties and must admit that for me it has been (and still is) a process of 'coming out'. I can only respond to your question about 'what to do' based upon my experiences but first I would like to share a few of these with you.

One incident that springs to mind was walking to our first team meeting when my line manager hinted strongly that I should maybe hold off using the phrase 'feminist methodology' - and in all honesty I heeded this warning. In fact, the biggest 'battle' I have had is gaining recognition as a sociologist, never mind a 'feminist medical sociologist'! For the first few years of my post the clinicians invariably introduced me as a 'psychologist' to their colleagues. My attempts to voice that this was not the case seemed to fall on deaf ears but I have persevered with my 'label'. In retrospect I think part of this misidentity was due to the clinicians not knowing what a sociologist 'is' or 'does', let alone perceiving that they may be of value - a communication lesson for us all perhaps.

A second (feminist?) 'battle' with which I am sure you are familiar has been promoting the value of a qualitative approach, although admittedly I think there was more inherent support for this - as one senior male clinician thankfully commented early on "how else can you research such a complex question?" Nonetheless, presenting and defending the results to clinical audiences was a daunting and at times humiliating prospect, but in hindsight a valuable experience - I think!

Then comes the not unrelated issue of how to promote your critical (feminist) perspective without fear of reprisal or having to bail out - as you imply. So, back to your question what is a feminist medical sociologist to do?

In such a short space I can elucidate only three strategies.

The first is to take what my mother refers to as the 'softly softly' approach. For example, if I had been introduced to a clinical audience as a 'feminist medical sociologist' I think they would have shut their ears or run a mile - similar to some of the men in my personal life I fear! Perhaps sometimes there is a place for being a little more discerning. So far I have always tried to bring gender into my analysis, but never claimed this as a 'feminist' perspective *per se*. She (my mother that is) would call this a cop out, preferring to be more confrontational in her own work, which probably

explains why she's often been given her marching orders. From your letter I feel that you have adopted a similar position to her and can only say that it is truly admirable. Standing out from the crowd (and biting the hand that feeds you) is not an easy path to follow but one that people will remember in time. And it certainly sounds like you got a reaction – some would congratulate you for this!

Ultimately, I have found that the most valuable approach is to build a broad support network of like-minded people within the sociological *and* medical realms - and for me this undoubtedly includes those women who may adopt the "I'm not a feminist but..." position. Perhaps I have also been fortunate in that our team comprises some very strong and well-respected female academics all of whom have become my mentors in their own particular ways. The visibility of other forthright women in the medical faculty has also been a tremendous inspiration.

Clearly you feel that your work is important and stimulating, and do not want your ideas to lose their critical edge, but in adopting this position I think you will always have to struggle against the grain in some way – how else is one to challenge the status quo? Admittedly I have yet to use the word 'feminist' in my RA work but now they know me I don't think it would come as much of a surprise to the team. Ultimately, I guess you try to adopt a position which feels true to you. One last thought - if you do move to a 'more conducive environment' I'd be very interested to see whether it's a case of jumping out of the frying pan and into the fire! No doubt you can update us on this at some point.

### **Slightly less disillusioned RA**

*Dear woman*

Sociology has made great advances into medicine over the past half century. Sociology is now recognised as an integral part of the medical curriculum, as shown by a recent study of behavioural and social sciences in UK medical schools (Russell et al. in print). In fact the guru of Health Services Research (HSR) Archie Cochrane himself, suggested the need for a two-day seminar held in London on the topic of sociology as a discipline relevant to community medicine (Acheson & Aird 1976: 1). One of the current complaints is that this version of sociological theory is perhaps too watered-down. Theory is threatening and scary to those working in a world of Positivism and science-based empirical experiments.

Perhaps this is also the case in HSR's famous fixation with randomised-controlled trials, although a field I am not directly familiar with. Have you considered the possibility that 'theory' is the scary word, and not necessarily the word 'feminist'? Not only is theory itself scary, the notion of a range of conflicting theories as found in sociology is doubly frightening. You must admit we haven't made it easy for outsiders to understand, for example take the "proliferation in the number of available standpoints... black feminism, lesbian feminism, material feminism and queer positions and the clear implication that labelling is not mutually exclusive" (Maynard 2001: 101). Do I need to add that "white women have at times felt that discrimination on gender lines must be the primary battle and that this should not be diluted by preoccupations with racism" (Neustatter 1990: 38)?

Sociology is supposed to ask the 'obvious' questions, the kind of questions that can make people uncomfortable; that process can be painful for the medical sociologist. S/he often has the added disadvantage of being the only sociologist in a medical department. That makes the battling as you describe it, all the more difficult.

My advice to you is twofold:

1. Most of us tend to rate our on-going performances at work, and that of our colleagues as 'good', 'okay', 'bad' or 'rubbish'. Instead, try banning judgements for a fortnight. (I've copied these last two sentences directly from my wife's magazine, so I'm not sure what happens next).
2. Learn to live with it. You know you're right, so you have the moral high ground. Some medics and health service researchers will come to see the world from your perspective one-day, but not all of them.

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## BOOK REVIEWS

A number of books are available for review and readers are encouraged to write a critique, in return for keeping the book

**Gilbert N. (2002) *Researching social life*. Second Edition. London: Sage [ISBN 0761972455 Pbk £16.99]**

This book aims to guide the reader through the different stages of social research and, to this end, is organised around the idea of the research process. However, it is immediately made clear that real life research projects rarely follow this linear progression through clear stages; instead social research can be a lot messier!

The book is organised into clear sections that each deal with a particular stage of the research process and the chapters contained within each section are more specific still. The book starts off with three chapters discussing the place and purpose of social research. Chapter one deals with the relationship between theory and research, chapter two with the conceptual tools used to link theory and data, and chapter three focuses on the relationship between social research and social policy.

The first part of the book, aptly called *Beginnings*, deals with issues around the ethics of social research (chapter 4) and the designing of samples (chapter 5). Both chapters provide good summaries of the issues to be considered in each case, covering a wide range of material and guiding the interested reader to further relevant material.

The next part, *Into the Field*, is considerably larger, the focus of the text is, after all, concerned with the conduct of social research. The topics covered in these eight chapters (six to thirteen) include the use of various different research tools, for example the questionnaire, the qualitative interview, focus groups and documents. These are complemented by the inclusion of two exemplars that illustrate how real research has worked out in practice. The first of these considers research into the environmental concerns of disadvantaged groups and the second compares the process of social research with police investigation. These case studies highlight how the clear, neat stages of social research can, in practice, begin to overlap and how pragmatic considerations around time and money can be as influential in shaping the research as the most well thought out methodological considerations.

Part three, *Back Home*, deals with the management and analysis of large amounts of data, both quantitative and qualitative. The first of the chapters in this section discusses the coding and managing of both quantitative and qualitative data. The use of computer packages to assist with this stage of the research is introduced and this is followed up in more detail in subsequent chapters (chapters fifteen and sixteen for quantitative, chapter eighteen for qualitative). A third exemplar chapter is included here (chapter seventeen) and discusses the secondary analysis of large government data sets to examine the effect of the government introducing more pension options for women. The chapter explores the strengths and weaknesses of this approach and follows the analysis through its various stages. The final two chapters in this section deal with the analysis of qualitative data more specifically. Chapter nineteen uses a discourse analytic approach as one example of how to analyse interview data, while chapter twenty explores some of the ideas and methods for analysing visual materials. This chapter is a welcome addition, together with the increased focus on computer analysis of qualitative data, to the second edition of this work.

The final part of the book, *Endings*, concerns itself with the process of writing about social research, as Gilbert argues that social research is only completed when its results have been published. The reader is taken through the process of dissemination and guided through the shape of a journal article in a fairly instructive manner before Gilbert then suggesting which of these rules can be broken!

In summary then, this book achieves its aim of guiding the reader through the research process clearly, but without creating the impression that all research will, or indeed should, follow this linear progression. The use of exemplars throughout the text serves to highlight the problems that have been encountered in real research and should reassure the beginner that they're not alone in encountering difficulties along the way. The inclusion of projects at the end of most chapters also serves to bring the research process to life and could provide valuable first hand knowledge and experiences to the reader.

**Natalie Armstrong, University of Nottingham**

**Higginbotham N, Briceño-León R, Johnson N (eds) (2001) *Applying Health Social Science: Best Practice in the Developing World*. London: Zed Books [ISBN 1 84277 051 9 Pbk £15.95]**

This book presents ten case studies, all aimed at addressing the question of how social science approaches can make a difference in improving human health, particularly in developing countries. The case studies are organised according to region, Asia-Pacific, Africa and Latin America. A diverse range of health related problems are covered, including schizophrenia, rational use of drugs, HIV/AIDS and smoking cessation. Each case study constitutes one chapter and the editors provide introductory and concluding chapters. Preceding each regional section is a description of the history and role of social science in each region in particular relation to medicine. The book has been compiled as a result of the International Forum for Social Sciences and Health (IFSSH). A background to the forum and comprising regional networks is given in the introductory chapter. The concluding chapter discusses the future for health social science research including cyber medicine and the avenues this opens up to social science researchers. I would suggest that the sum up of studies, also given in this chapter, is more useful than the chapter outline given at the start.

The themes running through the case studies are similar so could probably be selected according to the reader's health or regional interests. The importance of ownership is highlighted in many contexts; the central argument being that interventions need to be both *culturally appropriate* and *culturally compelling* if health related behaviours are going to change. The case studies consistently show the importance of looking at culture to understand health beliefs and the inclusion rather than exclusion of traditional medicine alongside biomedicine. An example of this is shown in a community approach to smoking cessation in a Fijian village where smoking levels had been rapidly increasing. The health team had a long established relationship with this particular village and sought to reduce smoking in the community by moving away from 'crisis-based' approaches to approaches with a longer-term impact. Initial efforts to educate villagers about the associated health risks were unsuccessful. However, the village determined its own policy and announced that the entire village would stop smoking and they would use the money saved to build the community centre, which was seen as a priority. Cessation rates were very high and relapse rates low. Interestingly the initiative was initiated by the youths within the village. This was the group that the authors felt had been most alienated during the initial anti-smoking methods.

One of the most appealing aspects of this book is that it tries to bridge the gap between knowledge and action and highlights the difficulties in doing so. The studies are chosen as examples of best practice. However, most explain in some detail the difficulties that were faced in carrying out the research. Chapter 3 in particular gives a good discussion on the conflict of taking a 'consumer-orientated' approach in developing interventions and the preconceived notions about what the community needed. The authors talk openly of the tensions between maintaining control over the intervention and empowering the community. It is a relief to read about the real problems researchers faced and the difficulties of achieving the often-mentioned ideals of participation, empowerment and action research. You feel that you are getting to read details in these case studies that would otherwise be left out if being published as a journal article.

The studies make use of a broad range of traditional and innovative social science methods such as a study into HIV/AIDS which uses the Genogram. This method is often used in clinical settings but in this community-based study it highlighted the way in which HIV/AIDS impacts on the individual, extended family and wider community. Such information did not come out from the individual written case studies used. In addition, all of the studies incorporate multiple methods, highlighting the benefits of triangulation. Hence, the other key theme that runs through the book is transdisciplinary research; the focus of the book is social science but it is clear that the studies are multidisciplinary.

Overall, the book would be very relevant for anyone involved in social science, development or health research in developing countries. Some of the chapters are less readable than others but all are worth persevering with. The process of writing this review has highlighted how dense the content of this book is and the broad range of professionals or students to whom it may appeal.

**Emma Pitchforth, University of Aberdeen**

**Bowling A. (2002) *Research Methods in Health: Investigating Health and Health Services* Buckingham: Open University Press (ISBN 0335206433 £24.99)**

This is the second edition of Ann Bowling's textbook on methods and methodologies which are applicable to researching health. As stated in the preface, the second edition is similar to the first, except for the inclusion of more updated references, and has been expanded to include more recent methodological developments. For those who have not acquainted themselves with this book in either edition, it is well worth checking it out. It not only provides a substantial introduction to research for students but could also be accessed as source material for courses pertaining to health research. Furthermore, all researchers, whether novice or experienced, should have a general guide to health research on the book shelf and if you have not yet acquired one, then do include this textbook on your shopping list.

*Research Methods in Health* is a very comprehensive overview of the range of research methods that can be used to investigate health and health services. Bowling's aim is to "guide the reader into choosing an appropriate method for addressing different research questions" (pg 1). This she certainly does. Not only does she include a glossary of essential terms at the back of the book, she also explains the research method from conceptualisation and theory through to operationalisation. Along the way, she stresses the key points, provides questions to test the readers' knowledge, summarises and suggests references for further reading.

The book is divided into five main sections. The first part, unsurprisingly, provides the introduction to the evaluation of health services, the different approaches that can be utilised in health research, epidemiology and health economics. From there, Bowling directs the reader through the principles of research (literature searching, research design) to two sections on quantitative research techniques. Section 3 explains the notions of sample size, sampling and statistical significance as well as describing two groups of quantitative studies – surveys and experiments (including randomised controlled trials). Section 4 builds on this with descriptions of data collection, questionnaire design, survey interviewing and coding. The final section deals primarily with qualitative methods of observational studies, unstructured interviews and focus groups, although there is an attachment of Chapter 17, which strings together "other methods using both qualitative and quantitative approaches", such as case studies, consensus methods, action research and document research.

Bowling's strength lies in her ability to provide an encompassing account of health research in a clear, concise manner. Not only would this help the newcomer to health to engage in choosing and implementing research methods but it would also provide him or her with some general background to the overall discipline of health research. This information can help the researcher to place his or her research within the different bodies of work that cohesively form 'health research'. Furthermore, Bowling has much to offer the more experienced researcher. As individuals advance with their work specialising in different methodologies and areas, it is easy to forget the basics of research and there is often the need to be refreshed about the techniques used by others in the same field. Bowling, in this regard, serves adequately as a reference book, which can be quickly flicked through in order to find a short, concise definition of the question at hand.

It is hard to fault this book when it is openly a textbook and it does serve its function well. Overall, I can recommend possession of this book for use in teaching and general information purposes.

**Catherine Heffernan, University of Oxford**

**Shaw M, Dorling D, & Mitchell, R (2002) *Health, Place and Society*. Pearson Education Limited: Harlow [ISBN 0130164550 Pbk £25.99]**

This book is designed as a textbook for undergraduate students in the social and health sciences who are interested in contemporary medical geography and medical sociology. It acts as an introduction to how and why health varies across people and place. The book aims to cover the different perspectives of medical geography and sociology, the different methods of gathering information and the different ways in which the data can be utilised. According to the preface, it comprises of three approaches – (1) a historical perspective on health, place and society with new ways of mapping and measuring them; (2) an illustration of the social and spatial patterning of health and a description of health inequalities and the role of spatial mobility in shaping the pattern; (3) an historical account of medical mapping from the mid 19<sup>th</sup> to the 21<sup>st</sup> century. Furthermore, the book is claimed as being “no dull textbook”, adding that it draws on a variety of sources including novels and films as well as the more traditional recommended reading lists.

Shaw, Dorling and Mitchell have certainly devised an introductory textbook to the disciplines of medical geography and sociology. The first half of the book describes the basic concepts and methods involved in the disciplines, whilst the second section consists of research examples and topics. Chapter 2 is effectively an introduction to medical sociology, looking at the rise in scientific medicine and the history of medicine in Europe. Chapter 3 provides a few of the basics of mapping in medical geography, alongside some of the more social scientific methods, such as surveys. The following chapter combines medical sociological and geographical viewpoints in looking at the 'global picture' of health, comparing countries. This then forms the backdrop to the ensuing chapters on health inequalities and social/spatial mobility before ending with Chapter 7 and its illustrations of research examples, including the detection of the factors involved in the spread of cholera in the 19<sup>th</sup> century in Britain.

The book was easy to read and informative for those new to health. However, it should be pointed out to those considering the purchase of textbooks on both fields that this is not a cohesive view of the approaches and methodologies of medical sociology and medical geography. At 221 pages (including index), the book could be more accurately described as an introductory discussion of the common ground between the two disciplines. In other words, it deals primarily with epidemiology, mapping of health and illness and the identification of inequalities in context and composition. Nevertheless, it adequately provides the basics, particularly in relation to health inequalities. The combination of the two fields is also commendable, especially given that these fields are sometimes at odds or may overlook each other's approaches. The authors had previously collaborated on spatial and social inequalities in health and when reading the book, one is filled with a sense of rapport that infuses the writing and makes it easy to visualise the possibility of the combination of approaches and methodologies in research on diseases and explaining health inequalities. Whilst I found the use of boxes containing definitions of terms both a practical and aesthetically pleasing tool, nevertheless, I do feel that some of the larger text boxes detracted from the flow of the text, especially in the later chapters.

Overall, I found this a light read yet an informative introduction to the mapping of disease and the explanation of health inequalities. The language is easy to understand and thus makes a very good starting point for newcomers to the field of health research.

**Catherine Heffernan, University of Oxford**

**Moreno JD (2001) *Undue risk: secret state experiments on humans*. London: Routledge, 2001 [ISBN 0415928354, £11.95]**

It can always be intimidating to review a book which has previously been well received; witness the praise on the back cover. Although entitled 'risk' there is nothing which gives intellectual vibrancy to the category. The text is written in the style of 'cinema verite': Facts, the product of many hours rummaging through declassified documents and getting key figures 'in the know' about secret experiments on humans to talk. Data, most of it interesting, is presented in the Jack Tesco style: 'pile them high and sell them cheap'. The underpinning ethical issues can best be described as 'descriptive ethics': with very useful exemplars with which to enliven lectures given to blurry-eyed students straight from 'nickel and dime' jobs (see B. Ehrenreich (2002) *Nickel and Dime. Undercover in Low Wage USA*. Granta Books). For example, prison research (including testicular radiation research) in the USA was confined to white men, being regarded as a 'privilege'. Denied minorities lobbied successfully under the civil rights movement to be included! By 1974 75% of all USA approved drugs had gone through prison research; many drug companies built experimental facilities next to prisons.

The message coming over in Moreno is the same one found in President Eisenhower's farewell speech to congress (lifted from C. Wright Mills): 'beware of the economic-military complex'.

For me the book's core is the account, often taken verbatim, of the Nuremberg Trial. Over 350 German doctors involved in camp experimentations could have been indicted. However, 'practical considerations' intervened: the defendant's dock was built to hold a maximum of 24 chairs! Should collective guilt be used? No - many doctors were 'spirited' away by the USA military to work for them under a project called 'paper clip': because their military usefulness was pinned to their so called denazification documents. The allies' prosecutor nearly lost the medical ethic charges. The defence lawyer, Servatius, spent a long time quoting from Life Magazine (June 1945) which had a spread on the use of 800 prisoners in a malaria experiment sponsored by the Committee on Medical Research. Shortly before the trial, a British researcher for the Medical Research Council, Professor McCance, asked the British occupational forces to notify him of all children with a meningomyelocele (spina bifida) so he could do experiments which he did not feel justified on doing on healthy children!

The ethical issue hinged on free/informed consent on the part of subjects taking part in medical experiments. Servatius quoted from USA documents showing that financial inducements were only given after the experiment was completed. The Nuremberg debate was won by the key prosecution expert witness, Ivy, lying about the USA experimental programmes. Ivy also wrote a new medical ethical (Nuremberg) code during the trial, as legitimisation of the Allies' position. The American Medical Association ratified the code.

The Nuremberg code later became an ethical dilemma for the USA human experiments on testing 'ABC' (atomic, biological and chemical) weapons. The 1950s debates used a system of rewards for volunteers and a 'promise' of government liability if things went wrong. The latter aspect of government recognition is still being fought over in the courts regarding Gulf veterans etc. It's worth noting that Clinton, April 2000, announced a unique compensation plan, removing the burden of proof from workers. This affected many nuclear workers e.g. the Kentucky uranium miners. Clinton also received in the White House black survivors of the (forgotten) Tuskegee syphilis study. However, the military still regarded health risks as part of a combatant's duty. The issue is one of what is a 'safe procedure'. The vaccine the Pentagon used in the Gulf War was approved by the FDA. However, the vaccine has to be given 5 times over 18 months, with an annual booster; but the inhalational anthrax has only been tested on monkeys!

The book makes slight reference to the Russian biological experimentations and the notorious Japanese camp, Unit 731 from 1939-42 under Ishii. The latter dumped plague, typhoid etc over the Chinese countryside. Some of the prisoners in 731 were Russian Jews; their holocaust story has not been told. The Americans never put Ishii and his doctors through a Nuremberg trial, fearing that their own new, human experiments would be revealed in another courtroom debate on ethics.

While the West is awaiting an Al Qaeda biological attack it is worth noting that the USA military secretly sprayed many cities. Between 1949-69 more than 200 'open air tests' took place. San Francisco experienced serratin spraying, bacillus globigii was been dropped on Florida, Washington Airport and Minnesota etc. The New York subways had similar 'self attacks', to learn about dispersal patterns.

Some of the stories in Moreno are well known, e.g. CIA experiments on LSD, but there is plenty which is new. We owe a debt to Moreno for telling us so succinctly what our good guys, as leaders, are doing in our name. Perhaps, in contexts like this, we don't need theory anyway.

**Joel Richman, Manchester Metropolitan University**

**Webster C (Ed) (2001) *Caring for health: history and diversity*. 3rd Edition Buckingham: Open University Press [ISBN 0335208401 Pbk £17.99]**

This book forms part of the OU level 2 course Health & Disease. As such it is written primarily for that specific undergraduate market in mind. However, let that not deter others from engaging with the text. As usual with this sort of work, it is well written, scholarly and well-worth the effort involved in updating it to the new edition. People familiar with the earlier editions will find the new one a significant improvement in presentation.

The book covers the history of health and health care in the UK, as well as devoting chapters to exploring the trends in the developing world and international patterns of health care organization today. For anyone wishing to explore these issues and social developments around the developments in health care in great depth, this is unlikely to suffice. This is not meant to be an analytical exploration, but as an introduction to the major themes in the social context of health care then this is an ideal vehicle for this.

The chapters are devoted to particular time frames in the development of health care, policy and services, ranging from the earlier pre-industrial health care from 1500-1750 right through to the current trend in the UK from 1974-2001. With the pace of change within health and social policy, the current situation is likely to change rapidly, so updating the text here might need to be done more frequently in the future.

As with most OU texts of this kind, it is written in a colloquial style with the learner in mind with frequent study questions to help guide the student in learning. Each chapter is summarised with its objectives and a series of questions related to the content. It is a tried and trusted way of helping students get to grips with what can initially be seen as daunting issues. The downside, I think, is that in doing this, it fails to get the student to think

more laterally when addressing issues which, in the social and health arena, can be just as useful. The range of source material is commendable and, interspersed with plenty of visual material, this is a book which can be easily read, browsed and digested.

The negative aspects for me refer rather more to the limited scope of the material used and the discussions presented, although one has to be aware of its target audience. The degree of exposure to critical exploration and analysis is weak, but here this could be developed through using the material presented as a starting point for such a process.

It might also be that the successful method of presenting the material in the way they do is getting a little tired and dated. A more creative use of different ways on constructing the learning process could be considered in future.

This book is not sociology of health, nor is it social policy or health policy. It is more a combination of the various strands of history, sociology, social policy, health policy and cross-cultural comparisons in a way which is accessible for the general reader and anyone wanting a way in to the complexities of current health policy and health concerns. And it does this excellently. In terms of analyzing various strands of the subject material, it does attempt to get to grips with it. It provides a very good analysis, for example, of the drive towards the 'individualization of responsibility' in health promotion and education campaigns seen over the last 25 years or so. But for anyone wanting depth of analysis as a whole, it might disappoint. It is a broad-based exploration and discussion with little room for the intricacies of social scientific analysis. But it is an excellent exploration and discussion at that.

**Mike Wrigley, Faculty of Health & Social Care, University of the West of England**

**Grinyer A (2002) *Cancer in young adults. Through parent's eyes*. Open University Press. [ISBN 0335- 21230-1 Pbk £19.99]**

Cancer in adolescence has been largely uncharted territory from a sociological perspective. Unfortunately, this is also the case in terms of health service research. Adolescents and young adults with cancer tend to receive their treatment on paediatric or adult wards, neither of which is wholly appropriate. This is one reason why a book like this is so welcome. It is one of the first to explore the impact of cancer in this age group in any depth and has much to say about the reality of cancer in young people.

Anne Grinyer invited the parents of 23 young people to describe their experiences. The outcome is a series of personal accounts that pepper the book. The stories are both powerful and humbling in equal measures. As one of the mothers says: 'Is there a less heartbreaking time for a child to die? I doubt it. I ached for her loss. I ached for myself...' The personal consequences of such an experience link each of the accounts.

The impact on the family unit centres on the turmoil that cancer brings. In ten chapters this is unpacked in a series of themes. Beginning with the impact on family dynamics, independence and the importance of 'normality' to young people are then explored. The middle sections explore sexuality, medical decision-making and the impact of cancer on siblings. The later chapters examine the practicalities of cancer on parent's marital relationships, finances and styles of emotional coping. Finally, the process and rationale for the book are described.

The strength of this book are the memorable accounts of how young people cling to life-stage norms whilst eventually being forced to return to their parents or hospice professionals to be cared for during their decline. Independence, and the desire to remain part of a peer group, are recurring themes that raise important issues for service providers and researchers alike. A number of other issues arise in the context of the participants' experiences. These include gender (the desire of Luke to hug his son who is undergoing treatment for testicular cancer), the symbolism attached to food and feeding (watching the body fade away between courses of chemotherapy), the impact on siblings and the financial costs of cancer in the family (standing in the hospital garden at night and praying for someone to help). The chapter on emotional care thoughtfully examines the inevitable way that loss is gradually incorporated into people's lives.

It is difficult not to admire this book. It eloquently captures the wisdom that people with serious illness, and their families, seem to display. It also offers a useful point of reference for anyone contemplating research on a sensitive topic like cancer. The only limitations were the brief mentions of cancer policy and related service developments for young people. This, however, is a minor point and I hope the book will find its way into the hands of those managing and planning cancer services. It would be a tragedy if it stays on the shelves of medical sociologists.

**Danny Kelly, City University**

**Higgs J, Titchen A (Eds) (2001) *Professional practice in health: education and the creative arts*. Oxford: Blackwell Science [ISBN 0632059338 £29.50]**

This volume is a collection of chapters that present a rationale for a new model of professional artistry and creativity in practice and a new model for creative and critical 'becoming' i.e. becoming a professional. The model of practice includes the perceived and interpreted needs of the client, the practical and technical competence of the practitioner and the professional artistry of the practitioner. Professional artistry is defined as a combination of practitioner qualities, practice skills, creative imagination processes and practice wisdom. The model for creative and critical 'becoming' seems more complex but is presented in only two (of the 22) chapters. The model is presented in the form of concentric circles at the heart of which is a void that represents the idea that being comfortable with, dealing with, having courage in the face of uncertainty lies at the heart of professional practice. The concentric circles illustrate the idea that professional development is continuous and never ending. Professional practice development involves all the four dimensions of practice: knowing, being, becoming and doing. In the model practice is informed by four theoretical perspectives: humanism, spirituality, phenomenology, and critical social science. An additional component of the model is the 'four fold way' which seems to both a process for and product of development. Briefly this involves developing the ability to adopt certain archetypal characteristics in response to particular situations.

If this sounds confusing, fortunately most of the chapters make this a lot clearer, despite rather than because of the numerous metaphors and diagrams used throughout. Although this is an edited volume the majority

of the authors worked on several chapters and there is a coherent theme and approach throughout the text. The book is divided into four parts. The chapters in parts one and two are largely descriptive/ prescriptive. One exception to this is chapter seven that provides a very accessible account of the Foucauldian concepts of discourse, social practices and power illustrated in the health/education domain. Parts three and four contain most of the best work in the book with some very clear high quality writing presenting some very interesting and thought-provoking ideas particularly for anybody involved in the teaching of health professionals. Some interesting chapters use reflective accounts of the author's own career development accompanied by a commentary to illustrate particular ways of thinking about and doing practice. The second half of the book is recommended to anyone who is trying to 'teach' health professionals anything. At the very least it should provoke you to reflect on what you are trying to achieve. It should also be compulsory reading for NHS clinical managers involved in the 'commissioning' of 'Education'. It would make challenging reading for those in the process of 'becoming' professionals although the ideas contained within it would need some careful elucidation in a undergraduate/ pre-registration context.

The starting point for the approach advocated in this text is that the conceptualisation of professional practice, and thus educational preparation for it, are dominated by a concern with the practical and technical competence of the practitioner. The authors diagnose that this is due to the dominance of 'scientific' discourse, which means that other forms of discourse such as 'craft knowledge', 'professional artistry' or 'tacit knowledge' are marginalised. The authors appear to propose their models as an alternative to this technical rational model. The question here is alternative to what? The only detailed discussion of anything that might be called a dominant 'model' of practice is a critique of Evidence Based Medicine (EBM). This critique claims that EBP undermines and devalues the art of medicine and claims that it seeks to do so by reducing the uncertainty involved in clinical practice. This is a misinterpretation of EBM. Using the vocabulary of the authors, EBM seeks to make public some of the dimensions or parameters of the 'void of uncertainty' for each particular clinical situation. Presumably developing and communicating a greater understanding of this 'uncertainty' could be thought of as showing a great deal of 'care' for your patients (i.e. by giving them medicines that are more likely to help rather than harm them). It seems to me that the authors of have made an incorrect diagnosis. 'Science' or propositional knowledge in itself has no power to dominate discourse. Rather the actors in social

structures appropriate and use different discourses including a 'scientific' discourse to legitimate actions that constrain the way in which professionals practice. It is difficult to develop anything other than a superficial relationship with a client in today's, target obsessed, under resourced public services. In this context professional education has become dominated by a managerialist vocational discourse that emphasises narrow conceptions of vocationalism, competence and transferable skills.

To a certain extent this links to a second weakness of the ideas proposed by the authors. In making analogies with the performing arts the authors seem to assume that professional healthcare practice is analogous to musical composition. Indeed one chapter makes the comparison explicitly. There are several ways in which this analogy seems weak. For every 'completed' composition there will be a waste bin full of scrap, for every 'Aida', there are a whole lot more 'Agadoo's', and a life time's work for a major composer may well amount to a few hundred pieces. A more appropriate musical practice analogy may be with the professional orchestra. Here the professional is part of a team, which has to perform to a high standard together everyday, and to do so for a lifetime. Professionals in the orchestra are highly technically accomplished musicians, yet it is together that their performance makes 'art'.

**Mark Newman**

**School of Health & Social Sciences and  
School of Lifelong Learning & Education  
Middlesex University**

**Williams C (2002) *Mothers, young people and chronic illness* Aldershot: Ashgate [ISBN 0754617890 HBk £37.50]**

I was already familiar with Clare Williams' work on young peoples lived experiences of asthma and diabetes, and so I was keen to read this monograph which is based on research carried out for her PhD. The central thesis is clear: the ways in which the two conditions are experienced and managed is highly gendered - both for parents and the young people themselves. The gendered nature of the health work is manifest in a number of ways. First, it is mothers who actually do most of the caring and this is recognised by the young people themselves. Forty in-depth interviews were carried out with young people who were in turn asked to nominate a parent who was most involved in helping them manage their condition - only one

nominated their father. Second, daughters and sons were managed differently, and were perceived by their parents to have different needs. Girls are seen as sensible, responsible and careful - boys are not. This can have very real consequences. For example, if girls do not adhere to their treatment regimens they are more likely to feel guilty about it than boys. Boys on the other hand are more likely to be amused by suggestions of their non-adherence and they appear to take them less seriously. At least that is their persona. Issues of autonomy and responsibility associated with disease management are negotiated between mothers and young people and these processes of negotiation are different for boys and girls. Whilst boys were less likely to adhere to their management routines, mothers were more likely to be accused of mollycoddling them. In other words prevailing cultural norms and expectations pervade relationships between parents and their children, but the ways in which they are played out can be intense and more precarious when the latter have to live with chronic illness.

Williams develops the concept 'alert assistant' - used in passing by Kathy Charmaz elsewhere. The term, 'implies that the needs of the person being assisted are identified, or preferably anticipated and subsequently met by the assistant'. Part and parcel of parenting perhaps! But again the concept has a particular resonance with the health care work described here. In particular the alter assistant - usually the mother carries out considerable emotional work. But again this is highly gendered. For example, mothers were far less likely to act as mediators for their daughter in either private or public spheres than they were for their sons.

Whilst the bulk of the caring work is carried out by mothers (in only 4 out of the 40 interviews did both parents play an equal role), Williams also touches on the varying involvement of fathers. In the one case where the father did the majority of the caring - this was because his work kept him at home during the day - the care work seemed to follow a similar pattern to the other mothers. Thus the gendered nature of the care work was bound up with norms associated with paid employment and 'family life'.

A further dimension of the gendered nature of illness experience pertains to the personal and social identities of the young people. For girls, their illness was more likely to be incorporated into their social identity than boys. Boys were more likely to 'pass' as 'normal' and keep quiet about their condition. This has very concrete consequences in that they would ensure that they did not have to administer any treatments in the presence

of their friends. Interestingly the minority of boys who could not 'pass' (in that they had not been able to control their diabetic symptoms and so their condition had become 'public') were not recruited for interview via the formal health care setting like the majority of study participants. Instead, their mothers had responded to an advert in the BDA magazine - *Balance*. Williams reveals that for these young men their identities seemed to be 'disparaged' or 'denigrated'.

These points are simply illustrate examples of some of the findings. I was struck by the ways in which the main findings seemed to span the two conditions - I was left wondering about possible differences between the two conditions. But could it be that the gendered responses to chronic illness are more powerful in shaping responses to the condition than the diseases themselves? The book is a great read and I find myself citing it - both when teaching and researching, and when talking with health practitioners. It is a shame it is only in hardback because I think it deserves a wide readership. It will be of interest not only to people working on areas of health and illness but also gender and youth studies - a title which made reference to gender and identities may have helped it gain more attention.

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***"Don't get hung up on the way I look. Don't judge a book by its cover.."***

***Rocky Horror Show***

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## Questions and Answers

Many of you may have noticed how the so-called 'quality' papers such as the Times and Guardian, like to publish examples of readers' perplexing questions to which illuminating answers are duly supplied. Research has revealed the need for such a service among the medical sociology community whose deepest and darkest questions have, until this moment, gone answered. In keeping with our desire to provide a service to our readers, we have instituted this question and answer section. To start us off we have two fascinating questions and would welcome your answers in good time for the next edition of *MSN*.

They are:

- ***What is 'social medicine' and what is its relationship to public health epidemiology and medical sociology?***
- ***Where does the term 'postmodernist' come from (and what use is it anyway? - ed)?***



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