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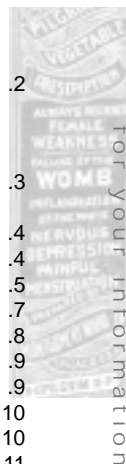
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Editorial

First, many apologies for the errors that crept into the last issue - most significantly an entirely fictitious deadline for the annual BSA Medical Sociology conference abstracts, which caused undue panic across the nation. Hopefully everyone intending to managed to get an abstract in on time. We remind you that the deadline for registration for the conference is 31st July 2000. Also, in the section on PhD abstracts we listed Elaine Denny's current institution, but not the awarding institution, which was Nottingham University.

The editors receive many requests for reprints of papers that have appeared over the years in Medical Sociology News. The most frequently requested is probably Mildred Blaxter's article reporting on a workshop on criteria for qualitative methods, first published in volume 22 No.1 1996, and widely cited since publication. As we are reduced to posting out an increasingly tatty photocopy, from the days before Medical Sociology News had an ISSN number, we are pleased to now reprint the original article, with a new introduction by Mildred Blaxter. This introduction discusses the aims of the workshop, and the uses to which the resulting criteria have since been put. Since then, there has been a growth of qualitative papers in medical journals, and the debate about the appropriateness of developing criteria continues. We would be pleased to publish other papers discussing possible criteria for judging qualitative research, or contributions to the debate.

The Criteria for Qualitative Methods article is not the only one which has been widely cited. Medical Sociology News is an excellent forum for work in progress, papers on professional matters or from studies not appropriately publishable in peer review journals but deserving of wider dissemination. As well as sending in your own articles, remember to encourage colleagues and students to consider sending us articles (and of course PhD abstracts).

In this issue, Adrian Savill writes on the implications of electronic and communication technologies for health care, reviewing the growing wealth of health related content on the web, and pointing to the potential impacts on professional-client relationships. Sheila Hillier writes our Classic Paper Review, reappraising Mark Granovetter's 'The strength of weak ties'.

Myfanwy Morgan, in our series on Teaching Issues, discusses the impact of London medical school mergers and the new medical curriculum on teaching sociology within medicine. In some schools, particularly those developing post-graduate entry 'fast track' courses, the new medical curriculum has significantly changed the role of sociology in the teaching of medicine, and to some extent broken down disciplinary divisions. We would welcome any further contributions to the debate about the potential implications for sociology teaching to this series. Congratulations to Caroline Allen and Rosemary Kyle, who recently received their PhDs - Abstracts are published in this issue.

Dear Margery (with a little help from readers) this week tackles a perennial problem - getting acknowledgement and recognition for contributions to the output of others.

Finally, can we draw your attention to two nomination forms mailed with this newsletter - for the Medical Sociology Committee and for Sociology of Health and Illness Editorial Board - and encourage readers to suggest nominations.

The Editorial Team

British Sociological Association

50th Anniversary Conference 2001: A Sociological Odyssey

9 - 12 April 2001 at the Manchester Metropolitan University

Call for Presentations

In a year when the British Sociological Association celebrates its 50th anniversary, this conference takes the opportunity to revisit many of the more engaging and popular themes of recent conferences. We seek to hold a conference, which reflects both the strengths and the diversity of contemporary sociology, in both its British and global manifestations. The streams of the conference, based upon themes from a selection of conferences from the past thirty years, are:

History, Development and Time; Power and Conflict; Sociology as a Discipline; Science, Method and Methodology; Health, the Body and Sexuality; Social Difference: Class, Race and Gender; Europe, Globalisation and the City; State, Education and Law; Open Stream

Each of these themes raises issues of great contemporary concern and yet each equally invokes some of the most thorny and contentious problems of the sociological tradition. We hope that the contributions will reflect this and we welcome papers, both theoretical and empirical, which can make a claim to do so.

Abstracts of no more than 250 words should be sent to the address below by no later than 30 August, 2000. You should include with your abstract: your name, institutional affiliation, full postal address, phone and fax numbers and e-mail address. Please indicate clearly which stream you are submitting your abstract to. There is no formal abstract submission form.

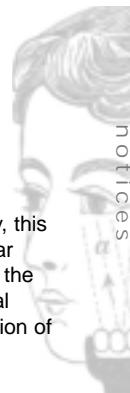
Call for Posters

Potential contributors whose work lends itself well to visual representation may wish to consider, as an alternative to paper presentation, poster presentation. Posters will be briefly introduced by their authors, for approximately five minutes, then displayed in an accessible viewing area for a half-day period. Abstracts for poster presentations should be marked 'poster presentation' but are otherwise identical to paper abstracts and should be submitted in the same way.

There are TWO ways to submit an abstract:

On disk (in word 6 or word 97 format) submitted to:
BSA Conference 2001
British Sociological Association
Units 3F/G, Mountjoy Research Centre,
Stockton Rd, Durham
DH1 3UR (UK)

Or by e-mail submitted to: conference2001@britsoc.org.uk





All abstracts are refereed by the organising committee

2001 Organising Committee

Professor Mike Savage, Dr. Paula Black, Dr. Nick Crossley, Dr. Colette Fagan (University of Manchester)

Professor Sandra Walklate (Manchester Metropolitan University)

Laura Turney - Academic Administrator

Last call for registrations

British Sociological Association, Medical Sociology Group and European Society of Health and Medical Sociology

Health in Transition: European perspectives

September 14-17th 2000

at the

University of York

Registration forms are available from:

British Sociological Association, Unit 3F/G, Mountjoy Research Centre
Stockton Road, Durham DH1 3UR; email: bsa.medsoc@britsoc.org.uk

And from: <http://medsocbsa.swan.ac.uk/>

The conference includes a free creche

Partners in health, partners in crime: Explorations of the relationship between criminology and sociology of health and health care

Call for papers

We invite outline proposals for contributions to the eighth monograph in the series to be published by Sociology of Health & Illness, in conjunction with Blackwell Publishers, in the year 2002. The monograph will explore the borderland between the realm of crime, violence and law enforcement, and the world of medicine and health care. Possible contributions include:

- * The medicalisation of crime in courts and law enforcement
- * Shifting medical conceptualisations of criminal acts, violence and criminal offenders
- * Changes in the criminalisation of contested medical interventions
- * Social patterning of crime and its relationship to addiction, violence, mental health and health care in general

We expect the majority of papers to report original empirical research but innovative theoretical and conceptual work will also be considered. We particularly welcome contributions from international researchers. The monograph will appear both as a regular issue of the journal and in book form.

Potential contributors from North, Central and South America should send an outline proposal of up to 800 words by November 30, 2000 to:

Stefan Timmermans, Sociology Department MS 071, Brandeis University, Waltham, MA 02154-9110, USA; fax (+1) 781-736-2653; e-mail: Timmermans@brandeis.edu.

Authors from Europe and elsewhere should send their outline by the same date to:

Jonathan Gabe, Department of Social and Political Science, Royal Holloway, University of London, Egham, Surrey TW20 0EX; Fax (+44) (0) 1784 434375; email j.gabe@rhnc.ac.uk.

Outlines should take a structured form and for empirical papers should include (a) the major thesis or hypothesis (b) methods (c) data sources (d) a summary of findings and (e) conclusions. We will review all proposals and give notification of the outcome by January 14, 2001. We ask those invited to contribute to the monograph to submit articles of 6000-7000 words by July 1, 2001. All contributions will be refereed in the usual way and should follow the journal's stylistic guidelines. The monograph's planned publication date is September 2002.

New web pages for the BSA Medical Sociology Group

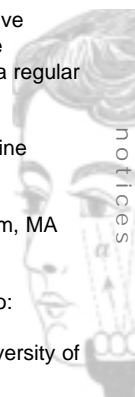
At the group's 1999 AGM it was suggested that the next edition of the Medical Sociology Register should perhaps be based on web pages rather than the traditional paper copy. It was agreed that this suggestion would be considered as part of a wider review of the Medical Sociology Group's website. The web pages for the BSA Medical Sociology Group (<http://medsocbsa.swan.ac.uk/>) have been designed and maintained by David Hughes and require continuous maintenance by David and his colleagues at Swansea. Adding the Register to the existing web pages would be a big task, not to mention the regular up-dating of the register.

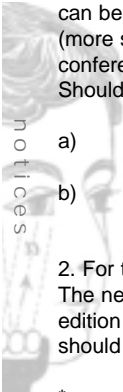
The BSA Medical Sociology Group Committee has considered a range of options presented by Edwin van Teijlingen and David Hughes and will present the following issues for discussion at the 2000 AGM at York.

1. The BSA has commissioned a web design company to design its web pages. The BSA web pages were launched in April 2000 at their annual conference (<http://www.britsoc.org.uk/>). It seems worthwhile to join forces with the BSA and to use the same company to design and write our pages. This raises a number of questions:

- * What are we willing (and able) to pay for this?
- * Who is going to maintain the web pages on a regular basis?

The main strength of web pages, especially for the Medical Sociology Register, is that it





can be kept up-to-date. There are many aspects of the site that require frequent updating (more so even than the Register) such as regional groups, books for review, forthcoming conferences, news, MSN. David Hughes currently updates the site at least once a week. Should we:

- a) Hire some clerical time from the BSA to get one of their staff to work on our pages (for example two days a month, or half a day a week)?
 - b) Decentralise the web pages and have volunteers to keep various parts of the web up-to-date.
2. For the Register in particular, we need to collect all information starting from scratch. The new Data Protection Act would not allow us to use the information from the 8th edition which, in any case is due to be replaced. A web-format raises the question of what should be included on the BSA Medical Sociology Register web pages.

- * The Committee is in favour of a minimal amount of information for each entry, but with a hyperlink to that sociologist's homepage (for example: http://www.abdn.ac.uk/public_health/phstaff/phevt.html), Medical Sociology Courses, Research Projects, etc. We should perhaps allow a little extra space for those sociologists who do not have their own web pages at their university. This would allow postgraduate students, and part-time researchers and teachers an opportunity to inform the rest of the academic community about their interests.
- * How could we ensure that the basic design template was sufficiently flexible to accommodate any new types of information we chose to include on our site?
- * Would we be interested in and/or willing to accept any sponsorship money for these web pages? Perhaps from publishers or like-minded organisations.

3. The final consideration is: How can we design the web pages in such a way that we are least likely to generate easy access for companies who are looking for address lists to send out junk mail?

If you are not able to attend the AGM during the conference in York in September, please let us know of your views.

Edwin R. van Teijlingen
Department of Public Health & Dugald Baird Centre for Research on Women's Health,
University of Aberdeen,
Aberdeen, AB25 2ZD
Email: evt@ph.abdn.ac.uk
David Hughes
School of Health Science, University of Wales,
Singleton Park
Swansea, SA2 8PP
Email: D.Hughes@swansea.ac.uk

The Commonwealth fund Harkness fellowships in health care policy

The Commonwealth Fund of New York is pleased to announce the Harkness Fellowships in Health Care Policy, and to invite applicants for the 2001-2002 fellowship cycle.

The Harkness Fellowships in Health Care Policy provides a unique opportunity for promising health policy researchers and practitioners (e.g., physicians, health services managers and government officials) who are early in their career to spend 4 to 12 months in the United States conducting a policy-oriented research project and working with leading U.S. health policy experts.

Fellows must demonstrate a strong interest in health policy issues and propose a well designed research study that falls within the scope of the Fund's national program areas:

- * improving health care services,
- * bettering the health of minorities,
- * advancing the well-being of elderly people, and
- * developing the capacities of children and young people.

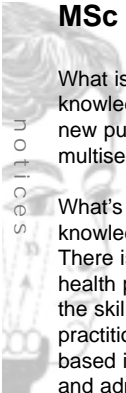
Studies that include comparisons between the United States and the applicant's home country are encouraged. The Fund will provide extensive support to successful fellows to help them develop and shape their research proposals to fit the U.S. context. Through its extensive network of contacts, the Fund will help identify and place fellows with a mentor who is an expert in the policy area to be studied. Fellows also will be required to identify a home country mentor, who will act as a liaison with the U.S. mentor, and supervise any cross-national comparisons that are to be conducted as part of the study.

The deadline for receipt of applications is October 2, 2000. In order to apply, applicants must be a citizen of the United Kingdom, Australia, or New Zealand and submit a formal application. Up to 10 Harkness Fellows in Health Care Policy will be selected annually.

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

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





MSc in Social Intervention for Public Health

What is the aim of the course? This innovative MSc aims to provide a cutting edge knowledge and skills base for both non-medical and medical professionals to address the new public health agendas, to address social inequalities and promote health through multisectoral-based interventions.

What's different about this MSc? This MSc is innovative in offering a multidisciplinary knowledge base in theory and practice of public health and community development. There is also a strong skills-based element to develop students' competences as public health practitioners and advocates within policy and political arenas. The importance of the skills element is reflected in the corps of course lecturers which will include practitioners with experience in developing, managing and implementing community-based interventions and change in public health, and of working within different policy and administrative structures in the UK and internationally. No other course provides the particular this combination of theory and practical, policy-relevant skill. Core study areas
The course will cover the following modules:

Module 1 The social basis of health, health behaviour and health responses

- * Understanding and measuring the health of individuals and populations
- * Concepts and theories drawn from social science, public health and medicine
- * Policy making and the policy process at local, national and international levels
- * Health care and the state - philosophical and ethical debates and the implications for health intervention

Module 2 Social intervention for public health

- * Historical and comparative development of public health
- * The uses of research for understanding and changing the health of populations
- * Management of public health planning
- * Social marketing and communication for public health intervention - theory and principles

* Module 3 Health interventions practice

- * Strategic, corporate and short term planning for health intervention
- * Social marketing and communication strategies
- * Public health advocacy - approaches and techniques
- * Implementing, managing and evaluating change

Where will the course be held? The course is run by the Department of Social Science and Medicine, in the new Centre for Primary Care and Social Medicine, Imperial College School of Medicine.

How to find out more?

Dr Carla Treloar, Course Coordinator, Ph +44 (020) 8846 6554, Fax +44 (020) 8846 6505
c.treloar@ic.ac.uk

<http://www.med.ic.ac.uk/df/dfpc/courseonoffer/MscSocialInterventions.html>

The editorial Board of the journal *Sociology of Health & Illness* announces the appointment of the New Editors from October 2000:

Robert Dingwall, Veronica James, Elizabeth Murphy & Alison Pilnick at the School of Sociology and Social Policy Nottingham University

Please continue to submit papers to the current editorial team until details on the editorial change over are published in the Journal



PhD Opportunities in Bristol

Applications are invited from graduates with good honours or Masters degrees in relevant disciplines for PhD studentships tenable from October 2000. Research areas include: quantitative and qualitative health services research; aetiological, lifecourse, clinical and nutritional epidemiology; effectiveness and acceptability of health services/care; health/illness/disability in older age. Projects in statistics/economics/sociology/psychology applied to medical/clinical issues also encouraged. At least two full-time scholarships are available including one from the MRC. For further details of potential topics and supervisors, and application forms,

Contact: Mrs Julia Mackay/Dr Jenny Donovan, Department of Social Medicine, University of Bristol, Canynge Hall, Whiteladies Road, Bristol BS8 2PR (0117 928 7337).

Email: julia.mackay@bris.ac.uk Web page <http://www.epi.bris.ac.uk>

Closing date for applications 30th April 2000.

Please note that only residents of the EU are eligible for studentships.

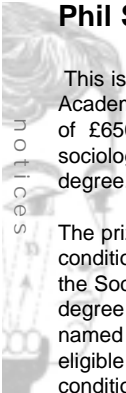
Candidates are encouraged to apply to study a topic of their own choice in an area related to the Department's core interests (see above and <http://www.epi.bris.ac.uk>). You are encouraged to discuss your ideas with potential adviser(s).

For an information pack about research studentships and contact details for advisers, apply to Mrs Julia Mackay, Department of Social Medicine, University of Bristol, Canynge Hall, Whiteladies Road, Bristol BS8 2PR

Tel: 0117 928 7337

julia.mackay@bris.ac.uk.

Deadline for applications: 30th April 2000.



Phil Strong Memorial Prizes for Postgraduates

This is the last call for applications for the Phil Strong Memorial Prizes available for the Academic year 2000-1. It is anticipated that there will be three or four prizes to the value of £650. 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.

The prize money may be used for fieldwork, travel, expenses and/or (subject to conditions) attendance at a specialist course. Applicants must be working in the field of the Sociology of health and Illness/Medical Sociology and be registered for a higher degree at a British University or other recognised British research institution, with a named supervisor(s) who is a member of the BSA. The draw for the prizes from all eligible applicants will be made at the Group's AGM in September. Full details and conditions are available on the Group's website (<http://medsocbsa.swan.ac.uk>) or from the British Sociological Association office.

All applications must be submitted in triplicate and should be sent by post to: David Field, Phil Strong Prizes, Centre for Cancer and Palliative Care Studies, Royal Marsden NHS Trust, Fulham Road, London, SW3 6JJ to arrive no later than July 31 2000. Incomplete applications and applications received after this date will not be considered.

Social Sciences & Medicine Conference

Conference title: Societies & Health in Transition

XVth International Conference on the Social Sciences & Medicine

Dates: 16-20 October 2000

Location: Golden Tulip Conference Hotel Koningshof, Eindhoven The Netherlands

Website: www.elsevier.nl/locate/ssmconf

Organizers: Elsevier Science/Social Science & Medicine

Secretariat: Tracy Collier
Elsevier Science Ltd
The Boulevard
Langford Lane
Kidlington
Oxford OX5 1GB, UK

Tel: +44 (0) 1865 843297
Fax: +44 (0) 1865 843958
E-mail: t.collier@elsevier.co.uk

Conference Topics

Arranged as a series of workshops, each led by a discussion leader, the conference addresses key issues relating to the behavioural and social aspects of health and healthcare. Topics include:

The health impacts of rapid economic change
Social, ethical and health service implications of the new genetics
Social support, social networks and health - What's new?
Evidence-based medicine and treatment guidelines
Equity in health and healthcare
Social capital and health promotion
Patterns of ageing and care of the elderly
Commerciogenic pathology
Nationalism, ethnic cleansing, war and implications for health
Private healthcare
The health sector in peace and reconstruction
Children at risk
Structural and cultural factors in emerging infectious diseases
New patterns of death and dying in developed and developing countries
Gender, identity and health
The role and limitations of the Cairo conference
Adolescent health
Ethics of research: responsibility or exploitation?
The development of international health policies: Accountability intact?
Comparative medical care systems.

Karen Purvis
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Mobile: 07712 106526

TENTH ONE-DAY SYMPOSIUM ON THE SOCIAL ASPECTS OF DEATH, DYING AND BEREAVEMENT

Department of Epidemiology and Public Health

University of Leicester

Thursday 2 November 2000 10.00 am until 5.30 pm

This small informal symposium is designed for sociologists and anyone interested in the field of death, dying and bereavement. As in previous meetings, it is anticipated that new ideas and work in progress will form the core of the day's proceedings, and papers can address any subject relevant to the general area of death, dying and bereavement.



The symposium takes the form of a workshop with presentations of 15-20 minutes followed by time for friendly discussion - the ideal setting for post-graduate students presenting their first paper! As this is the tenth anniversary of the symposium, the day will end with a round table discussion led by key academics in the field, who will reflect on how social research related to death, dying and bereavement has changed over the last decade and where it may go in the future.

Anyone who would like further information should contact:

Catherine Exley
Dept. Epidemiology and Public Health
University of Leicester
22-28 Princess Road West
Leicester LE1 6TP

email: cee5@le.ac.uk
Tel: 0116 252 5420/3156
Fax: 0116 252 3772

Announcement - new MedSoc web site address

The Medical Sociology web site has been moved to a stand-alone site. The URL will be <http://medsocbsa.swan.ac.uk>

I have arranged for a link from the old address. I am having the site set up so that some similar URLs will also work:

<http://www.medsocbsa.swan.ac.uk>
<http://bsamedsoc.swan.ac.uk>
<http://www.bsamedsoc.swan.ac.uk>
<http://medsoc.swan.ac.uk>

Thus people who guess the address will have a better chance of connecting.

David Hughes
The University of York

Department of Health Sciences and Clinical Evaluation Research Scholarships for Postgraduate Study at York



The multi-disciplinary Department of Health Sciences and Clinical Evaluation has been established to develop the role of scientific evidence in health and health care through teaching and research. The graduate programme aims to enhance the research skills with the key disciplines of economics, epidemiology, psychology, social policy and statistics. The Department has 2 full-time and one part-time MRC funded studentships for the MSc degree, and one full-time MPhil/DPhil studentship to award. These studentships will include payment of fees at EU rates and a maintenance award. All degrees involve a large research component, and we would be particularly interested in candidates who expressed interest in developing research covering one of the following topics:

- Patient and clinician decision making
- Uptake and impact issues in health screening and diagnosis
- Methodological aspects of clinical trial designs
- Evaluation, including economic aspects, of interventions for substance use or misuse
- The role of personality in moderating the relationship between stress and illness
- Survival and multilevel analysis of data especially related to diabetes, rheumatology and foetal ultrasound monitoring.

Candidates should have, or expect to achieve, a good honours degree in a relevant discipline or have experience as a health care professional. All candidates are expected to provide an outline research proposal.

For further information about the degrees please visit the website at <http://www.york.ac.uk/depts/hsce/gsp/welcome.htm> email mds6@york.ac.uk or write to:

Denise Shingler, Departmental Secretary,
Department of Health Sciences and Clinical Evaluation,
Donald Irvine Wing, Alcuin College, Heslington, York, YO10 5DD.

Informal enquiries can be made to Professor Christine Godfrey, phone 01904 434507; email cg2@york.ac.uk.

Application forms can be obtained from the Department of Health Sciences or the Graduate office or downloaded from the web at

<http://www.york.ac.uk/admin/gso/gsp/apply/forms.htm>



News from regional and national groups

Liverpool

The Liverpool Group has held two successful meetings this year which were open to everyone working in the broad area of health.

The next two meetings have been arranged to take place in Room B.09 in the Whelan Building University of Liverpool. Any one requiring directions or a parking permit should contact Tracy Quillan on t.quillan@liv.ac.uk, or on (0151) 794 5503.

Gail Mc Gonigal, from Liverpool John Moores University will be giving a talk entitled,

'Where is the power in research? Rethinking research in the community.'

Wednesday 28th June, 2000, 12pm,

Lunch will be provided.

This discussion draws on Gail's long experience of working in clinical occupational therapy in the UK, USA and Canada, and focuses on her recent research into the quality of life experienced by older adults.

In the following meeting Alex Scott-Samuel, Senior Lecturer in Public Health, University of Liverpool, will be giving a talk entitled,

'Surfing with the glitterati: health inequalities, politics and policy under New Labour.'

Thursday 27th July, 2000, at 12pm,

Lunch will be provided.

If you would like to be added to our mailing list, please contact Jude Robinson, on (0151) 794 5621/ 5503, or j.e.robinson@liv.ac.uk.

Scottish Medical Sociology Group

The group met twice over the last nine months and has begun to enervise debates in Scotland on the relationship between research and policy and explore the sometimes problematic areas of commissioning and tendering for health research.

At the October meeting Sally MacIntyre, MRC Social and Public Health Sciences Unit, University of Glasgow and Steve Platt, Research Unit in Health and Behavioural Change, University of Edinburgh, spoke on the topic Inequalities in Health: Research Findings into Practice. Steve opened up the debate by considering the changing world of health policy in Scotland with the new Parliament but identified the many barriers that remain to promoting a more productive relationship between the research and policy communities. Sally spoke about her varied experiences with the work of the Acheson Report. Thus the two presentations provided a theoretical frame and very practical example of the issues facing researchers who wish to impact on the development, implementation and evaluation of health policies.

Kathryn Backett-Milburn, Research Unit in Health and Behavioural Change, University of

Edinburgh and Claudia Martin, Scottish Health Feedback spoke on the processes and ethical issues surrounding the Commissioning of and Tendering for Health Research at the Spring meeting. In a lively debate participants exchanged experiences and made suggestions to improve processes and enhance awareness of roles and responsibilities of commissioner and researcher.

Meetings in 2000/1: The next meeting is provisionally scheduled for February 2001 on the theme of the lifecourse and will be run in conjunction with the BSA Scotland Committee. Speakers and venue have yet to be confirmed. A mailing will be sent out in the Autumn and details posted on the website:

<http://jimmy.qmced.ac.uk/usr/cilaur/dynamic/ScotMedSco.htm/>

Unfortunately, due to a change in job Eric Laurier has ceased to be co-convenor. In the meantime Linda McKie will continue to convene the group and can be contacted by email: L.McKie@gal.ac.uk

Please note that there will be no Autumn meeting as so many members of the group are participating in the joint BSA/ESHMS conference in York in September. I look forward to seeing old friends and welcoming new faces at York.

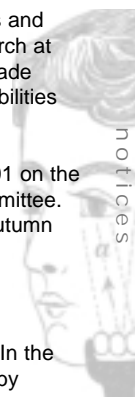
Linda McKie
Glasgow Caledonian University

South West Regional Group

The group has continued to grow in membership. Two meetings have been held over the year - a seminar at University of Bristol when Rona Campbell gave a talk about qualitative data collection in a randomised controlled trial. A second meeting was held at the University of Southampton when Mike Hardey discussed his research on personal accounts of illness on the internet. At the same meeting Caroline Knowles presented a paper on the racial politics of madness. Both meetings had small audiences because of the difficulties of travelling across the region. Proposals to hold a one day event next year are being considered and the group aim to meet at the forthcoming Medical Sociology Conference in York to agree a programme for 2001.

In addition to these two meetings another group has been meeting to discuss 'Researching Interprofessional Work in Health and Social Care'. This group met in September and again in February and speakers included Pat Taylor (UWE), Pat Turton (Bristol Cancer Help Centre), Liz Lloyd (Bristol Univ), David Memel & Carol Langley (UWE).

For further information about the SW group please contact Julie Kent (Convenor) at Julie.Kent@uwe.ac.uk or telephone 0117 9656261 ext 2356.



Wales Group

The Wales group continues to hold regular meetings in Swansea and Cardiff. The next meeting will take place in Cardiff on Friday July 7th, 2000 at 2.30 pm. Our two speakers are:

Claire Williams University of London "Mothers, young people and chronic illness: meanings, management and gendered identities"

Fiona Wood, University of Cardiff: "Lay accounts of help seeking behaviour for mental illness: results from a study using focus group methodology"

Venue: Room 817, School of Nursing and Midwifery Studies, University of Wales College of Medicine, Heath Park, Cardiff.

Enquiries to: Dr Davina Allen, Centre for Nursing Research, School of Nursing Studies, UWCM, Heath Park, Cardiff, CF4 4XN.

Email: AllenDA@CF.AC.UK; telephone: 01222-743837

The Wales group is run by an informal committee comprising Davina Allen, Lesley Griffiths, David Hughes and Sue Philpin. The organisers are interested in improving participation throughout Wales and are willing to consider future meetings in new locations. Interested persons should contact

David Hughes E-Mail D.Hughes@swansea.ac.uk or telephone 01792 295810). The latest news on the current programme is available on the MedSoc website: <http://medsocsbsa.swan.ac.uk>

North East and Midlands Group:

The North East and Midlands Medical Sociology Group held an afternoon seminar at Sheffield Hallam University on April 5th 2000 where papers were delivered by Gerry Larkin on 'Professional Regulation and Professional Formulation'; Ellen Annadale on 'Interprofessional Working: an ethnographic study of emergency care'; and Constance Putnam on 'Bridging the gap between hospice and right to die movements in the US: points of agreement, points of disagreement'. Everyone enjoyed the afternoon and a lively discussion took place.

We hope to hold a similar afternoon, probably at the University of Leicester in November: date to be confirmed. Help with travel costs can be made available for students and speakers.

If you would be interested in joining the group please contact Jane Seymour at the University of Sheffield. Tel 0114 2620174 or email:

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North West (Greater Manchester) Study Group

The North West BSA (Greater Manchester) Medical Sociology Study Group had a second successful year. We had a full programme and most of the presentations were well attended. On average there were 25 participants to each session, coming from all over the North West and beyond.

We would like to say a special thank you to all our speakers whose papers resulted in lively debate and discussion. They were:

Rhett Moran (University of Salford) Refugee Health: Developing health care practice materials. A barrier overcome?

David Jary (Staffordshire University) The Sociology of Audit

David Skidmore and Stuart Connor (Manchester Metropolitan University) The Manchester Debate!

Ursula Sharma (University of Derby) Beauty Therapy: the relationship between the aesthetic and the therapeutic



Judith Green (London School of Hygiene and Tropical Medicine) Evidence based injury reduction; contemporary medical practice and the elision of morality

David Field (Institute of Cancer Research, Royal Marsden Hospital) Ready to Go? Older people attitudes to death

Tony Warne (Manchester Metropolitan University) The Family Practitioner Family

On the 7th June we are holding the 2nd Post Graduate Research Forum. We have 14 papers for presentations and if last years attendance was any thing to go by, should see around 60 people in attendance. We are very pleased and proud of this development. It gives new researchers the opportunity to present work in progress, discuss issues that have arisen and to share others experiences - all in an environment of support and encouragement.

Next years programme is already nearly complete, and again we have a range of high quality speakers from around the UK who have agreed to present papers. If you would like details or would like to go on our mailing list please email A.R.Warne@MMU.ac.uk.

The group is vibrant, healthy and continues to make a useful contribution to all those working or studying in the health and social care environment.

Emma Hayter

Study Group Convener

London Group

Venue: Room 1.16, Franklin Wilkin Building, Kings College London, 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 a discussion (which often continues over drinks and/or supper).

- | | |
|---------------|---|
| 12th July | The Body: key, boundary or redundant concept for medical sociology
Ronnie Frankenberg, Centre for Study of Health, Brunel University |
| 11th October | Rationalism and Evidence Based Surgery
Catherine Pope, Dept of Social Medicine, University of Bristol |
| 8th November | Violence in General Practice
Mary Ann Elston & Jon Gabe, Dept of Social & Political Science,
Royal Holloway, University of London |
| 13th December | Icelandic Genes: the commodification of nature and bio-information
Hilary Rose, Dept of Sociology, City University |

Copies of the programme are available from Mark Newman, m.newman@mdx.ac.uk
tel: 020 8362 6702; Paul Godin, P.M.Godin@city.ac.uk tel: 020 7505 5933; Medsoc
website: <http://nursing.swan.ac.uk/bsa/medsoc.htm>

To receive next year's programme please e-mail Mark Newman, m.newman@mdx.ac.uk.
Joint LMSG Organisers: Paul Godin (Convenor), Rachel Grellier, Anne Jones, Mark Newman, Susan Robinson, Margaret Rogers.



The Journal Social and Preventive Medicine: Call for manuscripts

Public Health is rapidly changing in Europe and globally. Today, we face new challenges in linking population based research with health promotion practice and health policy.

The Journal Social and Preventive Medicine (SPM) is responding: From Spring 2001 on Health Survey Research and Health Promotion will become a new focus of SPM. In doing so, we will provide an international and interdisciplinary platform for publishing high quality manuscripts in these two interrelated areas of Public Health research and practice.

There will also be changes in the formal status and the processing of submissions, such as a new subtitle "International Journal in Public Health", shorter time spans between submission and publishing, etc.

SPM offers the unique possibility to publish original articles in either English, German or French including abstract in all three languages. SPM is indexed in Medline and Current Contents and carries, as one of few European Public Health journals, a small yet lately increasing impact factor.

We would like to invite you and your colleagues to submit high quality manuscripts particularly in the areas of Health Survey Research and Health Promotion, but also in other areas of Public Health.

Prof. Dr. Thomas Abel, PhD
 Prof. Alfredo Morabia, MD, PhD
 Editors-in-Chief

Contact:
 Nicole Graf
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New PhD abstracts

Allen, C.F. (1999) Power, Identity and Eurocentrism in Health Promotion: the Case of Trinidad and Tobago. University of Warwick.

While health promotion is ostensibly concerned with the full range of processes through which people might control and improve their health, this thesis shows that existing approaches and the literature are limited by Eurocentrism, focusing primarily on the health concerns of Western people and obscuring those of others.

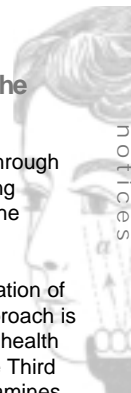
Following literature review, the thesis examines the historical process of the formation of health promotion as a hegemonic discourse within the West. A world-system approach is then used to situate health promotion in a transnational structure, and to analyse health data from Trinidad and Tobago regarding the relevance of health promotion in the Third World. Fieldwork among non-governmental organisations (NGOs) in Trinidad examines interpretations of health promotion, drawing attention to areas of difference from hegemonic discourse and the symbolic identities invoked.

Health problems in Trinidad and Tobago were found to be related to patterns and fluctuations in capital accumulation on a transnational scale, with problems usually associated with “modernisation” coexisting with diseases associated with “poverty”. Health promotion strategies need to take account of how both production and consumption are structured globally.

In their health promotion work, most NGOs blended elements of non-Western understandings, particularly in the area of spirituality, with hegemonic concepts grounded in biomedical science. The postcolonial concept of hybridity is used to analyse responses and resistance to Western discourse. Respondents maintained that spirituality enabled people to transcend racism and to enhance subjective well-being and control over health.

The results highlight that to devise appropriate health promotion strategies means to respect difference, not by adopting a position of cultural relativism but by understanding how transnational relationships of power pervade relationships between cultures and affect health. Strategies should nurture the creative expression of local views, contesting the centralisation of knowledge and material resources for health within the West.

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Middle class men's conceptualisations of food: a sociological investigation

Rosemary Kyle

The thesis is an exploratory study about men's conceptualisations of food and eating. Starting out from the discipline of nutrition, the thesis moves towards a sociological perspective on food and eating. The thesis draws on data generated by holding unstructured audio-tape recorded interviews with a small group of middle class, middle-aged men. The study was carried out to begin to address the scarcity of men's views on household food and eating in the sociological literature.

Three major themes emerged from the interviews. Men talked about food in relation to health, the family, and their contribution to household food work. The main health concern was heart disease, but most men had not changed their diets in accordance with current nutritional recommendations. Using a complex system of explanation, men assessed their own risk of heart disease, and thus whether dietary change is necessary. Talking about food and health brought conceptions of balance and moderation to light, which contrast with the customary use of these terms in nutrition health promotion materials.

Juxtaposing men's views of food and eating in the household, with the opinions of men's behaviour reported by women in previous research, revealed similarities and differences between men's and women's viewpoints. Men's views are considered by reference to the age, life stage and social class of the informants, as well as taking into account the date and region of previous studies. Although in most households, shopping and cooking is undertaken by women, men whose wives had full-time jobs were often responsible for these activities. Most men reported that they did some cooking, but how 'cooking' is defined by men may have implications for deducting their actual contribution household food work.

Men adhered to an ideal of the family meal, but there was little evidence to support the privileging of men's food preferences. The thesis discusses how this study about food and eating gives a preliminary insight into the ways in which men view their role, and hence define their masculinity, in the private domain of the household.

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New E-mail addresses

I am writing to inform you all I have now got my email back
We've been sharing one machine since early March with all our email addresses being diverted to a temporary email address.

We have had a complete new system installed over the past two weeks
and unfortunately it cannot accept some of the email addresses we had previously.

The medsoc email address being one of them. The problem is the full stop between Bsa
and Medsoc. Therefore please note as of now the new address will be

Bsamedsoc@britsoc.org.uk

Any information sent from the office will include this email address so I can inform people
that way.

Any emails sent to the old address will bounce back unavailable so that should prompt
people to contact the office.

Can you please ensure this address is on anything you may send out that would include
the email address. I am copying this email to David Hughes so that he may amend the
website.

In addition

Due to the installation of the new system we have had a large number of days without
any computer access therefore since my return to the office on May 2nd I have been
unable to deal with emails received during the BSA conference and after it.

During the transfer to the new system we have lost all this back log of emails sent to the
BSA since our return from the conference.

If you have sent an email to anyone at the BSA office during the conference or in the past
three weeks and you have not received a reply can you please re send the email.

Nicky Gibson

Classic Paper Review

Sheila Hillier reviews 'The strength of weak ties' by Mark Granovetter

One way to judge the utility of a concept is the extent to which it is taken up and used in fields far from its point of origin. Thus Merton's 'latent' and 'manifest' function is found in political theory, psychotherapy and architecture; Rene Thom's morphological concept of 'catastrophe' occurs in cell biology and meteorology. Rather than tut-tutting at this diffusion, and grumbling about accretions to and alterations of the pure original we should probably welcome it and perhaps recognise that a degree of imprecision in the original allowed this creative latitude.

That would certainly be the final position of the author of my chosen article 'The strength of weak ties'. Mark Granovetter was a student of the Harvard sociologists, Harrison White and Charles Tilly who were themselves greatly influenced by Simmel. After Harvard, Granovetter moved to Berkeley and in 1973 published 'SWT' as it came to be called, in the American Journal of Sociology. A lot of interest was generated because the paper promised a refinement of social network theory. The network approach, exemplified in John Barnes' studies of a Norwegian island community (1954), and Elizabeth Bott's important 'Family and Social Network' (1957) had provided a way of understanding grouping and affiliations outside the bounded categories then in use, of kinship, residence, class and work. It based the definition of 'community' (and by implication kinds of social support, control and identity that occur) using non spatial networks. Network studies in North America inevitably expanded into quantitative research, attempting to identify ranges, sizes, frequency of contacts and their duration. Granovetter's paper seemed to offer a means of maintaining theoretical power and richness, and rather than simple numerical counting, retains only the idea of quantitative equivalence.

The theory begins unpromisingly. 'Our acquaintances (weak ties) are less likely to be socially involved with one another than are our close friends (strong ties). Granovetter presents us with the unprepossessing 'Ego' (likely to generate antipathy in this audience) and places 'Ego' in among a collection of close friends most of whom are in touch with other - a densely knit 'clump' of social structure. On the other hand, few of Ego's acquaintances know one another. But, (and from now on it becomes more interesting) each acquaintance has their own clump of close friends (strong ties), and the weak ties that Ego has with an acquaintance is actually 'a crucial bridge between two densely knit clumps of close friends'.

Granovetter showed empirically that individuals with few weak ties [no matter what the density of their 'strong' ties] would be less likely to obtain information from more distant parts of the social system, and would be disadvantaged in the labour market. He argued that social systems lacking weak ties would be fragmented and incoherent. With great foresight he suggested that subgroups separated by race, ethnicity and geography would have difficulty reaching a modus vivendi without weak ties to link them.

In this paper Granovetter freed sociology from the belief that few strong ties and many weak ones (as found, for example, in large cities) necessarily signalled alienation. The tyranny of the 'social man' proposed by early Marx, with his self-sufficient abilities to hunt, fish and philosophise all in a single day is replaced by individuals who as participants in

the division of labour have relationships of organic solidarity. This in turn generates the weak ties from which new knowledge and information flow.

The 1982 paper in which Granovetter revisited his theory and reviewed work that had been influenced by it showed some modifications. Other sociologists had demonstrated class differences (as measured by occupational groups) in the relative occurrence of strong and weak ties. People in professional groups were more likely to make use of weak ties, whilst those in blue collar groups, called upon their strong ties. This rather begs the question of whether ties are simply a function of class position. The answer from Granovetter was somewhat ambiguous: strong ties are important to the poor, and they are a result of economic pressures. Whilst economic pressures intensify reliance on strong ties for all classes, this will be pervasive for the poor. Strong ties are characterised by elaborate reciprocity and require a lot of maintenance. This further encapsulates and fragments poor people. Without time or energy to invest in weak ties they stay trapped.

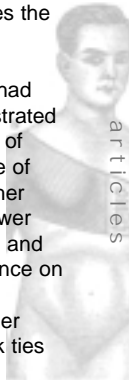
Further research has shown that weak ties can spread culture more rapidly than the Web and that high risk innovations in science are more likely to emerge at the margins of a network. The formation of powerful cliques is cited as a counter argument to the strength of weak ties; but in this case we must study such cliques over time, consider their origin and 'life cycle' and observe, as studies of banking have done, how the most successful banks maintain widespread weak intercorporate ties within which the cliques can flourish. One could attempt to adapt this to the current position of the medical profession with the National Health Service, and speculate upon likely directions in July 2000.

The weak ties thesis could be used in other ways too; we might worry less about the distinctions between 'compositional' and 'contextual' explanations for spatial variations in mortality and health behaviour and look at the quality of all resources generated by the ties people display, either on a community or individual basis. We would consider how the use of weak and strong ties could predict effective health care organisation, especially under circumstances where a diversity of specialities must work together. Counterintuitively we might see how schism, factionalism and divorce which disrupt strong ties at one level build continuity at another, larger level. We could refashion concepts like social exclusion and social capital in a more dynamic way. We could relieve ourselves of the mechanistic hammer and anvil ideas of structure and agency.

That there are flaws in the theory as in all others, I have no doubt. There is one way it might be useful. If, when next going for a job they tell you, 'Here people do their own thing and chat in the corridors', go for it. If they smile and say 'we like to think of ourselves as one big happy family' pick up your bag and run. They won't last long.

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E-health: Will it make doctors or patients better?

Adrian Savill

Healthcare has traditionally been slower and more cautious in adopting information and communication technologies (ICTs) than other spheres of human activity. However, there is a feeling that this inertia is about to be transformed in a momentum which will have far reaching effects on both the practice and type of healthcare available, particularly in the relationship between the health care "professional" and the patient.

The dramatic heading for the recent e-Health Europe 2000 conference [1], held in Maastricht, Netherlands on 9-11 April 2000, reads:

"E-Health Europe addresses 'How the Internet Changes Health Care'. It covers the Internet issues relevant to Health in Europe.

There are early indications that the Internet will change many aspects of health care at an unprecedented pace. The dramatic impact of Cyberhealth requires immediate recognition and responses by health planners, governments, professional associations and caregivers.

Recent surveys show that 'health surfers', including professional clinicians, are the biggest measurable group of Net Users. It is said that 25% of material available on the Internet is health related. Look up 'health' on Yahoo(tm) and you can expect 500 categories and 20,000+ sites.

The doctor you seek advice from or the pharmacist who fulfills your prescription may no longer be round the corner but just a click away on the other side of the world. Does this herald global changes in the way that health care will be practised?"

Therefore the three components involved in using the Internet in healthcare are:

- * Change at unprecedented pace
- * Many users
- * Much material

Change

Much of this change and its pace have been predicted, for example, in the substantial

research programme, MIT 90 [2], which identified information and communication technologies as the transforming influences in society. The fact that mobile technology was not so much in its infancy but more struggling to climb out of the cot, when the bulk of this work was being enacted is a dramatic illustration of some of their prophecies with regard to the changing faces of technologies.

The Government's White Paper on Building the Knowledge Driven Economy [3] acknowledged and identified the four important structural changes transforming many parts of the economy and society, viz:

- * revolutionary changes in ICT
- * more rapid scientific and technological advance
- * competition becoming more global
- * changes in tastes, lifestyle and leisure that go with increased incomes.

The health care sector, through the paper Information for Health [4], was to embrace these changes in a seven year programme. It does seem, however, that this paper underestimated not only alterations in the way services are delivered but the transformation in the type of services being provided.

Cyberhealth is probably a word that needs to be kept for the future with e-health, aka e-commerce, being a better descriptor for the application of ICTs within health care. It is, however, disconcerting that the Webopedia site [5] does not have a definition of 'e-health', despite there being organisations running conferences devoted to this subject.

Refusal to adopt techniques and experiences from other sectors is a peculiarity of health care organisations and professions. However, a brief comparison with the definitions of e-commerce will demonstrate both the feasibility and appropriateness of the term e-health for the huge range and type of services that will be offered using ICTs in all their manifestations.

E-commerce has been defined as [5] conducting business on-line. This includes, for example, buying and selling products with digital cash and via Electronic Data Interchange (EDI).

Digital cash is a system that allows a person to pay for goods or services by transmitting a number from one computer to another. Like the serial numbers on real dollar bills, the digital cash numbers are unique. Each one is issued by a bank and represents a specified sum of real money. One of the key features of digital cash is that, like real cash, it is anonymous and reusable. That is, when a digital cash amount is sent from a buyer to a vendor, there is no way to obtain information about the buyer. This is one of the key differences between digital cash and credit card systems. Another key difference is that a digital cash certificate can be reused. EDI is the transfer of data between different companies using networks, such as the Internet. As more and more companies get connected to the Internet, EDI is becoming increasingly important as an easy mechanism for companies to buy, sell, and trade information.

A definition of e-health as conducting healthcare on-line would seem a useful rubric for describing the use of existing and new ICT products such as handheld computers, cellular phones, digital TV, etcetera within healthcare. Similarly it could encompass the new "tele" services such as telecare, telehealth, telemedicine, telemetry, tele-



dermatology, tele-radiology- telecare, telehealth, telemedicine, tele-psychiatry, tele-dentistry, tele-nursing, telemetry, tele-dermatology, and tele-radiology.

These are increasingly being supplemented by the same type of services prefixed by Web, demonstrating the rise of Internet-based, interactive services - possibly but not exclusively aligned with digital TV.

E-health is also likely to encompass new services made possible by mobile technologies (i.e. m-health) involving such things as satellite-based web access, radio telemetry and global positioning systems. Emergency ambulance services are one area where such developments look set to take off. M-health would therefore be a subset of e-health.

Many Users

These technological changes are being driven by the increasing number of users. A survey from the research group, AC Nielsen, found that one million people went online in the UK during April 2000, and that about 30% of the population now access the internet from home, bringing the total to nearly 18 million UK homes [6]. The survey suggested that 8.2 million of these were active web users. This leaves the UK still trailing some way behind the US - where 50% of the population has home internet access - but the recent emergence of free internet telephone calls and a price war among other ISPs is closing the gap.

This must be set alongside the explosive growth in the use of related technologies that may change the way users interface with the web. In Japan, the mobile phone is set to overtake the computer as the most popular way to access the Internet. New figures from Japan's mobile phone operators show the number of phones with internet access could top 10 million by the end of May 2000, and that about 18% of users have web-compatible phones [7]. A recent mobile e-zine suggested [8] that the Asia-Pacific (excluding Japan) region now has about 100 million mobile phone subscribers, up from 61 million at the beginning of 1999. The volume of users is said to be three times that of the number of PC users. (Using words like mobile e-zine is an example of a possible linguistic circle whereby the delivery of e-zines to mobile phones (using Wireless Application Protocol-WAP) will mean the return of the m(aga)zine!)

Much Material?

So the numbers of potential e-health 'consumers' are growing and the necessary technology exists, but will this translate into new patterns of health care? The amount of health content available digitally generally is huge much on the Internet is huge. [Ref 1] states that 25 % is related to health and searches on "health" will turn up figures of 2,810,733 Web pages (Author using Lycos) . There is an increasing amount of digital material being produced for TV e.g. the newly launched The Medical Channel" <http://www.themedicalchannel.co.uk>

However, there is also the question of whether the practical software products and electronic resources that will make e-health a working reality are being developed as quickly as is necessary. Two projects at each end of the size spectrum illustrate the types of projects that are underway.

Firstly the Centre for Health Informatics, part of the School of Health Science University of Wales Swansea, has funding for a small-scale project, prompted in part by patients asking why they are unable to communicate electronically with the Health Service.

The project aims to establish how many patients use e-mail and have Web Access within a General Practice and, of those, how many would use them for the receipt and transmission of health care information between themselves and the various health care organisations

The hypothesis is that there will be a high level of agreement to use ICTs for these purposes- based in part on the widespread uptake of Internet banking; and this will create considerable consumer pressure which health care services will have to meet. The problem will be ensuring equity of access for those patients unable to use ICT or not in possession of the technology.

The second research initiative will require the political will of healthcare organisations to co-operate on a global basis. The Nuffield Trust suggests pooling global health knowledge through a series of dedicated websites - and setting up an internet-based charity to run them - which could be part of the answer to tackling conditions such as flu, tuberculosis and AIDS. The Internet-based charity would provide direct contact and assistance internationally on diseases responsible for killing millions of people world-wide each year. [9]

Major themes emanating from these and other projects are:-

- * Patient records viewable by patients anywhere
- * An increase in patient /consumer organisations
- * Access to best clinical practice information globally
- * Comparison of costs and services globally

The increased and transforming use of information and communication technologies, will make information available to all (i.e. to patients as well as the health care professionals). With health care being knowledge based , it can be imagined that there will be some vigorous debates regarding the differences between information and knowledge. Patients are likely to use patient /consumer organisations and their accumulated knowledge as a counterbalance to professional power and advice. ICTs are reducing the knowledge gradient between the professionals and the laity, and have the potential to make both the doctor and patient better in health terms and in terms of performance. There is little doubt that the changes in will provide a number of rich seams for research by medical sociologists.

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Teaching Issues

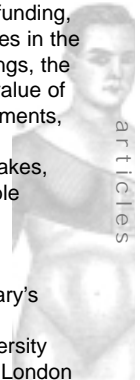
All change in the London Medical Schools: some personal reflections and experiences

Colleagues frequently ask what is happening in the London Medical Schools, for as they rightly observe 'everything seems to be changing'. These changes and discussions about the future of the London Medical Schools have been ongoing since the early 1980's and are well illustrated by my own changing affiliations. I first moved to London in autumn 1980 to take up a post as 'the Thomas' medical sociologist', with responsibility for the pre-clinical sociology course. However, two years later with the merger of St Thomas' and Guy's I was transferred to the staff of what was rather clumsily known as the United Medical and Dental Schools of Guy's and St Thomas' Hospitals (UMDS). I therefore joined with 'the Guy's sociologist' (David Armstrong) to teach a joint pre-clinical medical sociology course, with lectures alternating between sites. The next major change occurred in 1998 when UMDS and the Institute of Psychiatry merged with King's College London. In my case this was also accompanied by geographical relocation, with the Department of Public Health Sciences moving from St Thomas's to Guy's campus at London Bridge as part of the strategy of concentrating undergraduate teaching on one site.

London Re-organisations

My experiences are shared with most London medical sociologists, and reflect a process of re-organisation that aimed to respond to what were seen as the problems facing the London Medical Schools which together educate about one third of medical students in the country. Particular problems were identified as the costs of running 12 undergraduate Medical Schools (plus various postgraduate institutes) and the consequent duplication of

services, the desirability of larger pre-clinical departments for attracting research funding, the impacts of the Government's reduced funding and policy towards overseas fees in the early 1980's, the costs of renovating the fabric of the large number of older buildings, the depopulation of inner London leading to a shortage of 'clinical material', and the value of educating medical students in a multi-disciplinary environment. Reports and statements, beginning with the 1968 Todd Report and followed by the Flowers report of 1980, configured changes in various ways (in terms of groupings of schools, student intakes, possible closures and staff redundancies, etc). These proposals led to considerable debate, lobbying and in some cases student protest.



The eventual groupings that emerged following Tomlinson (1992) led to what are commonly referred to as 'The Big Four': Imperial College London (including St Mary's and Charing Cross Hospital Medical Schools), Queen Mary College (including St Bartholomews and the Royal London), University College London (including University College and Middlesex Medical Schools, and the Royal Free) and King's College London (including King's Medical School, UMDS and Institute of Psychiatry). St George's continues as the only free standing medical school in London, although the Faculty of Health Care Sciences at St George's has links with Kingston University. Most of us are therefore now part of a large multi-faculty institution. However, although there have been major building works, including new large lecture theatres and considerable refurbishment, these institutions remain spread over several sites. For example King's College London has sites at London Bridge, Westminster, Waterloo, and Denmark Hill. The new large Colleges created by these mergers are currently seeing the beginnings of considerable internal re-organisation with the aim of increasing their research strengths. In some Colleges this involves the replacement of departments and divisions as foci of research with Interdisciplinary Research Groupings (IRGs) and Centres. In addition, at King's this has included assessments of the feasibility/desirability of a School of Social Science and (possibly the beginnings of this?) with the recent concentration of some sociologists from disparate departments in the School of Education. However, at present the mergers are fairly recent, while the next five years are likely to see considerable changes as new groupings are established and greater coherence is achieved across sites.

Medical Sociology and the mergers

What have been the impacts of the mergers and other changes for teaching medical sociology? Firstly, the development of new curriculum has been a frequent activity to accompany each merger. Many of us are therefore now in the midst of a third curriculum review. The general requirements and framework for this are of course shared with our colleagues in other parts of the country and based on 'Tomorrow's Doctors'. However, the London medical school mergers presents new dimensions and challenges as it has also involved bringing together staff from different institutions and a large increase in numbers of students. For example, the new King's Medical School had an entry of just over 340 undergraduate students this year and 2.5 staff responsible for medical sociology teaching, with the other Colleges being of a similar order. Interestingly, none of the London medical schools has opted for a full problem-based learning approach to the curriculum, although there are differences between schools in the emphasis given to formal teaching and self-directed learning. All schools offer Special Study Modules, which occur at all stages of the curriculum, and involve small groups of students studying a particular topic in depth. A few schools also undertake some class teaching for the main Sociology course, made possible through employing part-time tutors.

However, the impracticality of providing classes for say 22 groups of 15 students without external input has meant that at King's we continue to teach the core sociology course largely as a lecture course which links with and complements students general practice experience. Students also write a 1500 word essay based on their interview with a patient with the aim of analysing the patient's experience of their illness drawing on sociological concepts. In line with the current emphasis on achieving horizontal integration between disciplines, the sociology teaching at King's is now part of a Practice of Medicine course, which runs across the first two years with inputs from Communication Skills, Ethics, Epidemiology and Statistics, General Practice, Psychology and Sociology. Integration is achieved by grouping the teaching around broad themes and co-ordinating inputs from different disciplines. One exam also consists of a series of case studies, with stems provided by different components of the course. The case studies have been difficult to devise and occupied very many hours of meetings, but in seemed to work well.

In some schools sociology teaching is characterised by a greater degree of horizontal integration and has also gone further in achieving vertical integration by providing inputs at different stages of the curriculum too. For example, the Queen Mary model is for medical sociology to be taught as a 'thread' throughout the 5 years together with public health, ethics, law and communication skills. Medical sociology is therefore taught as part of a 'core course' as well as through Problem Based Learning exercises and contributions to a Personal and Professional development block.

Quality Assessment

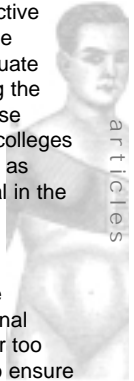
In the last few months the newly merged medical schools underwent the process of TQA assessment and GMC visitation. These were a cause of considerable trepidation given all the demands and inevitable problems associated with merger, greatly enlarged student numbers, and the first year of a revised curriculum. Fortunately the outcomes were generally positive, leading to a collective feeling of relief! Nevertheless we are now involved in reviewing the first year and making changes with the emphasis on lecture reduction, greater integration, etc., as we move into the second year of the new curriculum.

Innovations in curricula development

A second major change following the mergers is that individual Colleges now have much greater autonomy, with a corresponding decline in the notion and reality of a federal university run from Senate House. For example, Colleges have their own curriculum rather than following a common university based framework, and have differing length of undergraduate terms and exam periods, and introduced differing fee structures for PhDs. Some schools are also pioneering specific innovations, including the four year accelerated medical programme for graduates introduced by St George's this year that may soon also be adopted by other colleges, the compulsory BSc as part of the medical course at Imperial College, and the introduction of access courses.

Organising intercollegiate courses is more difficult in this new situation and was a major reason for the demise of the intercollegiate BSc in Sociology as Applied to Medicine Colleges in 1998. This degree course was established in the early 1970's and had run most successfully. It generally recruited about 8-10 medical students from different London medical schools following their first two pre-clinical years. Teaching on this course formed an important common activity for the London medical sociology teachers, providing a reason for meeting once a term, discussing teaching matters and lunching

together. However, we have attempted to maintain our informal links through an active Subject panel. The Subject panel which meets termly at Senate House and has the formal function of commenting on university wide policies, intercollegiate postgraduate courses, and developments in training, and overseeing common matters regarding the teaching and examining of medical sociology in the medical schools. However these meetings also provide an opportunity to catch up with what is happening at other colleges in terms of curriculum changes, teaching developments and other matters, as well as continuing our informal tradition with discussion continuing over a drink and a meal in the local Italian pasta house.



Looking back and looking forward

The challenges of teaching medical sociology in the London medical schools have certainly changed a lot over time. I sometimes look back with nostalgia to my original situation of teaching 100 medical students at St Thomas', with nobody being either too interested or bothered about what I taught. The main challenge at that time was to ensure that medical sociology was not overlooked and became firmly established as part of the medical curriculum. Nowadays, sociology has achieved this aim and there are many opportunities for teaching medical sociology throughout the curriculum. However, complementing this with some core teaching is important in teaching the basic concepts and perspectives.

Although recent mergers mean that teaching medical sociology presents some special challenges in the London medical schools, the demands and opportunities of the new curriculum mean that all sociology teachers in medical schools share much in common. It may therefore be useful to co-ordinate our efforts through the Web, including developing a bank of exam questions (case studies, SAQ, MCQ etc) and in-course assessments, and identifying people with experience of particular teaching formats who are willing to be consulted.

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Criteria for Qualitative Research: Mildred Blaxter, University of East Anglia

I welcome the opportunity to set the record straight about the Criteria which follow, first printed in *Medical Sociology News* vol 22 No.1, 1996. At the Medical Sociology Conference in 1995, a workshop was held to discuss a problem which was concerning many qualitative researchers: that they felt their work was difficult to place in the medical journals. They wanted to make their voice heard in the professional literature, but they found that editors and referees were offering inappropriate responses to their submissions. How could misunderstandings of qualitative method be overcome? The conclusion of the Workshop was that if an agreed set of criteria could be prepared, it would be useful in dispelling any mistaken idea that these methods lacked rigour and a theoretical base. It was reported that referees had, in fact, asked for guidance.

During the subsequent year, attendants at the Workshop, and some others, were circulated for their views. Over 30 people participated, by post, in successive revisions of a draft document. Not surprisingly, perfect agreement was difficult to reach: there are, of course, different types of qualitative research, and a few people remained of the opinion that any universal criteria would be not only impossible but actually undesirable. However, most finally agreed upon the document which was presented at another workshop at the Conference in 1996 and accepted by the Group.

It was circulated to journal editors together with a letter which noted that "There is considerable concern among medical sociologists and other health service researchers that inappropriate criteria are being used in evaluating qualitative research papers. Qualitative methods have not always been seen as having equivalent scientific status to quantitative research. However, methods of equal rigour and sophistication are now available, and consensus on evaluation has developed." In offering the criteria approved by the BSA Medical Sociology Group, it was made clear that they were not exhaustive but simply a set of suggested guidelines, and not every one might apply to every type of work.

The idea had also been floated that a list of medical sociologists willing and competent to referee qualitative papers should be compiled and offered to journals. However, again unsurprisingly, the plan was found to present problems and was dropped.

Ever since the subsequent publication of these guidelines in *Medical Sociology News*, there has continued to be a large number of requests for copies. In one way this has been gratifying, but the growing realisation that they were being used in methods teaching was a little disconcerting, because of course this was not their original purpose. The audience for which they were prepared explains some of the language used - populations and samples, cases and variables, validity and reliability - and the implicit emphasis on the differences between qualitative method and that which might be more familiar to those from a biomedical background. Some types of research were ignored simply because they would be unlikely to be submitted to medical journals.

Even these few years later, there has been considerable change : qualitative research is much more readily accepted in these journals. However, the Criteria may still serve some purpose. For general methods teaching they may well be somewhat restricted in

range and proscriptive in tone. They have, though, been found useful for teaching qualitative method to medical or other professional students, and they may still be relevant as a checklist for people writing research proposals for some audiences, as well as papers.

CRITERIA FOR THE EVALUATION OF QUALITATIVE RESEARCH PAPERS

1. Are the methods of the research appropriate to the nature of the question being asked?

- * i.e. does the research seek to understand processes or structures, or illuminate subjective experiences or meanings?
- * Are the categories or groups being examined of a type which cannot be preselected, or the possible outcomes cannot be specified in advance?
- * Could a quantitative approach have addressed the issue better?

2. Is the connection to an existing body of knowledge or theory clear?

- * i.e. is there adequate reference to the literature?
- * Does the work cohere with, or critically address, existing theory?

METHODS

3. Are there clear accounts of the criteria used for the selection of subjects for study, and of the data collection and analysis?

4. Is the selection of cases or participants theoretically justified?

- * The unit of research may be people, or events, institutions, samples of natural behaviour, conversations, written material, etc: in any case, while random sampling may not be appropriate, is it nevertheless clear what population the sample refers to?
- * Is consideration given to whether the units chosen were unusual in some important way?

5. Does the sensitivity of the methods match the needs of the research questions?

- * Does the method accept the implications of an approach which respects the perceptions of those being studied?
- * To what extent are any definitions or agendas taken for granted, rather than being critically examined or left open?
- * Are the limitations of any structured interview method considered?

6. Has the relationship between fieldworkers and subjects been considered, and is there evidence about the research was presented and explained to its subjects?

- * If more than one worker was involved, has comparability been considered?
- * Is there evidence about how the subjects perceived the research?
- * Is there evidence about how any group processes were conducted?





7. Was the data-collection and record keeping systematic?

- * e.g. were careful records kept?
- * Is the evidence available for independent examination?
- * Were full records or transcripts of conversations used if appropriate?

ANALYSIS

8. Is reference made to accepted procedures for analysis?

- * Is it clear how the analysis is done? (Detailed repetition of how to perform standard procedures ought not to be expected)
- * Has its reliability been considered, ideally by independent repetition?

9. How systematic is the analysis?

- * What steps were taken to guard against selectivity in the use of data?
- * In research with individuals, is it clear that there has not been selection of some cases and ignoring of less-interesting ones? In group research, are all categories of opinion taken into account?

10. Is there adequate discussion of how themes, concepts and categories were derived from the data?

- * It is sometimes inevitable that externally-given or predetermined descriptive categories are used, but have they been examined for their real meaning or any possible ambiguities?

11. Is there adequate discussion of the evidence both for and against the researcher's arguments?

- * Is negative data given? Has there been any search for cases which might refute the conclusions?

12. Have measures been taken to test the validity of the findings?

- * For instance, have methods such as feeding them back to the respondents, triangulation, or procedures such as grounded theory been used?

13. Have any steps been taken to see whether the analysis would be comprehensible to the participants, if this is possible and relevant?

- * Has the meaning of their accounts been explored with respondents? Have apparent anomalies and contradictions been discussed with them, rather than assumptions being made?

PRESENTATION

14. Is the research clearly contextualised?

- * Is all the relevant information about the setting and subjects supplied?
- * Are the cases or variables which are being studied integrated in their social context, rather than being abstracted and decontextualised?

15. Are the data presented systematically?

- * Are quotations, fieldnotes, etc. identified in a way which enables the reader to judge the range of evidence being used?

16. Is a clear distinction made between the data and its interpretation?

- * Do the conclusions follow from the data? (It should be noted that the phases of research - data collection, analysis, discussion - are not usually separate and papers do not necessarily follow the quantitative pattern of methods, results, discussion.)

17. Is sufficient of the original evidence presented to satisfy the reader of the relationship between the evidence and the conclusions?

- * Though the presentation of discursive data is always going to require more space than numerical data, is the paper as concise as possible?

18. Is the author's own position clearly stated?

- * Is the researcher's perspective described?
- * Has the researcher examined their own role, possible bias, and influence on the research?

19. Are the results credible and appropriate?

- * Do they address the research question(s)?
- * Are they plausible and coherent?
- * Are they important, either theoretically or practically, or trivial?

ETHICS

20. Have ethical issues been adequately considered?

- * Is the issue of confidentiality (often particularly difficult in qualitative work) been adequately dealt with?
- * Have the consequences of the research - including establishing relationships with the subjects, raising expectations, changing behaviour, etc. - been considered?



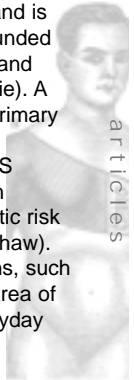
The Centre for the Study of Health, Sickness and Disablement (CSHSD), Brunel University, West London

The CSHSD celebrated its 10th Anniversary last year. Growing out of previous large scale national sociological research programmes on neurological conditions, especially multiple sclerosis and motor neurone disease, the scope of the Centre is now very substantially broader, and in many respects unique. A major injection of medical anthropological perspectives, methods, and personnel into what was its base disciplinary perspective of sociology, has produced an innovative, enticing and often radical blend of approaches to contemporary - and increasingly international - issues, concerning health, healthcare and their broader context.

The key element in almost all the research, and postgraduate Master's (in Medical Anthropology) and PhD teaching undertaken by the Centre, has been its focus on challenging conventionally received wisdom, and common assumptions about how health, sickness and disablement is understood and lived. This has been achieved through systematic, detailed, and often long term participant observational research on indigenous everyday beliefs and practices - in general practice, in hospitals, amongst medical researchers, in schools, in villages, in other organisations, amongst informal groups of people, and so on. Given this strategy - to seek to understand arrays of individual beliefs and actions within many different social and cultural settings and networks - surprising findings often emerge, which reflect the complexities and ambiguities in local worlds as they are lived. The cosmopolitan and international context of many of our interests provides an important antidote to ethnocentricity in our research endeavours, and in particular constantly challenges narrow sociological categories and assumptions about how people think - in the context of their cosmologies and epistemologies - and why they do what they do - in the context of their possibilities of choice, set in local and national processes, their roles, and their interactions with others. In the current world of evidence based health care these perspectives allow a considerably expanded awareness of analytical possibilities in relation to how evidence is constituted and employed. This is especially so as the emphasis begins to turn away from a relatively straight jacketed, uniform and universal application of validated interventions, to a more negotiated view of evidence in which local context, and the perceptions of patients and others are inherent components.

Amongst our projects, ESRC funded work on white and other ethnicities in Southall for example (Ian Robinson, Ronnie Frankenberg, Aaron Turner and Raminder Kaur), demonstrates the multiple ways in which 'ethnicity' is variously relevant to everyday action, depending on social context and setting. Our companion ERSC funded work on vulnerability in childhood (Frankenberg, Robinson and Amber Delahooke) shows how vulnerability is not so much an unchanging essence of children or childhood, but operates differentially and often contagiously in different contexts. Our NHS funded work on out of hours primary care of those with young children (Kathryn Ehrich) reveals how the everyday practices of parents, triage nurses, doctors and other players construct very different views of 'appropriate' out of hours medical contacts, and how they might be managed. Continuing medical education, and disability has previously been the core of Ruth Pinder's research, although she is now analysing a wide array of social strands arising from an experimental housing scheme based on 'befriending' between older people and medical students. Cecil Helman continues his broad based research on the

cultural context of primary care interventions internationally as well as nationally, and is just publishing a fourth edition of his text on culture, health and illness. An NHS funded Fellowship on live kidney transplantation is revealing the many different practices and challenges operating in, and in interaction with the transplant world (Alison Crombie). A more recent NHS funded Fellowship is focusing on complementary therapies in primary health care (Christine Barry). Other research projects are concerned with detailed understandings of how gay networks operate in London in relation to HIV and AIDS (Melissa Parker), and with the impact of HIV and AIDS on social and cultural life in Botswana (Suzette Heald), as well as with the constructions of disability and genetic risk by Pakistani families and health care professionals, including geneticists (Alison Shaw). Our work on the experiences and understandings of living with long term conditions, such as MS has continued (Robinson and Maggie Hunter), and has extended into the area of the public understanding of (medical) science through ESRC funded work on everyday perspectives on clinical trials (Robinson).



Our research students, using similar approaches, range in their interests, for example, from UK based studies investigating everyday practices and processes in relation to hospital resuscitation procedures (Susie Page); continuing medical education (Andrew Singelton); to the construction of ADHD in children (Tanya Dennis); childhood asthma and ethnicity (Rachel Cane) ; to young children and disability (Barbara Kerzman); to excretion (Rachel Lea); and in relation to overseas based studies, focus on the cultural constitution of young children's lives in South India (Gabriele Alex), in Greece (Kirstin Schmidt), in Malawi (Isabel de Salis) and in Vietnam (Rachel Burr); on Portuguese migrants to Switzerland (Marianne Ruf); on contrasting healing systems in Pakistan (Mark Southard); on comparative Japanese and British understandings of shiatzu (Glyn Adams); on indigenous practices in relation to mental health in Mexico (Enrique Erosa); and on malaria in Kenya (Isaac Mwanzo). Many of these projects are concerned with examining the local cultural politics of interventions in health and health care, through paying detailed and long term attention to the ways in which interactions between all the parties concerned are configured and operate.

Overall, much of the research of the CSHSD emphasises the importance of 'working from below' as being complementary to, and often an antidote for an over concentration on 'changes from above'. Thus studying the local as much as the global, or indeed how the global may be embedded in or be dissonant from the local is a principle interest of many of our projects. Furthermore and finally, in a world in which everything seems to be changing all the time, an attention to the role of continuities - as much as changes - in the aspirations, beliefs and practices which condition the lives of all those involved in health and health care has been a special and often salutary concern of our research.

Further information on the CSHSD can be obtained from Ian Robinson (Director), CSHSD, Dept. of Human Sciences, Brunel University, West London, Uxbridge, UB8 3PH, UK, or via e-mail (ian.robinson@brunel.ac.uk); or tel: 01895-203306; or fax: 01895-203078; or via the CSHSD website www.brunel.ac.uk/research/cshsd/

Sociology of Cancer Study Group

The establishment of this new Study Group took place in May at our first meeting; a one-day workshop 'Critically Examining Psychosocial Oncology' hosted in London by the Centre for Cancer and Palliative Care Studies at the Royal Marsden. More than 30 people registered for the workshop and 26 of us gathered for a series of discussions of key articles on psychosocial oncology. The first business of the meeting was to agree a statement of Group Aims and Objectives:

- * To promote and disseminate sociological research on cancer;
- * To provide a forum for seeing and providing support and information about research on cancer;
- * To promote collaborative multidisciplinary research and writing;
- * To provide a resource for the discussion and exchange of key ideas and publications.

This done we elected a Committee: Jonathan Tritter as Convenor, Geraldine Leydon as Secretary and Clare Moynihan as Treasurer.

The 'formal' establishment of the Study Group accomplished we began the main substantive work of the day in three groups facilitated by Clare Moynihan, Clive Seale and Jonathan Tritter. The initial discussion focussed on the work of Lesley Fallowfield (1995) and parallel research in the US by Meyer and Marks (1995), as well as considering the role of self-help groups in psychosocial care. The second session was structured around Stephen Greer's work (1991) on personality types and coping strategies as well as examining work that is more recent by German academics Faller et al. (1999). After lunch we returned for a group discussion of key issues ably chaired by Jane Seymour.

Key issues that emerged included the stress in psychosocial oncology on conceptualising individuals as quantifiable and predictable in terms of responses to stimuli and further, that the simple aggregation of individual responses permits predictions about populations. Inherent characteristics of the individual (personality) are straightforwardly and definitively linked to their morbidity and mortality, which promotes a 'blaming' approach to getting cancer. It was agreed that these propositions raise important sociological issues. First, about the ways in which individual experience and biography are typically missing from the evidence used in assessing the need for psychosocial care and second, the lack of consideration of the patient's social context.

The Group felt that the discussion helped to set an agenda for future work exploring the role of sociological theory in underpinning research, but also ways in which sociological methodologies need to be applied to research on cancer as well as informing research programmes and bids. We hope to explore these issues further at our next meeting at the Medical Sociology Group Conference in September and at a one-day event at Leicester University in the winter. For further information about these events or to join the group, please get in touch.

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A Report of the RCN Annual Nursing Research Conference, April 2000, Sheffield

'Nurse researchers developing evidence-based practice are in a key position to influence government health policy, according to RCN general secretary Christine Hancock' (Dinsdale 2000). This is how a recent article in the weekly, *Nursing Standard*, opens. The article is under a banner 'Robust research is key to nurses' political influence' and I think this aspiration gives a fair account of the spirit underlying the RCN Annual Research Conference, run by the RCN Research Society, in Sheffield in April of this year. Attenders at this conference since 1991, may well have noticed a gradual increase not only in presenters' political awareness but in the investment made by nursing leadership in nursing research as an activity likely to promote the profession. Only in the last two or three years has the RCN general secretary's opening address been a feature.

The talk of effectiveness and cost effectiveness in health care, and more recently, of evidence based practice, has shifted how nursing research is viewed within the profession's leadership-from an activity to be indulged in by a few (in 1991 you needed a Master's degree to be allowed to join the RCN Research Society) to something that RCN activists were being urged to take on as part of their armoury of persuasion in their dialogue with NHS trust managers. The first phase of this transformation, roughly corresponding to a period when a great deal of attention was being given to issues of skill mix and role substitution in the early 1990s, featured the hope that nursing research would demonstrate that nurses could effectively manage many of the conditions traditionally dealt with by doctors and at far less cost. A second phase, influenced by the rise of the evidence based movements, involved the drive to discover the basis in science of nursing activity, against the background of the perhaps unspoken anxiety that any activity without such a justification would be precarious in a modern and rational National Health Service. More than this, the accumulation of such evidence could deflect criticism of the profession as a whole that it was based on myth and tradition. One nursing leader has 'urged nurses to identify evidence to justify their practice and suggested that this is how they will be accepted as 'players' within the evidence-based medicine/clinical effectiveness movement' (McClarey and Duff 1997).

So nursing's annual showcase of research activity might be looked to for some insight into how nursing's research establishment, if there is such a unified force, has responded to such a changing view and how it has contributed, or otherwise, to the promotion of its own activity.

The conference opening featured an address by Diana Garnham, Chief Executive of the Association of Medical Research Charities. Her talk identified the changing profile of the major funders of medical research. For a figure in her position, she was refreshingly frank about the origins, motivation and constituencies of some of these charities, many of them small and orientated to particular units or groups of clinicians. Diana Garnham's own involvement with the RCN owes much to her contribution to the College's recent priority setting exercise for nursing research which aimed to identify possible research programmes and, crucially, possible funders. The medical research charities as funders are largely unexplored by nurse researchers and Diana Garnham's information and advice has been seen as an important conduit to this rich seam.

An impression gained at the conference this year compared to 1991 is that more of the work which was reported springs from funded research, although this is impossible to verify from the conference programme. Nursing research, as a relatively young activity, has in the past perhaps been characterised by a proliferation of unfunded work carried out for higher degrees, work which reflected the personal context-educational-of those undertaking it. Now, partly as a result of changes in funding of research within the NHS, research into practice problems by nurses is less unusual. The joint appointments of senior nursing academics across health and higher education sectors, which is seen to have pay off for both, is certainly growing and the rate of growth in the numbers of nursing chairs appears to be accelerating.

But if more of the work presented represents successfully funded research, possibly carried out by senior figures, the individual, sometimes idiosyncratic research which was not unusual five years ago is, thankfully, still apparent, although no longer the norm. While the range of methodological approaches is broad, often methodological discussion is limited and robust critiques of established approaches to research, nursing or healthcare are not to be found. In terms of mainstream interests a large number of papers this year seemed to be addressing, in some form or other, the question of the promotion of nursing research findings and evidence based practice. An implicit theme running throughout the conference was the issue of establishing nursing's political influence, and as I suggested before, the interest in implementation and EBP can be seen, in part, as contributing to this project.

One of the closing addresses came from Prof. David Thompson, the first Professor of Nursing Research to be appointed (in 1998) to the Department of Health and NHS. As someone who is clearly extremely successful at drawing funding not only for his own research but to found departments, his disciplinary horizons are impressively broad. His 'Exploration of knowledge development', presented a historical sweep of epistemological traditions, from Plato (or did I dream that?) via Bacon and the Enlightenment, to today's issues for nurses involved, as David has been, in cardiac rehabilitation. He avoided the temptation to identify with any particular tradition or research approach though lost a chance, I felt, for a critical look at the government's approach to science and research funding, particularly as expressed in NHS policy.

Probably like any disciplinary conference it is possible to leave feeling that you have been stimulated more by contact with old friends and colleagues than by the content of any particular paper. Nursing research, at least as expressed by this long-standing annual event, appears to be becoming slightly more coherent and mature in terms of political know-how. However, this development is perhaps not matched by methodological or theoretical adventure.

Michael Traynor, London School of Hygiene & Tropical Medicine

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Conference report 1st Qualitative evidence-based Practice

An innovative and exciting conference took place recently at Coventry University. The 1st Qualitative evidence-based Practice conference brought together qualitative researchers and evidence-based practitioners from throughout the UK and around the world. The 3 day conference gave delegates the opportunity to explore the spectrum of qualitative research and to discuss the role of qualitative approaches to evidence-based practice. The conference was both multi-disciplinary and multi-professional in nature, with delegates from the fields of health and social care, health education and health promotion, management, education and business studies.

The conference commenced with a series of 'hands on' workshops, where delegates had the opportunity to use computer packages for analysing qualitative data, discuss the process of interpreting qualitative data, and practice the skills of critically appraising qualitative research papers. The conference was opened by Prof. David Gillingham (Pro-Vice-Chancellor, Coventry University). Delegates heard keynote lectures from a number of eminent speakers, including: Prof. Mike Bury (University of London) talking about illness narratives; Prof. Gareth Williams (Cardiff University) discussing ways in which qualitative research can influence policy; Prof. David Field (Institute of Cancer Research) outlining an approach to systematically reviewing qualitative research; and Dr Marie Donaghy (Queen Margaret University College) presenting ways of integrating reflection and experiential knowledge into evidence-based practice.

The main focus of the conference, however, was the paper sessions and symposia, which gave delegates the opportunity to explore a wide variety of issues pertinent to both qualitative research and evidence-based practice. The topics discussed included levels and a hierarchy of qualitative research, information seeking and approaches to identifying qualitative evidence, participatory action research in developing countries, and off-shore risk management. Papers were grouped into 7 themes: Qualitative research in health care; Qualitative research in management; Qualitative research in education; Qualitative research in social care; The spectrum of qualitative research; The application of qualitative outcomes in practice; and Influencing policy and practice through qualitative research. Further details of the conference plan, abstracts and the text of selected papers can be found at the conference web site: <http://www.leeds.ac.uk/educol/qebp2K.htm>

The networking, methodological discussions and social aspects of the conference were ably facilitated by the Conference wine reception and the Conference dinner.

The conference was diverse and wide-ranging and it provided delegates with a unique opportunity to explore the complexities and variety within qualitative approaches to evidence-based practice, and to be involved in developing this new, and important, dimension to evidence-based practice. It is hoped to publish a book developing the themes of the conference and including selected papers from the conference.

This highly successful conference is set to become an annual event. The 2001 Qualitative Evidence-based Practice conference will be held, in Coventry, on 14th to 16th May, 2001, the theme of the conference is 'qualitative evidence-based practice: taking a critical stance'. Abstracts of up to 200 words should be submitted (in either MS Word or text format) to the Organisers (Dr Maggi Savin-Baden & Dr M Clare Taylor). Further

information on the conference is available from:

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Book reviews

This section publishes book reviews written by readers. A number of books are available for review and readers are encouraged to write a critique, in return for keeping the book

Book reviews should be accurate: Carol Thomas responds to a review of her book in our last issue

I was very disappointed with the review of my book *Female Forms: experiencing and understanding disability* in the March 2000 *Medical Sociology News*. Of course it is to be expected that reviewers will find fault with one's work, but one does not expect the readers of reviews to be given factually incorrect information about a book's content. The reviewer states that the book 'gives a comprehensive critique of two dominant models of disability, namely, the ICIDH's social model of disability and the WHO's social-medical model'. This is completely incorrect. The book actually critiques (1) the social model of disability developed within disability studies in alliance with the disabled people's movement, and (2) the ICIDH 'model' used by the WHO and most medical sociologists. The reviewer's characterisation of my conceptualisation of disability is thoroughly muddled - but I suppose that is for others to judge. She is entitled to her opinion that the qualitative data I present are 'anecdotal', and that I am in 'self-denial' about my own impairment (!), but it would have been nice if she could have mentioned to an audience of medical sociologists that there is an entire chapter on the debate between medical sociology and disability studies. Oh well, c'est la vie.

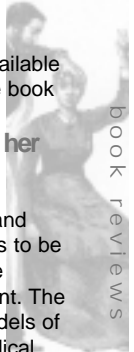
Carol Thomas Senior Lecturer
Lancaster University

1. Thomas, C (1999) *Female Forms: experiencing and understanding disability*.
Buckingham: Open University Press.

Sarah Li, original reviewer replies

I have read the book comprehensively, this is the interpretation I have formed. I am well aware of the existing debate between medical sociology and disability studies and of the fact that the book 'critiques the two models of 'disability''. I would rather like to think that the author of this book has confused her 'perception' of the 'inaccurate' reading of her book or 'incorrect information' about the book with my 'interpretation' and therefore 'perception' of her writings as read by me, and indeed I am 'entitled' to my opinion. Despite my review, I would like the author to know that I have recommended her book to my students at Kingston University'.

Sarah Li, Senior Lecturer, Kingston University.



Nettleton S, and Watson J. (1998) *The Body in Everyday Life* London: Routledge (ISBN 0415162017 Pbk £16.99)

This edited book is divided into four sections: 'Physical and Emotional Bodies', 'Health and Illness', 'Gender' and 'Ageing'. These empirical studies represent diverse ways of looking at peoples lived experiences of the body and also diverse ways of researching this subject matter. Perhaps for this reason each chapter stands well on its own and can be dipped into for the specific subject areas. I am not fully convinced however that the sections had strong enough common threads running through them to make them necessary. For example, despite the section 'Health and Illness', health seemed to run as a common theme throughout much of the book and the book could have functioned just as well without these sections which can otherwise be misleading.

One of the books stated aims in the introduction is to correct a present imbalance that has generated more theoretical texts than empirical texts in the sociology of the body. This aim it achieves within the emancipatory framework of allowing peoples embodied experience to be described from the perspective of the people themselves. It is a strength of the book for those, such as myself, who are interested in the sociology of health and illness that health has been used by many of the researchers as the vehicle to encourage the research subjects to discuss their relationship with their bodies. This facilitates an understanding of the practical importance the sociology of the body can have for those of us working in the health/illness service.

The book contributes specifically to the issue of gender and embodiment and unlike many texts, that discuss 'gender' yet only have studies relating to women, this book has several texts relating to masculinity and the body. For example, Bendelow and Williams work (chapter 11) provides a useful analysis of the relationship between gender, pain and the body. Of particular interest to me is the insight given into the contradiction often found that men are both 'babies' and 'stoic' when it comes to the experience of pain. Within masculinity, this area of public stoicism and the private need to be 'mothered' in regard to pain, and possibly in ill-health in general, is one that I am sure would benefit from further research. Likewise, Watson's study (chapter 9) provides insight into how male 'lay theorising about the body operates in constructing self and others health'. Again, the book need not limit itself to having a section on gender as the differences and similarities of the gendered experience of embodiment are present throughout the book and could be missed if one concentrated on that section alone.

As well as the obvious focus on the sociology of the body, the book has some interesting nuggets relating to the research process and wider sociological debates. Higate's work (chapter 10) draws on the work of Morgan (1987) and Plummer (1983) to provide an interesting potted account of the role that autobiography can have in sociological research, perhaps an approach that is often neglected or not fully utilised. Howson's work (chapter 12) debates Foucault's notion of health surveillance and self-surveillance. She examines, through an analysis of cervical screening, Foucault's concept of power in relation to health surveillance and the body and suggests that much of the discussion around the idea of the 'clinical gaze' has been about the body rather than related to peoples embodied experience where this can be seen as 'thinking through the body' (Grosz 1994). As a result, she says, Foucault's approach conflates the body and embodiment which makes it difficult to identify local resistance to surveillance programs and also that this focus on surveillance can obscure wider issues of governance.

Overall, a significant contribution to research relating to the embodied self as experienced in daily life and real world situations. It combines a wide range of research approaches, settings and topics and yet maintains a specific focus throughout.

Steve Robertson, University of Lancaster

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Grosz E. (1994) *Volatile Bodies*. Indiana University Press, Bloomington

Morgan D. (1987) 'It will make a man of you': Notes on national service, masculinity and autobiography. *Studies in Sexual Politics* 17. Manchester University, Department of Sociology

Plummer K. (1983) *Documents of Life*. Allen & Unwin, London

**Arskey H. (1998) *RSI and the Experts: the construction of medical knowledge*
London: UCL Press (ISBN 1857288130 Pbk ,14.95)**

A recent spate of exchanges on the qual-software mailbase discussion group has revolved around computer use in transcription and its effects on Repetitive Strain Injury (RSI). Where were these discussions ten years ago? *RSI and the Experts* goes a long way towards answering this question, and extends its scope of inquiry to address many other related issues as well.

This book is much more than a resource for those either suffering from or investigating the phenomenon of RSI. It presents a systematic and engaging account of the myriad of opinion, evidence and factions that work (often uneasily) together to influence the construction and interpretation of a medical condition. Such an examination is useful when looking at other contemporary contentious illnesses, such as CFS/ME or Attention Deficit/Hyperactivity Disorder (ADHD), or indeed for anyone interested in the non-linear path that exemplifies the development of scientific and medical knowledge.

Arksey uses RSI to explore three overarching themes: 1) the supposed neutrality of medical knowledge; 2) a critical examination of the notion of expertise and the whether 'specialist' expertise is possessed only by professionals; and 3) the democratisation of the production of scientific knowledge. This framework is relevant to both the sociology of scientific knowledge and the sociology of health and illness, although she makes clear in the introduction that her interest is largely located in the former.

After giving a detailed account of the development of RSI abroad and in Britain, Arksey discusses the interweaving of medical and non-medical knowledge and perspectives. She draws on the claim that medical science is constructed through collective interaction, and is not solely based on 'facts' (using Fleck's hypothesis from the early 20th century). Beginning with a refutation of the objectivity of science, we are then introduced to the means by which professional groups adhere to models of medical reality that both support and advance their specialities.

These are contrasted with the experiential expertise of people other than doctors. The



book uses Collins' idea of the 'core-set' to elucidate the relationship between scientists and doctors (professional 'experts'), and the lay community, encompassing sufferers, trade unions and lawyers. Finally, actor-network theory is employed to assess the potential for the formation of successful alliances between sufferers and professionals.

I found a couple of issues in the book to be disconcerting. Arksey discusses her own 'capture' by the lay contingent, and although she explicates this bias by invoking the notion that there is no such thing as a neutral actor in the research process, this stance influences in her analysis and conclusion. The lay input into the construction of medical knowledge is privileged over that of the professional 'experts', and is on the whole presented as a homogeneous voice in comparison to professional diversity borne of self-interested power struggles. For me, this perspective somewhat belies a full commitment to the constructivist thesis promised by the title. It does, however, form the basis of the final chapter, 'Empowering the Dispossessed', which gives an excellent brief sociological overview of how sufferers (of any illness) can influence medical and public policy, as well as more specific suggestions for the route ahead for those with RSI.

Arksey employs a wide range of qualitative methods to collect her empirical data: interviews, focus groups, documentary analysis and field notes from official meetings, and even living for up to four days with sufferers. Unfortunately, we are not made privy to the potentially rich descriptions that would have resulted from this last strategy, such as the personal circumstances in which RSI had taken hold, or the sufferers' views of their own pasts and futures and those of the condition, although none of these was an explicit aim of the work. I also missed a broader critical review of the social and cultural context in which RSI has flourished: a time of individualisation, better general health, burgeoning personal legal actions, and an increase in support groups and political patient advocacy in general.

Overall, this is a book I would certainly recommend to anyone who wants to know more about the construction of scientific and medical knowledge, and who seeks to examine the notion of 'expertise' in medical knowledge and the myth of medical certainty. Hilary Arksey provides an extensive investigation into the complex course that medical and scientific knowledge travels, from professional to lay and back again. It is a book I will return to as a resource for future explorations into the question of how illnesses become a part of our society and, even more intriguingly, part of the discussions on the qual-
software mailbox.

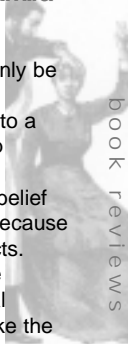
Susan Robinson, Royal Holloway, University of London

Green E. (1999) Indigenous Theories of Contagious Diseases London: Altimira Press

Edward C. Green, experienced anthropologist and prolific writer, offers what can only be described as an engaging comprehensive account of ICT (Indigenous Contagion Theories). Opening with a conversational literary style, Green draws the reader into a description of the popular stereotype of African native medicine, which conjures up images of spirit possessions, witchcraft and magic. This form of imagery can be considered to impede medical progress in African. It contributes to a widespread belief that African medicine is irreconcilable with the western world's biomedical model because the Africans interpret illnesses personally and cannot relate to biomedical constructs. Green does not dismiss this concept entire. Instead he points out that while some African indigenous medical accounts do rely on the supernatural, there are rational explanations of diseases or illnesses inherent in African medicine that are not unlike the logical theorising found in Western medicine.

When understanding etiologic models, medical anthropologists place an emphasis on the cause attributed to an illness and the practices used in connection to its prevention and treatment. They denote a distinction between 'illnesses' and 'diseases'. The former refers to a folk construct of explaining the cause of an illness, which tend to be personalistic; the latter describes the biomedical construct, which are interpreted impersonally and are considered naturalistic. Diseases such as cholera, AIDS, amoebic dysentery, typhoid and sexually transmitted diseases are conceived within indigenous medicine using a framework that is complainant with the biomedical construct. Terming the framework the Indigenous Contagion Theory (ICT), Green points out the belief that one can be contaminated by an outside agent or 'dirt'. This theory can be further divided into three sub-parts: (1) 'naturalistic infection' or folk germ theory (2) 'mystical contagion' or pollution (3) environmental dangers. Green then focuses on the pollution theory and offers many illustrations of how Africans believe that people can become ill through contact with someone or something that is unclean, impure or contaminated.

The first few chapters were at times a little tiring on the concentration. Green does bombard the reader with details of various anthropological theories and studies done in Southern Africa. Of course, it is acceptable that Green has to give background information to his argument and has to introduce anthropological theories to readers who are potentially ignorant of the area. Nevertheless it would have been more interesting if some parts were edited to reduce the feeling of the author trying to justify the existence of medical anthropology rather than supporting his own argument. Despite this, Green does offer some rather compelling points of view on the former failings of anthropologists and other social scientists in dealing with ICT. He backs these opinions with some wonderful illustrations on the contamination associated with women's menstrual periods and death, which are the two prime areas where the 'rationale' of pollution theories is applied in Southern Africa. Anyone with an interest in gender studies will enjoy these documentations. Another belief within the pollution theories of ICT that should be mentioned, is the existence of the 'internal snake'. Believed to exist in the stomach but capable of spreading throughout the body, the notion can reflect a positive force used to resist disease or the idea of something existing within someone that can poison others or oneself. While this could be described as veering towards the supernatural, in some African societies, the concept has offered a reason to care for digestion and other bodily functions.



The chapters dedicated to specific illnesses - 'Childhood Diarrhoea', 'Sexually Transmitted Diseases and AIDS' and 'Malaria, Tuberculosis and Other Infectious Diseases' - were thoroughly engrossing. The chapter on sexually transmitted diseases was particularly interesting, especially in relation to the distrust of hospitals due to the drugs being considered inadequate in irradiating diseases. This belief is not irrational as the antibiotics are diluted to last longer or are used on an antibiotic resistant population. The usage of condoms and the evidence of changes in sexual behaviour due to AIDS health promotion also raise questions that could be applied to studies done on health in western societies.

Overall, this book appears to be geared towards those who have little or no knowledge of social explanations of illnesses or of 'layman' beliefs. The author does manage to convey quite successfully the details of indigenous medical explanations in a language that is easily accessible. This book is a good introduction to the area for undergraduate social scientists, health professionals and the general public.

Catherine Heffernan, University of Oxford.

Coveney J. (2000) *Food, Morals and Meaning: the pleasures and anxiety of eating* London: Routledge (ISBN 0415207487 Hbk ,55)

There are many books and articles relating to food, eating, appetites and hunger from anthropological, psychological and sociological perspectives. Particular attention has focused on the concept of 'food entitlement' and the social construction of food desires. Food is often construed in terms of what it symbolises for the consumer. How it is prepared, how it is eaten and what constitutes 'food' for different people are all affected by their social milieux. In addition, there have been articles on the consumption of food (or lack of it) stratifying people by age, social class, religion, gender and ethnicity.

This book is divided into nine chapters. The first chapter comprehensively summarises Foucault's theories on discourse, power and ethics, relating his concept of 'governmentality' to concerns with nutrition. The second and third chapters build on this to explain the process whereby individuals are required to meet specific obligations in relation to food set out by the authorities. Coveney suggests that these obligations are well established in antiquity and the chapters trace the history of this from Greek to early Christian times. There is an interesting explanation of the role of food at the Eucharist and the problem of 'appetite' amongst monastics cultures.

The fourth chapter focuses on the theories of Kant and examines the ways systems of thought emerged during the Enlightenment and were influenced by a belief system founded on Christian austerity. The fifth chapter looks at how nutrition developed as a science through the provision of food in prisons and the workhouse, and the moral practices attached to such institutions. There is a fascinating section on the role of food in both punishing prisoners and as a way of disciplining souls. Foucault's theories of regulation inform chapter six on the nutritional policing of families in Australia. There is an emphasis on the disciplinary nature of family nutrition programmes which ensured the medical surveillance of children through growth charts at health clinics.

Chapters seven and eight utilise a nutrition 'homescapes/landscapes' concept and look at

the way nutrition discourses exist in contemporary western culture. Coveney suggests that nutrition became an important research concept after the second world war. In Australia, like elsewhere, individual responsibility for diet related diseases led to a policy focus on lifestyles. There is acknowledgement of some of the gender issues raised in such debates (e.g. the role of women in food shopping) but they are judged to be part of the 'nutritional landscape'.

Chapter nine is an empirical chapter drawing on interviews with families undertaken to examine family eating habits. The interviews are framed by Foucault's 'technologies of the subject'. It is very interesting to read respondents' views on food and nutrition, particularly around eating together and communication. The author suggests that by examining the role of parents in relation to food choice we can see how nutrition opens up a number of possibilities for the discipline and training of family members. There is a tendency however not to use the quotations thematically but as 'evidence' to a point. Hence, there are often three or more respondents quoted at the same time.

This book states that it 'will examine the development of our current attitudes to food, pleasure and the body' and explains at the outset that it will not deal with issues around individual gender, socio-economic status or culture. I felt the book could have been improved if these issues were acknowledged in greater depth, specifically with the homescape of nutrition chapter. This is particularly obvious in the interview chapter where we know very little about the people involved. It would have been useful to know their age or ethnicity for example and how that might have informed their attitudes towards the family and eating habits. Respondents are described as the average Australian family but no lone parents were interviewed. This aside, *Food Morals and Meaning* is theoretical engaging and conceptually challenging. It is very informative and an excellent reference book for anyone interested in the theories of Foucault as applied to nutrition. I would recommend it for inclusion in a library collection or for anyone who wanted to study food and eating from a Foucauldian perspective.

Rosalyn Harper, Office for National Statistics

Rogers A., Hassell K. and Nicolaas G. (1999) *Demanding Patients? Analysing the use of primary care* Buckingham: Open University Press (ISBN 0335200907 Pbk £16.99)

This book addresses health policy issues of contemporary significance. The concepts of need, demand and supply are major themes within Health Services discourse. Funding and efficiency issues, and a fundamental desire to offer equal access to health care, also inform the debate. Managing the gap between the demand for health care and the ability to supply it is seen as a leading health policy challenge. This book's focus is how people manage illness, and how this may inform policy issues. Its main line of enquiry is the decision-making process of patient consultation. It explores the multi-faceted and fluid social contexts of this process and examines the influences and factors which impact on the relationship between health, need, and demand for care. The authors focus on the experience of lay people, and the circumstances in which they choose to utilise various types of formal or informal care.

The book is divided into three sections. Part I explores the definitional problems of the concepts of need and demand. The authors point out that the traditional discourse on health, need and demand is value laden; the professional view has dominated the debate and the patient has been constructed as the problem. Thus, the notion of inappropriate demand within formal primary care has gained currency. Managing demand is also explored, and the authors address the roles of organisational and professional changes. Rogers et al then outline a variety of theoretical approaches which have attempted to elucidate an understanding of the use of primary healthcare services. Using symptoms as a starting point, the iceberg of morbidity is addressed. This is followed by a thumbnail analysis of: the health belief model, the rational choice model and the socio-behavioural model. Having briefly assessed these approaches, the authors then go on to explore the usefulness of what they identify as the social process model. This model focuses on decision-making as a process in a fluid social context.

Part II addresses the experience of illness and service use and how this impacts on help seeking behaviour. The authors draw on their own qualitative research on 'pathways to care' to illustrate the process of the lay evaluation of illness, and the relationship between past and future use of services. They outline patterns of service use and explore the variety of ways in which people cope with illness, and are triggered into care seeking action. Identity, cultural norms, labelling, social interaction and networks are all implicated in help-seeking behaviour and are addressed by the authors. They also point out how the interaction between doctor and patient, which includes organisational and professional factors, impinge on utilisation of primary health care services. The roles of self-care and lay care in managing illness are also discussed. Policy implications are highlighted; in short, the authors suggest that a better understanding of the patient perspective could potentially lead to more appropriate health care service use, from both patient and professional perspectives.

Part III examines the role of the pharmacy in primary care. At a time when the public is being increasingly encouraged to use their local pharmacies for advice, as opposed to visiting the doctor, this seems a particularly appropriate section. The extent and nature of pharmacy use are dealt with, as is the impact of patient, organisational, and geographical factors. A further concern of this section is the relevance of information in managing demand. The dissemination of a variety of types of information, both formal and informal is addressed, and the effect this has on the utilisation of health care is explored.

Overall, the book demonstrates that any analysis of need and demand in primary health care is necessarily complex. The writers conclude that patients' views and actions should be explored to enable consumers to play a more active role in the re-organising of service delivery. This book provides the reader with a suitable framework from which to explore further the complex issues of need and demand. It invites one to read more on the variety of theoretical approaches which focus on the use of services. It refers to a wealth of literature and includes a resourceful bibliography. It is an informative book, which will be useful to those who have an interest in primary care and the management of demand at degree and postgraduate level.

Anne Mills, University of Glasgow

Dowrick C, and Frith L. (eds.) (1999) *General Practice and Ethics: uncertainty and responsibility* London: Routledge (ISBN 0415164990 Pbk £14.99)

General Practice and Ethics is one of a series of texts on professional ethics edited by Ruth Chadwick from the Centre of Applied Ethics in Cardiff. The rationale is to examine ethical issues in the professions both critically and constructively. This volume focuses on general practice and is edited by an academic general practitioner (Dowrick) and a philosopher of health care ethics (Frith).

The book is a collection of papers on the ethical issues facing general practitioners (GPs). A wide range of perspectives are covered: from sociology (May and Mead) to the law relating to confidentiality as it relates to general practice (McHale). In order to add some structure the collection the book is divided into two parts: general ethical and philosophical themes (Part I) and the exploration of particular topics of relevance to GPs (Part II).

Part I considers the problems of making ethical decisions in conditions of uncertainty and the tension between the GP's responsibility to both the individual patient and the community. Dowrick teases out the GP's unenviable task of dealing with both considerable uncertainty and responsibility in encounters with patients. He does this by describing the various levels of uncertainty (of diagnosis, of management strategy, of overall approach to the problem) and proposes a set of pragmatic strategies which GPs use to reduce uncertainty. As a GP I find Dowrick's analysis plausible and the topic certainly merits further sociological enquiry (he cites one sociological work: the classic work by Fox in the 1950s). The most pertinent article in this section to readers of MSN is that by May and Mead entitled 'patient-centredness: a history'. UK general practice lays great stress on the importance of practising 'patient-centred medicine' and new GPs are exposed to a diet of continual 'self-examination' by the use of videotape recording and assessment of their consultation 'performance'. The strength of this article is that it provides a clear and accessible account of the rise of 'patient-centred medicine' and uses its sociological and historical sources well. Its central argument is that 'patient-centred medicine' is both demanding of the doctor when faced with a 8 minute consultation and has shifted the focus away from 'relationships' - the doctor as reflexive listener, striving to make sense of the patient as a person - to one of 'acquiring technical skills' - a videotape of the doctor's behaviour is treated as measurable evidence of the use of communication skills. Both practitioner and sociologist alike could read this article with profit.

Part II discusses ethics in relation to general practice prescribing, the management of depression, the area of 'advance directives' and the role of research in general practice. Jones offers a clear introduction to the ethics of conducting research in general practice, one which would be of use to a researcher coming new into the field of 'research in primary care'. He is particularly good at describing the practical ethical problems in recruiting patients in general practice and teases out the particular pitfalls of conducting qualitative and quantitative work in this setting.

My overall assessment is that this volume has a number of articles of relevance to those conducting research in general practice but I am less convinced that the volume works as a coherent whole.

Tim Stokes, University of Leicester

Fielding SL. 1999 The Practice of Uncertainty: voices of physicians and patients in medical malpractice claims London: Auburn House (ISBN 0 86569 284 X Hbk

47.95)

BOOK REVIEWS

There is a growing literature around medical/clinical errors stimulated by the USA experience. The compensation culture is almost a way of life. Car stickers pronounce: 'send your son to medical school and keep three lawyers in business!' This book was a long time in gestation: the in-depth interviews of doctors who had been sued, patients who had sued, and malpractice administrators commenced in 1990. Many were elusive and did not want to talk. Many states refused to co-operate. The New Jersey Board of Medical Examiners wrote: 'Even if the Board has the information you are seeking it would not consider that information to be public' (p.203). Contrastingly, sixteenth century medicine was always publishing what it considered to fallacies to be condemned. Laurent Joubert's *Erreurs Populaires au fait de la médecine et régime de santé*, 1578, remains a classic.

A study of medical error provides an illuminated trench through most aspects of medical hegemony. Despite the protective mass of medical technology, uncertainty exists over the diagnostic interpretation. Increasing medical commercialisation with doctors investing in ancillary services, e.g. lab testing and therapy centres (rehabilitation) generates distrust between doctors and patients; the latter not certain whether their 'cross referrals' are necessary. The bureaucratic miasma under which doctors work, generated by private insurance, form filling actually reduces clinical time with patients; but overall time in professional practice is constantly increasing (about 60 hours per week). Patients who are satisfied with their doctor's consultation style sue less frequently. Women claimants were generally angrier than their male counter parts. The anger lasted for years. Noticeably, women physicians are sued less frequently than men and for lesser amounts (despite the severity of the injury). However, when they do go to court in New York State they lose 63% of their cases, compared with 33% for male physicians. Within the court room's inquisitorial setting female physicians are perceived as less competent than men.

Most studies of malpractice claims rely heavily on statistical data - usually insurance claims or patient surveys. The researcher has to use 'hit and miss' reflexivity to say what the surveys really mean. Fielding has collected a marvellous array of 'compensation stories', although few have been used to their optimum in the chapter, 'Gender and Story Telling'. Prior studies showing that males get a better deal than females in civil cases because of compensation for loss of income, are refuted.

Interesting profiles of doctors most likely to be sued are offered; those at the peak of the career are most vulnerable. Frequently more than once and were more likely to settle out of court, with average payments of about \$140,000. Malpractice claims become the main means by which the public police the medial profession. Doctors have responded by getting out of 'risky' specialisms, like obstetrics and orthopaedics. Nurses who have moved into obstetrics are not immune from malpractice claims. Insurance premiums are soaring: 1980 obstetricians in Long Island, New York paid \$100,000 a year for coverage. UK rates are increasing, but nothing like the USA scale. Many private insurance companies cease to underwrite medical liability; like inner city coverage it is not profitable. Some physicians form their own insurance alliance, joint underwriting associations (JUAs), for cover. They carefully gatekeep 'suspect' colleagues.

Fielding does have some sympathy for doctors (although Waitzkin wrote the forward) and discusses 'frivolous claims'. It seems that almost everybody knows someone who has sued, who encourages others. In a UK hospital I have sat waiting my turn, with the theft-proof TV monitor showing a video of solicitors ready to take your case of medical negligence. All systems, not only medical, carry a risk. Human negligence is not the only factor. A paradox appears in American medicine; although at the apex or 'cutting edge' of complex, technological procedures most doctors practice defensive medicine, as a safeguard: routine, old tied and trusted methods.

Fielding has produced a very readable and well crafted book using multimethods. I get the impression he is a medical man converted to the social sciences. Concepts, like 'marginality', which he deploy, are more complex in the history of ideas than he assumes. That is forgivable. The text is a welcomed addition to the sociology of medical malpractice.

Joel Richman, Manchester Metropolitan University

Kohn T, and McKechnie R. (eds) (1999) *Extending the Boundaries of Care: Medical Ethics and Caring Practices* Oxford: Berg (ISBN 1859731414 Pbk £14.99)

This collection of eight chapters focuses on care, caring and carers. The editors' introduction points to their general origins as papers presented at a workshop in Oxford. This must have been a stimulating day since the resulting contributions are, each in their own way, thoughtful and instructive.

Two main themes are said to link the contributions: firstly, a feminist perspective and secondly, an inter-disciplinary interest. The first is more obvious. The second less so.

The collection opens with a commentary by Oakley on the experience of caring about her mother during her growing debility and final move to nursing home care. The position of daughters as stereotypical carers of their parents is central to the literature: generally stay-at-home spinsters predominating. Here care is portrayed less instrumentally, for Oakley lived at a distance and as an independent academic. Her observant eye ranges over the minutiae of her mother's domestic life, the evidence of the past and the circumstances of the nursing home. She also uses her enquiring mind to ask about and explore the diagnosis, conveniently and easily labeled Alzheimer's Disease, which later proved to have been CJD. Care then is manifest in numerous forms and Oakley's narrative brings together the personal, the painful and the professional in a compelling read.

By contrast, this chapter is paired with a discussion of the challenges of caring for a family of triplets. Price places the event of a multiple birth and its aftermath in the context of growing numbers. She reports on the findings of a study of parents of triplets and other multiple births to outline the social pressure on mothers, in particular, to cope with the extra caring demands entailed. Little help, she reveals, was available to such mothers and few had been prepared for the tasks. This was despite the increased risk of multiple births particularly for those with assisted conception.

Issues close to the medical: care interface are tackled in the two following chapters on controlling care. Russell explores the Depo-Provera (injectable contraceptive) debate through a policy framework. In the main he uses U.S. case material, although many international perspectives arise as this contraceptive device has been seen as facilitating population control in developing countries. Russell makes a helpful distinction between the broad sweep of population control and the individualised notion of birth control: one associated with caring about the planet or the particular society, the other placing a means to control fertility among individual. Different cost: benefit calculations seem to be carried out for these two groups and Russell argues that the ethics of such processes must be considered more carefully.

Further debate around the presumptions in relation to care is taken up by Dembour who provides another international overview. Her chapter explores whether medical care is a human right or entitlement. Rather unfashionably perhaps, at a time when the notion of human rights is assuming legislative importance, she cautions against too great a reliance on individualistic rights.

This critical approach continues with Lambert's exploration of screening. Using a case study approach she looks at one interest group concerned with coronary heart disease. This is a fascinating dissection of a group that describes itself as a patients' support organisation and the inter-dependency between it and the medical/drug interest groups. While not dismissing these alliances, Lambert points to the combined pressure for screening of apparently health populations as having costs as well as benefits. As he notes, there are evidently fundamental differences in what 'care' means depending on whether a person is involved in extending screening for particular conditions or whether a broader approach is taken to public health. Similarly, McKechnie's chapter on HIV and male sexual relations with men, points to the importance of perceptions and individual positioning. This chapter bridges debate between researchers and their 'subjects' by integrating the purpose of research and its apparent need to provide sensible explanations.

The two final chapters conclude the collection with a focus on nursing. In many ways nursing operates a prism for the subject of care: nurses may be seen as carers, as caring and careful. The phrase 'nursing care' contains a wealth of meaning. As the editors note, the status of nursing appears tied to the status of caring. The first contribution focuses on nursing or caring ethics. Bergum argues that nursing care is in effect a dialogue and this dialogue helps to clarify the appropriate ethical stance. This is an interesting chapter and succeeds in combining the book's avowed feminist and interdisciplinary themes.

In the final chapter Salvage again refers to nurses and caring. She draws in particular on a study in which observation of nurses and ward-patients provided clues about nurses' occupation of the ward and patients' space or territory. Nurses appeared to take significant 'space' on the ward, other professionals and visitors were welcomed or tolerated. Nurses set up systems of boundaries between themselves and patients, but also allied themselves with patients on 'their' ward.

Much concentration on care has aligned the term with community and so this book is a welcome reminder that care does not have to be narrowly located within long-term illness or disability debates. Similarly, the term carer is becoming somewhat precious and so this book again may force readers to question whether the high profile of carers is being

interpreted too exclusively. This is a well-organised, interesting publication for those interested in ethics, care and social research, both singularly and in combination.

Jill Manthorpe, University of Hull

St Leger AS, and Walsworth-Bell JP. (1999) Change-promoting research for health services: a guide for resource managers, research and development commissioners and researchers Buckingham: Open University Press (ISBN 0-335-20220-9 pbk £22.50)

Most people recognise that in the new health service, R&D has a crucial role to play in promoting change. However at the same time research still tends to be viewed from a traditional perspective, and it is only recently that more attention has been given to the relationship between research and its implementation, or to the ways in which change is actually achieved.

This issue is tackled head-on in this new book, by Selwyn St Leger and Jo Walsworth-Bell, which follows on in some ways from their earlier volume, *Evaluating health services' effectiveness*. Its core theme is about different research paradigms for health services research, with the classic Kuhnian concept being defined here as 'a belief system shared by scientists working within an established discipline' (p. 25). St Leger and Walsworth-Bell suggest that traditional research, called here theory-enhancing, will be increasingly supplanted by a new variant, change-promoting. Both managers and researchers will have to accept a new paradigm, 'which is not about simple purity in either the research or the management world, but necessitates the complexities of collaboration, engagement with all sorts of issues and opportunities for continued learning' (p. ix).

The book is made up of three parts. The first examines the background and rationale for R&D, considers the issue of implementation, and introduces the new paradigm of change-promoting research. Part two provides an overview of commissioning, offers some examples taken from the North West of England, and examines how commissioning is put into practice. The third part examines both doing and using research, provides an introduction to some qualitative and quantitative methodologies, and considers how decisions might be improved and other dilemmas resolved. A final concluding section draws these threads together and offers a series of recommendations for four groups - managers, researchers, universities, and others.

There is a danger in a book of this kind that it will fall between two stools - neither sufficiently engaged on commissioning matters for the needs of managers, nor providing an adequately sophisticated guide to research for the academic community. Some might claim that the book claims too much for the new paradigm, and argue it is simply an amplification of applied research. There are times when a longer book may have been necessary. The section on 'doing research', for example, covers quantitative techniques like sampling, study design, and statistical modelling in some detail, whereas the overview of qualitative techniques is fairly superficial. And some of the examples of commissioning in action (pp. 58-66), in areas such as family therapy for schizophrenia, and irritable bowel syndrome, are focused on the experience of one city, and arguably are of little general interest.



However the strengths of the book are certainly greater than its weaknesses. The book's frequent pot-shots at academics, and the recurring stereotype of the ivory tower (surely redundant now), will irritate some. But many of its other points - on joint working by managers and researchers, on the need for multidisciplinary research, and on the importance of dissemination - are well made. To take one example, that of systematic reviews, the authors argue convincingly that reviews should seek to incorporate other types of evidence, they may be too detached from practical issues, and they run the risk of being irrelevant to the needs of the service (pp. 186-90). Each chapter is prefaced by a list of the key points, while others are summarised in bulleted lists in boxes within the text, and the final list of recommendations provides a useful summary.

Overall then, this is an original and forcefully argued book, which offers a provocative new paradigm for health services research. St Leger and Walsworth-Bell claim that 'R&D can fulfil its purpose only if it is led by the agenda of resource managers and if it produces findings that aid their decision making' (p. 152). No doubt some will disagree. However in the meantime, and while they consider their response, this is a very useful contribution to the debate about the role of R&D in promoting change.

John Welshman, University of Lancaster

Holder HD. (1998) Alcohol and the community: a systems approach to prevention Cambridge: Cambridge University Press (ISBN 0521 59 18 72 Hbk £40.00)

Alcohol prevention strategies aimed at individual problem drinkers are ultimately doomed to fail. Whilst they may help in the short term, replacement abusers will soon appear. Such isolated approaches need to be substituted by more sophisticated and complex strategies in which we widen our perspective and incorporate all subsystems of a drinking community. This is the central tenet of Holder's book, which he hopes will be the new paradigm and driving force behind alcohol prevention strategies at the beginning of the twenty first Century.

The community systems approach recognises that drinking behaviour is influenced not only by the individual drinker's personal choice, but also by genetic, economic, social and environmental factors. Not a new observation by any means, but one that is often neglected when prevention strategies are implemented. These ideas are clearly and thoughtfully developed in the first chapter, progressing neatly onto the need for computer models to simulate the underlying mechanisms of the community as a complex adaptive system. The programme SimCom is used to illustrate the predictive potential of such models and referred to throughout the book.

Chapters Two to Seven deal with the six community alcohol subsystems, as envisaged by Holder: Consumption, Retail sales, Formal regulation and control, Social norms, Legal sanctions and Social, Economic and Health consequences. These are described in depth with good use of flow diagrams showing interactions between subsystems. Examples of previous empirical and theoretical research, mainly from America and Europe, provide the reader with a wealth of further references.

Holder brings his ideas together in the final chapter with an illustration of how prevention planners can use computer-based simulation models to explore alternative strategies. This chapter somehow fails to provide the nuts and bolts of reality which are required after the reliance on theory and hypothesising. The example given is a comparison of alternative strategies to reduce alcohol-induced drink drive fatalities; a relatively quantifiable and well-researched phenomenon. It is less clear how one would model a reduction in teenage alcohol abuse when the data required are less reliable and processes less understood.

The intended readership is researchers and those actively engaged in planning prevention strategies. We are assured that computer modelling need not be complicated and a package such as SimCom is “easier for lay persons to grasp”. However, throughout the book, Holder illustrates some of the mathematical formula which are hidden beneath the surface logic of the simulation package and many readers would understandably be deterred from contacting SimCom’s Californian inventors to place an order.

National alcohol control strategies have been placed high on public health agendas in developed countries - partly to be seen to be doing something, but also in the belief that they are effective. However, their relevance is weakening with increasing globalised interactions. For example, in the European Union, it is becoming harder for individual countries to regulate alcohol prices, availability and advertising. Now, more than ever, Holder argues, is the time to break away from traditional national level approaches and to think and act at a local level, using local knowledge of social, cultural and economic dynamics.

Annie Britton, London School of Hygiene & Tropical Medicine, University of London

**Hildt E, and Graumann S. (Eds.) 1999 Genetics in Human Reproduction
Aldershot: Ashgate (ISBN 1 84014 825 X Hbk £39.95)**

This collection is based on contributions made to the Second Symposium of the European Network for Biomedical Ethics, held in Holland in 1998. A previous volume in the series discussed medical, social and ethical issues relating to the latest developments in IVF. In contrast, this volume focuses on the issues related to the current as well as to possible future technological progress in genetic technologies linked to IVF, such as preimplantation diagnosis and germline gene therapy. It aims to explore these from scientific, medical, social, legal and ethical viewpoints. The 31 articles are divided into six main sections: medical and scientific views; personal and moral implications; moral rights and duties; social concepts and moral implications; choices and decision making; and health care, justice and regulation.

In many ways the breadth of this book is one of its problems, in that no one area is discussed in any depth. Many of the articles in the first section on medical and scientific perspectives are fairly technical, and would probably not interest the majority of medical sociologists. As is common with any collection of this type, the standard of the contributions is variable. The majority of authors are ethicists or geneticists, with sociologists notable only by their complete absence, although this is not a criticism of the editors, as presumably no sociologists took part in the conference. There is only one contribution from an anthropologist, Sarah Franklin, but she makes a persuasive

argument for the consideration of the cultural context in terms of the ethics of cloning. I also enjoyed Ruth Chadwick's article which explores the ways in which preimplantation diagnosis has the potential to affect genetic counselling.

Perhaps partly due to the lack of space, there were a number of sweeping, unproblematised statements, such as that in Guido de Wert's contribution on the ethics of preimplantation genetic diagnosis, in which he states: 'I take it for granted that there is a strong consensus concerning the acceptability of prenatal diagnosis and PID for two categories of diseases: lethal childhood disorders.....; severely handicapping non-lethal conditions which manifest themselves early in life (e.g. Down's syndrome)' (pg 82).

Although this book might serve to provide a useful, albeit superficial introduction to a wide variety of topics for someone new to this complex area, I think it will make frustrating reading for many sociologists, and at this price there are probably more useful books on the market. In many ways the collection serves to highlight the view of the Wellcome Trust, that more social scientists should become involved in the areas of new genetics and ethics.

Clare Williams, Institute of Education, University of London

Armstrong F, and Barton L. (eds.) (1999) Disability, Human Rights and Education: cross-cultural perspectives Buckingham: Open University Press (ISBN 0335204570 Pbk £17.99)

This book comes as a welcome addition to the 'Disability, Human Rights & Society' series. It stands out with its non-theoretical, tangible case studies from around the world. The editors stress that the idea was not to cover the globe but to include as many different situations as possible. This comes across very clearly, and the grid of issues concerning rights and education that they build up is quite exhaustive.

The case studies can be described by the parameters of four axes. One axis spans all things related to the state: the legal system, conventions on human rights, educational policies and practice, economics, ruling regimes, and civil rights and duties. Another spans the individuals concerned: disabled persons, their families, caregivers, teachers and members of the surrounding community. These are considered as receivers and actors in the struggle for the right to education, with all their strengths, weaknesses and limitations. The third concerns the grey area in the middle: culture, belief systems, attitudes, perceptions of disability, historical frameworks, power relations and societal norms. And, as in the real world, the fourth dimension is ever ubiquitous and lies in the concepts of empowerment, conscientization, awareness, equity and social justice, which were clearly the driving forces for the interventions and studies described. These parameters precede the geographical location and, equally, describe it.

The impressive group of contributors speak of the struggle for human rights and education of disabled people in a refreshingly reflective nature. The accounts are frank and evaluative of the interventions or efforts that have taken place over the years; and their concluding remarks and questions tie together the lessons learned from the experience and, more often than not, confess to the need for much more work on the

issue at hand.

Each chapter takes care in drawing the reader into the specific setting, providing the cultural context and tracing the history of disability and education in each case. It is this candid picture that provides the most insight into the problem that lies in ensuring education for disabled persons, whether in the re-enactment of a law, or in inspecting the social perceptions of disability more closely. And it is through these forays that additional issues relating to race, gender and the West vs. East discourse arise.

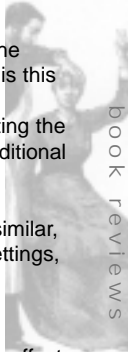
However, the descriptions that set the 'disability' scene were often too general or similar, which sometimes served to illustrate the 'universality' of the problem in different settings, and at times became redundant. This may be the outcome of compiling an edited collection, which otherwise tied in neatly with the editors' concluding chapter.

Furthermore, while the main topic of the collection was on education, which mainly affects or involves children, there was a striking absence of children's voices throughout the book. The voices of the disabled generally made rare appearances in the text. This is not uncommon of most of the literature on children, and of studies concerning the disabled, which once again leaves any analysis lacking by not considering their points of view.

On the other hand, it was refreshing to find that the fashionable debate of institutions/special schools versus inclusive/mainstream schools only received as much attention as it deserved. After all, the main issue precedes this debate by discussing the right to any form of education. In this sense, the texts and discussions on the human rights aspects were much more engaging and interesting than the local details of the educational system. These did much to illuminate and enforce my own understanding of rights where disabled persons are concerned, and reflect upon how much "non-disabled [people] do not understand disabled ones", as the book non-maliciously accuses us at some point.

In this sense, and for several of the reasons mentioned above, this book provides an essential contribution to the educational literature on disability, in parts and as a whole. It complements the largely theoretical and intellectual debates found in most books on disability - it embodies several existing theories in hard, real facts, and goes to great lengths to span the debate from end to end, and to highlight areas in need of further thought and research. It is a highly commended effort, and a thoroughly rewarding read.

Maha Damaj, London School of Hygiene and Tropical Medicine, University of London



**Read J. 2000 Disability, the Family and Society: Listening to mothers
Buckingham:Open University Press (ISBN 0335203108 Pbk £18.99)**

This book is one in the series 'Disability, Human Rights and Society', in which disability is defined as a form of oppression and is examined in terms of rights and equal opportunities.

Central to the book is a small-scale study of 12 mothers of disabled children. Read uses these mothers' accounts of their struggles to combat discrimination, together with theoretical work on motherhood generally, to explain why and how they take on the role of mediator for their children.

In the first chapter Read provides overviews of both policy and research in the last 20 years - the approximate lifespan of the disabled children. She charts the growing awareness of the need for inclusive policies and the increasing numbers of children with significant support needs. In terms of research, she charts the shift from blaming problems on dysfunctional families to actively seeking parents' (and later children's own) views on needs and services, and goes on to talk about disability being located within debates on social oppression, civil rights and exclusion.

Chapter 2 describes the study, carried out in 1996 in the West Midlands. The 12 participants were all mothers who had children with physical or sensory impairments, aged over 16. Read wanted to find out what was distinctive about the things that mothers of disabled children had to do, in particular in terms of mediating with other people: explaining to their children the attitudes of other people; explaining their children's behaviour or impairments to family, friends and outsiders; negotiating with / challenging powerful professionals.

These 12 mothers' experiences are set in context in Chapter 3 which looks at the literature concerning the mothers of disabled children generally, including their often extended caring role, their worries about balancing the needs of other family members, their potential social isolation and their unequal relationships with professionals.

The theoretical perspectives of motherhood, mothering and caring are discussed in Chapter 4, eg. psychoanalysis, Marxism and feminism; in Chapter 5 she looks at the (changing) theoretical perspectives of disability. The participants in this study recognise the many changes that have occurred in their children's lifetimes but they know that they still live in a discriminatory and sometimes hostile environment.

In the final chapter Read argues that the mothers' role of mediator on behalf of their disabled children is similar to but is a much magnified version of the role most mothers adopt on behalf of their children. But these mothers have to conduct their lives much more publicly and their motives are scrutinised much more closely. The experience of mothering a disabled child has forced some in the study to change their own attitudes to disability; has led some to the discovery of previously unnoticed injustice and unfairness; and many have found they have to fight unfairness from a position of powerlessness and isolation.

I read the book from cover to cover in one session and found it to be accessible, absorbing and at times very moving. I did not feel I learned anything new from this book,

but because the reader is taken expertly through all the issues it will be invaluable for readers new to the debates surrounding disability and motherhood.

This book will be of interest to students of disability studies, social policy, women's studies and sociology. I would like to see it become compulsory reading for professional service providers (working in the likes of local health authorities, local government and voluntary organisations) together with the other books in this series.

Paulene Hudson, Bath Spa University College

Costain Schou K, and Hewison J. (1999) Experiencing Cancer: quality of life in treatment Buckingham: Open University Press (ISBN 0 335 19891 0 pbk £15.99)

The book is aimed at those interested in current developments in the sociology and social psychology of the body and would be of particular use to doctors, nurses and other health and caring professionals or health studies students. It should also be read by those who are responsible for planning, delivering and evaluating cancer services since it goes beyond much of the rhetoric around service provision by offering the perspective of those for whom the services are provided. The central focus of the book is the concept of quality of life and although the context is that of oncology the evidence presented is applicable to other specialities or clients with life threatening illness. The book is well written and draws upon a range of literature and research predominantly from the sociology and psychology of health and illness. There is a brief but useful appendix on the methodology of the research, its analysis and the subsequent theoretical development. The presentation is clear, the book is easy to use and the text is illustrated with transcribed material from qualitative interviews. My only reservation is the absence of any consideration of clients from minority ethnic groups. The authors are critical of the functional, pathological and individualist emphasis in existing quality of life studies and aim to move beyond these to examine the psychosocial aspects of cancer and cancer treatment. They are critical of the developing area of psychosocial oncology and its impact on health care and professional practice and in particular the individualistic perspective which locates problems of treatment in the patient rather than in the process of treatment itself. They propose an alternative view of cancer treatment as a social interaction where people become patients and experience treatment. The evidence is drawn from a qualitative study of people receiving cancer treatments at a major UK regional centre and is based on the concept of an illness calendar. The clients' experience at different stages from diagnosis and treatment is explored and the impact of professional attitudes, limited resources and availability and accuracy of information is discussed.

The interview material highlights how the participants saw the therapeutic function of the cancer unit more in terms of providing social support than the actual biomedical treatment given. They describe the comforting little world of the centre and although plagued by resource problems it was an area where disparate groups of lay and professional people, patients and their families learned about illness, treatment, survival and death. The process of diagnosis is particularly painful and the excerpts testify to the way in which the majority of patients are not given a diagnosis but make intuitive assumptions from the euphemisms used and the words avoided by doctors. They also articulate the way in which social issues such as the need to work or problems with travel to and from

treatment are excluded from the medical agenda. They demonstrate the effects of the lack of choice about when treatment takes place, and the failure to obtain adequate information about the effects or side effects of treatment and prognosis.

The excerpts describe the additional difficulties experienced because of lack of continuity of professionals, uncertainty about who could give information and conflicting advice from different personnel. Administrative problems with appointments, missing records, equipment failure and backlogs for treatment all extended the treatment calendar for patients and induced much stress and uncertainty. These and many more experiences are vivid and real but are rarely in the forefront of thought of service providers or professionals working with cancer patients. Many of the issues highlighted do not require major financial or educational investment to put right but all impact on quality of life with people with cancer. The authors argue for a social view of illness and treatment experience not dominated by functionalist definitions of quality of life which ignore the meaning and experience of cancer. They argue for a more sophisticated understanding of measurement which genuinely takes account of the patient's agenda and the context within which their experience is constructed.

A valuable book for all health and social care professionals especially those working with people and families who are chronically or terminally ill.

Mary Tilki, Middlesex University

Walter T. (1999) *On Bereavement: the culture of grief* Buckingham: Open University Press (ISBN 0 335 20080X Pbk ,17.00)

Tony Walter's *On Bereavement* represents the fourth contribution to the *Facing Death* series. Whilst earlier contributors to this series focussed on developments in palliative care and treatment calendars associated with cancer experience, Tony Walter moves discussion beyond the dying process and death itself to deal with the concept of bereavement. Tony Walter produces a thorough sociological analysis of this awful, frequently very complex, yet ubiquitous experience.

Tony Walter's earlier chapters focus on the ways which differing human societies engage and relate to their dead. In doing so he explores how anthropological literature contributes towards our understanding of how societies integrate, or fail to integrate, their dead members. This all helps the reader make sense of relationship with the dead, yet paradoxically helps explain our role in the 'living' world.

Tony Walter examines the importance of conflict in the twentieth century as a basis for our reactions to bereavement and how these have been shaped by differing nations, and gender. In times of 'relative' peace Walter suggests our perspective on death, and its meaning is very different - forgetting, not remembering the deceased.

Walter also draws upon theoretical constructs to help the reader understand the many ways in which grief are socially defined in modern societies and cultures. Walter refers to this as 'policing grief'. Inevitably and interestingly, the contemporary experience of the death and dying with reference to Dunblane and Princess Diana are explored as models of individual and public 'expressiveness'.

Tony Walter applies his sociological insight to help account for one of the most personal and painful of human experiences. On Bereavement represents valuable reading to students, researchers and health and social care professionals with an interest in the field.

Jonathan Koffman, King's College, University of London

Books available for review

Aggleton P. (Ed.) 1999 Men Who Sell Sex: International perspectives on male prostitution and HIV/AIDS London: UCL Press

Aggleton P, Hart G, Davies P. (Eds.) 1999 Families and Communities Responding to AIDS London: UCL Press

Ahmad WIU. 2000 Ethnicity, Disability and Chronic Illness Buckingham: Open University Press

Argyrous G. 2000 Statistics for Social and Health Research London: Sage

Battin MP, Rhodes R, Silvers A. (Eds.) 1998 Physician Assisted Suicide: expanding the debate London: Routledge

Bellaby P. 1999 Sick from Work: the body in employment Aldershot: Ashgate

Catalan J. (Ed.) 1999 Mental Health and HIV Infection: psychological and psychiatric aspects London: UCL Press

Hayry H. 1998 Individual Liberty and Medical Control Aldershot: Ashgate

Malin N, Manthorpe J, Race D, and Wilmot S. 1999 Community Care for Nurses and the Caring Professions Buckingham: Open University Press

Moatti JP, Souteyrand Y, Prieur A, Sandfort T, Aggleton P. 2000 AIDS in Europe: new challenges for the social sciences London: Routledge

Saltman RB, Figueras J, and Sakellarides C. (Eds.) 1998 Critical Challenges for Health Care Reform in Europe Buckingham: Open University Press

Scherer JM, and Simon RJ. 1999 Euthanasia and the Right to Die: a comparative view Oxford: Rowman & Littlefield Publishers

Tovey P. (ed.) 2000 Contemporary Primary Care: the challenges of change Buckingham: Open University Press

Scott WR, Ruef M, Mendel PJ, Caronna CA. 2000 Institutional Change and Healthcare Organizations: from professional dominance to managed care Chicago: University of



Chicago Press

Watson J. 2000 *Male Bodies: health, culture and identity* Buckingham: Open University Press

Watson J, Platt S. (eds.) 2000 *Researching Health Promotion* London: Routledge

Wood B. 2000 *Patient Power? The Politics of Patients' Associations in Britain and America* Buckingham: Open University Press

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About Medical Sociology News....

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

Copy Deadlines

	Issue date	Copy deadline
Volume 26 Number 3	December 2000	27th October 2000

Subscription rates for three issues are:

Overseas	£15
Institutions(Total and otherwise)	£15
UK (waged)	£10
UK (unwaged)	£5

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Problem page with Agony Aunt Margery

Marge has had a bulging post-bag over the last few months, and she was particularly taken with one lonely young academic who sent not only a detailed description of life's little problem areas, but also a rather fetching photo. In fact, so devoted has Marge been to solving this correspondent's problems, that we haven't been able to pin her down to reply to others. Luckily, two readers have helped Marge out with this issue's Star Problem, which we reprint here, with two replies. If other readers have any sensible (or otherwise) suggestions for Ignored of Inverness, do write. We are hoping Marge can be dragged from her (over) personal correspondence in time for the next issue, so please continue to send your Dear Marge letters, care of the editors, and we will endeavour to sit her down to provide sage advice.

Dear Margery

It is often said that it is the little things in life that annoy us most. One of the issues which annoys me is the lack of appreciation I receive for my time spent with students, colleagues, and 'strangers' on sociological research issues. I am a medical sociologist working in a medical school and I find that often people show much greater appreciation to the advice given by statisticians than to the advice I give. For example, statisticians are likely to be asked to be co-authors of research papers for giving advice on final data analysis, but I might not even be acknowledged in someone's paper. Meanwhile I have probably spent far more time with the author(s) before and during the research project.

And it is not only the medics who fail to appreciate the sociology input. Not so long ago a MSc student, to whom I had given a lot of time both during her research project and the write up stage, published a paper on her study. In this paper she acknowledged the support of a statistician and her other supervisor (who happens to be a unit director), and failed to mention my assistance.

It could, of course, be the case that my advice is simply less useful. But assuming that this is not always the case, can you give me any advice? What should I do to get people to acknowledge my input?

Yours truly,

'Ignored of Inverness'

Dear Ignored of Inverness

Your dilemma is instantly recognisable as an all too common scenario. In my experience it is part of the "handmaiden syndrome" in which social scientists are employed for their research skills while at the same time being given little or no credit for their work. The worst cases I have seen have involved MD theses, for which the social scientist may do a tremendous amount of work while the medic gains their MD. Whether or not this describes your situation, I think that some of the reasons may still apply. For many medics, sociology represents "common sense", and they fail to appreciate that it is a separate discipline with its own literature, concepts and methodologies. Often the problem is structural, if the sociologist is in a junior position on a short term contract. It may also be a gender issue, if the sociologist is female.

Never mind all this, what can you do about it? I have a number of suggestions none of which represents an easy solution, and some of which may be unrealistic.

- * You could simply refuse to give advice, perhaps giving your reasons ie lack of acknowledgement (the direct approach) or lack of time (the indirect approach)

- * You could ask people why they have sought your advice, to try and make them see that you have something they value

- * You could ask people to acknowledge your input, once you have spent more than a minimal amount of time on them

- * You could raise the issue with your unit director, head of department or whoever is in a position to make an issue of it

- * You could ask for guidelines to be drawn up in the department, analogous to guidelines about authorship

- * Assuming that this is part of a much wider issue, you could form a support group in your department, division, medical school, union, or whatever forum is most appropriate to your circumstances

Whatever you think of the other suggestions, I think you should give serious consideration to the last. In my own department, the contract researchers have formed a closed group to discuss these kinds of issues, and I think it has provided a very important forum.

Yours,

Nicky Britten
GKT Concordance Unit

Dear 'Ignored of Inverness'

I sympathise with your plight. It's not always easy being a non-clinician (as we're thought of!) in a medical department. Medics and sociologists are trained, and often still live, in different worlds and while some will respect your expertise, others remain dismissive, or at least disinterested. However, you need to be a lot more bolshy than you're being at present. This is not "one of the little things in life" that is mildly annoying, it's a group of people devaluing your professional skills and training. It's very unlikely that your advice is not useful or else people would not keep coming to you for assistance, so don't be so meek and don't undervalue yourself!

First, check whether there is a departmental policy on authorship. If not, it is worth looking at various models of attributing authorship and acknowledgements (eg BMJ guidelines are on-line and see the Editorial on authorship in *Social Science & Medicine* 1997 45 (1) p1-2).). Ask colleagues which model they work from. They may not have considered this, but at least it gives you a starting point from which to discuss authorship. Secondly, decide how much time you are willing to spend on consultations. Have office hours when you're free to see people, and times when you're not. You may decide you wish to allot more time to students, depending on your teaching commitments. However, with colleagues and 'strangers', it may be best to have an initial meeting to see what their requirements are, to see whether you are willing to help, and if so, in what capacity. It's often worthwhile being up-front about this and asking them directly how much help they require, and how they see your contribution to their paper. If it's a subject you're interested in, you may wish to devote more time. If not, you can still be helpful by drawing on your research knowledge, suggesting some relevant reading and / or directing them to others in the field.

Finally, work out who you really want to work with and where you want to publish. If there's a like-minded medic in the department, why not write a grant proposal with them? If not, work with other medical sociologists with similar interests. Make sure your CV does not get too specialised in case you wish to move out of the medical department. Life's too short to work with people (of any discipline) who don't respect your skills.

Yours

'Hard-nosed of Harrow'



