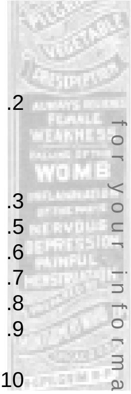

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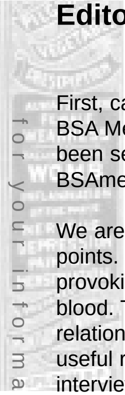


Editorial

First, can we remind readers of the 27th April deadline for submission of abstracts for the BSA Medical Sociology Annual Conference? Booking forms for the conference have been sent in a separate mailing - further copies are available from the BSA office (email BSAmedsoc@britsoc.org.uk) or from the web site on http://medsocbsa.swan.ac.uk/

We are pleased to publish two articles which take personal experiences as starting points. The first, by Ursula Harries and introduced by Helen Busby, is a thought provoking reflection on the ‘Gift Relationship’ in the light of her experience of giving blood. The second is Kathryn Ehrich’s account of being ‘on the other side’ of the research relationship. Her discussion of the emotional impact of a research interview is a really useful reminder for all of us to consider carefully what the process might feel like for our interviewees.

Many congratulations to Jon Adams, Lesley Lockyer and Margaret Rogers who have all been awarded PhDs recently. Abstracts of their theses are published in this issue.

Also in this issue are: a brief report on a ‘Virtual Centre’ for Medical Sociology, Social Theory and Health at UCL; sage advice from Agony Aunt Margery and two readers on how to manage research in a short term culture; and reports from various conferences.

We are, as always, very grateful to colleagues who have contributed copy for this issue of Medical Sociology News. Many renewal cheques came with positive notes about past issues - so your efforts are appreciated! Although the pressure on most of us is to concentrate on publications which are going to ‘count’ for the RAE, MSN is a good way of disseminating new research findings, information and thoughts on teaching to colleagues in the field. So please continue to send articles, letters, conference reports and book reviews to the addresses listed at the back.

Finally, Virgina Olesen, in the School of Nursing at the University of California, has kept copies of Medical Sociology News going back at least ten years. She has offered them to anyone who would like them for archives. If any readers are interested, we can pass on contact details.

The Editorial Team

Learning from HIV/AIDS

2001 Symposium of the Biosocial Society

9am-5pm Friday 27th April 2001

Elvin Hall

Institute of Education

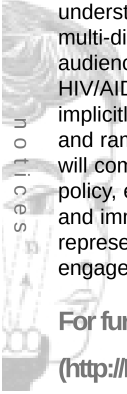
University of London

Contact: http://BioSoc2001.ioe.ac.uk/BioSoc/ (website available from 20th December 2000)

Continuing the Biosocial Society’s tradition of fostering a multidisciplinary approach to drawing together research from different disciplines as well as perspectives from academic, statutory and voluntary sector organisations, the 2001 Biosocial Society Symposium, Learning from HIV/AIDS will examine what HIV/AIDS might tell us about the bio(logical and)social nature of the human condition at the beginning of the 21st century.

HIV/AIDS threatens not only to reverse the improvements in health brought about by advances in sanitation and medicine, but also to undermine the provision of public services and the impact of development policies and globalisation. These concerns have resulted in substantial research activity, both theoretical and applied, and have led to an unprecedented array of publications examining individual, familial, communal, and global “responses” to HIV/AIDS. Drawing on its multidisciplinary traditions, the Biosocial Society’s 2001 Symposium seeks to understand the extent to which HIV/AIDS (as both biological entity and social phenomenon) might reveal hitherto unexposed characteristics of the bio(logical and)social world in which we live. Such an approach would ask the question: “What can HIV/AIDS (as a unique, yet diverse and unprecedented phenomenon) tell us about the biological and social nature of human society, and the way these two are inter-related?”. It is an approach that will draw together parallel (if not necessarily complementary) strands of research to explore what HIV/AIDS, and responses to HIV/AIDS, can tell us about the biosocial nature of society the nature of the human immune system and biocultural predictors of risk, the nature of social structures and identity, public policies and epidemiological economics, as well as the contextual nature of the research process itself. By examining what researchers from very different disciplines have observed in their research on HIV/AIDS, a biosocial approach seeks to transcend disciplinary boundaries and synthesise a broader understanding of what it is researchers have found and how their approach influences the insights and conclusions they have made.

The Symposium seeks to engage not only with the Society’s existing constituency of academics and students (interested in promoting a greater



understanding of biological and social issues through an explicitly multi-disciplinary, biosocial approach) but also to engage with a broader audience of academics, advocates and health care practitioners involved in HIV/AIDS-related research, advocacy and practice, many of whom apply an implicitly multidisciplinary approach when seeking to understand the causes and ramifications of this phenomenon. To this end, the one-day Symposium will comprise presentations from researchers in the fields of social policy, economics, social psychology, anthropology, evolutionary biology and immunology, together with responses from practitioners, advocates and representatives of public, private and voluntary sector organisations engaged in the prevention, treatment and support of at-risk populations.

For further details, please contact the Symposium website (http://BioSoc2001.ioe.ac.uk/BioSoc2001/ which will be available from 20th December 2000)

North East and Midlands Medical Sociology Group

25th April 2001

at TRENT PALLIATIVE CARE CENTRE at 1.00 pm

1.00 Nick Fox, Institute of General Practice, ScHARR
 - Beyond Health postmodernism and the body

1.40 Lorna Warren and Joe Cook, Sociological Studies, University of Sheffield - Older women talk health

2.20 tea

2.35 Ian Shaw, School of Sociology and Social Policy, University of Nottingham - Managing difficult patients -primary care psychiatry

3.15 Alicia O'Cathain, Medical Care Research Unit, ScHARR - How do nurses make decisions in NHS Direct - the 24 hour nurse led help line

Jane Seymour, Catherine Exley, Rose Woodhill (NEMSHIG co-ordinators)
#...
I will/ will not be attending the above

Name ....

Address..e.mail.........................

Please return to Pauline Hutchinson, Trent Palliative Care Centre, Sykes House, Little Common Lane,
Abbey Lane, Sheffield Sll 9NE Tel 0114 2620174 fax 0116 2362916 email spcsg-conferences@sheffield.ac.uk Map sent on receipt of this form

Human Values in Health Care Forum

President	**Lord Kilpatrick of Kincraig**
Chairman	**Dr Paul Wainwright**

Programme for 2001

Unless otherwise indicated, meetings are held at 2.00 p.m. in
Gresham College, Barnard's Inn Hall, Holborn, London EC1 2HH.

Wednesday	March 28	New NHS : New Values for Old? Speakers: Drs. Nick Hicks & Iona Heath
Wednesday	June 6	AGM followed by Inequalities in Child Health: Why do they persist and what can be done ? Speakers: Prof. Helen Roberts, City University; Kath Moser Office of National Statistics
Monday	October 1 2.00-5.30pm	Joint meeting with Royal Society of Medicine in Wimpole St. Humanitarian disaster relief : ntrusion or moral mandate? Speakers : to include Prof. Donna Dickenson

Further details can be obtained from the Secretary to the Forum.

Dr. Andrew Dicker,
Cambridge Surgery,
93 Cambridge St., London
SW1V 4PY

Preliminary Announcement

BPOS Annual Conference Call for Papers

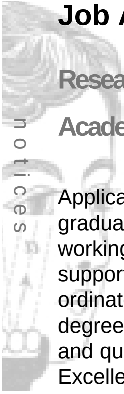
The annual conference will take place on m6th and 7th December 2001
at
The Royal Marsden Conference and Education Centre London SW7

The themes of the conference will focus on:

* Training and service issues
* The media and cancer
* Ethics and decision making
* Ethnicity

Preliminary enquiries to the co-organisers: Maggie Watson and Clare Moynihan
Tel: 0208 661 3009

Email: Clare@icr.ac.uk or maggie.watson@rmh.nthames.nhs.uk



Job Advertisement

Research Assistant, Familial Prostate Cancer Screening Study,

Academic Department of Radiotherapy, Cancer Screening and Evaluation Unit.

Applications are invited for the post of a full time social science researcher with a post graduate degree, preferably to doctoral level or equivalent. Previous experience of working with people with serious illness, preferably cancer, is required. The study is supported for three years by the Cancer Research Campaign and you will need to co-ordinate a study to assess the psychological and social impact of screening in first degree relatives of men with prostate cancer. You will have experience in both qualitative and quantitative research methods including interviewing techniques and analysing data. Excellent organisational skills are required as well as previous experience in setting up and managing a computer data base.

Informal enquiries to Clare Moynihan on 0208661 3071 or
e-mail: clare@icr.ac.uk

Salary will be in the range of £18,437 - £28,588 p.a. inclusive.

To apply, please send two copies of your CV including the names and addresses of two referees to the Personnel Office. The Institute of Cancer Research, 123 Old Brompton Road, London SW7 3RP quoting reference number B219. For further particulars please call our 24 hr recruitment line on 020 7 970 6061.

Closing date 30th March 2001

University of Surrey

Day Courses in Social Research

The following day courses are available in Spring 2001

Analysing Qualitative Data	14th February 2001
Designing Interviews & Questionnaires	*13th - 14th March 2001
Designing & Creating Pages for the WWW	4th April 2001
Researching Childhood & Children	2nd May 2001
Video-based Studies of Social Interaction	9th May 2001
Designing Samples for Surveys	16th May 2001

Venue: University of Surrey, Guildford, GU2 7XH

Cost:
£110 (£90 for educational institutions/charities)
*£180 (£160 for educational institutions/charities)
£20 “standby” places for full-time PhD students

Contact:
Elizabeth Stutchbury:
Tel: 01483-259458
Fax: 01483-259551
email: day.courses@soc.surrey.ac.uk
web: http://www.soc.surrey.ac.uk/

4th Biennial International Nursing and Midwifery Conference: Contesting Conversations in Practice, Education, Research and Policy

Adelaide Convention Centre, Adelaide, South Australia

Sunday 4th - Wednesday 7th November 2001

Where else but in Adelaide in November 2001 - will you be able to hear: Patricia Benner on ‘Interpretive Phenomenology’ & ‘Competence, Expertise & Advanced Practice’, Ray Rowden on ‘The Quality Agenda’ and ‘Clinical Management’,Cindy Shannon on ‘Indigenous Health’, Gary Rolfe on ‘Reflective Practice & Writing’ and ‘The Theory Practice Gap’, Philip Darbyshire on ‘Health, Illness, Arts and Literature’, Paul Lewis on Midwifery, Tina Koch on ‘Participatory Action Research’, Julianne Cheek on ‘Discourse Analysis & Poststructural Research Approaches’ and The Joanna Briggs Institute on ‘Evidence Based Practice and that is only the Pre and Post Conference Seminar Programme! Don’t even THINK of missing the most exciting Nursing & Midwifery Conference of 2001!

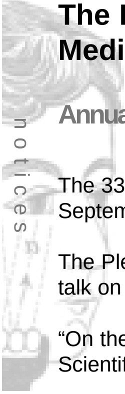
4th Biennial International Nursing and Midwifery Conference:Contesting Conversations in Practice, Education, Research and Policy, Adelaide Convention Centre, Adelaide, South Australia, Sunday 4th - Wednesday 7th November 2001

Keynote Presenters:Patricia Benner, Professor of Nursing, University of California, USA.Paul Lewis, Professor of Midwifery, Bournemouth University, UK.Cindy Shannon, Assoc. Professor, Director, Indigenous Health Program, The University of Queensland, Australia. Gary Rolfe, Reader in Nursing, School of Health and Social Care, University of Portsmouth, UK.Philip Darbyshire, Professor of Nursing, Women’s & Children’s Hospital, University of South Australia and Flinders University, Australia. Ray Rowden, Hon Professor of Clinical Management, University of York, UK.

Since its inception in 1995, the International Connecting Conversations Conference series has become one of the most stimulating, interactive, enjoyable and valuable events in the nursing and midwifery calendar. This year’s conference in Adelaide, Australia will be no exception. We once again bring together internationally renowned keynote presenters, and recognised expert pre and post conference workshop presenters, with nurses, midwives and other health care professionals to debate and discuss vital issues, to share new initiatives and exciting innovations in research, education and practice and to network with leading national and international colleagues. On behalf of the Conference Organising Committee, I invite you to join us for this important event. This is the ideal forum to present and discuss your research, showcase your practice initiative or clinical advance, highlight your educational innovation, or add your critique of a current health or professional issue. The deadline for submission of abstracts is 5.00 pm, March 30th, 2001.All of the contact details and information regarding abstract submission, registration, pre and post conference seminars, travel and tourism are available on the conference web page at:

www.sapmea.asn.au/Conventions/CCERP/ccerp.htm

Visit this page or contact ccerp@sapmea.asn.auto register your interest or to request any information about the conference or about making that trip to Australia that you've always been promising yourself. We look forward very much to welcoming you to Adelaide in November.
Very best wishes Professor Philip Darbyshire
CCERP Conference Organising Committee



The British Sociological Association Medical Sociology Group

Annual Conference 2001

The 33rd Annual Conference of the BSA Medical Sociology Group will be held on September 21st - 23rd at the University of York.

The Plenary Speaker will be Professor Michael Bloor SOCSI, Cardiff University, who will talk on

“On the consulting room couch with Citizen Science: the approach of the Sociology of Scientific Knowledge to practitioner-client relationships”

Those wishing to present a paper must submit an abstract by April 27th 2001. Abstracts received after this date will not be considered.

Further information, abstract submission form and booking form available from
the BSA Medical Sociology Group web site:
http://medsocbsa.swan.ac.uk/

or available from:

The British Sociological Association
Unit 3F/G Mountjoy Research Centre
Stockton Road
Durham DH1 3UR
email Bsamedsoc@britsoc.org.uk

Reports from regional groups

North West (Manchester)

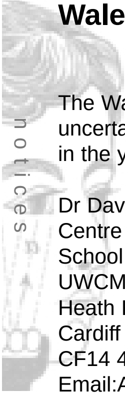
The Greater Manchester Medical Sociology Study Group (MSSG) is organised by a committee comprising: Emma Hayter, Joel Richman, Lynn Sbaih and Tony Warne.

We aim to meet once every month (the first Wednesday). Usually each session will start at 4pm with refreshments, followed by the presentation of paper at 4.30 pm. We would welcome offers from the field of anyone wishing to present a paper. Work in progress and completed studies would be equally welcome.

For further information on the North West BSA (Greater Manchester) Medical Sociology Study Group or the Post Graduate Research Forum, please contact:

Emma Hayter, The Manchester Metropolitan University, Department of Health Care Studies, Elizabeth Gaskell Campus, Hathersage Road, Manchester, M13 0JA, tel: 0161 247 2514

OR Tony Warne, email: A.R.Warne@MMU.ac.uk



Wales

The Wales Group has not so far held a meeting in 2000, largely because of uncertainties about available funding. It is hoped to resume meetings later in the year. For information about the group please contact:

Dr Davina Allen
Centre for Nursing, Health and Social Care Research
School of Nursing and Midwifery Studies
UWCM
Heath Park
Cardiff
CF14 4XN
Email:AllenDA@CF.AC.UK
tel: 029-20743837

or:

David Hughes,
School of Health Science,
University of Wales Swansea,
Swansea SA2 0LT.
Email D.Hughes@swan.ac.uk
tel: 01792 295810

South West Regional Study Group

A one day seminar was held on Saturday 24th February hosted by Dr Catherine Pope at the Department of Social Medicine, University of Bristol. It was well attended by members from Exeter, Plymouth, Cardiff and Bristol.

The theme for the day was Sociology and Public Health. Two papers were presented the first by David Evans (Avon Health Authority/University of West of England) on public health professions in the NHS. This discussion of current debates around the appropriate knowledge, skills and training of public health specialists drew on sociological analysis of the professions. It explored relationships between those public health professionals with and without medical training and examined recent policy in this area. The second paper was presented by Professor Gareth Williams (University of Wales, Cardiff) and examined area inequalities in health. Referring to recent work on the connections between place (context) and morbidity (composition) this paper discussed the findings of research looking at the health of mining communities in Wales. It was a successful and enjoyable day and the group plan to convene another seminar later in the year in either Plymouth or Exeter.

For details of further meetings please contact Julie.Kent@uwe.ac.uk, tel: 0117 3442356.

Regional Group - LONDON

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

MEETINGS 6PM - 7PM

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

Forthcoming meetings:

14th March Look good, feel better: the aesthetic and the therapeutic in beauty therapy Paula Black, University of Manchester & Ursula Sharma, University of Derby.

11th April Resisting risk technology: anti-rational discourses and the pursuit of health Judy Green & Nicki Thorogood, London School of Hygiene & Tropical Medicine.

9th May Media representations of infant feeding Jenny Kitzinger, Brunel University.

13th June The exotic and the mundane: trends in the sociological examination of reproductive technology Jane Sandall, Kings College, London.

11th July Women's understanding of genetic "risk management" Nina Hallowell, Cambridge University.

12th Sep Working with men in a clinical setting, Clare Moynihan, Institute of Cancer Research & Royal Marsden Hospital Trust.

For further copies of this programme please contact Paul Godin 020 7505 5933. To receive details of all LMSG meetings contact Mark Newman, m.newman@mdx.ac.uk or visit the BSA website: http://medsocbsa.swan.ac.uk

Joint LMSG Organisers: Paul Godin (Convenor), Rachel Grellier, Anne Jones, Chris McCourt, Mark Newman, Susan Robinson, Margaret Rogers.

PhD Abstracts

Pain talk in oncology outpatient clinics.

Rogers, MS (2000) University of Cambridge

Despite improvements in cancer management over the past 25 years, unrelieved symptoms continue to be reported. Little is known about how patients' problems and concerns are communicated to professionals during oncology treatment.

This research investigates communication between cancer patients and clinicians in hospital outpatient clinics. Data were collected by non-participant observation and audio recording of consultations. Analyses were by qualitative content analysis and conversation analysis. An Objectives, Strategies and Tactics model was applied to organise the findings.

74 consultations between cancer patients and 15 doctors were observed and audio recorded. Pain talk is defined and identified as a substantial topic, occurring in 39/74 consultations. Doctor-initiated questions are the predominant discourse feature occupying over two-fifths of pain talk sequences. Their questions are prominent not only in initiating discussions but also in directing further talk. In other words, clinicians' questions control both the content and order of talk within pain talk sequences (eg, over three-quarters of doctor-initiated questions are in a closed form which focus narrowly on limited physical aspects of patients' pain). It is argued that this limited information exchange alongside other communication tactics, is used to identify the 'right kind' of pain which may benefit from cancer therapy and to truncate talk of problems perceived to be outside of this specialist remit.

It is argued that although patients do not overtly challenge clinicians' authority and expertise and their contributions are at times very brief, they are active participants nonetheless. How patients talk about pain is associated with how the topic is instituted. Patients who initiated pain talk use communication tactics that amplify their pain experiences apparently in order to have their suffering attended to by their doctors and obtain relief from their distress. Those patients for whom pain talk was introduced by doctors, use communication tactics that minimise their pain experiences in an apparent attempt to conceal potential cancer recurrence or progression. Although clinicians have a range of pain management options available to them, cancer therapy is most frequently utilised and analgesics are rarely prescribed.

It is concluded that communication about pain in oncology outpatient clinics is controlled by doctors and information is used to make cancer treatment decisions and not primarily for symptom management purposes.

Margaret Rogers
General Practice and Primary Care Research Unit
Institute of Public Health, Robinson Way
Cambridge CB2 2SR
msr1002@medschl.cam.ac.uk

The Experience of women in the Diagnosis and Treatment of Coronary Heart Disease

Lesley Lockyer

There is currently little sociological research on which to understand the meaning and understanding of coronary heart disease for women who have heart disease.
This lack of research has appeared to have led to health policy for women, being based overwhelmingly on research undertaken on white middle aged men. Without research on women many interventions (e.g. health education, well women clinics, referral procedures, drugs and clinical procedures) may be both inappropriately designed and used.

The research was undertaken in two stages and used quantitative and qualitative methods. The first stage was a survey of two hundred and twenty four randomly selected medical records of women admitted to a tertiary centre to give quantifiable information on their referral, treatment and outcome of treatment. Data analysis allowed women to be identified who met the interview criteria; a diagnosis of coronary heart disease, aged over eighteen and no documented medical condition suggesting they would be unable to give informed consent for a research interview.

The second stage consisted of interviews with twenty nine women focused around their experience of diagnosis, referral and treatment and the feelings and meanings given they gave to these experiences.

Analysis of the qualitative data allowed the women’s narrative to be discussed and linked back to the quantitative data. It appears from this study that women’s experience of coronary heart disease does not reproduce the picture of men’s experiences painted in the recent literature. The biomedical progression of the disease ensures that the dramatic nature of coronary heart disease portrayed in media accounts of myocardial infarction and cardiac surgery are unreal for many women, ensuring that women themselves do not recognise their own level of risk of developing coronary heart disease and coronary heart disease symptoms when they occur.

(PhD from Dept of Social and Political Science at Royal Holloway College, University of London.)

Lesley Lockyer
Research Fellow
School of Healthcare Studies
Baines Wing
University of Leeds
Leeds LS2 9UT

Innovative Health Technologies

An ESRC Research Programme

New Research for a New Health System

Launch on May 8th in London, Chaired by Dame Mary Warnock

Issues relating to a wide range of innovative health technologies (IHTs) are currently being widely covered in the media. Developments in genetics, imaging technologies, cloning and stem cell research continue to challenge people's traditional concepts of the NHS – the concepts of the patients and carers themselves, the government, and the legal system. These new developments are clearly going to have an impact upon all our lives and they have, therefore, given rise to many new and diverse questions for social science.

The Innovative Health Technologies Programme, due to be launched in May 2001, will seek to address some of these questions. Funded jointly by the Economic and Social Research Council and the Medical Research Council, this new Programme will examine the role that these and other new technologies now play – and will increasingly play in future – in redefining the way we manage and experience health and medicine. Recent debates about rationing are also relevant to the current debate, since these technologies may redraw the boundaries of health need and provision.

The £5m Innovative Health Technologies Programme will provide an opportunity for all those interested in promoting, understanding and regulating developments that will have a dramatic effect on our lives. Claims and counterclaims as to the benefits and risks such developments have brought, and will bring in the future, reflect the contested terrain occupied by IHTs. They focus debate on definitions and meanings of health and illness, of social values and human identity and of risk and opportunity.

The overall aim of this Programme is to advance our understanding of the interaction between innovative health technologies and wider changes in society. The central question of the Programme is therefore:

How will people and society be affected by, and in turn affect, innovative health technologies?

The programme will be launched on Tuesday, May 8th, in London. Dame Mary Warnock will chair an 'Any Questions-style' debate at the launch event. However, entry is by invitation only. For further details, contact:

Professor Andrew Webster

Science & Technology Studies Unit, Department of Sociology,
University of York, Heslington, York YO10 5DD

Tel: +44 (0)1904 43 3064 Fax: +44 (0)1904 43 3043 Email: ajw25@york.ac.uk

Programme details are available on www.york.ac.uk/res/iht

PROJECTS

Professor JW Abraham
University Of Sussex
Regulation Of Innovative Pharmaceuticals In The EU And US: A Comparative Analysis

Professor B Salter
University Of East Anglia
Reforming The Governance Of Human Genetics: The Politics Of Public Trust

Dr B Woods, Mr R Watson & Professor D Mackenzie
University of York & University Of Edinburgh
A Historical Sociology Of The Wheelchair

Dr D Armstrong, Dr J Ogden, Professor S Wessley & Professor R Lilford
Kings College London & Birmingham University
Quality Of Life As An Innovative Health Technology

Professor PA Atkinson, Dr AJ Clarke, Dr M Worwood, Dr R Hutton & Dr R Ravine
Cardiff University & University Of Wales College Of Medicine
Genetic Screening For Susceptibility To Disease: The Case Of Haemochromatosis

Dr S Cohn
London: Goldsmith's College
The Challenge Of Recent Neurology To Conceptions Of Mental And Physical Illness

Dr P Flowers, Mr JCG Imrie, Professor GJ Hart & Mr M Davis
Glasgow Caledonian University & Royal Free University
Transitions In HIV Management: The Role Of Innovative Health Technologies

Professor J Hewison, Dr J Green, Professor HS Cuckle, Professor RF Mueller & Mr J Thornton
Leeds University & St James' University Hospital
Social And Ethnic Differences In Attitudes And Consent To Prenatal Testing

Dr G Hanlon, Dr A O'Cathain, Dr D Luff, Dr D Greatbatch & Dr T Strangleman
University Of Nottingham, University Of Sheffield & London: King's College
NHS Direct: Patient Empowerment Or Dependency

Ms J Heaton, Ms J Noyes, Dr P Sloper, Dr R Shah
University Of York
Technology And Time: Home Care Regimes And Technology-Dependent Children

Dr S Franklin, Professor A Rutherford & Professor P Braude
Lancaster University & Guy's King's & St Thomas'
Definitions Of Genetic Knowledge & Pre-Implantation Genetic Diagnosis: An Ethnography

Dr FE Griffiths, Professor E Green, Dr GA Bendelow & Dr KC Backett-Milburn
University Of Warwick, University Of Teesside & University Of Edinburgh
IHT's At Women's Midlife: Theory And Diversity Among Women And 'Experts'

Dr FJ Henwood, Dr SME Wyatt & Dr A Hart
University Of East London & University Of Brighton
Presenting And Interpreting Health Risks And Benefits: The Role Of The Internet

Professor GA Lewando-Hundt, Professor J Sandall, Dr K Spencer, Professor R Heyman, Dr C Williams & Mr R Grellier
University of Warwick, City University & Institute Of Education
Social Implications Of One Stop First Trimester Prenatal Screening

Professor DJ Mason, Professor EM Ettorre, Dr GJ Lankshear & Professor HR Greene
University Of Plymouth
The Technological Management Of Childbirth: Risk, Empowerment And Accountability

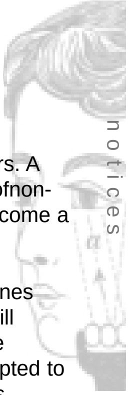
Dr M Michael & Dr N Brown
Goldsmith's College & University Of York
Xenotransplantation: Risk Identities And The Human / Non Human Interface

Professor JV Pickstone & Dr DJ Cantor
Manchester University
Innovation, Assessment And The Hip Prosthesis

Dr LF Prior, Dr J Gray, Professor D Hughes & Dr R Pill
Cardiff University, University Of Wales College Of Medicine And University Of Wales: Swansea
The Construction Of Risk Estimates In A Cancer Genetics Clinic

Dr JE Seymour, Dr DM Gott, Professor D Clark, Professor SH Ahmedzai & Dr G Bellamy
University Of Sheffield
Technology And Natural Death: A Study Of Older People

Dr SP Parr, Dr BL Petheram & Professor SC Byng
City University & University Of The West Of England
Inclusive Internet Technologies For People With Communication Impairment



Unconventional Therapies in General Practice: Boundary - Construction, Identity and Authentication

Jon Adams

The field of unconventional medicines - including acupuncture,homeopathy and hypnotherapy - has undergone far-reachingdevelopments over the last twenty years. A significant number ofpatients are now using unconventional medicines, the ranks ofnon-medically qualified therapists have swollen dramatically and the therapies have become a central topic of public andprofessional debate.

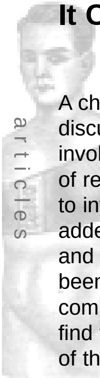
Alongside this general expansion there has been a growinginterest in other medicines from within the orthodox medicalcommunity. While unconventional therapies are still locatedpredominantly outside both National Health Service (NHS)provision and the practice of the medical profession, a range ofhealth care professionals have attempted to forge closer working relations with unconventional medicines. General practice has become a particularly important site for integration and a small yet growing number of general practitioners (GPs) are personallypractising one or a range of unconventional techniques inaddition to more conventional medicines to treat their NHSpatients.

Based on transcripts from twenty-five in-depth interviews conducted with GPs practising unconventional therapies in Edinburgh and Glasgow, the thesis critically examines rank and file GPs' accounts of their direct integrative practice. Particular emphasis is placed on examining the rhetorics and boundary-work conducted in the accounts as the doctors attempt to appropriate and authenticate the therapies in the general practice setting.

Combining social worlds theory with a number of other sociological perspectives the GPs' presentations are contextualised within wider debates and conflicts in the medical arena. While supporting earlier work which has interpreted the growing practice of unconventional medicines by doctors as an attempt to quash the threat posed by non-medically qualified therapists to medical dominance, this thesis also explores themes neglected by earlier research. Emphasis is placed upon the more positive gains unconventional practice may bring GPs involved in direct integration. The analysis demonstrates how unconventional medicines provide these doctors with a valuable resource for maintaining and enhancing their professional identity and territory with regard to both current inter-professional and intra-professional struggles.

(PhD undertaken at the Science Studies Unit, Department of
Sociology, University of Edinburgh. Awarded October 2000)

It Could Be You



A chance remark led to the idea of writing this short piece. Over a recent lunchtime discussion about the current emphasis in NHS guidelines for research applications to involve ‘users’ or ‘consumers’ in research[i], I mentioned my experience of being a ‘subject’ of research. It was a salutary one, informed by my work as a researcher, and continuing to influence me ever since. ‘Please write about it for Med.Soc.News!’ should perhaps be added to the traps awaiting us when we chip in our tuppence worth to such discussions, and hard to resist in pleasant circumstances. Although it was at least a brief job, it has been quite painful to dredge up the details, many of which I will spare myself from committing to print. If readers have not themselves ‘participated’ in research, you may find these comments useful in understanding how research can feel from the other side of the (in-depth, semi-structured) questionnaire. You never know, you might even find yourself in a similar situation in the future.

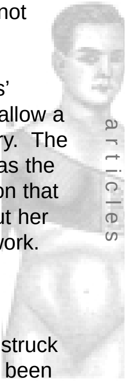
The research project I took part in was about the impact on families of a particular chronic illness. My husband was the main ‘subject’ and I was the marriage partner. We were invited to visit the psychology department in a prestigious university and meet the lead researchers, a professor and senior lecturer. We were told that our comments would be treated confidentially, and that they hoped taking part in the research might help us. The meeting soon began to slide into therapeutic language, with the researchers probing us about specific ways in which the chronic illness affected our marital relationship. Although the researchers went to some lengths to try to put us at our ease, I felt their questions were increasingly intrusive and that my husband and I, for different reasons, were being put in a difficult position.

Let me say here that I am not referring to the more obvious issue of addressing sensitive topics such as sex and money. At the time, I was employed by the Medical Research Council on a project that involved me as a researcher asking people what I considered to be very personal questions about such matters, and was often surprised how little it bothered some people to talk about them. Our vulnerabilities in relation to the researchers on this occasion were as much to do with our lives outside of our personal relationship as within it.

Part of the trouble was that as the questions went on, put so carefully and allowing for reflective and heavily quiet pauses, we found that the research agenda was fully theirs, with no space for asserting our own experience of living with chronic illness. There was no dialogue, only the opportunity to answer questions cooperatively or not. My response was increasingly the latter, and I felt misunderstood as though they thought I was presenting ‘resistance’. Their psychological model of ‘effects on family life’ had its own focus. Our focus was simply not particularly of interest.

What would we have wanted on the agenda? The consequences of long-term unemployment and illness (financial, career, life plans, social, emotional etc. etc.) and the anxiety of uncertainty over the long-term prognosis. Our hopes for successful treatment and the repetitive cycle of having to summon up the emotional and physical energy to take part in new regimens, to recover from them, and the disappointment when they didn’t work. Having to be a good patient: not too demanding of doctors’ time and resources, yet having to remind them from time to time that not making a fuss did not mean a cure had miraculously occurred.

Despite this initial encounter, we agreed some weeks later to allow the researchers' assistant to come to our home and interview us. Perhaps, we thought, this would allow a more relaxed approach, and we would be able to be more frank on our own territory. The research assistant was indeed more easygoing, though we increasingly were not, as the same orientation was evident behind her questions and her rather naïve assumption that we would quickly develop a confiding rapport with her. She told us quite a lot about her own career plans and how this research experience fitted into her path to clinical work. She asked me about my work for the MRC and I even gave her a lift to her next appointment, as I was heading that way.



When we eventually received a two line letter thanking us for taking part, we were struck by a feeling of having been exploited. This was not in so crude a sense as having been cheated or forced to give valuable information, but that the researchers' gain seemed to have been entirely at our expense. That is, we had been made uncomfortable by intrusive questioning, made to feel powerless to make our own assertions about our experience, given our time and involvement at some emotional cost, and for what in return? We didn't feel that the 'data' they had collected about our case reflected the issues of real importance to us, so we didn't derive even vicarious benefit from their (presumed) publications. We didn't gain anything from our discussions with them, least of all when they were adopting their therapeutic stance, and we have heard no more about the research since then.

And the final twist in this tale: add to my earlier agenda list, fear of the effect on the relationship with our GP of not being cooperative with research.

The last point was most acute when our GP helped recruit my husband for a research project on behalf of a colleague. On this occasion, he presented himself at another university, attached to a hospital, to be met initially and very briefly by the main researcher (a hospital consultant), but then passed on to "a doctor" who refused to give his name, undertook no explanations or consent process at all, but immediately started firing questions from a questionnaire and expected immediate compliance not only with this procedure but to a strenuous treatment programme. My husband was sent off to make appointments in another part of the hospital. This time, however, my husband simply left and went home, but had to consider very carefully how to address this with our GP. In the event he was entirely supported by the GP not to continue with the research.

We have not taken part in any further research, although my husband still suffers from the same illness and hopes someone will discover an effective treatment for it. In my research encounters I hope I have been more honest with participants about any benefit they and I may gain from taking part, and what the costs may be. I have urged them to comment on any issues they feel are relevant that I may not have raised, and not made unrealistic promises about keeping them involved. But that reminds me, I did promise a couple of people I'd send them any papers I wrote about my research...

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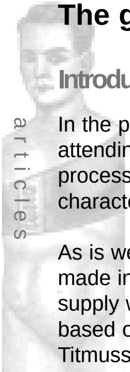
23 January 2001

The gift relationship: 2000



Introduction

In the piece which follows, Ursula Harries gives a description of her experience of attending a blood donation session. Her account raises interesting questions about the process, meaning and context of giving blood, referring as her title does, to Titmuss' characterisation of voluntary blood donation as a gift to strangers.

As is well known amongst the readership of this newsletter, this characterisation was made in the context of an empirical study comparing the quantity and quality of blood supply within the UK and US systems. (Titmuss, 1970) Blood collection in the UK was based on voluntary donation, whilst in the US some donors were paid, a practice which Titmuss criticised as ultimately less efficient. Drawing on his reading of classic anthropological texts about gift relationships, Titmuss explored the social meaning/s of blood donation.

Whilst ideas about gift relationships are in themselves subject to rethinking in a contemporary context, the idea that the gift is part of a system is perhaps the most important feature of the literature (Douglas, 1990). Accordingly, most of the anthropological literature emphasised the idea of being able to and indeed obliged to return a gift. Some have argued that a blood donation could not be seen as a gift relationship in this sense, as the recipient is not known to the donor. But the significance of Titmuss' work is precisely the argument that the 'gift to strangers' allows 'ordinary people to articulate giving in morally practical terms outside their own network of family and personal relations', thus underpinning the idea/l of welfare systems which could draw on altruism as a resource (Titmuss, 1970; 226).

It is in France in particular that ideas about gift relationships have constituted an axis of intellectual debate, and in France too where the issue of the damage which could be wrought by such a gift received widespread attention in the wake of the HIV/transfusion crisis. The comparisons of the efficacy and complexity of systems are no longer so clear, as Godbout and Caille note: What if Titmuss had compared the American and French systems in the 1980s ? It has been argued that the French system floundered in the absence of a profit motive, whereas (in the US) 'private firms, for fear of legal action, did not wait for official orders before applying preventative measures.' (Casteret, 1992: 229, cited in Godbout and Caille, 1998).

The dramatic and evocative image of a poisoned gift has received a good deal of attention from sociologists, historians, and the media. But there are less dramatic implications of the aftermath of these developments, such as the implications of donor selection for those motivated to give blood. The account below describes an experience of feeling alienated by the ethos, management -and staff !- of the donor session, an experience which recurred when the author returned several months later to give blood 'successfully'.

Clearly, there are a number of directions which empirical research about blood and other tissue donation can take. The idea of tissue donation (of various kinds) as a gift seems to be re-emerging, partly in response to urgent ethico-legal concerns about the status of

stored or ‘abandoned’ human tissue samples. This idea risks being imposed or codified. Yet the concept remains one that is good to think (critically) with.

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The Gift Relationship: Year 2000

The scene: a large and slightly grotty sports hall in a small local authority leisure centre in a Manchester suburb. Two rows of hospital beds are set out in the middle of the hall. Three of the beds are occupied with people giving blood.   At the far side is a long table with 10 nurses in uniform clustered around chatting with each other.

Enter the main character; a white woman in her mid-thirties (the donor). She is dressed comfortably, bordering on scruffy. Looks a little dishevelled. The donor walks past the beds to the table where the nurses are sitting.

donor: is this where I start?
nurse 1: (businesslike) yes, take a seat.

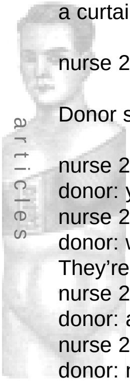
Donor sits opposite nurse and hands over her blood donor’s card. Nurse 1 starts typing information into a portable computer on the table between them.

nurse 1: quite a while since you last gave.
donor: yes
nurse 1: still at same address?
donor: yes

nurse 1 continues typing information into computer. Then takes a print out from the printer and puts it into a wire tray in front of donor. Hands donor card back to donor. A second nurse comes up, picks up papers from tray, smiles at donor.

nurse 2: just come with me

Donor follows nurse to opposite corner of the hall, where 2 chairs are screened off behind



a curtain. Donor and nurse sit down opposite one another behind curtain.

nurse 2: its quite a while since you've given. I just have to ask some questions.

Donor smiles somewhat apprehensively.

nurse 2: have you had something to eat and drink this morning?
donor: yes
nurse 2: you're not planning anything strenuous this afternoon?
donor: well, (laughs) I'm picking up my daughter and one of her friends from school. They're both 5 - so that's sometimes quite strenuous.
nurse 2: (smiles enigmatically). Ever had an operation?
donor: a Caesarean section, 5 years ago.
nurse 2: anything else?
donor: no
nurse 2: ever had a blood transfusion?
donor: no
nurse 2: do you suffer from diabetes?
donor: no
nurse 2: are you taking any medication from your doctor at the moment?
donor: no
nurse 2: are you seeing any of the following at the moment: physiotherapist?
donor: no
nurse 2: acupuncturist?
donor: no
nurse 2: homeopath?
donor: no
nurse 2: anything else like that?
donor: (hesitates) well, I'm seeing a counsellor at the moment. Does that count?
nurse 2: (looks up from papers, laughs slightly nervously). You are alright though?
donor: I think so.
nurse 2: have you ever been to Africa?
donor: no
nurse 2: ever had sex with someone from an African country?
donor: no
nurse 2: have you ever injected drugs?
donor: no. There's a lot more questions than the last time I gave blood.
nurse 2: yes, I say these in my sleep (both laugh)
donor: (taking off sweater) its really hot in here.
nurse 2: yes, its the glass ceiling. Okay, just come over here with me.

Nurse 2 leads donor back to the table where the nurses are sitting. Indicates a seat opposite the table. Donor sits down. Nurse 2 joins other nurses gathered round the table engaged in lively conversation. Donor sits quietly listening to nurses discussing the merits of various treatments for sunburnt skin. One nurse loudly proclaiming that cold tea poured onto the skin is the best treatment. Others show lively interest in this.

After 2-3 minutes, another nurse (nurse 3) comes over to donor and asks her to take a seat at the end of the table. Donor comes over and sits down opposite some plastic phials of coloured liquid. Nurse 3 busies herself preparing an automatic needle stick.

nurse 3: just hold out your thumb please.
donor: (holds out thumb). Is this where you prick my thumb?
nurse 3: (cleaning thumb with sterile wipe). That's right.

Nurse 3 punches thumb using automatic needle stick. Takes small amount of blood and drops it into one of the phials of coloured liquid. Watches with concerned look on her face whilst blood floats to the top of the liquid.

nurse 3: I'll just do another one of them
donor: are you testing for iron?
nurse 3: yes, that's right
donor: is it low?
nurse 3: just a bit, that's why I want to check with another one.
Donor holds out thumb for a second prick. Nurse 3 repeats the process. Looks concerned as blood continues to float to the top.

nurse 3: it looks a bit low. We've got a machine that can check more accurately. We need more blood for that. We'll have to take some from your arm. Just come over here with me.

Nurse 3 walks over to another part of the room, where there is a small table with some equipment on it and 2 chairs.

nurse 3: take a seat here
donor: (sits down) what happens now?
nurse 3: someone will be along in a minute.

Nurse 3 walks back to large table where nurses are sitting. Takes a seat and joins a conversation about holiday destinations. After a couple of minutes, nurse 2 gets up from the table and walks over to where the donor is sitting.

nurse 2: this machine can check your iron more accurately. I'll have to take some blood from your arm though. Could you hold out your arms please.

Donor stretches out both arms and nurse 2 inspects veins on inside of elbow.

nurse 2: I'm just trying to see which one is best. I think the right one is best. I want to save that for when you give, so I'll just take this from the left.
donor: (looks concerned) oh dear.
nurse 2: just make a fist for me with your left hand.

Donor makes fist. Nurse applies tourniquet, and takes a syringeful of blood from donor's left arm. Puts it in a container and then into machine on table in front of them. A few seconds later, the digital display on the meter in front of them shows a reading of 11.1

nurse 2: you need to be 12.5

Donor looks quizzical.

nurse 2: its a bit low, but nothing to worry about.
donor: so am I anaemic then?
nurse 2: its just a bit low. Nothing to worry about. You look quite well, quite pink. Its just that we wouldn't want to give your blood to anyone else. It has to be at least 12.5.
donor: I think this has happened to me before.
Nurse 2: its nothing to be concerned about. We'll contact you in 4 months to check you again. You know all the things to eat. You're not vegetarian or anything like that are you?
donor: well, sort of.

Nurse is cleaning equipment and tidying bottles. Not looking at donor.

nurse 2: Thanks for coming anyway. You can have a drink before you go if you like.
donor: yes, I think I will.

Donor goes over to far corner of the room where plastic cups of orange squash are laid out on a table. Helps herself to an orange squash and a chocolate chip cookie. Sits down to eat and drink. When she's finished, gets up and leaves the hall. In the background nurses discuss the naming of Cherie Booth and Tony Blair's new baby.

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i Hanley et al (1999) Involving Consumers in R&D in the NHS: Briefing Notes for Researchers, NHS Research Support Unit

Text, narrative and poetics: a one day symposium at City University, February, 2001

A great many conferences nowadays are boring, particularly the ones about new NHS policy. This is partly to do with a (my) scepticism about whether the latest clever ideas will really make any difference, and partly to do with a certain dulling predictability, both of ideas and the language they are expressed in. It is as if there are barely enough combinations of words and concepts to go around at any one time, supporting my impression that language whirls through culture like tumbleweed blowing around derelict Western film sets.

The Text, narrative and poetics symposium organised by Dr Anthony Pryce of the Division of applied psycho-social sciences at City University, was, I can safely say, the least predictable academic gathering I have ever attended (well, during the hours of daylight), and one in a series of provocative symposia held at the same institution; the others being *Images of Health* held in 1999, *Deconstructing Risk* held last year, and a forthcoming event scheduled for 8th June: Transgression and surveillance: the darker shadows of nursing. (Speakers will include: Professor David Holmes, University of Ottawa, Canada, who will be presenting his Foucauldian research on penitentiaries in the US and the role of the clinical nurse specialists in the execution of prisoners.)

More than thirty people turned up for Text, narrative and poetics, a mixture of practitioners and academics-the latter, I would guess, from a number of different theoretical orientations and disciplinary fields. So, unlike being in a room full of post-structuralists or devotees of reflective practice (perhaps there are a number of factions within this field so this isn’t a valid category), it was never possible be confident that you knew how the audience was responding to papers, ideas, questions from the floor. This, combined with a certain geographical intimacy to do with a small number of people spending the day together in a small room dealing with emotionally charged material, gave the event a certain tension-at times electric, but never, I hope damaging. Refreshingly, I found myself continually wrong-footed by speakers. Carol Cox, from City University opened the day with a paper about reflective practice and clinical supervision, Telling lies: Faking the story. It started-apparently- as a disappointing and completely uncritical overview of the subject, albeit with musical soundtrack and accompanying photographic images then pivoted around a distressing story about a nurse telling a story about bizarre behaviour in order to impress a reflective practice supervisor. However, the story within the story turned out to be lies, but the story itself was true. The point was that nursing students had learned to perform reflection for entirely instrumental reasons, to ‘fake’ authenticity. This began to overturn my preconception that reflective assessment was, at least potentially, a rather dubious form of disciplinary control of students. Carol Cox was tricking us all along.

Cox’s paper, like many of the day’s presentations, invited the audience into an area between academic criticality an emotional response to powerful topics. This can be stimulating because it forces us to ask whether we are using academic ‘distance’ to protect ourselves from engaging personally with difficult issues. On the other hand, it provides opportunities for manipulation because speakers can present material that is quite problematic in terms of its assumptions or the rigour of its ideas or its political implications and, if the topic is emotive enough or presented emotively, we may feel it rises ‘above’ the usual criticality we would apply to other less charged material.

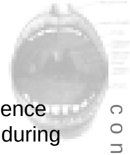
Other wrong feet included the speaker who started her PowerPoint presentation with the slide The End and proceeded to invite questions from the audience. Strangely, questions came, but it turned out that they were from plants, with mischievous intent.

My focus on the spectacle of this event should not give the impression that the day was all style and no content. We thrashed out (not in the sense of sorting out the answers) the ambiguities of narrative approaches to textual data, the difference between medical and literary accounts of illness, the poetry that one researcher was surprised to hear in his interview data and some of the implications of reflection.

I can unreservedly recommend the next in this series of symposia for anyone who is beginning to despair that academia has become a place where we agonise over contracts and funding and have forgotten about ideas.

Michael Traynor

Conference Report - Sociology of Cancer Study Group



What is the Sociology of Cancer?

The newly founded Sociology of Cancer Study Group held their first annual conference on the 11th of December at the University of Leicester. The six papers presented during the day brought together a range of different speakers all looking at aspects of cancer from a sociologically informed perspective. A key aim for the day was to learn about different approaches, both methodological and theoretical, that are being taken to research on cancer. Attended by over 30 people from all over Britain the setting promoted a lively discussion.

Jonathan Tritter (University of Warwick) welcomed participants and then presented (on behalf of the User Involvement in Cancer Services Project Group) a paper that linked his current research on user involvement in cancer services to current reforms in NHS policy. He outlined ways in which not only were there important contributions that sociology could make to the theoretical understanding of cancer and people's illness experiences but also that we were currently at a key moment in which sociological research had an excellent opportunity to influence policy and practice.

Jane Seymour (University of Sheffield) presented the second paper, which dealt with the use of vignettes on research with older people's beliefs about end of life decisions. The discussion focused on the development of a vignette around a patient with end stage cancer. This cogently highlighted the relationship between gerontology and palliative care, as well as the contested definition of risk and innovative technologies to prolong life. It was also hoped that comparing data collected in response to a cancer and a non-cancer vignette would help to illuminate the particularity of cancer.

The third paper presented argued for more use of biographical methods in the study of cancer, to incorporate the particularities of age, gender and ethnicity. Sangeeta Chattoo (University of Leeds) suggested that such an approach would illuminate the similarities between different demographic patient populations rather than stressing differences that come to be linked to ethnicity. Chattoo urged the development of a sociology of cancer that concentrates on common experiences, such as the need for people with cancer to reconstitute their identity and the complex tensions around caring and family and between independence and self-control.

The differential impact of cancer on patients and carers was clearly illustrated in the paper presented by Sarah Morris (University of Lancaster). This research demonstrated the ways in which carers, as well as patients, negotiate an identity and a role when affected by a cancer experience. The uncertainty of the carer's place, space and task changed over time. The 'ownership' of the cancer story by the patient complicated carers attempts to legitimate their own changed identity. While information seeking has been long identified as a key reaction by those diagnosed with cancer, for carers in this study it was even more central and often they sought information that the patient did not want to know.

Mary Dixon-Woods (University of Leicester) presented the next paper, which examined parents' accounts of the process of diagnosing their children's cancer. A qualitative study that explored the ‘work’ of parents in seeking a diagnosis for their children illuminated the different role of carer and patient for childhood cancer. Further, the examination of parent’s stories together with data extracted from medical records highlighted the way issues of power, control and knowledge emerge in the contestation between parent and health professionals and how such struggles frequently led to disputes.

The penultimate paper, presented by Carol Thomas (University of Lancaster), outlined a sociological approach to understanding an area of cancer dominated by psycho-oncologists. The paper highlighted the need for an alternative sociological definition of psychosocial need using the key concepts of care work and emotional work. This provided a framework for understanding the experiences of both people with cancer and those who care for them at different ‘critical moments’ in the Cancer Journey. The paper reminded us, as sociologists, of the need to engage with dominant theoretical models of cancer but also of the importance of providing alternatives.

Illustrating the impact of technology and the internet on research on cancer, Alison Chapple and Sue Ziebland (University of Oxford) illustrated a pilot prostrate cancer website as part of the DIPex project. Video recorded interviews of men with prostate cancer form the basis of the data and also the substance of the website. The paper highlighted the ethical issues related to such a project as well as the complexity of working with multiple disciplines, ranging from doctors to television technicians. While using sociological research techniques for both collection and presentation of the data, the aims of the website to inform reshape the research work. The paper offered clear examples of the ways in which sociological research on cancer could be harnessed to shape policy and practice.

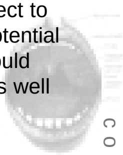
Towards a sociology of cancer

Current theoretical models of cancer fail to account sufficiently for either the social context of individuals or their variation from each other and over time. This conference illustrated some of the ways that sociology can make an immense contribution to understanding the psychosocial aspects of cancer. In particular, issues of changing identity of those affected by cancer and definitions of patient, parent, child and carer are challenged by cancer. Similarly, health inequalities, gender and the social aspects of illness need clearer articulation, in part to try to understand the double-binds so apparent in the patient-carer relationship. Both medical uncertainty and the different nature of time at various points in the cancer journey would also benefit from further theorizing. Key concepts that must be embedded in an emerging Sociology of Cancer include emotion work, and lay knowledge and suggest the importance of narrative in explicating the experience and understanding of those affected by cancer.

Thanks to all of you who contributed papers or attended for making our first conference such a success.

Future Plans: How you can help

Currently we are negotiating with Psycho Oncology for a special edition of the journal tentatively titled ‘Understanding the Social in Psychosocial Oncology’. In addition, we are putting together a proposal for a book series on Social Aspects of Cancer and expect to submit this to Routledge in the next month. We would welcome suggestions for potential titles and other publishers. Finally, it was suggested that our Spring Workshop should look at “Challenges to Palliative Care”. We are currently seeking key references as well as suggestions of a time and place for this workshop.



We look forward to hearing from you,

Jonathan Tritter, Clare Moynihan and Geraldine Leydon

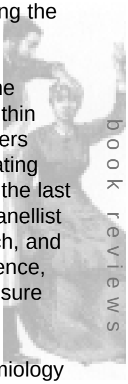
Symposium of Social Aspects of Death, Dying and Bereavement

The tenth one-day symposium on social aspects of death, dying, and bereavement was held at the University of Leicester on Thursday 2nd November 2000. The symposium continues to provide an excellent forum for new postgraduates as well as established academics, to present and discuss their research in a friendly and supportive environment.

The meeting started later than planned due to extreme weather conditions. Unfortunately, this year's conference coincided with the worst floods for sixty years and many of the delegates suffered considerable disruption to their journey. However, this did not prevent those taking part, from enjoying what was a eventful and thought provoking series of papers.

The morning's programme began with two contrasting, yet equally stimulating accounts of death and dying. In her paper, 'Do-not-resuscitate decisions' Basiro Davey discussed the implications of a recent Age Concern publication that suggested DNR decisions were being written in the medical notes of elderly patients without their knowledge. Conducting fieldwork on two acute surgical wards, Davey revealed serious departures from BMA/RCN guidelines in that surgical teams rarely consulted the nursing staff or patients and only occasionally informed the relatives when a DNR decision had been taken. In the next paper, 'In Morte Media Jubilate' Angela Armstrong-Coster introduced the importance of narrative theory in the dying process. Based upon research into how people with cancer interpret media messages, Armstrong-Coster suggested that the various metaphors used by authors contribute to formulate a specific subjective audience interpretation. Minna Pietila, in her paper 'Moral order in family members' suicide bereavement talk', used membership categorisation device analysis to describe how family members use certain understandings of 'the family' when interpreting a case of suicide. She explained that family members' experiences involved specific constructions of the concept of 'the family', which implied a contradiction between idealised image of a caring and sharing family union and the family members' inability to understand and help each other. In a paper entitled 'Getting a life: reconstruction as a grief survival mechanism', Gordon Riches gave a poignant insight into how the bereaved utilise and manipulate their identities to maintain some semblance of a normal life in the face of major personal loss that threatens to overwhelm and destroy cherished perceptions of self. Using case studies, Riches suggested survivors might draw upon aspects of late modern society to create order in a potentially meaningless life and to find self-esteem in a reconstituted identity.

The early afternoon's programme began with Craig Spence discussing a few of the historical and contemporary disasters to befall people who venture out onto the River Thames in London. In a paper entitled 'A river runs through it: Modernity, disaster and the River Thames', Spence used these incidents as a window through which one might gauge the socially defined and culturally constructed responses to sudden death and disasters. In a similar vein, Anne Eyre's paper - 'Disaster Research: What have we learned and Where are we going'- argued that disaster research remains on the periphery of the broader field of death, dying and bereavement. In the light of more recent tragedies such as last year's train crash at Paddington, Eyre called for more



research and public discussion surrounding the human impact of disasters, including the nature and implications of collective grief and bereavement.

Finally, as a way of celebrating it's tenth anniversary, the remaining two hours of the symposium included a panel discussion made up of many of the leading names within the field reflecting on the state of play thus far. Chaired by David Clark, the speakers included David Field, Jenny Hockey, Peter Jupp, Neil Small and Tony Walter operating under the collective title, 'Death, Dying and bereavement research: Reflections on the last decade and future directions'. The discussion produced a lively debate as each panellist gave their opinion on the highs and lows of death, dying and bereavement research, and where exactly it was heading. This rounded off what was a very successful conference, which generated many interesting questions and discussions; many of which I am sure will be addressed at next year's conference.

Next year's symposium will take place on 8 November 2001 in the Dept. of Epidemiology and Health at the University of Leicester. The organising committee are: Angela Armstong-Coster, Catherine Exley, Stephen Handsley Carol Komaromy. Further details will be available shortly.

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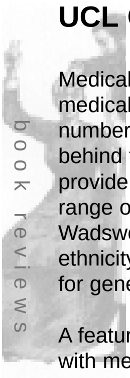


UCL Centre for Medical Sociology, Social Theory and Health

Medical Sociologists at University College London have established a ‘virtual’ centre of medical sociology, social theory and health in order to bring together the relatively large number of sociologists working within the college on health related issues. The purpose behind the initiative was to enhance the communication between sociologists and to provide a forum for exploring the links between social theory and medical sociology. The range of interests of those involved, who include Graham Scambler, Mel Bartley, Mike Wadsworth, Robert Power and James Nazroo, range from health inequalities, through ethnicity, drug use and sex work to ageing. It is hoped that the centre will act as a focus for generating cross-departmental research.

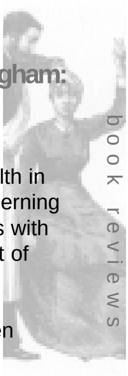
A feature of the centre is the involvement of others from outside UCL who share interests with members. These include psychologists, gerontologists and world systems theorists. Since the beginning of 2000 the centre has hosted a number of seminars drawing on researchers from Britain and beyond (well USA) and pursued themes such as globalisation, historical sociology, critical realism, and the difference between generations and cohorts. It is hoped to make these seminars an important focus for theoretical innovation.

As well as M.Phil/Ph.D students, there are currently two M.Sc programmes asociated with the centre, one in ‘Sociology, Health and Health Care’ and one in ‘Sport, Health and Society’. For further details contact Graham Scambler (020 7679 9461)

Paul Higgs

Book reviews

Allandale E, and Hunt K. (eds) (2000) Gender Inequalities in Health Buckingham: Open University Press (ISBN 0335203647 Pbk £15.99)



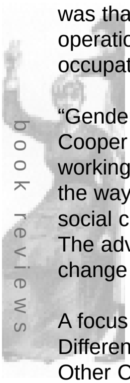
This edited collection seeks to examine the literature on gender inequalities in health in the light of recent developments in social theory which raise important issues concerning gender inequalities and the restructuring of gender related experiences. It engages with the current debates on both a theoretical and empirical level, examining the impact of various social changes on gender and health.

Chapter One, "Gender Inequalities in Health: Research at the Crossroads" by Ellen Annadale and Kate Hunt, questions orthodox approaches which tend to focus on inequalities in paid and domestic work and their implications for status and income. Annadale and Hunt suggest that this approach is both conceptually and theoretically limited, because it rests on a binary sex/gender division and because it has failed to incorporate social changes in the lives of men and women in contemporary society. They point to changes in patterns of work and employment and new patterns of economic inequality, such as those between different age groups of women, which need to be included in gender comparative work. A more inclusive research agenda is suggested, involving gender comparative samples and examining all aspects of work relevant in principle to men and women.

"Reinforcing the Pillars: Rethinking Gender, Social Divisions and Health" by Mick Carpenter also emphasises the need to re-examine the theoretical foundations of research on health inequalities. Carpenter suggests that it is necessary to incorporate recent sociological thinking into theories of gender inequalities in health. For instance, he argues that the social theory of Giddens, the analysis of gender provided by Connell and the critical realism of Bhaskar can help to inform and modify a more sensitive structuralist analysis of health inequalities.

"Narrative in Research on Gender Inequalities in Health" by Jennie Popay and Keleigh Groves continues the critique of grand narratives in gender inequalities. They highlight theoretical and methodological limitations of traditional research methods and call for research which illuminates the relationship between identity, agency and structure. Popay and Groves suggest that qualitative research using narrative accounts of daily life may be useful in this regard and provide examples from a case study on tiredness in men and women.

Hilary Graham's chapter, entitled "Socio-Economic Change and Inequalities in Men and Women's Health in the UK", begins by stating that "Social class is written on the body" (page 90). Graham argues that British class divisions (and health inequalities) are persisting and sometimes widening as a result of rapid economic and social change. She presents data on increasing poverty and economic polarization and links this data to health outcomes by suggesting that individuals take the strain of the structures of inequality to which they are exposed. "Class privilege brings health advantage", she states (page 116). Finally, Graham calls for further research into the ways in which gender structures and mediates these experiences. My only concern with this Chapter



was that “class”, which is central to Graham’s work, was never really defined and was operationalised by examining proxy indicators such as employment status and occupation. This seemed theoretically and empirically unsatisfactory.

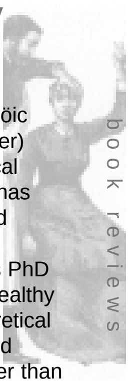
“Gender and Inequalities in Health Across the Lifecourse” by Sara Arber and Helen Cooper examines gender differences in health status at three stages of life - childhood, working life and later life. Using British data, Arber and Cooper present a rich picture of the way gender inequalities in heath are associated with age, family structure, education, social class, employment status, marital status, household income and housing tenure. The advantage of using a lifecourse perspective, they suggest, is that it takes social change seriously and demonstrates the dynamic nature of people’s circumstances.

A focus on mortality is common to both Ingrid Waldron’s Chapter on “Trends in Gender Differences in Mortality: Relationships to Changing Gender Differences in Behaviour and Other Causal Factors” and Laurent Chenet’s Chapter on “Gender and Socio-Economic Inequalities in Mortality in Central and Eastern Europe”. Waldron stresses that gender differences in mortality have been influenced by diverse factors. For instance, there have been decreasing gender differences in lung cancer, car accidents and workplace accidents but increasing gender differences from other types of mortality, such as accidental poisoning and accidental falls. Waldron concludes by calling for cross-national investigation of these trends. Chenet’s Chapter takes up this challenge, highlighting increasing sex differentials in life expectancy following the collapse of communism in central and eastern Europe. Examining Russia in particular, Chenet documents wide differences in male and female mortality rates. Male mortality rates are far in excess of female mortality rates, due in part to higher mortality rates from alcohol and violence. However, socioeconomic differentials are far greater for women than men. So Chenet emphasises that the change to a market economy has particularly disadvantaged women from lower socioeconomic groups. This is an under-researched area, and Chenet’s contribution with this Chapter full of rich data is both unique and valuable.

Unfortunately, very few of the Chapters in this book examine the interactions between gender inequalities and other structures of inequality, such as ethnicity. This area deserves more attention. However, the book will still be quite useful to people teaching medical sociology and to those interested in gender inequalities in health because it makes a number of interesting contributions, both in terms of suggesting new ways to research health inequalities and in theorising about those experiences.

Mark Sherry, University of Queensland

Watson J. (2000) Male Bodies: health, culture and identity Open University Press: Buckingham (ISBN 0335 19785X Pbk £15.99)



A series of distinguished sociologists (for example, Mike Bury, Bryan Turner, and Löic Wacquant) have taken the literature on the sociology of the body to task for its (over) emphasis on theoretical exegesis, and its concomitant lack of grounding in empirical social research. Thus Watson (2000: 51) suggests that the sociology of the body has “privileged theorizing of ‘the body’; bracketed out the individual; and largely ignored practical experiences of embodiment.” This book sets out to begin to fill out these lacunae via a report of an empirical research project (which, I suspect, is Watson’s PhD thesis) that investigated the lay health beliefs of a group of 30 ‘middle-aged’ and healthy men in Scotland. For “contemporary treatment of the body has: mainly been theoretical rather than empirical; focused on the social body rather than the physical body; and tended to interpret the body from an etic (outsider/social science) perspective rather than from an emic (insider/lay) perspective... Lay accounts [therefore] hold the key to understanding the complex relationship between body, self, culture and society” (Watson, 2000: 60).

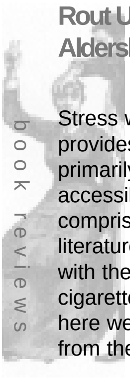
The ‘medical sociology of the body’ has tended to focus on two main areas: firstly, the physical, psychological and social consequences of illness; and secondly, on medical reconstruction, for example, through surgery, transplantation, genetics, and new reproductive technologies. This book seeks to add a new dimension (a ‘third way’!) to existing work on another area: that of health as body maintenance, for example, through exercise, diet, and the avoidance of ‘unhealthy lifestyles’ via an empirical research study of men’s health. For, as Turner (1992: 12-13) argues: “We live in a ‘somatic society’ where the body is the focus of cultural, social and political activity. We want to close up bodies by promoting safe sex, sex education, free condoms, and clean needles. We are concerned about whether the human population of the world can survive global pollution. The somatic society is thus crucially, perhaps critically, structured around regulating bodies”.

Watson’s study is a contribution to the sociology of embodiment. In the first two chapters he provides a succinct overview of both the major perspectives that are shaping men’s health, and of an array of work on social theory and the body. These theoretical insights are then grounded in the data from his informants in the next four chapters that examine: lay knowledge of health, the male body in everyday life, ‘being in shape: the embodiment of masculinity’, and the embodied experiences of a well men’s clinic. In the conclusion Watson discusses the implications of his findings on the daily existence of male embodiment for the practice of health promotion. Watson (2000: 8) sums up the male view of health promotion as: “ordinary, unexceptional bodies embedded in the detritus of daily living.” I suspect that I would probably find that view echoed by my fellow male travelers as we commute by train to and from London. If only I asked them!

References

Turner, B.S. (1992) Regulating Bodies: Essay in Medical Sociology Routledge: London

Steven P. Wainwright, King’s College London



Rout UR, and Rout JK. (2000) Understanding Stress in Doctors' Families. Aldershot: Ashgate (ISBN 1859725910 Hbk £35)

Stress within the medical profession is currently an active area of research and this book provides a clear overview of the main issues that have been identified and is aimed primarily at readers new to this area. The way this book is presented makes it readily accessible to the reader as each chapter has a clear structure and objective. This book comprises six chapters and begins with a brief, comprehensive review of existing literature with regard to health and well being within the medical profession in general, with the focus on issues such as physical and mental health, alcohol consumption, cigarette smoking, drug abuse and suicide. However, some of the statistics presented here were based on research carried out several years ago and would have benefited from the inclusion of more recent information.

Throughout the middle section of the book the authors draw on data from their large scale studies carried out during the 1980's and 1990's, which incorporate both quantitative and qualitative data through the use of large scale questionnaires and interviews, respectively. The second chapter is concerned with stress in general practitioners and highlights the key areas which lead to perceived stress such as patient expectations and interruptions. It provides an informative review of research in this area and is illustrated with extracts from the interview data which provide an interesting insight into the stresses encountered and the coping strategies that the doctors employed. The third chapter is concerned with stresses that face women doctors, and in particular difficulties that are encountered with the work-home interface. The fourth and fifth chapters offer an extension to the literature in the area of stress in doctors by including research carried out with doctors from overseas and also the families of doctors both in hospital medicine and general practice. This is a welcome addition to the literature and provides a glimpse of the particular issues that arise.

The qualitative data analysis presented in this text is mainly descriptive and is not presented in depth but the inclusion of quotes from participants enlivens the book and provides interesting insights into how stress affects doctors and their families. The authors have a wealth of experience working in this area and they direct the reader to their further publications for a more detailed analysis of their research if the reader wishes to pursue their reading further. The final chapter is concerned with ways to manage stress and it provides useful outlines of the ways in which both individuals and organisations can manage and alleviate stress by the use of suggestions and strategies. However, both this chapter and the previous one are written with an androcentric assumption that the doctor is male and the spouse is female. This may not always be the case and indeed previously in the book the authors spoke of the growing numbers of female doctors. Furthermore, within the final chapter on stress management, some of the suggestions or advice given could be regarded as inappropriate or outdated by some readers. In particular the advice given to female partners of male doctors to be 'supportive and understanding of the work patterns of their husbands' which could be regarded as reminiscent of ideologies in the 1950s and 1960s. Despite these shortcomings in the final chapter, this book is generally not only a welcome introduction to readers new to this area, but also a useful source of insight and information to those readers familiar with this area. This is due to the clear way in which it is structured and also the addition of qualitative data from the larger surveys which helps to raise awareness of the particular effects of a medical career on the spouses and children of the doctors who took part.

Thelma Daly, University of the West of England

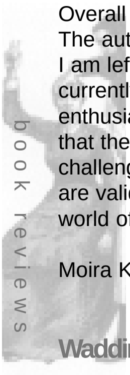
Tovey P. (ed.) (2000) Contemporary primary care: the challenges of change Buckingham: Open University Press (ISBN 033520095 Pbk £18.99)

Primary care is currently the focus of a great deal of attention in health. The notion of a 'primary care led NHS' initiated by the last government is being pursued by the present administration through setting up local primary care groups and trusts which all practices are part of. How will such changes influence practice and what are the implications for professionals and patient populations? How will service need be decided and outcomes assessed? Tovey has drawn together an interesting selection of papers that highlight and explore these questions.

The book is set out in three sections covering: context and organisation, practice, and research. The first section is a good introduction for anyone new to working in primary care practice or research (which is where my interest arose) or who wants to source a useful review of past and current policy. This includes a review of the historical development of primary care throughout the 20th century by Dowell and Neal, which is helpful in understanding how primary care works and why there is such variation in local services. Current changes are looked at in more depth by Heywood who considers the nature and implications of some key changes in policy, such as the move to 'a patient-led NHS' and the effect on 'continuity of care'. Wilson explores positive and negative aspects of the move to a more integrated primary care team approach in many practices, such as the sometimes rocky relationship between the nursing profession and GPs.

The 'practice' section of the book covers specific topics: older people, disability, the 'new genetics', and health inequalities. The authors write with conviction and challenge primary care to improve quality and access to care for patients with particular needs. This may mean considering approaches to health other than the medical model, such as the social model advocated by Mercer and Barnes'in their chapter on disability. The need to develop new skills in response to developments in research and technology is demonstrated in Kumar's chapter on the 'new genetics'. I particularly liked Arblaster and Hastings' chapter on inequality and the inverse care law. They consider the role of primary health care in promoting local population health in deprived areas. Related to this, accurate assessment of local need for service planning ideally requires the establishment of information databases that produce data comparable across practices. The difficulties inherent in setting up such systems are described by Jordan.

The `research' section of the book essentially highlights the need for innovative ways of carrying out research and collecting routine data that take into account what is going on in daily practice, rather than what policy says should be going on. Using the example of counselling, Mellor-Clark reviews the problems involved in privileging the randomised controlled trial as the basis for evidence of whether particular interventions work or not. Adams and Tovey draw attention to a more theoretically informed integrative research approach, using complementary medicine as a basis for their discussion.



Overall this is an interesting and useful book that delivers what it promises in the title. The authors raise many challenges, some of which will be difficult to address. This said, I am left with a feeling that although primary care is not without its problems, there is currently scope for a lot of positive change if it is picked up on by those with the enthusiasm and energy to do something about it. Writing as a sociologist I would say that there is a role for greater involvement of social scientists in addressing these challenges. A particular role could be to assist in developing ways of doing research that are valid and reliable, yet practical and appropriate to the complex and often nebulous world of primary care.

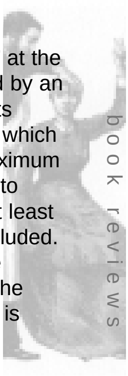
Moira Kelly, Queen Mary and Westfield College, University of London

Waddington, I. (2000) Sport, Health and Drugs : a critical sociological perspective London: E. and F.N. Spon (ISBN 0419252002 £19.99 pbk.)

In this book the author brings together a set of essays on a series of interlinked themes and issues in the sociologies of health and sport, some of which have previously appeared as papers in academic journals. Central to the author's plot is an attempt to attach an examination of the deeply ideological set of social practices known as modern sports, to the much better established sociology of health and illness, although for practitioners of the latter, sport may still represent unfamiliar territory as a focus of intellectual and research interest.

What does the promised critical sociological perspective amount to? This is introduced as the figurational approach, the distinctive hallmark of the 'Leicester group' of whom Norbert Elias and Eric Dunning are the most familiar names. In methodological terms, we are enjoined to 'find connections between particular social events, how their sequence can actually be explained, and what help sociological theories can offer in explaining and determining the trend of social problems...' This will require a processual, historical dimension, the need to locate matters in the context of wider social processes, relations and dependencies, and for the investigator to be able to display the appropriate degree of 'detachment'in the analysis of the state of play. In the event, the conceptual complexities of figurational sociology do not unduly detain the author, who appears to be much more comfortable, and convincing, in a series of detailed chapters of a more substantive kind which form the bulk of the text. Here the conceptual framework becomes largely submerged.

What then can the reader expect to find? The book is divided into two sections, the first of which includes a review of the epidemiology of sports injuries, and challenges the ideological assumptions of the overriding health gain from sports participation, especially with regard to highly competitive, risk-tolerant forms of sporting masculinity. An examination of recent developments in public policy towards sport and exercise then follows, succeeded by chapters on two vulnerable sub-populations, one being the child athlete, and the other, which includes some rich ethnographic accounts from on-going research, explores aspects of the world of the professional footballer. Students of health and illness may find this section particularly useful, documenting as it does the culture of 'risk', the role conflicts endemic within the medical back-up provision in a structure which values client control, playing hurt, and produces clinical encounters of a special kind. The physical damage endured by professional sportsmen is seen as equivalent to an



industrial disease.

The second part consists of a series of chapters which analyse aspects of ‘doping’ at the elite end of professional sport. Sociological understanding is in this case enhanced by an appreciation of the competitive and commercial context of top level sport, and by its increasing encirclement by sports science and sports medicine, the programme of which is the production, in John Hoberman’s phrase, of ‘mortal engines’ designed for maximum efficiency and performance potential. Given the broader theme of ‘medicalisation’, to which Waddington makes reference, it is hardly surprising that ‘substances’ play at least some part in the development of the sport/medicine axis - drug companies not excluded. Examples include the case of the former East Europe, especially the GDR, but the network of relationships and cross-pressures is brought most clearly into focus in the author’s detailed account of the notorious 1998 Tour de France to which chapter 9 is devoted. It may be in this section that the ‘nexus of interdependencies’ is best exemplified, with the errant cyclist seen as a fly caught up in a web rather than a maverick seeking to take advantage of his competitor- colleagues.

This is followed by summary chapters which discuss policy aspects of doping control, and the prospects for substituting an agenda based on an assessment of ‘risk’, harm reduction and concern for the long term health and welfare of athletes, rather than the current obsession with the identification and penalisation of ‘cheats’ and ‘deviants’.

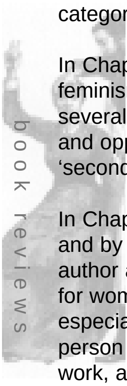
Interested readers may find that at least some of the contents of this well produced book represent a helpful contribution towards a common agenda for scholars whose mutual interests and concerns are outlined here. Those with a special interest in the sociology of the body may feel that further integration could have been attempted.
The essays are not heavily theorised, and are very suitable for general undergraduate use. There is a substantial bibliography of recent work to augment the text.

George Reid, University of Teesside

Fawcett B. (2000) Feminist Perspectives on Disability London: Prentice Hall (ISBN 0 582 36941 Pbk £14.99)

This is the first book in the Feminist Perspectives series I have read and I would unhesitatingly recommend it to anyone new to the debates in both feminism and disability, and to anyone with knowledge of one of these areas and an interest in the other. Fawcett tackles, systematically, contemporary debates in both feminism and disability, highlighting similarities and differences between the two. She demonstrates that insights gained from postmodern feminism(s) can be employed in consideration of disability issues.

Chapter 1 sets the scene simply and concisely and includes a summary of the overall structure of the book. Chapter 2 concentrates on ‘disability’ as a contested term: discussing the key features of the medical and social models; emphasising disability as a social construct; explaining how the categorisation process uses simplistic and stereotypical criteria for administrative purposes (often associated with negative valuations); how the social model has brought about more positive valuations in self-



categorisation, and appraising risk factors.

In Chapter 3 the author identifies points both of comparison and distinction between feminism and disability. In an attempt to develop the social model of disability, she covers several topics, including issues of unity, difference, privileging of experience, the body and oppression. She identifies similarities between the social model of disability and ‘second wave’ feminism.

In Chapter 4 she considers notions of ‘community’, ‘care’ and community care (both in and by the community); raising issues of needs, empowerment and citizenship. The author agrees with others that notions of care and caring, already far from straightforward for women are even more complicated for disabled women and men. This is an especially interesting chapter, dealing as it does with the reality of life as a disabled person coping with changes in legislation relating to social services, benefits and paid work, and the interface between public and private arenas.

Anyone new to postmodern feminism will find Chapter 5 invaluable. Here the discussion takes in poststructuralism, postmodernism and outlines the similarities and differences between feminism and postmodernism. Also included are feminist critiques of postmodern conceptualisations - particularly important in terms of the content of this book - conceptualisations of the body.

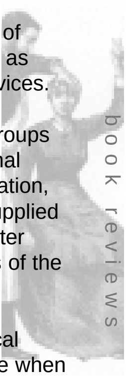
Chapter 6 revisits issues introduced in previous chapters and reviews the ways in which postmodern feminist perspectives can be applied to debates in the field of disability. Feminist movements experienced tensions between the projection of a unitary front designed to achieve particular political ends and the celebration of difference and diversity. These tensions mirror those within the disability rights movement. Fawcett believes that lessons can be learned from the experience of feminist movements and that further changes can be achieved for disabled people by the actions of smaller strategic alliances.

On a practical note, I really liked the layout of the book, the outlines and summaries given at the beginning and end of each chapter, and the comprehensive ‘further reading’ lists provided with each chapter. In spite of the complexity of the issues, this is a clearly written, accessible text that left me eager to read more.

Paulene Hudson, Bath Spa University College

Wood B. (2000) Patient Power? The Politics of Patient’s Associations in Britain and America Buckingham: Open University Press (ISBN 0335203671 Pbk £19.99)

The focus of Bruce Wood’s book is summed up by the opening sentence of chapter 6: “Whatever they may say, disease-related patients’ associations are clearly a political phenomenon”. Thus, in a nutshell, is the crux of his enquiry: the political influence and machinations of patient organisations, rather than their support activities. While Wood bemoans the fact that, on the whole, medical sociologists have concentrated on the self-



help and support roles of such groups (e.g. G.Williams; Kelleher), his account nevertheless would be of interest to the sociologist whose interests lie in the fields of health care organisation, patient advocacy or lay involvement in health care policy, as well as those investigating the effects of health care reform on the provision of services.

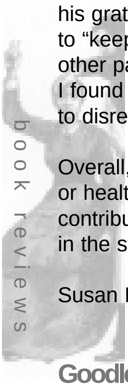
The material used in the book is based on a survey, covering approximately 500 groups in total in the US and Britain, in which six questions were asked about organisational structure, finances and activities. Annual reports, newsletters and other documentation, self-selected by the respondents, supplemented these replies. Further data are supplied by a comparative study of a smaller number of patient organisations based in greater Manchester and in St. Louis, USA, in which the relative strengths and weaknesses of the different structures, administrative functions and activities were identified.

Part one of the book is given over largely to the justification of undertaking a political examination of patient associations, and to the methodological dilemmas that arose when deciding the criteria for the inclusion or exclusion of groups. In the end, Wood chose to include only those which related to specific medical or clinical conditions that involved regular treatment or monitoring by doctors, and excluded any organisation that had a educational or welfare focus, or which represented people with a disability rather than a disease.

The second section takes national views of the American and British associations, providing background material about the scale and organisation of disease-related patient groups, including numbers, size, activities and finances. This is followed by an assessment of their organisational strengths and weaknesses, their political influences at different levels, and their significance in their relative health care systems. I found two elements of this discussion particularly interesting. The first was about the ‘colonisation’ of patient associations by medical professionals, suppliers of health technology, and corporate payers and providers of health care (insurance companies and the NHS in the US and UK, respectively). The other is the analysis of patient organisation’s attempts at influencing policy on three levels, that of the professional, the institutional and the national, focusing on their strategies, styles and means, including ‘turfism’ and, alternatively, collaboration. In section three, we are finally presented with the results of the local studies of Manchester and St. Louis, again examining the set-up, administration and attempts at influence of the groups operating in the respective cities.

I felt the book was oddly divided: the theoretical meat of the argument was largely confined to the twenty-page conclusion (Section Four), while the introductory chapters and those based on the empirical work were, on the whole, disappointingly descriptive. Indeed, the conclusion provides an excellent discussion, which itself is divided into five main themes: patient associations as ‘challengers’, institutional issues (funding), patient associations and the state, as contributors to the democratic polity, and the design of effectiveness indicators. Although obviously centred on political theory, this relatively short examination of the roles of patient groups was certainly enough to whet my appetite to think more about the strategies employed by these organisations, and their often ambivalent position in the complex triangle of the state, medicine and patients.

Despite the aim towards a critical political perspective, Wood reneges on this approach in the final paragraph of the book. He relates that he sought advice from the UK Stroke Association after a personal illness towards the end of writing. He offers the Association



his gratitude for their “welcome support and useful literature”, and recommends to them to “keep up the good work that you are doing”, going on to apply this message to the other patient associations examined in the study. From a medical sociology point of view, I found this parting shot somewhat of a surprise, as it seems to negate his determination to disregard the support functions of the groups.

Overall, I would suggest this book to those who are primarily involved in the social policy or health service research end of the sociological spectrum. It would make a good contribution to a departmental or institutional library, but its usefulness as a primary text in the study of health and illness is somewhat limited.

Susan Robinson, Royal Holloway, University of London

Goodley D. (2000) Self-advocacy in the Lives of People with Learning Difficulties. Buckingham: Open University Press (ISBN 0335205267 Pbk £18.99)

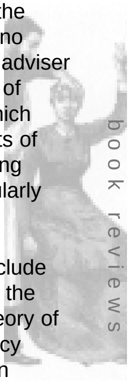
Part of the Disability, Human Rights and Society series, this book originated from Disability Research Units at Leeds and Sheffield Universities. It assumes the social model of disability and of learning difficulties - that disability is not an intrinsic deficiency but is constructed through extrinsic barriers and negative attitudes. Goodley critiques negative, individualistic and medicalised accounts of learning difficulties, and starts from positive perspectives of capacity rather than deficiency. His aim is to stimulate debate, to encourage further theoretical and empirical work in this important area and, through his evidence and analysis, to promote changes in policy and practice.

Definitions and a history of self-advocacy movements are followed by critical discussion of the need to re-appraise different models of individual and group self-advocacy. The section which analyses narrative, life-stories and ethnography about self-advocacy is later vividly illustrated by five life-stories. People’s almost casual descriptions of their competent contributions to their families and communities are mixed eerily with many examples of how they were denigrated and confined into institutions. These `top self-advocates’ explain the difference which joining groups such as People First made to them. Like feminists, they gained awareness which made sense of the contradictions in their lives, and skills to resist attempts to disable them.

Numerous examples illustrate the contradictions between their abilities and how they were regarded and treated. Sophie (p 199) was taken the walkable distance to her self-advocacy group by taxi because her records said that she would be `unable to learn to cross the road’. When the taxi had left, she would cross the road to the shops twice, so that as the group’s `shopping manager’ she could buy milk for the coffee break.

Self-advocacy groups for people with learning difficulties heavily depend on their advisers. The complications, advantages and disadvantages are explored of having advisers with divided loyalties, such as when advisers are members of staff at the Centre where group members live or work. They may be comrades or dictators. The reports are detailed and critical yet respectful.

Ethnographic study of four groups illustrates the complex variety in the groups’ workings and aims, and in the members' expectations, experiences and rewards. Whereas the relevant literature tends to favour certain models, Goodley concludes that there is no clear better or worse model of self-advocacy groups. A review of different types of adviser support shows the importance of not being `obsessed with the changing elements of service provision and support' (p 195). Broader and explicit attention to ways in which disability is constantly reconstructed is also vital. As I have joined the growing hosts of researchers, who are commissioned to evaluate methods of consulting and involving seldom-heard groups such as patients and children, I found these chapters particularly useful.



The final chapter discusses complications which require further analysis. These include resilience (which enable disabled people to maintain crucial dignity and optimism); the tacit informative discourses of care and pathology; relations between the social theory of learning difficulties and of physical impairments; relations between the self-advocacy movement and the disability movement; between theory and practice; and between researchers and activists and the people being researched.

The appendices give examples of written and illustrated leaflets for life-story narrators and self-advocacy groups, and report Joyce Kershaw's life-story: `...raise your voice and not be frightened of them and stick up for yourself.' This salutary book ranges far beyond learning difficulties and self advocacy. It contains numerous points about research method, theory, and links to policy, which many kinds of health and other social researchers will find valuable.

Priscilla Alderson, Institute of Education, University of London

Brown N, Rappert B, Webster A. (Eds.) (2000) Contested Futures: a Sociology of Prospective Techno-Science Aldershot: Ashgate (ISBN 0754612635 Hbk £42.50)

In areas of very rapid change, sociologists are posed with the problem of how to avoid writing history - records which have been superseded by changes before the reports are published. Our contemporary accounts cannot even benefit from historians' hindsight/foresight. So how can our research, for example about genetics, inform or warn about the future if it is confined to solid evidence which rapidly becomes defunct? And yet speculation about likely futures seems equally to risk becoming irrelevant and misleading.

Researchers in Britain, the Netherlands, Spain and France address such problems in this timely book. They raise new problems and solutions, and lay the bases for social research which examines responsibility for the future. Barbara Adam's foreword notes that `the techno-science of today creates future presents for our successors' who cannot influence today's decisions. `It is [therefore] the socio-political task of the present' to research future as well as current needs. We can explain and render visible present taken-for-granted and disattended processes, Adam proposes, when we examine `how the future is created, constructed, contested, colonised and consumed, how it is materialised, managed and mastered,' how opportunities and uncertainties are also managed, and risks played against potential profits (xii-xiii).

The authors do not attempt to create models of the future, identify trends or provide prognoses. Instead they analyse how others predict the future. They show how predictions concentrate almost entirely on technology and gadgets, and pay little attention to human relationships or to how technologies may shape societies to become more divisive or more inclusive. Each chapter examines how predictions are usually based on assumptions that certain outcomes will prevail over others. The assumptions dismiss or devalue all other possibilities, by implying that certain choices are inevitable - or inevitably superior. They thus close off many other potential futures. This book aims to show how various predictions arise from certain interest groups and are contested by others, how groups orchestrate opportunities, and create `path dependencies', and `lock-ins'. Economists' narratives `lock-in' promisingly high-yield technologies and thereby `lock-out' all other possibilities.

The authors contend that the future is not linear or naturally evolving. Instead, the futures of science and technology are actively constructed through present claims and numerous competing counter claims. These make it harder to manage and stabilise people's rising expectations. Discourses of uncertainty and risk conflict with those of optimistic certainty, such as reports of medical `breakthroughs'. The rhetoric of the `breakthrough' motif curiously transfers agency away from human actors on to idealised scientific products and processes. Like Dolly the cloned sheep, these take on their own momentum and determine their own seemingly irresistible futures. The key question transfers from whether the technology should be developed to when it is expected to be developed. The future itself may be seen as the `agent' which brings inevitable progress or threat in ways which implicitly diminish human agency. `Stake-holders' is another term which is deconstructed to show how power, gender and class inequalities are flattened and hidden, thus raising questions about whose interests are served or undermined by this process. The authors examine how metaphors, narratives and promises are used to shape predicted futures, and they formulate questions to help us to examine the predictions critically through unpacking their hidden assumptions and rhetorical techniques.

This densely argued book examines numerous approaches towards understanding the future. It considers how the material world shapes representations both of the future, and of the present in which those futures are made to perform. Promises are shown to harden quickly into requirements, contracts, mutual obligations and, eventually, dependencies when new `needs' have been created. Narratives set the stage, the plot and the key actors of future `progress' in ways which come to be assumed.

A history of science fiction illustrates how past predictions in Marxist and feminist science fictions took their impetus from, and inspired, social political and economic reform. Some past predictions have remained unfulfilled. This happens especially when societies use new technologies to continue to live in old, though faster, ways instead of adopting radically new ways of living. For example, teleworking is much less popular than was anticipated. In such cases, it appears that the necessary social and political changes have not been addressed as thoroughly as the technological ones.

The book's final section reviews how policy agendas are mobilised at local and national levels, in varying organisations and domains. Governments' Foresight programmes are examined as fictive scripts which perform to construct futures through socio-technical networks. The character and significance of the new genetics depend crucially on how

they are configured within health care and other networks. The notion that predictions are based mainly on calculative rationality is challenged. They are also influenced by contextualised reasoning, particularly about how other actors might react, and how routines are carried from the past into the future. As new demands and new agents influence services, such as health services, professionals and policy makers lose their former control over future agendas and have to engage with new uncertainties and new relationships with patients-as-citizens. All these developments need to be analysed for how agenda are set, by whom and for whom. This is a valuable book for all researchers concerned
with future trends as well as present realities.

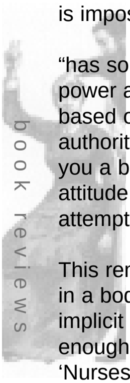
Priscilla Alderson, Institute of Education, University of London,

Rolfe G. (2000) Research, Truth and Authority: Postmodern Perspectives on Nursing London: Macmillan (ISBN 0333776372 Pbk £15.99)

I do not believe that I am alone in finding many expositions of post-modern social and literary theory tremendously perplexing, or in finding some attempts to apply it to areas in which readers of Medical Sociology News work more than a little unsatisfactory. But I was eager to see this book all the same, in part because its title suggested that it might illuminate clinical nursing practice using some of the theoretical perspectives that fall within the ambit of the post-modern. The book's purpose, however, is rather more complex than this.

The book is in two parts. The first half (written by Gary Rolfe) introduces notions of modernity and post-modernity, and explores their implications for the authority of research-based knowledge. To my mind this is the most successful part of the book.. Rolfe sets out a clear but very abridged account that sets up a historical survey of the shifts from notions of research based knowledge as a basis for authoritative statements about the natural and social world, to the highly problematised sense of knowledge that we find in late modernity. The second half of the book consists of a series of previously published articles by a small but international set of contributors (including Rolfe himself). Each article is paired with a gloss by Rolfe which explores its relevance to the intellectual problems set out in Part I. This is much less successful. In part this is because having established a line of approach in the first half of the book, Rolfe has to accommodate contributions that differ very widely in terms of perspective. Amongst these are ones by Claire Parsons on the nurse researcher as ironist, and Rolfe's own article on reflexivity and writing, that are models of intellectual purpose and clarity. A piece by Kim Walker on the poetics and politics of orality is altogether less successful, and I found it hard to reconcile his discussion of 'The poetic moment as a counter-hegemonic technique of sensibility' with what else I know about the substantive topics of nursing research. In fact, I wondered what he meant by it all.

So far I have written about this book as though it were really an introductory guide to 'post-modern' social philosophy applied to nursing. That is, as a book that would fit into a place in the syllabus, and introduce a topic. But it has a more overtly political purpose too. From the very beginning Rolfe is concerned to critically interrogate not only the knowledge that is constructed within nursing, but also the knowledge (the 'evidence') that



is imposed upon it. He makes this clear at the outset, asserting that post-modern theory

> “has some highly pertinent things to say (...) about the relationship between knowledge, power and authority; which is of direct relevance to anyone who has to make decisions based on best evidence (...) and also to those of us who have misgivings about where authority is invested in the nursing profession. Reading postmodernism might not make you a better practitioner, but it hopefully will help you to develop a more questioning attitude and make you generally more troublesome to those in the profession who attempt to be authoritarian without being authoritative” (p.xiii)

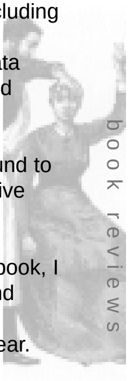
This reminder that the purpose of scholarship is to incite critical inquiry is a welcome find in a body of literature that Rolfe himself observes is often editorially organised around the implicit assumption that nursing students are, to be frank, not intellectually sophisticated enough to deal with complicated ideas. Here he tells us that in proposing this book, ‘Nurses, I was told, only buy books that tell them directly, and in simple language, how to do nursing practice’ (p.xii). That is not an accusation that could be levelled at this book, which has an altogether more interesting (and laudable) project.

Carl May, University of Manchester

Kerrison S & MacFarlane A. (eds) (2000) Official Health Statistics: An Unofficial Guide (ISBN: 034073132X Pbk £16.99)

This is a marvellous book. Not only is it essential reading for anyone involved in health research, it will also be useful for anyone interested in all official statistics and their methods of collection and interpretation. Furthermore, it is a very interesting read. The editors have chosen to use a very wide definition of official health statistics, so the book also includes information on related social and environmental issues like poverty, wealth, unemployment, industrial pollution and transport. It is an up-dated and expanded edition of The unofficial guide to official health statistics published by the Radical Statistics Health Group in 1980 and covers data collected in England, Wales, Scotland and Northern Ireland. It starts by giving us a potted history of the Government Statistical Service. An outline of the potential problems with data collection and interpretation follows including, for example, changes in entitlements to benefits, changes in definitions, disinterestedness of those collecting and recording the data.

Each chapter deals with a group of related issues and describes the data available. For example Chapter 3 is entitled ‘Matters of life, death and illness’ and covers ‘births, congenital abnormalities, death, cancer and communicable diseases’. So there is information about birth registration (at the local registrar’s office, via the midwife, to the district director of public health and collected through the Hospital Episode System); about specific notification systems (congenital abnormalities); about abortion notifications; about laboratory reports of infectious diseases; about death registrations; cancer registrations etc. It provides a full and comprehensive guide to the types of data collected, how they are compiled, how reliable they are and what they are used for. Each chapter also mentions, where relevant, sources of information (or lack of information) about private health and health care.



Chapter 8 deals with statistics on health care and the performance of the NHS, including staffing and costs. Again it provides us with a history of the development of data collection from the 1890s to the present day, charting the massive expansion of data production and collection and explaining the plans for change to deal with gaps and deficiencies. In this chapter we find information on clinical activity within hospitals, paramedical staff, about other services (dentists and ophthalmic services etc.), prescriptions, immunisation programmes and so on. When space has not been found to include detail about data on a particular issue, for instance exercise, the authors give references to publications where information can be found.

Having chosen two chapters more or less at random to describe the scope of the book, I hope to have conveyed that this book is a mine of information. It is full of useful and practical information about which data are available, how to access them and the potential pitfalls in using them. It also lists the main publications in which they appear.

Twenty-eight authors have contributed to nine chapters, each of which is written by a different group of authors but the style is consistent, accessible and thoroughly readable. The presentation is good, giving the reader clear directions to related topics. I know I shall find it invaluable and I shall make it compulsory reading for my health studies students.

Paulene Hudson, Bath Spa University College

Argyrous G. (2000) Statistics for Social and Health Research. Sage Publications (ISBN 0 7619 6818 0 pbk 538 pages £24.99)

This text provides both an explanation of statistical concepts and procedures, and an introductory guide to the use of SPSS for Windows. As the author makes clear, the book does not attempt to link statistical analysis with other aspects of the research process, and nor does it seek to engage in a critique of statistics in the broader context of research. Recognizing these limitations on its scope, the book certainly succeeds in its objectives.

No previous statistical knowledge is assumed, and concepts and procedures are explained in terminology that is only as technical as it needs to be. Formulae are presented in a comprehensible way, and the material is presented in such a way that the formulae are not indispensable to an overall understanding. Both descriptive and inferential procedures are dealt with, and in both cases the underlying theory is covered in detail and with clarity. The content of the book is divided into parts, and their titles summarize well the range and nature of the material: univariate descriptive statistics; bivariate descriptive statistics; inferential statistics - the one-sample case; inferential statistics - two or more independent samples; inferential statistics - two dependent samples; multivariate descriptive statistics.

The explanations given throughout the book are clear and comprehensive. For example, the account of measures of association (Chapters Seven and Eight) is detailed, and fuller than those available in most comparable texts. The explanations of how to use SPSS (version 9 is demonstrated) are clear, and are supplemented by a CD-ROM of data files.

A slight drawback of the examples used to explain the material is that these are sometimes inappropriate. Hence, a two-segment pie-chart is shown (p. 95), whereas such a figure would almost always be redundant, a bar chart is used incorrectly to display variate (rather than frequency) data (p. 254), and a standard deviation is quoted for a distribution for which it would surely be an inappropriate measure of scatter (p. 103). The text is largely error-free, though an unfortunate error occurs in the table explaining Type I and Type II errors (p. 273). A more substantive difficulty is with the rationale given for using one-tailed hypothesis tests. The author does not, in my view, engage adequately with the objections to this approach - e.g. that the direction of a test should be determined by what is theoretically feasible, rather than by what the researcher hopes or expects to find - and as a result students may not be sufficiently judicious in their choice between one-and two-tailed tests.

Quibbles aside, this is a text that can be strongly recommended. Its focus is not of special relevance to medical sociology, but it employs examples that are germane to health and health care more generally. I would imagine this book would be useful as a set text for undergraduate modules in social statistics, or as a resource on postgraduate degrees in social science that take a quantitative focus. In each case, a parallel source on the philosophical, social, political and other contextual aspects of quantitative research would also be required.

Julius Sim, Keele University

Hayry H. (1998) Individual Liberty and Medical Control Aldershot: Ashgate (ISBN 1840145722 Hbk £29.95)

Heta Hayry's book is an important contribution to medical sociology. Hayry's central concerns in the area of medical control are euthanasia, medical authoritarianism, health education, preventive medicine, legal restrictions, and democracy. Hayry's own position, located at the intersection of Millian utilitarianism and Rawlsian notions of justice, is that individual rights and principles of autonomy can never be privileged at the cost of her/his responsibility to fellow beings. However, she is also clear that coercion in any form is unquestionably anti-autonomy.

In her chapter on euthanasia, Hayry distinguishes between biological death and personal death. The latter is essentially the death of the person, as s/he is known. Hayry is unequivocal on the point: medical assistance must go to the persons-who-are rather than persons-who-are-not-yet (foetuses) or no-longer-persons (brain dead). Surveying the forms of 'medical paternalism' (the attitude that people's own wishes need not always be respected because people do not always know what is good for them), Hayry rejects all forms of 'strong' coercion that circumscribe individual autonomy. Extending this argument to issues of medical care, Hayry traces the modes of medical control: emotional blackmail ('medical maternalism'), concealed knowledge ('medical censorism') and the right/capacity of authorities to know the best ('medical paternalism'). Hayry concludes that maternalism and censorism are more insidious because it manipulates consent through its use of emotional pressure and the patient's ignorance.

Hayry suggests a health education that disseminates truthful information and one which

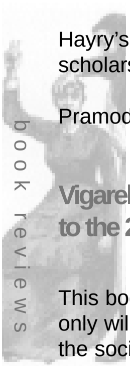
enhances the individual's autonomy. Further, Hayry argues that rather than the forced inoculation, quarantine or legislated medical care, public health authorities must work towards an ideal of obtaining the informed consent of patients. Finally, in her section on democracy and health, Hayry attempts a compromise between individualist liberalism and totalitarian collectivism. Hayry outlines two central stages in a liberal-egalitarian approach: (a) defining the most basic needs of the people, (b) to ensure that the fundamental autonomy of individuals is protected without threatening the 'basic-need satisfaction' of others (100-101).

Hayry's strength is her organisation of the debates: 'situating' them before offering her own critique. Her liberal approach ensures that the 'tyranny of the majority'- the governing principle of utilitarian social health care - does not infringe upon the individual's agency. However, this also results in specific difficulties which Hayry (understandably) cannot resolve. One area where the dilemma between choosing the greatest good of the greatest number and individual's right to freedom is the issue of quarantine. Does the forced isolation of an individual or group of individuals for the benefit of the larger population violate a fundamental human right? Do more number of lives get priority over the one? Obviously such questions do not have ready answers, and Hayry's brave attempt is to be appreciated. Hayry's (postmodern) stress on the opening up of knowledge is a crucial argument, and one that will find ready support in the field.

Three specific problems remain. Hayry merely mentions the role of the Church in influencing medical decisions. This issue, especially in the context of developing nations or the minorities within developed nations, is of enormous significance. Practices like clitorictomy in the Middle East and Africa have medical and socio-religious roots. Hayry's Eurocentric multicultural liberalism, runs into what appears to me a major difficulty here. Multiculturalism, an admirable ideal in itself, treats all cultures as equivalent, their experiences as interchangeable, and therefore as uniformly 'legislatable'/'treatable'. This, however, is not the case. Experiences of aging, sexuality and illness differ between societies and cultures. These experiences frequently have culture specific socio-religious roots that produce effects which cannot be equated to the experiences (in the same areas) for another culture.

Secondly, (following Bryan Turner and the social constructionist views of illness), one needs to analyse the 'sick role'. Individuals are classified and regulated by professional groups and institutions in terms of their 'disease'. Notions of 'sin', 'deviance' and such amorphous moral criteria are equally instrumental in medicalising the body. The experience of illness/sickness (the 'sick role') is intimately connected with both the 'actual' physical disease and social perceptions of the same. The sick role, for instance, implies that the 'patient' is under an obligation to acquire medical treatment and return to 'circulation', while being absolved of social responsibilities for the period s/he is sick.

Thirdly, disease has a dialectical structure (Sander L. Gilman, 1988): fearing our own collapse we project this fear and gain control over it by locating disease in others, especially in those we believe are more prone to sickness. This therefore moves 'secular' medicine into addressing issues like racial bias and normativisation of sexual preferences. Thus the 'moral panics' (Kenneth Thompson) over, say, AIDS emerge in a framework where the projection of illness is crucial to agendas of medical health and social perceptions of the same. That is, sexual/racial/gender aspects of illness remains a subtext that underwrites social responses (including legislation) to illness.



Hayry's work is an admirable survey of the debates in the field, and is surely a primer for scholars in the discipline.

Pramod K. Nayar, University of Cambridge

Vigarelo G. (2000) A History of Rape: Sexual Violence in France from the 16th to the 20th Century Cambridge: Polity Press (ISBN 0745621708 Pbk £15.99).

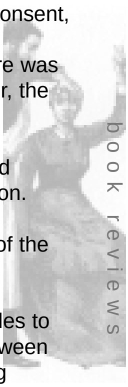
This book presents an excellent social interpretation of rape and sexual violence. Not only will it be extremely valuable to social historians but to those interested in sexuality, the social construction of deviancy, and the changing status of women and children. Vigarello examines the changing status of rape and sexual violence through an investigation of socio-cultural attitudes and legal processes. The text is presented in 5 parts and provides a detailed account through case studies of the evolution of contemporary ideas about rape and acts of violence.

Part 1 examines sexual violence in the ancien regime, when serious crimes were an everyday fact of life. Standards and tolerance of aggressiveness were also different to today. Although sexual crimes were adamantly condemned few were punished or reported. Furthermore, the social position of perpetrators was very influential, such that masters committing acts of sexual violence were rarely if ever prosecuted. Also influencing reporting was that rape was seen as an act of violence and incorporated a religious principle, equally condemning the victim and the perpetrator.

Part 2 explores the changing public opinion towards sexual violence at the end of the eighteenth century and the lack of change in the law. Increasingly, distinctions between acts against persons and property were being made. Attitudes towards rape and shame remained unchanged.

From 1750-60, new feelings towards childhood were observed and children were regarded as more fragile and vulnerable to adults. Consequently, complaints and prosecutions of child rape increased. This section then examines the judges who aimed to reform substitute the idea of sin with that of physical danger in trials. This meant greater attention paid to individual suffering and the force of attack. Furthermore, the Code of 1791, made victims more independent of their guardians and recognised varying degrees and forms of sexual violence. However, for the most part the shame of the victim was still present.

Part 3 discusses the law in the nineteenth century and the hierarchy of criminal acts. A key feature of this time was the desire to rank crimes and to understand their causes. Murder was the highest rank of criminality and sexual violence had a low rank. However, child rape begun receiving a higher ranking. The Code of 1810 significantly changed rape trials by defining acts of sexual violence previously ignored, particularly affront and assault. The code incorporated all acts of sexual violence, under the heading of 'offences against decency'. However, its limitation was that it did little to change the judgements of adult rape.



This section then discusses the changing relationship between violence and non-consent, resulting in the recognition of moral violence against adult women. Vigarello then examines trends in prosecutions, verdicts and complaints of sexual violence. There was an increase in numbers of sexual crimes reported, particularly child rape. However, the overwhelming culture of shame and suspicion prevailed.

Part 4 examines the end of the nineteenth century and in particular the rapist. Child sexual assault ranked alongside murder and rapists received greater public attention. Furthermore, scientific investigation into the physical attributes of sexual criminals increased. For instance, Gall argued that rapists had an ‘excessive development of the cerebellum’. In addition forensic psychiatry was emerging as a science.

Part 5 examines the twentieth century. Vigarello argues that the changes in attitudes to rape, and particularly towards women, is related to changes in the relationship between men and women. As a partial result of feminism, women no longer accepted being subordinate this change in status meant that sexual crimes took place among two equal persons and gave the raping of an adult woman greater weight. As a result, acts of sexual violence are sentenced and treated with greater severity.

Overall, this is an excellent book that is easy and interesting to read. Although the examination of rape takes place in France, the major themes in the book are applicable to most western European countries. It is extremely well researched and a valuable resource to anyone interested in changing attitudes to sexuality and sexual crimes.

Patricia Kingori, University College, London

Riches g. & Dawson P (2000) An Intimate loneliness: supporting bereaved parents and siblings. Buckingham: Open University Press (ISBN 03351999720 Pbk £17.99)

Recently, I attended a lecture given by the eminent solicitor Imran Khan (Justice for Ricky 2000) in memory of a young student called Lakhvinder ‘Ricky’ Reel. Ricky died by drowning in the River Thames in Kingston on 14th October 1997, three years ago. It was believed to be motivated by racist attack. He was only 20. To Ricky’s family, the pain of losing such a precious and much loved son and brother, was very personal, and very raw still even after three years. At first hand, I heard a mother’s desperate wish to will her son to get up when she saw him lying in his coffin three years ago. She stood alone on the platform, once again re-living those terrible and painful moments. She was forced to become a public campaigner. She spoke of her inability to grieve and of having to put her life on hold.

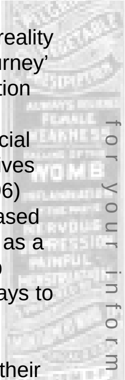
The story of Ricky, and his mother’s struggle to make sense of Ricky’s untimely death parallel the family stories told by the participants in Riches & Dawson’s research. This tragic story epitomizes some of the central themes running through the book: a mother in prolonged pain (p.182, Figure One) from a difficult death by murder (p.133) and from a total lack of preparation (p.23) for his death; a search for the meaning of his death (p.8); a mother in absolute and total pain created by the death of their child; sibling loss and

bereavement (p. 76). For Ricky's parents, coping with 'complicated grief' (p.145) of this kind and profound loss would likely be 'measured in years rather than in months' (p.144). For them, a sense of self-identity, i.e. parental role (p.4) is destroyed by the death of their child. 'Coming to terms' (p.33) with the death of their son may never be achieved because it has left a huge 'hole' in their 'bleak domestic landscape' (p.48 &.6) which is never going to be filled . For them also, the value of social support (p.9-10) has temporarily helped them to achieve a sense of 'order out of chaos' (p.15). It has created a temporal space for them to focus their energy and time on the present campaign to 'achieve justice' (p.133) for their son. For them, 'successful grief resolution' (p.128) may take the form of their instinctual need to maintain a continued bond with their son as opposed to the wider cultural expectation of the necessity to write 'the last chapter' (p.36, 122, 180). In my opinion, the book has essentially captured the very essence of the experience of profound grief and loss.

The book has seven chapters and an introduction. The methodology chapter is in the appendices. As my general rule for book review, the first thing I look for is the method chapter which usually helps clarify my understanding of the authors' intentions, their methodological approaches and the methods used. Riches and Dawson have done just that. A critical post-modernist and constructionist approach to this ethnographic study drawing from a variety of data sources was clearly stated. In stressing the importance of collaboration with families, they entered the field as 'sympathetic outsiders' and became recognized and accepted by participating individuals in their study as 'associates' or 'honorary members of the groups' (p.196-197). In my view, it was through this process of gradual emersion into the field that different voices of grieving parents and siblings could be heard, at first hand. The authors recognized the limitation of their study and made no claim to representation of findings which should be understood as 'eclectic, partial, inevitably superficial at times' (p.191). Their aim was to provide insight into the value of different grief models in a culturally plural society. I feel that this chapter is very important. Therefore it should be in the main text as a chapter in its own right.

I was instantly drawn to the title of this book when I spotted it listed in one of my sociology catalogues. It was eye-catching. The title also implied a personal touch and depth. I thought it was unique which should be interesting. I was not disappointed. The authors began with an examination of current grief and bereavement culture in western society. Drawing extensively from a wide range of literature which included sociology, psychology and anthropology as well as using case studies from their own research, they actually investigated and refuted the cultural assumptions and expectations associated with the meaning of death which underlies conventional models of grief. They examined psychotherapeutic, psychological and bereavement counseling principals. They noted the underlying assumption of universality in current grief models in terms of placing too much emphasis on individual's pathology (p.2, 101). They exposed the failure of different discourses of grief to address the diversity of cultural belief systems which influenced and shaped how the family in the post modern society responsed to grief. Indeed the qualitative detail of their research material supported the notion of cultural diversity. In my view, they made an excellent case for the non-universality of grief and advocated for a flexible and open-minded approach to understand grief.

The authors proposed to put forward a socio-cultural perspective of grief which stressed the importance of meaning in terms of how individuals perceived their loss (P.8) because meaning played a central role in adaptation. Grief as a concept was multi-layered and



laden with multi-meanings. They demonstrated that no one model was sufficient in explaining grief in our post modern society. They argued that re-adjustment to the reality of life should be understood as a 'very individual journey' (P.119) and a 'solitary journey' (P.124). The journey may be long or short. They suggested that successful resolution may depend on resources at three levels: namely, personal, social and cultural. Successful resolution may also take many forms. They argued that the value of social support was primary in helping bereaved parents and siblings to reconstruct their lives disrupted by different kinds of death. The authors were influenced by Walter's (1996) biographical model of grief. They proposed that the relationship between the deceased and survivor need not end with death. This new relationship should be understood as a continuing bond with the deceased. The authors made suggestions for how to help bereaved parents cope with the death of their child. They advocated for realistic ways to achieve this with a clear discussion of the steps that professionals could take.

What I would like to see included in the book is that perhaps more examples from their data to illustrate arguments presented in the middle chapters which seemed to be a little bit too heavy with theoretical discussion. Also a focus on socio-cultural perspective might have underplayed the role of economic factors in the process of re-adjustment and adaptation.

Sarah Li, Kingston University and St George's Hospital Medical School

Books available for review

Abraham J and Lewis G. 2000 Regulating Medicines in Europe: competition, expertise and public health London: Routledge

Cobb M. 2001 The Dying Soul: Spiritual Care at the End of Life Buckingham: Open University Press

Cohen S. 2001 States of Denial: Knowing about Atrocities and Suffering Oxford: Polity

Field D, Clark D, Corner J, Davis C. (eds.) 2001 Researching Palliative Care Buckingham: Open University Press

Graham H. (ed.) 2000 Understanding Health Inequalities Buckingham: Open University Press

Grant M. 2000 Galen on Food and Diet London: Routledge

Hancock P, Hughes B, Jagger E, Paterson K, Russell R, Tulle-Winton E, Tyler M. 2000 The Body, Culture and Society: an introduction Buckingham: Open University Press

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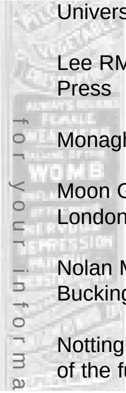

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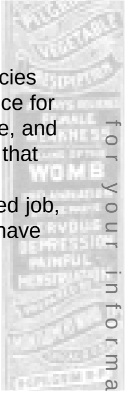


Agony Aunt Marge

Aunty Margery has survived more department reorganisations, waves of redundancies and central admin ‘streamlinings’ than most of you have had hot dinners. Her advice for coping with increasing short termism in academia is to make yourself indispensable, and make sure you have compromising photo’s of the head of dept to utilise whenever that end of contract looms. However, this didn’t help Over-Committed of Ormskirk, who has a secure tenured job, but whose research staff don’t. Two readers have some additional advice...

Dear Aunt Marge

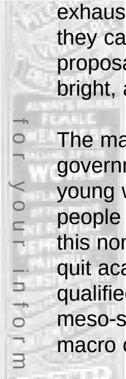
‘The disappearing researcher’

We are under increasing pressure to bring in research income. This means that many of the grants I manage are for work actually being carried out by short-term contract research staff - research assistants and research fellows employed on soft money. As they have no job security (our institution only offers bridging salaries for those employed for more than two years), they inevitably have to look for new jobs before the end of the research project. This is clearly less than ideal for junior research staff, who have to leave projects at the point when they are being written up and either work (unpaid) on papers while in their new post, or have a reduced input into the writing. It is also problematic for senior staff, who are left with (potentially) several projects to complete, often with little detailed knowledge of the literature or data. Any suggestions for how to manage grants in the knowledge that key people often have to leave before the end?

Over-committed of Ormskirk

Dear Over-committed of Ormskirk

Your letter addresses an issue that - in sociological terms - has macro, meso and micro social consequences. You’ve described the micro-social consequences very well, so let’s deal with the other two. At the meso, or organisational level, the result of this short-termism is that Universities are less able to bring in research funds because their bright, able grant-holders are busy writing up the data, publishing, and then becoming



exhausted. They naturally need a break from writing or applying for money, which means they cannot put time into the next proposal or, if they do, it is not enough and the proposal isn't funded. This is a complete waste of University resources, and leaves the bright, able researcher feeling unsupported and resentful.

The macro consequences of short-termism of the kind you describe are societal and governmental. The next cadre of possible senior researchers (who were once those young women and men who had to move on to the next contract) is severely depleted as people wish to put down roots in one place. They can no longer take the uncertainty of this nomadic existence - as they acquire mortgages, and responsibilities - and therefore quit academic life. This means that we are not properly planning for, and feeding highly qualified personnel into, future health and social scientific research. Of course, the meso-social impact of relatively small numbers of grant applications (see above) also has macro outcomes in terms of the quality and nature of the science generated.

What's to be done? Well, it may sound idealistic, but we need research to be funded for the time it takes to get done and written up. Grant applications should set out the proposal for the research, and at the end a year should always and invariably be added to the costs. This must be kept entirely free for writing up, and the development of further proposals. The cost of this third, fourth or fifth year should come directly from the Government's science budget, and dispersed automatically when studies are supported by research councils, health authorities and other organisations registered as legitimate research funders.

This doesn't address your immediate management problem, but demonstrates a straightforward way of improving your lot, that of your contract researchers (they get the publications that will lead to a more permanent post) and of the dissemination of publicly funded research, to the greater good.

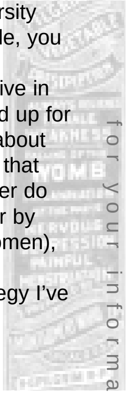
Yours truly,

Someone who's got 'nae hair' and been round a wee while

Dear Over-committed,

Well you sound like the opposite to the 'disappearing researcher' - what I would call the "disappearing principal investigator"! I have noticed that DPIs are there at the beginning when signatures need to go on grant proposals, and then they aren't seen for the duration of the project. However, then suddenly they pop up again when it's time to discuss authorship of publications. The most extreme form of DPI doesn't even write the grant proposal - instead he or she "works" the system exploiting the fact that funding bodies such as the MRC and Welcome do not allow contact researchers to be grant holders, and becomes the principal investigator of a proposal he or she has not written or been involved with. You may not be this most extreme kind of DPI, but there are plenty around.

In answer to your question about how to stop contract researchers disappearing before the end of their contract. Well, that’s a difficult one. The short termism of the university system seems to conspire against most good working practices. On the grand scale, you could start lobbying for changes in employment practice in your institution, e.g. underwriting contracts. But I agree that is a lonely path to tread. The other alternative in the medium term is to get more grants in. That way you can have the next job lined up for your contract researcher before the end of their contract, preventing their worries about paying the rent or mortgage making them jump ship early. The only downside with that approach is that you can spend so much time writing grant proposals that you never do anything else. Finally, the only thing I can suggest is trying to keep your researcher by making them feel guilty about leaving you high and dry (usually works well with women), or issuing vague threats about their “disloyalty” and “lack of commitment” being remembered and used against them in the research world (also a successful strategy I’ve seen employed).



Good luck!

Slightly Cynical of Sutton Coldfield

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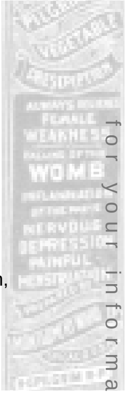

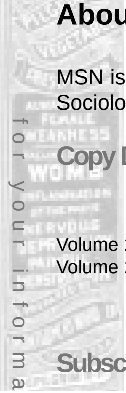

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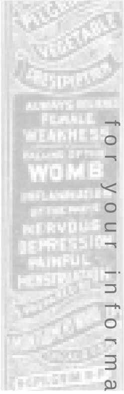

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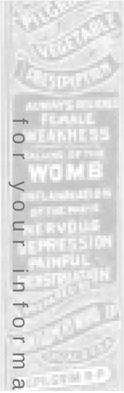
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