

# PAPER ABSTRACTS

listed in alphabetical order of first author

<b>2<sup>nd</sup> September 2010</b> Patient Organisations & Support Groups	<b>09:00 - 09:30</b> Engineering 102
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*Aglen, B., Hedlund, M., Landstad, B.*

*Nord-Trondelag University College*

## **SELF-HELP GROUPS, HEALTH AND EMPOWERMENT IN A VOLUNTARY CONTEXT**

This paper focuses on how self-help groups contribute to empower people with mental health problems and disability. According to the notion that empowerment implies gaining force through one's own efforts, investigating self-help groups in a voluntary setting becomes interesting. These groups are organized outside a clinical setting, out of reach for professional interference. Self-help relies on mutual sharing of experiences and support between peers. The empowerment or disempowerment processes in these groups are here studied and analysed in relation to Antonovsky's theory of Salutogenesis and resistant resources. Participating in Self-Help Groups can lead to individuals developing resistance forces to manage stress or problems in everyday life and to maintain a sense of coherence. Moreover, participation in Self-Help Groups can contribute to enforce resources that can be helpful in managing struggles in life. The paper relies on a social constructivist perspective when studying phenomena such as health and empowerment for participants of Self-Help Groups. The analysis is based on case-studies using multiple sources and methods for data-collection; interviews of the participants and key-informants, focus group interviews, field notes and memos written after contact with the informants and the groups, and document analysis of public documents referring to self-help groups as a health promotion strategy. The data are organized using the NVivo program and analyzed with an inductive open coding process to reveal patterns, themes or categories and to find sensitizing concepts related to the theoretical perspective that underlies this study.

<b>2<sup>nd</sup> September 2010</b> Cancer	<b>15:10 - 15:40</b> Engineering 101
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*Arber, A., Spencer, L., Quirin, S.*

*University of Surrey*

## **'IT'S ALL BAD NEWS', THE FIRST THREE MONTHS FOLLOWING A DIAGNOSIS OF MALIGNANT PLEURAL MESOTHELIOMA.**

MPM is a rare cancer with a rising incidence associated with asbestos exposure. Most of the asbestos used in buildings was imported into Britain during 1960-1980 and many workers in the building and demolition industries may be exposed. The disease is invariably fatal with many people dying within a year of diagnosis with typical survival of only 7-10 months. This study explores how patients with MPM cope during the first three months following diagnosis. The study uses narrative interviews with 10 people diagnosed with MPM in the first three months following diagnosis, from two hospital trusts in the UK. Data was analysed using the constant comparative method to identify common categories and then themes. A key theme that emerged from the data was the feeling of hopelessness associated with MPM in that it is 'all bad news'. Participants describe suffering distress around how their disease will progress. They avoid seeking information as everything they hear about the disease is so negative and there are few effective treatments available. Participants are surprisingly stoical about being exposed to asbestos during their working lives. The study identifies a lack of psychosocial and emotional support for people with this condition leading to a sense of isolation, fear and uncertainty about the future and the progress of the disease.

<b>3<sup>rd</sup> September 2010</b> Sleep	<b>10:45 - 11:15</b> Engineering 102
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*Arber, S.L. Lallukka, T., Meadows, R.*

*University of Surrey*

## **UNDERSTANDING SOCIO-ECONOMIC INEQUALITIES IN SLEEP: LINKS TO HEALTH AND GENDER**

Sleep is fundamental to health and well-being, with lack of sleep increasingly shown to impact on cardiovascular risk factors and diabetes, as well as accidents. Yet sleep has been the subject of little research within health and medical sociology. Inequalities in health research has not been matched by parallel research on inequalities in sleep among representative population samples.

The paper analyses socio-economic status (SES) patterning of reported sleep problems using a representative sample of 7000 men and women (aged 16+) from the UK Psychiatric Morbidity Survey, 2007. We analyse self-reported sleep problems on four or more nights per week. Logistic regression models were fitted to examine how sleep problems varied with age, gender, marital status, children, worries, physical/mental health and measures of socio-economic circumstances.

Strong links between socio-economic circumstances and poor sleep quality are found, including equalised household income, housing tenure, non-employment and low educational qualifications. Reported worries, smoking, health status, BMI and psychological health are associated with sleep problems, but do not explain the identified associations of disadvantaged material circumstances with poor sleep. Women reported significantly more sleep problems than men, especially in midlife (age 45-64). SES inequalities and worries accounting for some of these gender differences.

Since disadvantaged socio-economic characteristics are strongly associated with sleep problems, we suggest more research on whether disrupted sleep may be a mechanism through which low SES is linked to poor health.

This research is part of SomnIA, a New Dynamics of Ageing project, supported by AHRC, BBSRC, EPSRC, ESRC and MRC, RES-339-25-0009.

**2<sup>nd</sup> September 2010**

Ethnicity & Migration

**11:55 - 12:25**

Maths 107

*Aronson, P.*

*Warwick University*

**MIGRATORY PROCESS AND HELP-SEEKING PRACTICES: MIGRANTS FROM THE FORMER USSR IN GERMANY**

The organization of migratory process, people's situation in the sending country, and ways in which they migrate and settle have a strong impact on identity and socio-economic status they acquire as a result of movement. This paper looks at migratory processes as mechanisms affecting migrants' health related practices. In particular, it will focus on how migrants from the former USSR living in Germany seek help in case of illness. Both formal and informal kinds of help will be discussed.

This presentation will start with conceptualization of two major migratory processes involved in movement from the (ex)USSR to Germany: self-funded and institutionalized migration. I will then highlight the effects of the Iron Curtain on these processes, and will demonstrate that contrary to the expectations of German policy makers, self-funded migrants are recruited from higher status groups of the sending society, are more likely to achieve higher status in the receiving society, and their experience with access to help has been mostly positive, both in the (ex)USSR and in Germany. In contrast, 'institutionalized' migration is associated with and is highly likely to produce lower SES in the sending and receiving country respectively, and migrants recruited in this process experience more constraints in receiving necessary help.

Thus, this paper will, on the one hand, address inequalities in access to help and will place them in the context on migratory process. On the other hand, it will challenge the understanding of (ex)Soviet people as homogenous in their health beliefs and help seeking practices.

**2<sup>nd</sup> September 2010**

Methods

**10:10 – 10:40**

Calman, Derman Christopherson

*Barnes, R.K., Regan de Bere, S.*

*Peninsula Medical School*

**A PATIENT FOR A TEXT: TALK ABOUT PATIENTS IN MEDICAL STUDENT PRESENTATIONS**

Although it is widely acknowledged that patient-centredness has an important role to play in the training of doctors, there has been scant research attention as to precisely how students talk about patients. Two researchers with expertise in discourse analytic methods independently coded video-recordings and associated transcripts of 60 medical student case presentations recorded between 2006 and 2008 (involving 16 students and 47 clinicians from 32 specialities in a range of settings across three geographical locations) in a UK medical school. The most prevalent linguistic patterns in how students talked about patients included the use of multiple non-recognitional initial referring expressions, category-descriptions involving moral indices, and socio-epistemic work around the authority of the patient's 'voice'. We compare our findings with those from a well-known previous study of formal case presentations by trainee doctors in the US. We demonstrate how the case presentation format provides for an interactional apprenticeship, teaching students how to talk about medical cases and conclude that students still talk about patients in far from 'neutral' ways. We suggest that medical talk about patients continues to be influenced by interactional, social and cultural constraints, and that these may constitute obstacles to good practice in future caregiving.

**2<sup>nd</sup> September 2010**

Health Policy

**14:35 - 15:05**

Calman, Rosemary Cramp

*Borgstrom, E.*

*Institute of Public Health*

**TOWARDS AN UNDERSTANDING OF THE PROMINENCE OF CHOICE IN CURRENT END OF LIFE CARE POLICY**

Choice is the buzzword in current end of life care policy and literature. Yet, choice and end of life care have not always been the forefront of British health care policy. Using a discourse analysis approach influenced by Foucault, this paper provides a genealogy of choice in UK health care and end of life care policy over the last few decades. It explores the context in which choice became a prominent policy element in end of life care and what choice in these documents presents. It looks at what choices are mentioned, who can choose, and when and how they can do this. The limitations to choice acknowledged in policy and by the researcher are also highlighted. In particular, the choices around place will be examined in detail, including the change of focus from place of death to place of care. To conclude, the power of the choice discourse and focus on key choices, like place, will be discussed as well as what this potentially implies for dying in the UK today.

<b>2<sup>nd</sup> September</b> Health Service Delivery & Organisation	<b>11:55 - 12:25</b> Calman, Ken Wade
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*Bourgeault, I.L.*

*Université d'Ottawa/University of Ottawa*

**COMPARING SOURCE AND DESTINATION COUNTRY PERSPECTIVES ON THE MIGRATION OF HIGHLY SKILLED HEALTH PERSONNEL**

This presentation compares source and destination country perspectives on health personnel migration. Cases include Canada, the U.S., the U.K., and Australia on the one hand, and India, South Africa, the Caribbean and the Philippines on the other. Data for both cases are primarily derived from a combination documentary analysis and over 100 key informant interviews, largely in the destination countries analyzed thematically in a linked fashion.

Destination Countries differ to the extent that their concerns with migration affect nationally based certification and integration policies.

- The U.K. stands out in terms of its explicit policies to address the ethical issues resulting from the active recruitment of health workers from countries in need.
- Though these issues are salient in Canada and Australia, the decentralized nature of their health systems make coordinated policy and action in this regard difficult.
- The U.S. has little policy nor action.

In terms of the Source Countries, India and the Philippines have a bifurcated policy - an increasingly active policy to 'export' health workers yet concerns with the negative health consequences of this policy.

- India and some Caribbean countries are pursuing a policy of medical tourism but this is yet another form of providing care to patients in developed nations.
- South Africa and some Caribbean countries experience both an outflow and inflow from other even more disadvantaged nations.

All countries will need to at least consider how to address each others' concerns in light of the WHO Code of Practice passed in May.

<b>2<sup>nd</sup> September 2010</b> Health Policy	<b>16:20 - 16:50</b> Calman, Rosemary Cramp
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*Brigham, L.L., Maxwell C., Smith A.*

*The Open University in the North*

**LEARNING TO LEAD IN PRACTICE:HEALTH VISITOR PERCEPTIONS OF ROLE, INFLUENCE AND IMPACT IN A CONTEXT OF CHANGE**

The study of Health Visitors was carried out in a recently merged Primary Care Trust to find out more about their current situated practice, in the context of both local organisational change and national policy drivers outlining a new lead role for them in delivering co-ordinated and integrated services tailored to local needs (Healthy Child Programme DH 2009; Healthy lives, brighter futures: the strategy for children and young people's health, DH and DCSF 2009; Getting it right for children and families DH, CPHVA, Unite, NHS). The study focused on perceptions of role and extent of influence, coping with challenges and change and perceived impact of their knowledge and expertise on service improvement. A qualitative methodology, with use of focus groups to generate data, was adopted and the transcripts were subsequently analysed for key themes and dimensions. The transcripts were interpreted through theoretical frameworks related to a 'communities of practice approach' (Wenger et al 1998 and 2002) and with reference to recently published findings from a four year study about inter-professional collaborations aiming to provide more joined up services for children (Edwards et al 2009). The latter draws upon Cultural Historical Activity Theory (CHAT) as an analytical framework and this framework was similarly applied to the Health Visitor study

By drawing together the grounded experience of Health Visitors, policy drivers and theoretical interpretations, insights emerged that pointed towards the need for a shift from co-ordination and co-operation to more fundamentally collaborative ways of working that change existing 'scripts' and working practices..

<b>2<sup>nd</sup> September 2010</b> Lifecourse: Ageing, Death & Dying	<b>09:35 - 10:05</b> Calman, Rosemary Cramp
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*Broom, A.*

*University of Sydney*

**MASCULINITY, MORALITIES AND BEING CARED FOR: AN EXPLORATION OF EXPERIENCES OF LIVING AND DYING IN A HOSPICE**

Hospices are playing an increasingly important role in end of life care in Australia and internationally and the in-patient hospice experience has not been well documented by social scientists. This paper explores some important facets of the contemporary hospice experience through an examination of the perspectives of twenty Australian in-patients in the last few weeks of their lives. Through a series of qualitative in-depth interviews, I explore their conceptions of death and dying and their experiences of being cared for. The results illustrate a range of important themes including: tensions around what constitutes 'the good death'; dying and caring as moral practice; and, the centrality of gender identity and relations in shaping experiences of dying and caring. I argue for a sociological approach to death and dying that better elucidates the interplay of identity, morality and relationality at end of life.

**2<sup>nd</sup> September 2010**

Ethics

**14:00 - 14:30**

Calman, Arnold Wolfendale

*Brosnan, C.*

*King's College London*

**THE SOCIOLOGY OF NEUROETHICS: EXPECTATIONAL DISCOURSES AND THE RISE OF A NEW DISCIPLINE**

The sudden emergence of the new discipline of 'neuroethics', coinciding with increasing hype surrounding the potential applications of neuroscience, is an intriguing event from the perspective of the sociologies of medicine, science and bioethics. To date it has received scant attention within sociology, although De Vries (2005, 2007) has argued for the need for a sociology of neuroethics. The paper responds to this call by setting out to explore the disciplinary identity of neuroethics, looking specifically at: how neuroethicists define the scope and role of their discipline; who is part of it; and the relationship between neuroethics and bioethics. This is achieved through a critical analysis of journal articles, book chapters and websites which explicitly aim to promote neuroethics as a discipline.

It is argued that in setting the neuroethical agenda, neuroethicists draw on expectational discourses about the future of neuroscience and, in doing so, actively align themselves with neuroscience, rather than maintaining the critical distance necessary to act as an ethical watchdog. Similar sociological critiques have been made of bioethics, but I argue that in its attempt to distinguish itself from bioethics, neuroethics risks becoming mired in scientific reductionism and neuroscientific hype. This is problematic and warrants further sociological investigation. At the same time, however, the call for a 'sociology of neuroethics' must itself be considered critically in light of recent debates surrounding the relationship between social science, bioethics and bioscience.

**2<sup>nd</sup> September 2010**

Lifecourse: Reproductive Health

**16:55 - 17:25**

Engineering 102

*Brown, N., Machin, L. and McLeod, D.*

*University of York*

**RECONFIGURING WASTE: VALUE AND SURPLUS IN THE NEW BIOECONOMIES OF UMBILICAL CORD BLOOD BANKING**

A national newspaper recently ran a story that began: 'Today, 2,000 babies will be born in Britain. Almost without exception, their umbilical cords will be clamped, cut – and incinerated. And this, say a growing number of parents and health professionals, is waste so flagrant it borders on the criminal'. This paper looks at the reconfiguration of bodily matter as 'waste', a means of attaching a morally binding value to flesh. Within the context of the nascent 'tissue economies' the extraction of surplus value is no longer necessarily and exclusively dependent on the labouring body, but the very meat of the body itself. Menstruation, ejaculation, ovulation, death and now birth are opportunities for the mobilisation of vast and increasingly sizeable bioeconomic markets. We argue that the category of 'waste' is prefigured by a range of sometimes contradictory and potentially irreconcilable forms of value and worth. The moral motivation for banking cord blood is premised on the umbilicus as something to be saved and not waste, banked and not discarded. And yet this promotional form of valuing raises questions for expectant parents anxious not to deny their own newborn the benefits of cord blood stem cells. In this paper, we elaborate on the shifting terms of waste, surplus value and the contradictions of biocapital in the increasingly contentious markets of the cord blood economies.

**3<sup>rd</sup> September 2010**

Mental Health

**11:55 - 12:25**

Maths 107

*Brown, P. Calnan, M.*

*University of Kent*

**COPING WITHIN A CRUCIBLE OF UNCERTAINTY AND VULNERABILITY: THE SALIENCE OF TRUST FOR PSYCHOSIS SERVICES**

Research suggests that trust is vital for quality healthcare and effective outcomes. If trust becomes necessary in conditions of vulnerability and uncertainty then it may be especially salient amidst the treatment of psychosis, where these phenomena typically exist in heightened form. Given the limited research into trust in this area, findings are presented from an exploratory study which applies qualitative methods to develop understandings of the nature and utility of trust for service-users, professionals and managers.

Trust appears to be salient and yet problematic for mental health services, not least in terms of approachability, disclosure and cooperation with treatment programmes. The paper seeks to apply and refine existing sociological theories of trust – particularly in terms of the linkages between vulnerability and a willingness to trust. The dialectical process by which a 'mutuality of accounts' is developed would also appear to be vital in bridging the often conflicting interests and lenses applied by professionals and those experiencing severe mental illness. The emergence of the concept of 'hope' at the margins of trust – and the relationship between these two concepts – will furthermore be considered.

<b>1<sup>st</sup> September 2010</b> Mental Health	<b>13:35 - 14:05</b> Maths 107
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*Brown, S.*

*University of Nottingham*

**HELP-SEEKING AMONGST PEOPLE EXPERIENCING PSYCHOLOGICAL DISTRESS: INTERACTION WITH THE WIDER HEALTH CARE CONTEXT**

This project forms the basis of a PhD and is a qualitative investigation into help-seeking that engages with contemporary constructions of mental health and mental illness as its primary focus. These constructions, drawn from the 'lay' public, interact with the wider environment of mental health care provision when an individual seeks help relating to emotional distress in primary care. The secondary purpose of this research is therefore to consider how such beliefs interact with General Practitioner (GP) responses (which are framed by their own, varied imperatives), and to consider where tensions or incongruence may exist. This is being done using the accounts of people who live within Nottingham city, who have and have not sought help, as a starting point for understanding some of their expectations and beliefs.

Method: Circa 25 semi-structured interviews (12 who have never sought help and 13 who have recently sought help from their GP for the first time) address how such constructions might feed into the help-seeking process as well as what expectations help-seekers might have of services. These findings will be considered alongside data obtained from semi-structured interviews with circa 10 GPs based upon their experience of meeting patient need. Data collection is ongoing and findings in this presentation will be based upon analysis of data from one group of respondents (non help-seekers), and its interaction with the policy context.

<b>2<sup>nd</sup> September 2010</b> Preventive Health	<b>10:10 - 10:40</b> Engineering 101
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*Buckingham, A.D.*

*University of Bath*

**THE ROLE OF WORKPLACE NORMS IN PROMOTING RESILIENT WORKERS AND LOW RATES OF SICKNESS ABSENCE**

Most studies of sickness absence have adopted managerial models of absenteeism, concentrating on identifying 'risk factors', ranging from the socio-economic characteristics of individual employees, through to company environment and management practices (Vaananen, et al., 2008). However, workers and work groups respond in different ways to these risk factors and rates of sickness absence are known to vary widely even in occupations which are comparable in terms of such factors (Xie, J. and Johns, G. 2000). Companies often find that the same type of job done in different regions or even in different parts of the same building can see widely varying rates of absenteeism.

Sickness absence behaviour may include a degree of voluntariness (Johansson and Lundberg 2004) where there is room for individuals and work groups to define acceptable and unacceptable absenteeism. In this way, sickness absenteeism can vary because of the absence or presence of resilient work group and individual attitudes (Vaananen et al., 2008).

The concept of habitus will be used to help develop a theoretical underpinning of how resilient work cultures are constructed, negotiated and reproduced in everyday working life. The empirical analysis consists of the identification of work groups with low rates of sickness absence and analysis of the ways in which resilience is constructed and reproduced within the workplace between work groups and individuals.

<b>2<sup>nd</sup> September 2010</b> Individual, Collective & Global Risk	<b>11:55 - 12:25</b> Calman, Arnold Wolfendale
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*Burnett, E.*

*University of Dundee*

**REPRESENTATION OF RISK: THE CASE OF MEDIA COVERAGE OF CLOSTRIDIUM DIFFICILE**

There have been a number of significant Clostridium difficile (C.difficile) outbreaks within the UK, generating national media attention. As the media are major sources of information for the public, they play a fundamental role in shaping public understanding and responses. A thematic analysis of newspaper coverage was undertaken over a three week period of a C.difficile outbreak. Coverage from broadsheets, tabloids, a Sunday and regional newspaper was studied, reflecting political shades of opinion, highbrow/lowbrow and readership. We explored how events were presented and made comparisons between newspapers and journalists. This involved examining main themes, structures of articles, headlines, statistical presentation, the role of rhetoric and language and the use of sources. Whilst there were significant differences between newspapers, remarkable similarities were also identified.

Drawing on a broad social constructionist approach, this paper explored the wider picture of information provision and communication about risk via newspapers. Journalists are often criticised for inaccurate reporting and committing sins of omission and sensationalism, yet it is surprising that little attention has been paid to the context in which they operate. Further research will involve interviews with key journalists and focus groups with the public in two contrasting areas (one where a C.difficile outbreak has occurred and one where no outbreak has occurred).

This adds to our understanding of the processes involved in public understanding of risk and emphasises the importance of the ways in which media professionals' responses are socially constructed. This has important implications for future dialogue between public health and media professionals.

**2<sup>nd</sup> September 2010**

Individual, Collective & Global Risk

**09:35 - 10:05**

Calman, Arnold Wolfendale

*Cant, S. Watts, P.*

*Canterbury Christ Church University*

**PURE AND DANGEROUS: COMPLEMENTARY AND ALTERNATIVE MEDICINE, RISK AND GOVERNMENTALITY**

If certain sections of the BMA and the media are to be believed the equation between risk and CAM is proven. At the same time the decision to consult a CAM practitioner is driven in part by the scepticism and perceived risks associated with orthodox medicine and the assumed natural 'risk-free' interventions of CAM – so risk and CAM are implicated whichever side one comes to the debate; and yet sociologists have been slow to interrogate the connections. Douglas (1966) contended that all societies must negotiate purity and danger, a task problematised by the multiple competing knowledge claims of late modernity. This is revealed in the ambiguous status of CAM, particularly in relation to the risks inherent or not in its use – it is simultaneously pure and dangerous. In this paper, drawing on theoretical and empirical material, we examine the usefulness of risk for an understanding of the practice of and demand for CAM, and suggest that that locating risk within debates concerning trust, professionalism and governmentality provides a powerful tool for comprehending both the growth and the management of CAM in late-modernity.

**2<sup>nd</sup> September 2010**

Preventive Health

**10:45 - 11:15**

Engineering 101

*Carlisle, S., Hanlon, P., Henderson, G.*

*University of Glasgow*

**'WELL-BEING': MULTIPLE PERSPECTIVES ON, AND DISCURSIVE PATHWAYS THROUGH, SOME COMPLEX AND CONTESTED TERRITORY**

The topic of 'well-being' now attracts much public and political interest, but those wishing to understand this field must confront a vast body of theory and evidence from various disciplines, where understandings of well-being are often framed in very different ways. This paper provides a rough guide to this complex and contested territory, mapping three main discursive pathways and encompassing evidence, theory and speculation en-route. The first pathway takes us through the shifting sands of well-being research itself. Here we discover a conceptual space where the key disciplines of psychology and economics draw on some incommensurable ontologies and epistemologies of well-being. The second pathway takes us into more sociological territory, where it has been suggested that ideas about well-being are constructed within the socio-cultural spaces of modern society, shaped in compliance with the demands of a capitalist economic system, and reflect the narcissistic 'therapy culture' of affluent societies. Our final pathway treks uphill through a third, radical discourse which extends the critical analysis of consumer culture's influence on well-being to the context of looming global problems such as peak oil, economic crises and climate change. This emerging socio-cultural-environmental critique arguably provides the widest perspective on the territory of well-being, and has the potential to bridge the gulf between otherwise disparate perspectives by placing concerns for individual and social well-being within the broader context of massive and inevitable global change.

**3<sup>rd</sup> September 2010**

Genetics & Experiences of Health & Illness

**10:45 - 11:15**

Engineering 101

*Carrieri, D.*

*University of Exeter*

**FAMILIAL MEANINGS OF NEUROFIBROMATOSIS TYPE 1: A FRAGMENTED BIOSOCIALITY**

Neurofibromatosis Type 1 (NF1) is a common, dominantly inherited disorder (births incidence: 1/3000) with a high spontaneous mutation rate. Physical features, cognitive symptomatology, and complications such as malignancy, are highly variable, both within and between families, and over the lifetime of affected individuals.

This study investigates the psychosocial implications of genetic knowledge and technologies for individuals with NF1 and their families. The examination of family dynamics and the interrelation between familial narrative of illness, responsibility, uncertainty and the individual experience of self, disease and genetic knowledge are at the centre of this investigation. The research is based on qualitative semi-structured interviews of NF1 individuals, their families (n=30) and professionals who work with NF1 (medical staff, genetic consultants, NF1 advisors) (n=10).

The outcome shows that the majority of participants, regardless of the severity of NF1 that they or a member of their family experienced, demonstrated 'genetic responsibility' behaviours concerning reproductive choices and the management of genetic risk and information. However NF1 does not appear to be associated with a strong disease identity or community. The identities of individuals with NF1 appeared fragmented around specific symptoms (malignancy, disability, cognitive difficulties, cosmetic problems). Moreover, mildly affected individuals often did not want to identify themselves (or be identified) with the more seriously affected, and vice versa. This study does not support the 'biosociality' theory that new social groups will coalesce around genetic conditions. The findings of this study have implications for understanding the psychosocial and familial aspects of other hereditary conditions.

2<sup>nd</sup> September 2010

Lifecourse: Ageing, Death & Dying

09:00 - 09:30

Calman, Rosemary Cramp

*Chapple, A., Ziebland, S.*

*University of Oxford*

**VIEWING THE BODY AFTER BEREAVEMENT DUE TO A TRAUMATIC DEATH: A QUALITATIVE STUDY IN THE UK**

Objective: Whether bereaved relatives should be encouraged to view the body after a traumatic death is uncertain. This study explores people's accounts of their decisions (and the consequences) about viewing the body.

Design: In-depth interview study with qualitative analysis.

Participants: A maximum variation sample of 80 people bereaved due to suicide or other traumatic death.

Setting: Most people were interviewed in their homes.

Results: Some were reluctant to view the body because they feared how it might look or preferred to remember the person as they were alive. Apart from the perceived requirement to check identity, some felt they ought to see the body or were concerned that the loved one was 'being cared for'; or to say good-bye. When the relative refers to the dead person by name or personal pronoun this suggests a continued sense of social identity. Sometimes the coroner prevented contact with the body until after the post-mortem, suggesting to relatives that it had become police property. Seeing the body brought home the reality of death; it could be shocking or distressing, but, in this sample, few who did so said they regretted it.

Conclusions: Even after a traumatic death, relatives should have the opportunity to view the body, and time to decide. Officials should prepare relatives and explain if there are constraints for forensic reasons. The way that relatives refer to the body can be a strong indication for professionals about whether the person who died retains a social identity for the bereaved.

2<sup>nd</sup> September 2010

Cancer

15:45 - 16:15

Engineering 101

*Chattoo, S.*

*University of York*

**THE MORAL MAZE OF CANCER RELATED THREATS TO FERTILITY: NEGOTIATING 'PRESERVATION', CONSENT AND CHOICE**

Theoretically, this paper cuts across the fields of cancer, ethnicity and infertility, providing a vantage point for understanding the long term –impact on self and relationships posed by cancer treatment and potential threats to fertility. The paper analyses how encounters with treatment bring younger men and women (18-40 years), from different ethnic backgrounds, face to face with profound questions of life, procreation, and death. The analysis focuses on the role of gender in potential 'forced choices' or 'non- choices' (cf. Franklin, 198 : 108) within the context of 'fertility preservation', and how individuals engage with various ethical dilemmas posed by the process of consent, leaning on competing medical, cultural or religious scripts. The process of consent surrounding 'preservation' of sperm, eggs and embryos locates the potential biographical disruption (cf. Bury) of infertility within wider cultural scripts of pronatalism, appropriate parenthood and 'best interests of the child' on one hand, and death and rights of (potentially) terminally ill individuals to have children on the other - even though posthumous use of gametes with prior consent is accepted within HFE law (cf. Simpson, 2001). The process leads to questioning and redefining transitory partnerships as (quasi) conjugal relationships.

At a methodological level, the paper problematises the notion of ethnicity by using a comparative method to analyse the biographical context within which treatment related threats to fertility are experienced and negotiated. The paper uses empirical data from a recently concluded two year qualitative study funded by the CRUK conducted at three sites in England.

2<sup>nd</sup> September 2010

Experiences of Health and Illness

11:20 - 11:50

Engineering 005

*Cooper, R.*

*University of Sheffield*

**RESPECTABLE 'ADDICTS' – IDENTITY AND OVER THE COUNTER MEDICINE ABUSE**

The sale of over the counter (OTC) medicines from pharmacies represents an opportunity for people to self-medicate and manage their own symptoms. However, some OTC medicines have the potential for misuse or abuse, and a range of concerns have been identified empirically, often using pharmacists' perceptions of those affected. This paper presents the findings of a qualitative study of twelve individuals who are or have been dependent on an OTC medicine. They were recruited via two UK on-line medicine abuse support groups during 2009 and 2010, and interviewed by telephone using semi-structured interviews.

A distinctive feature of the interviews was the complex and potentially conflicting identity claims being expressed. These included explicit recognition of their status as 'addicts' wherein they recognised their dependency to an OTC medicine – often a codeine-based analgesic. Recurrent patterns of drug-seeking behaviour were described, including purchasing and use rituals, such as brand specificity, anxiety when supplies diminished, and complex shopping routes to different pharmacies. 'Addict' emerged as a personal identity but appeared also partly a social identity, developed through membership of the on-line fora, although on-line pseudonyms were common. Participants contrasted themselves with those who were addicted to illicit drugs or alcohol - based, for some, on experiences of attending treatment facilities with such individuals but also in terms of the perceived lack of treatment options and medical awareness more generally. Moreover, this difference was actively reinforced by frequent reference to 'professional' and 'intelligent' social identity claims, and a desire to avoid their problem being recorded medically.

<b>1<sup>st</sup> September 2010</b> Health Technologies	<b>13:00 - 13:30</b> Calman, Kingsley Barrett
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*Corbett, K.P.*

*Canterbury Christ Church University*

**INSIDE THE BLACK BOX OF THE ANTIBODY TEST: DECONSTRUCTING THE OFFICIAL CLASSIFICATIONS OF RISK IN TESTING FOR THE HUMAN IMMUNODEFICIENCY VIRUS.**

This paper analyses United Kingdom (UK) guidance that since 1985 has officially governed medical diagnostic testing for antibodies to the human immunodeficiency virus (HIV). Using the work of Latour and Lipton, I analyse how these black boxed processes address the interpretative flexibility of HIV antibody tests by balancing test sensitivity and specificity to try to optimise diagnostic accuracy within populations classified as being 'at risk'. Inside this black box, different judgements can be made based on the seroepidemiological risk classification of blood donors, irrespective of the laboratory test result. Further limitations on diagnostic accuracy exist given the technology is a surrogate for the presence of HIV. This situation has led to test regulators developing algorithms to both help minimise interpretative flexibility and to maximise diagnostic accuracy using a form of inference to the best explanation. These findings aid understanding of the role played by laboratory regulation, interpretative flexibility and the seroepidemiological construction of risk to underpin population-based testing. Using data from tested subjects and officially published accounts, the paper deconstructs the classification of risk embodied by official test algorithms and analyses how this characteristic of all medical tests has sociological implications for medical decision-making, self-identity and new social movements that contest the official classifications of HIV risk groups.

<b>2<sup>nd</sup> September 2010</b> Embodiment & Emotion	<b>16:20 - 16:50</b> Calman, Derman Christopherson
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*Corrigan, O.P., Letherby, G.*

*University of Plymouth*

**'RUNNING AROUND LIKE A HEADLESS CHICKEN' F1 DOCTORS' (LACK OF) TIME AND EMOTION MANAGEMENT**

The time of transition from medical student to junior doctor has long been experienced as stressful. Despite recent and ongoing changes to undergraduate medical education aimed at better preparing doctors for practise, a new programme of initial training and support during the first year (F1) and restricted working hours for junior doctors following the introduction of the European Working Time Directive, this remains an extremely stressful period for trainees.

Our analysis of qualitative data (interviews and audio diaries) collected from 31 respondents based in five hospital Trusts in Devon and Cornwall in the South West of England suggests that these individuals feel that they have little control over time and feel pressurised about lack of time at the beginning of their F1 experience. In some cases the support of others (senior doctors, colleagues, friends and family) helps F1s to achieve a sense of control over time and allows them to better manage the emotional stress they undergo as they experience the emotional challenges involved in their work. Drawing on social theories of time and emotions, we will explore these issues further with particular reference to our respondents' views on balancing time, overtime (long hours), improvements over time and time for the self or not.

<b>2<sup>nd</sup> September 2010</b> Mental Health	<b>14:35 - 15:05</b> Maths 107
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*Cotton, A., Jinks A, Rylands I*

*Edge Hill University*

**MULTIPLE MEANINGS AND INTIMATE PARTNER VIOLENCE:IMPLICATIONS FOR MENTAL HEALTH CARE**

There have been numerous discursive approaches to exploring intimate partner violence/domestic abuse; such multiple disciplinary perspectives illustrate the complexities in naming, researching and 'intervening' in a subject that occupies an uneasy space within contemporary western culture.

This paper reports on an integrative review of qualitative and quantitative empirical studies which have as their intention the ways that intimate partner violence is approached and addressed with people within the context of mental health care settings.

Attempts to address violence in intimate relationships within mental health assessment is fraught with tensions, with 'screening' a particular concern. Mental health policy directives, and recent legislation on domestic violence may be juxtaposed against who comes to name the experience, and how the often disparate epistemological positions within sociocultural discourse may mean confusion within mental health practice



<b>3<sup>rd</sup> September 2010</b>	<b>10:10 - 10:40</b>
Genetics & Experiences of Health & Illness	Engineering 101

*Cowley, L.*

*Newcastle University*

### **CHOICE AND RESPONSIBILITY IN GENETIC TESTING**

This is a PhD project exploring experiences of an extended family who were one of the first internationally to have a genetic mutation identified causing a predisposition to cancer.

15 members of the family who had tested positive or negative for the mutation were involved in the fieldwork, which used multiple qualitative interviews, visual methods such as photo elicitation, social mapping and engaged with the biomedical representation of family. Through these methods an exploration of ways in which families and identities are constructed and defined by or in the context of genetic testing was undertaken.

A compelling theme to emerge is the dichotomous notion of choice and responsibility. Narratives of choice are explored illustrating complex boundaries that participants continually negotiate in making sense of their choices about closeness, who is family, who is kin and who chose to be tested. Whilst choice is framed as an immutable right, participants discursively negotiate boundaries of responsibility to those they call kin and this is intensely highlighted in their narratives about those who declined genetic testing. It is at this intersection of choice and responsibility that a moral lens appears through which participants view those who declined testing and it is within this emotive setting that kinship ties have the potential to be disrupted and family dynamics disturbed.

These insights contribute to an important narrative about the cultural engagement with the new genetics. The paper engages with work from Rose, Stacey, Lupton and Peterson, among others, in its focus on choice and responsibility.

<b>3<sup>rd</sup> September 2010</b>	<b>11:20 - 11:50</b>
Lifecourse: Reproductive Health	Calman, Rosemary Cramp

*Coxon, K., Sandall, J., Fulop, N.*

*King's College, London*

### **BIRTH PLACE DECISIONS: HOW RISK DISCOURSE AND MORAL HYGIENE REDUCE 'CHOICE' OF PLACE OF BIRTH**

According to the current Department of Health 'Maternity matters' policy, pregnant women in England can choose between giving birth at home, in a 'midwife led' birth unit, or in hospital. However, it can be difficult for women and their partners to make sense of this opportunity, when for many years they have been shepherded towards giving birth in hospital for safety reasons.

This paper draws on antenatal interviews with women and their partners from a longitudinal, qualitative study. It identifies ways in which individuals seek information about place of birth, and why some sources of knowledge are selected whilst others are ignored. At an early stage of this study, it seemed that a risk-based moral framework was operating in relation to both 'home' and 'hospital' birth and here I use Douglas and Wildavsky's (1982) theory of the cultural selection of risks to describe this framework and to suggest how it impacts upon birth place preference. I argue that a range of metaphors of moral hygiene (such as 'safe hospital birth' or 'natural home birth') are used within contemporary discourse, to distinguish between birth at home and 'non-hospital' settings on the one hand, and hospital based 'obstetric ward' birth on the other, and I explore the premise that a subtle process of moral signposting occurs at a time when women are expected to 'perform' responsible motherhood, effectively reducing the different 'birth place' options available to them.

<b>3<sup>rd</sup> September 2010</b>	<b>10:10 - 10:40</b>
Theory	Engineering 005

*Cresswell, M. Karimova, Z.*

*Durham University*

### **PSYCHIATRIC SURVIVORS AND THE PROBLEMATIZATION OF SELF-HARM**

This paper considers a conundrum within the history of psychiatric survivor activism within the UK. In particular, it concerns activism which surrounds the 'politics of self-harm'. Previous research has established that this emerged in the late 1980s from a confluence of feminist and survivor activism culminating in the formation of the National Self-Harm Network (NSHN) in 1995.

The conundrum is this. If we locate the origins of the 'politics of self-harm' in that feminist/survivor confluence after 1986, what then was happening apropos self-harm activism in the years prior to that? The authors' historical research into both feminist and survivor archives suggests that there was virtual silence upon the issue and no activism explicitly connected to it.

This suggestion raises two questions:

1. Why, when feminist and survivor activism explicitly campaigned around such diverse issues as eating distress and psychiatric iatrogenesis, was there no mobilisation, before 1986, of a 'politics of self-harm'?
2. What, then, were the 'conditions of possibility' for a politics of self-harm?

The paper argues that such a politics depended upon a specific problematization of hegemonic discourses surrounding self-harm. And this problematization, rather than being the achievement of a mass social movement, demonstrated, rather, the power of small numbers of activists working together in networks to raise awareness of medical and psychiatric iatrogenesis. The paper thus clarifies how a problematization of self-harm emerged in the late 1980s within one highly specified spatio-temporal field. Theoretically, the paper mobilises the late-Foucauldian historiographical concept of the 'process of problematization'.

3<sup>rd</sup> September 2010

Inequalities

09:35 – 10:05

Calman, Arnold Wolfendale

*Curran, S., Uzwiak, B.*

*Amnesty International Ireland*

**MASKING THE DEMISE OF PRIMARY HEALTH CARE IN CAYO, BELIZE: COMMUNITY HEALTH DECISION-MAKING AMID CIRCULATING NOTIONS OF POOR HEALTH**

"This paper examines access to the primary public health care system and health decision-making in the western Cayo area of Belize, Central America. This is based on primary and secondary field data including interviews with local health professionals and national policymakers, a local community health survey, and several community focus groups. Over the past ten years, residents of Belize have experienced a decrease in Primary Health Care delivery in rural areas, the downgrading of hospitals to polyclinics, and a lack of health personnel, basic medications and equipment. Despite this, "lifestyle" and "cultural preferences" are increasingly cited as reasons for individual poor health (this despite the more than 33.5% national poverty rate and the highest rate of HIV infection in Central America). This discourse of individual responsibility masks structural inequality in a national and global context, and also masks the roles of key decision-makers in reproducing health inequalities within and outside the health system. This is seen in a disjuncture between local explanations for poor health, and national and international explanations. This focus on individual choice also shifts analysis away from socioeconomic reform. Despite the rhetoric of "Equal Health for All," the social organization of medicine reinforces socioeconomic, ethnic, and gender based divisions. The paper discusses residents' perceptions and experiences of Primary Health Care in light of circulating ideas that blame the failure of the public system on poor individual choice. The poster suggests that it is neoliberal reform, rather than "lifestyle choices," that creates poor health and health differentials.

3<sup>rd</sup> September 2010

Lifecourse: Reproductive Health

10:45 - 11:15

Calman, Rosemary Cramp

*Davis, K.*

*Univeristy of Edinburgh*

**FROM 'GOOD BABIES' TO 'BAD MOTHERS': CHOICE, COMPLEXITY AND INTERPRETATION IN MOTHERING**

How a 'good' mother is defined changes through time according to the social and political context in which women experience their childrearing. Changes in the politics of parenthood encompass changes in how parents are to relate to their children as well as how they are to concentrate on the daily minutiae and caring practices. Many of the methods and approaches involved within 'motherhood' have altered and multiplied in the last six decades, but consistent throughout were moral discourses of both citizenship and the fulfilment of the maternal responsibility of socialising children. Drawn from my doctoral research that explored how kinship and expert advice affect the process by which women in Scotland learn to mother, this paper focuses on mother's narratives and professionally published childrearing literature from three cohorts and time periods covering 1945-2004. I will show that the increasing multitude of practices and choices regarding childrearing contributed to two phenomenon as described by my interviewees: first, that as childrearing advice diversified alongside changing notions of a properly socialised child there was a narrative shift from 'good babies' to 'bad mothers', and secondly, that as mothering expectations became more intensive and complex, a greater burden of interpretation fell upon the mothers.

2<sup>nd</sup> September 2010

Ethics

16:55 - 17:25

Calman, Arnold Wolfendale

*de Andrade, M.*

*University of Strathclyde*

**'PHARMAFILLIATION': A CASE STUDY**

If regulators are to fulfil their mission of protecting and promoting public health, then it might be expected that they act as dependable, authoritative decision-making bodies. Guided by the assumption of accountability, calls for transparency and an overriding obligation to act with scientific integrity, patients, medical practitioners, and the government should trust that regulators ensure proper standards in the practice of medicine. This article explores why this trust is sometimes misplaced by examining a case study which traces the actions of the General Medical Council's (GMC) handling of claims of scientific misconduct over the osteoporosis drug, risedronate (Actonel). Numerous internal and public documents were analysed, and interviews and Freedom of Information requests supplemented documentary research. The analysis exposes the somewhat farcical and cumbersome processes of regulation employed by the agency and highlights its existence as an exonerating body failing to safeguard public health. It identifies three concerns: the time taken to deal with the complaint and the way in which it was handled; a lack of attention to the primary complaint; and a failure to recognise and act upon behaviour the GMC had previously condemned. Furthermore, it reveals an area of 'regulation' that is unregulated: it is not clear whether scientific deception involving drugs is within the organisation's remit or indeed if it falls within any health regulators' remit. A new concept called 'Pharmaffiliation' is described and applied to guide the investigation by taking into account the various stakeholders involved in the process of communication.

*Deacon, M.*

*University of Chester*

**THE IMPLICATIONS OF DOCUMENTARY WORK FOR THE PRACTICE OF COMMUNITY MENTAL HEALTH NURSES**

This paper will report on an ongoing study concerning the documentary practices of Community Mental Health Nurses (CMHNs). The study aims to investigate organisationally driven documentary practices to inform policy and enhance practice.

CMHNs complain that rules regarding the amount and completion of documentary work are consistently growing and that this has negative implications for their work with service users. A particular complaint is that of much duplication of information. Complaints of growing bureaucracy are a contemporary feature of organisational life and this has been associated by some with the idea of the audit society. It is argued that the practice of auditing is the fundamental driver for document production, that is, that documents must meet the needs of the auditor first and foremost. This study sets out to analyse these issues by systematically examining the documentary practices of a group of CMHNs as a case example.

Following ethical approval by the relevant NHS research ethics committee the following data collection methods are being used: thematic, audio-recorded interviews with a sample of CMHNs from two Mental Health NHS Trusts; documentary analysis of the documents that they use in routine practice and investigatory contact with CMHN paperwork organisational recipients. The complex documentary trail will be followed through the organisations and will reveal a 'whole systems' picture of the data collected and its multifarious functions.

The paper will set out the background and conduct of the study and discuss some emerging findings and their implications for mental health care policy and practice.

*Denny, E. Culley, L. Papadopoulos, I.*

*Birmingham City University*

**ENDOMETRIOSIS AND CULTURAL DIVERSITY: THE EXPERIENCE OF MINORITY ETHNIC WOMEN**

'Endometriosis and cultural diversity' (the Endocul project) explored the experience of women from minority ethnic groups living with endometriosis and their needs for culturally specific information and support. The study focused on five minority ethnic groups: African Caribbean, Chinese, Greek/Greek Cypriot, Indian and Pakistani.

The project aimed to develop, in collaboration with community groups and patients, evidence based and culturally sensitive resources for women with endometriosis from these communities and for the health professionals providing services to them.

In order to meet this aim primary research was first conducted with women from community groups, women with endometriosis from the target communities, and health professionals

This paper is concerned with individual interviews with minority ethnic women with endometriosis. Semi-structured interviews were conducted with women from each community (n=29) which focused on the meaning of endometriosis in their lives, their experience of health service provision, and their information needs.

The women studied had many similar experiences and concerns to other women previously reported in the literature (e.g. Denny, 2004; Gilmour and Huntington 2005, Seear, 2009). They also identified cultural factors as having an impact on their experience of endometriosis and of health services. These factors centre on the role of women and the importance of reproduction within their communities, and the influence of religious beliefs.

Cultural values can generate unique meanings and experiences of endometriosis. In order to develop culturally sensitive resources and services for women these need to be incorporated, whilst resisting essentialising culture as a fixed and bounded concept.

*Dent, M.P., Tutt, D., Eason, K., Waterson, P.*

*Staffordshire University*

**INTEGRATING CARE, CARE PATHWAYS AND INFORMATION SYSTEMS: THE CASE OF THE FRAIL ELDERLY**

This paper examines the challenges of information systems design for the coordination of care for one patient group. It draws on a comparative qualitative study of two primary care trusts (PCTs) and is concerned with the design and implementation of systems and pathways to primarily support the care of the 'frail elderly', people who present the PCTs and health professionals with particular challenges. These include the management and coordination of care for complex conditions while avoiding frequent and unplanned hospital stays. We will discuss how the care of this patient group involves a set of reciprocal dependencies between agencies and very tight coupling and task interdependence in times of critical need (Thompson, 1967).

The two PCTs have organised the management of the complex care of the frail and elderly patients in similar ways, but the patient care information systems underpinning this are organised rather differently. This reflects, we will argue, an inherent tension between the competing local rationales of information systems and patient care pathways (e.g. Timmermans and Berg 2003; Berg and Bergen 2004).

(Acknowledgement: this research is funded by the NIHR SDO)

**2<sup>nd</sup> September 2010**

Health Service Delivery & Organisation

**10:10 - 10:40**

Calman, Ken Wade

*Dopson, S., Heron, P., Kessler, I.*

*University of Oxford*

### **HEALTHCARE ASSISTANTS AND THE PATIENT EXPERIENCE: A DISTINCTIVE CONTRIBUTION?**

The sociology of work has treated the assistant role in a limited way: it has been seen as a 'cheap' source of labour or as a convenient 'dumping ground' for the delegation of routine tasks as 'superordinate' occupations seek to professionalise. This perspective is reflected in public policy as it relates to the healthcare assistant (HCA), the role being viewed, within the context of NHS modernisation, as a flexible source of labour with scope to 'free up' the nurse. Policy makers have, however, tempered this view with suggestions that the role has a distinctive contribution to make to healthcare quality. Implicitly this is seen to lie in the structure of the role and in those filling it, making care more accessible to the patient. Nonetheless, there are policy risks associated with the increased use of the HCA: the role remains unregulated, with the possibility that patients regard treatment by HCAs as a diminution rather than enhancement of care quality. This paper addresses whether the HCA enhances and/or diminishes the patient care experience in a hospital setting. Drawing on interview, survey, focus group and observational data from four hospitals, it explores the HCA-patient relationship from the perspective of three stakeholders: the HCA, the patient and the nurse. These data provide a strong evidence base for the suggestion that HCAs develop a distinctive and 'positive' relationship with patients. However, perceptions of this relationship display some contradiction and suggest that any 'positive' contribution might be contingent on certain management practices.

**2<sup>nd</sup> September 2010**

Randomised Controlled Trials & Evidence-Based Medicine

**14:35 - 15:05**

Calman, Kingsley Barrett

*Eborall, H.C., Dallosso, H., Daly, H., Martin-Stacey, L., Speight, J., Carey, M., Davies, M., Khunti, K., Heller, S*

*University of Leicester*

### **THE FACE OF EQUIPOISE: VIEWS AND EXPERIENCES OF DELIVERING STRUCTURED EDUCATION AS TWO ARMS OF A RANDOMISED CONTROLLED TRIAL.**

This paper reports findings of qualitative study embedded in a randomised controlled trial (RCT) comparing structured education programmes for two methods of patient self-monitoring for Type 2 diabetes (urine and blood). The paper focuses on educators' experiences of delivering education about these two methods to patients.

Focus groups were conducted with educators (N=14) before and after educators were trained in the delivery of the intervention. Further focus groups were conducted when the trial was underway. Individual interviews were conducted with educators towards the end of the trial. Data analysis was informed by the constant comparative method.

We found that pre-trial training raised educators' awareness of equipoise and made them think about their own preferences. Educators acknowledged that they held personal preferences with regard to the two methods (urine versus blood), and thus they were not in individual equipoise. Their preferences changed throughout the trial and were influenced by their experiences of delivery. However, educators themselves did not believe that their own preferences impacted upon their ability to deliver the programme in equipoise. Educators' commitment to the principle of equipoise in this trial was embedded in feelings of duty and professionalism, and a desire for the RCT to succeed so that the findings would enable them to deliver evidence-based practice in the future.

The discussion will consider the influences of professionalism and duty of care, and will consider the potential related conflict for deliverers of an intervention. The findings will also be considered within wider debates about individual and community equipoise.

**2<sup>nd</sup> September 2010**

Health Service Delivery & Organisation

**14:35 - 15:05**

Calman, Ken Wade

*Finch, T., May, C., Murray, E., O'Donnell, C., Mair, F.*

*Newcastle University*

### **NORMALISATION PROCESS THEORY: DEVELOPMENT OF AN INSTRUMENT TO ASSESS NORMALISATION POTENTIAL IN E-HEALTH**

Health care interventions are often costly in terms of money, time and effort, and are increasingly complex to implement and evaluate. Normalisation Process Theory (NPT, Carl May et al) provides a framework for understanding complex interventions that shifts the focus beyond implementation, to understanding the processes by which new technologies and practices become routine and embedded. For theory such as NPT to become practically useful however, there is a need for simple assessment instruments that can be used in health care settings by practitioners, managers and researchers to assess such processes of normalisation. This project extends an ongoing programme of qualitative research on NPT, to develop a structured instrument for assessing normalisation processes relating to e-health in healthcare contexts. The paper will focus on the instrument development work undertaken to produce a set of theory-derived process measures, and preliminary testing of it. The methods included item development work drawing on theory and a variety of empirical data, an online survey of authors of e-health review papers (n=63), and online surveys in two NHS contexts (n=46 and n=231) using different e-health technologies. A 30-item instrument is presented for further testing and validation in future research. The discussion will focus however, on key challenges in operationalising theory for measuring processes of implementation, normalisation and embedding of new technologies and practices in collaborative health care environments.

<b>2<sup>nd</sup> September 2010</b> Embodiment & Emotion	<b>16:55 – 17:25</b> Calman, Derman Christopherson
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*Fisher, P., Byrne, V.*

*University of Huddersfield*

**'YOU CAN'T DO IT IF YOU'RE NOT PASSIONATE ABOUT IT': WHY THOSE WORKING IN LEARNING DISABILITY SERVICES NEED EMOTION**

We suggest that there is a need to debate some of the received wisdom of good practice in learning disability (LD) services in the UK. Practice in LD services is in the process of being transformed away from a focus on care to one based on an ethos of consumer choice. Technologies of welfare are directed towards promoting a particular understanding of citizenship – the citizen consumer/worker. Drawing on observations and 10 interviews conducted with staff at Mencap, this paper considers how transitions in current practice are impacting on the identities of those working in learning disability services. It raises important questions as to how enabling practice is constructed within policy discourse, and how this is received and understood by those working 'on the ground' in learning disability services. We draw theoretically on MacIntyre's, seminal work, *After Virtue*, and apply his conceptualisation of internal and external goods to analyse the discourses of Mencap staff in relation to their views and approaches to their work. We argue that excellent practice is often underpinned by a desire to pursue the internal goods of practice and that this requires an emotionally based orientation towards work with service users. Such an approach, however, is at odds with official discourse that equates service user empowerment with a need to maintain rational detachment.

<b>3<sup>rd</sup> September 2010</b> Theory	<b>11:55 - 12:25</b> Engineering 005
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*Fox, N.*

*University of Sheffield*

**CREATIVITY AND HEALTH: A DELEUZIAN TAUTOLOGY?**

Many studies have suggested that creative activity is 'good for you', specifically, that there are health benefits which range from improved mental health to longevity. Why should this be? Various psychological and social explanations have been proposed, but all suffer from the failure to fully specify the nature of creativity, or in the case of sociology, a focus on the epiphenomena of creativity, for instance, the organisational or social factors supporting or inhibiting its expression. Recently, however, an interest in embodiment, identity and reflexivity suggests a new sociology of creativity.

This paper addresses creativity and health from a novel perspective, arguing that effectively these two concepts are features of an underlying will to power of the organism. It is thus unsurprising that there is a relationship between creative activity and health, particularly if the latter is conceived as the capacity of the body to 'become-other'. Drawing on Deleuzian scholarship, I will explore how we may conceptualise creativity and health as different facets of a becoming-other organism, and set out a research agenda that addresses this confluence.

<b>2<sup>nd</sup> September 2010</b> Health Policy	<b>14:00 - 14:30</b> Calman, Rosemary Cramp
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*Gabrielsson, F., Stokken, R.*

*Jönköping University*

**UNEMPOWERING LOVE: ON PATIENT CHOICE AND PROFESSIONALISM**

In Sweden, health care experiences an increasing focus upon patient's right to choose. On basis of discharge planning, we discuss the consequences of this from a care-perspective, focussing upon the contradiction between respecting choice and taking on the role as carer for other person's wellbeing.

While Parsons frame the health worker as the patient's guardian, modern health service conceives health professionals as partners to autonomous patients that got the right to choose. Mol frames the contradiction between these two to be between the logic of care versus the logic of choice.

Our discussion is based upon investigation of 27 discharge planning processes. In addition health professionals were interviewed and observed at discharge-planning meetings. In this total body, we focus the empirical section upon one case.

The case concern Ida that is eager to go back home, and her spouse that due to experiences not dear to take her home. The result is Ida moving into an elderly nursing home. At the end of the meeting, when the discharge planning team has left, Ida's spouse apologies for – of love to her – not daring to have her at home.

We discuss in special challenges deriving from the discharge planning team respecting the choice of Ida's spouse, without investigating the case further. The result is that all parties act from meagre information, and a situation where all parties in some sense becomes losers.

**1<sup>st</sup> September 2010**

Experiences of Health and Illness

**14:45 - 15:15**

Engineering 005

*Gibson, B.J., Boiko O, Baker SR, Robinson PG and Locker D*

*University of Sheffield*

**THE EXPERIENCE OF DENTINE SENSITIVITY: POLYCONTEXTURAL MEANING, ACCOUNTS OF ILLNESS AND NARRATIVE IN DENTINE SENSITIVITY**

Narratives of illness experience are not only a central theme of attempts to deal with the complexity of illness in modern society. The sociology of health and illness has participated in attempts to grasp the importance of the changing nature of illness by making illness experience accessible and therefore more visible to society. This discussion has largely been preoccupied by the significance of these accounts and their emergence in modern society. Much less discussed have been the structural aspects of illness narratives. Whilst the function of narrative appears to be to bring together the disparate impacts of illness in experience, there is also a polyphonic aspect to narrative. Narratives are determined by and determining of participating systems such as morality, the medical system, law and the economy. The aim of this paper is to use data from a study on the impact of dentine sensitivity to explore the polycontextural meaning of accounts of illness. Data were collected from interviews with 23 participants exploring dentine sensitivity. The accounts of illness turned on the distinction between a private pain and a public imperative. The public imperative was that dentine sensitivity was not a problem for medical systems. Yet the condition had multiple impacts. The clash between the public imperative and the private nature of their pain meant that the condition was privatised. Dentine sensitivity is structured as a health condition rather than an illness proper. Sufferers must therefore seek privatised solutions, usually provided by a carefully watching and listening consumer capital.

**1<sup>st</sup> September 2010**

Mental Health

**14:10 - 14:40**

Maths 107

*Gilbert, A.P. Farrand, P; Lankshear, G*

*University of Plymouth*

**I DON'T WANT TO LIVE LIKE THIS ANYMORE: DISRUPTED HABITUS IN YOUNG PEOPLE AT RISK**

This presentation reports on interview data gathered between 2004 – 2007 from 27 young people involved with a street level service for young people considered 'at risk' of diagnosis of personality disorder. The service aimed to promote social inclusion through early interventions using elements of youth work and assertive community treatment. Young people experiencing difficulties in at least five areas of life, accessed a third sector street level service where a caseworker worked with them on an individual basis to explore practical solutions to problems. Interviews with these young people explored the events that led to their initial contact and their experiences from that point onwards. Using a twin track approach, narrative analysis provided a description of 'how' these young people describe their lives in terms of 'I don't want to live like this anymore' while 'what' they describe provides an often harrowing account of dangerous relationships and social isolation. In the process, the discussion draws on a theoretical framework developed from the work of Pierre Bourdieu particularly his notion of crisis. The relevance of this presentation to the sociology of health and illness emerges from the accounts of the participants, many of who have experienced trauma and abuse, compounded by often unsympathetic responses of health and welfare services. In addition, there is a paucity of accounts in the literature by people with personality literature, even fewer that take a sociological perspective and non to our knowledge of young people 'at risk'.

**2<sup>nd</sup> September 2010**

Lay-Professional Interface

**14:00 - 14:30**

Engineering 005

*Gimlin, D.L.*

*University of Aberdeen*

**CONSTRUCTING THE 'OTHER' IN AESTHETIC COSMETIC SURGERY**

This presentation addresses questions of narration and intersubjectivity in cosmetic surgery by examining the practice cross-culturally. Drawing from interviews with 80 British and American women who have had an aesthetic procedure and 16 British and American cosmetic surgeons, it explores constructions of the surgical 'Other' – i.e., the woman who has cosmetic surgery with little consideration of its risks, is motivated by vanity rather than need, has unreasonable expectations regarding its outcome and/or is obsessively concerned with her appearance. My research shows that constructions of surgical otherness are deeply contextual and interactive. They involve the production of narratives that reflect individual experience, are shaped by cultural imagery and incorporate narratives provided by others with whom we communicate. They also function as a form of identity work, as patients and surgeons draw upon them (and assist in reproducing them) in their performances of self. As part of that process, physicians not only confirm the patient's self-presentation as a 'good surgical candidate', but also aid in producing her as such. Practitioners too engage in their own presentations of self; their negative commentary on surgical Others implies a criticism of – and, thus, an effort to differentiate themselves from – the surgeons responsible for their production. Finally, although the processes involved in constructing the Other of cosmetic surgery vary to some extent cross-culturally, they serve in both settings to define the types of bodies that women can reasonably expect to achieve and to distance both patients and surgeons from many of the problematic meanings of aesthetic intervention.

*Gjernes, T.*

*Nordland Research Institute*

### **INVESTIGATING THE LOGIC OF CARE IN NURSING HOMES**

Nursing homes is supposed to care for elderly and diseased people, and the residents today are often very ill before admitted. Nursing theory put strong emphasis on the quality of care, with emphasis on communication and recognition of the patient as a person and not only a body to be taken care of. This high quality caring is described as a major characteristic of professional nursing. Hence, an ideal exists among staff members about the content of their caring work. This paper investigates caring practices in Norwegian nursing homes. A major question is what does caring work mainly consist of. How much is basic body work and how much is categorized as sentimental work? The latter refers to the kind of caring described as essential in nursing. Is emotional work typical of caring? Focus group interviews with staff members in ten nursing homes revealed that they rarely had time for sentimental work. Paper work had high priority and so had basic body work. This led to frustration and concerns about the quality of care they were conducting. The data revealed that the institution is there for the patient, but the staff is to a large degree there for the institution. This is interesting since sentimental work is described as central to caring and emotional work has become a priority in many other service occupations. The paper investigates the logic of care in nursing homes, and if this logic of care influence the high sick leave level in these institutions.

*Godbold, N.J.*

*University of Technology, Sydney*

### **'I CAN HARDLY SEE TO TYPE THIS' : MAKING SENSE OF DIALYSIS VIA ONLINE RENAL DISCUSSION BOARDS.**

This paper explores how contributors to online renal discussion boards make sense of dialysis and kidney failure, focussing on their sense making strategies with respect to ongoing change. Making sense is viewed here as a process whereby meaning is co-constructed within communities. In existing patient experience literature, patients' experiences are usually examined by taking snap shots of participant's perspectives at a point in time, obtained via interviews. Acknowledging that situations and perspectives are not static, this research explores how renal patients make sense over time. In the renal discussion boards, contributors make sense of their situation using typed narratives to which other contributors respond. This "naturally occurring" data allows analysis of ongoing peer-to-peer interactions between renal patients. Because contributors provide updates of their situations, their sense making narratives can be observed, changing and developing. Taking a longitudinal approach reveals shifting ways in which contributors describe and cope with their experiences providing a perspective to observe reactions to change, and allowing progressions of sense making themes to emerge. Early analysis of the data has revealed ways that themes such as control and normality are used by contributors to make sense of their experiences.

*Graham, T., Grace, A., Hanley, R.*

### **'SIGN ON THE DOTTED LINE': MEDICAL POWER AND LAY COMPLIANCE.**

The thesis we are testing is that the form commonly used in hospitals to obtain so-called 'informed' consent from patients represents a transaction where the balance of power is weighted disproportionately in order to protect the medical profession. This exercise in medical power has never previously been examined, and even though there is copious literature on the concept of informed consent, the instrument by which this consent is commonly obtained has not been considered.

The concepts of power considered here can be found in the second and third dimensions of Lukes (1974), i.e. the power which is used to prevent decisions being taken, or to exclude items from discussion altogether; and the power which is represented by the ability of some groups in society to manipulate the wishes and desires of others. Gramsci's (1917/1977) concept of hegemony is also relevant. He felt that powerful groups in society -such as the medical profession- may exercise control over other groups in the population by having their particular ideology accepted as the norm and even interpreted as a benefit by those so dominated.

This thesis is tested by interviews with patients, health care workers and medico-legal personnel to elicit their views on the consent form. Research is still in progress, but results to date suggest that this particular professional/lay interaction has become so embedded in practice that the power implications are taken for granted, never questioned by anyone and no alternative considered.

<b>1<sup>st</sup> September 2010</b>	<b>13:35 - 14:05</b>
Methods	Engineering 102

*Green, J. M.*

*London School of Hygiene & Tropical Medicine*

**DISENTANGLING POLITICS AND METHODOLOGY: REFLECTIONS ON THE USE OF QUALITATIVE METHODS IN LOW-CAPACITY SETTINGS.**

There has been considerable debate about the 'transferability' of conventional qualitative data collection methods to low and middle income countries. Issues raised include: the potential cultural inappropriateness of private one-to-one interviews; cultural differences in extent of 'courtesy bias', which might limit how far interviews are likely to generate personal views; challenges of qualitative data analysis across languages. Reflecting on a literature review of qualitative studies of quality improvement in health in Former Soviet Union countries and a case study of primary care in Uzbekistan, this paper discusses the difficulties in disentangling politics from methodology.

In many resource poor settings, there is limited in-country capacity for accessing international funding streams and for conducting qualitative research. Partners from high income countries, often unfamiliar with local languages and culture, therefore collaborate on study design, analysis and dissemination. Appropriate designs and methods have to be sensitive to local social and political contexts, but also likely to generate rich, relevant data. However, local research teams may be unfamiliar with qualitative methodologies, policy actors and gatekeepers often consider qualitative research to have low credibility and foreign partners have limited understanding of local contexts. It can then be difficult to separate reported cultural barriers (eg prohibitions on interviewing in private) from political structures (which, eg, may limit the credibility of patients' 'private views'). Methodological choices are inevitably political, but a key challenge for qualitative health researchers is perhaps to identify whose political interests are being served by methodological decisions, and build this reflexively into data analysis.

<b>1<sup>st</sup> September 2010</b>	<b>14:45 - 15:15</b>
Mental Health	Maths 107

*Griffith, L.*

*University of Oxford*

**"I WAS TOLD THAT I WOULD END UP IN BROADMOOR OR DEAD" : MEANINGS OF RECOVERY AND LIVING WITH A DIAGNOSIS OF SCHIZOPHRENIA.**

This paper is based on accounts of experiences of people diagnosed with schizophrenia who were interviewed as part of the Healthtalkonline project ([www.healthtalkonline.org](http://www.healthtalkonline.org)). This research follows on from work exploring person-centred narratives of recovery in schizophrenia (Davidson 2003) and work on recovery in mental health (Ridge 2008). This paper examines three different aspects of these narrative accounts: receiving a diagnosis; negotiating different, and possibly conflicting, accounts of the cause and nature of 'schizophrenia'; and the accompanying changing conceptions of self during this process. Across these three areas, I will examine notions of recovery, as participants have understood it.

Participants describe their lives before involvement with mental health services, accounts of 'crisis's', involvement with services and the radical rebuilding of their lives after such periods. Particular emphasis is placed upon the importance of hope amongst close family and friends, and the establishment of coping strategies and alternative accounts of 'mental illness'. The analysis highlights the limitations of particular models of recovery that are circulating within the health services and argues for the development of contextually specific understandings of recovery that are led by the person concerned. Despite extensive medical sociological and anthropological attention placed upon the sick role and the experience of illness, remarkably little attention has been paid to the social and experiential process involved in the restoration of health and well being.

<b>2<sup>nd</sup> September 2010</b>	<b>09:35 – 10:05</b>
Health Service Delivery & Organisation	Calman, Ken Wade

*Griffiths, F., Palmer, J.*

*Warwick Medical School*

**RADIODIAGNOSTIC IMAGING: TRANSPARENCY, UNCERTAINTY AND TECHNOLOGICAL CHANGE**

Medical images are often seen as interchangeable with the body rather than as a construction of it. This 'myth of transparency' (Joyce, 2008) rests on a long tradition of scientific endeavour that seeks to 'reveal' the natural world, without human mediation (Shapin and Schaffer, 1985, Haraway, 1997). Use of MRI, CT, and PET symbolise progress, the 'gold standard' in care. However, belief in transparency erases the human values and labour involved in image production, and the social, economic and political context of the technology and its use. Sociologists have critiqued this by drawing attention to the social and technological construction of radiodiagnostic images (e.g. Burri, 2008, Dumit, 2004, Joyce, 2008). The aim of this paper is to review the existing literature through the lens of technological change and to ask whether there is now an opportunity to further explore uncertainty in medical imaging. We will consider advances in image production, processing, storage and transmission. Analogue images on film have been replaced by digital images that can be extensively manipulated, e.g. to suppress noise, or to increase contrast. Multi-detector CT can produce thousands of axial images and combine them into 3D, or read in 'stack' (cine) mode; for certain organs, a 'fly-through' or 'image-navigation' technique is used. Do such techniques serve to remind us of the technological construction of an image? Do multiple images of the same body occasion more awareness of the role of human decision-making in rendering pathology visible or invisible?



**3<sup>rd</sup> September 2010**

Lifecourse: Reproductive Health

**10:10 - 10:40**

Calman, Rosemary Cramp

*Hall, M., Gibson, B.J, Rodd, H.D, James, A.*

*University of Sheffield*

### **ACCOUNTS OF CONGENITAL CONDITIONS: CLEFT STORIES AND NEGOTIATED MEMORIES**

Approximately one in 700 babies born in the UK each year is diagnosed cleft lip and/or palate (CLP), which is a developmental condition. A well-established 'care pathway', provided by a multidisciplinary team and consisting of surgical and non-surgical interventions begins at birth and continues into the late teens. The aim of this research was to explore children's accounts of the pathway. This qualitative study sought the views of children and young people receiving care at a dental hospital. The research facilitated the emergence of children's voices through the use of participatory methods, one of which was a timeline.

Eight boys and nine girls, aged 8-16 years, with various cleft types, each took part in two interviews. The first explored their general life stories, which tended to include CLP, though it had different levels of prominence for each child. A follow-up interview explored specific aspects of the condition and its treatment. 'Cleft stories' emerged which detailed the ways in which the children made sense of the condition. Since CLP-related interventions frequently commence in infancy, there were many aspects that children could not remember themselves. Accordingly, cleft stories were composed of an interplay of both children's and adults' representations.

Findings suggest that adults occupy a key role in the construction of biographical accounts of cleft and that their perspectives shape their child's understandings. One of the key characteristics of congenital conditions, such as CLP, is that they pre-date memory. Therefore, a special feature of CLP is the shared nature of these memories.

**2<sup>nd</sup> September 2010**

Cancer

**16:55 - 17:25**

Engineering 101

*Halls, A.*

*Durham University*

### **HUMAN INTEREST STORIES IN THE MEDIA: BREAST CANCER, HERCEPTIN, AND NICE**

The dualism between the individual and society is of prominent sociological consideration (Ritzer and Goodman, 2004). This paper is based upon a case study investigating the relationship between individuals and institutions within the context of patients and NICE, focusing on breast cancer and the drug Herceptin. The case study focused on a time period in which Herceptin was licensed only for use in cases of advanced breast cancer, and numerous patients with early stage breast cancer took or threatened legal action against their Primary Care Trusts, in an attempt to fund Herceptin on the NHS. Newspaper coverage of early stage breast cancer and Herceptin, in the form of human interest stories, was analysed: this medium reflected the dichotomy between the individual and the institution, and how the individual can be removed and yet re-incorporated back into this framework. By concentrating on the language and metaphors used within this medium, with a specific focus on those related to 'struggle', this research explores the relationship between named individuals and institutions, focusing upon contrasts and balances between identities taken by both individuals and institutions, and political and consumer standpoints used to express these.

**1<sup>st</sup> September 2010**

Preventive Health

**13:00 - 13:30**

Engineering 101

*Harrington, B.E.*

*Durham University*

### **THE BENIGN OCTOPUS? THE HEALTHIFICATION OF WALKING**

Recent research has drawn attention to the way in which the natural environment is being promoted as a space for health and becoming a "transactional zone" for public health to promote physical activity and mental wellbeing. The emphasis on individual responsibility for health with the increase in concerns over the growing "obesity epidemic" have increased the public health policy interest in walking. This paper presents preliminary findings from a study investigating the impact of visual culture on motivating people to walk in the UK countryside. The study takes an ethnographic approach using qualitative in-depth interviews with people who regularly go for long walks (5-10 miles) and observation to explore their motivations. Current visual culture is also analysed to explore the depiction of walking and landscape in, for example, magazines and television. The study shows that in promotional material for a national walking organisation the public health message has come more to the fore in recent years. However, findings from interviews with participants pose important questions about how far the public health messages (particularly the emphasis on physical fitness) are valued by participants and have inspired them to go walking. The presentation then goes further to question the wisdom of subsuming this leisure activity into public health policy. It contends that this is essentially a reductionist policy that ignores many of the complex reasons people give for wanting to go walking and may result in discouraging people from engaging in this leisure activity.

Hartley, J.

Medical Research Council

### **SEX, ROMANCE AND THE MEDIA: YOUNG PEOPLE'S CONSTRUCTION OF GENDERED IDENTITIES**

The UK has a poor history of sexual health among young people. The media is often cited as a source of influence for young people relating to sexual health. It may also be a formative influence in shaping gender identity. However, little research has specifically addressed these issues in Britain.

The paper reports findings from interviews conducted with 13-15 year-olds in two Scottish schools. These explored accounts of media portrayals of sexual /romantic relationships, and how these portrayals were perceived to influence the opposite sex's expectations of gender-appropriate behaviour with regards to sexual / romantic relationships.

Deciphering if, or how, the media has any influence on young people is difficult. However, a 'third person effect' was prevalent in the data; that is, young people claimed not to be influenced themselves by media portrayals but thought that others were. For example, boys would say that they are not influenced by the media, but that girls they know are. Furthermore, there was evidence of young people being influenced by the media in a circuitous way, through the presumed influence on others. For example, boys may presume that girls watch films that portray girls who want to be told they are loved before they have sex. Accordingly, in real-life, the boy may then tell a girl that he loves her in order to have sex with her.

The paper will assess the evidence for such indirect influence, discuss the implications for gender identities, and whether these findings confirm Milkie's Presumed Media Influence theory.

Heaven, B., Bamford, C., May, C., Moynihan, P.

Newcastle University

### **WHEN 30-40CMS BECOMES A PROBLEM: FEEDING, FOOD-WORK AND THE SPACE BETWEEN PATIENT AND PLATE ON HOSPITAL WARDS**

Approximately 60% of patients aged 65+ are at risk of malnutrition, or their situation worsening, whilst in hospital (Age Concern, 2006). We report the results of an ethnographic study of the meal services at 5 hospital sites across two regional locations, focusing on older patients admitted for stroke, fractured neck of femur or with dementia. Data were collected through: observation of meal services from storeroom to patient; semi-structured interviews with NHS staff (n=47) and stakeholders (n=7); a focus group with former patients and carers (n=5); and participant-observation in two workshops designed to generate 'solutions' to malnutrition. Normalization Process Theory (NPT) informed the analysis.

A range of factors contributing to malnutrition were identified. These varied from broad organisational and structural issues, to patterns of work and priorities on individual wards. Centrally 'food-work' and the interpersonal care of the patient were regarded as fundamental to adequate nutrition; however these activities were conceptualised differently across organisational, disciplinary and policy contexts. Junior staff explained the tacit, technical and nuanced nature of interpersonal work, yet attributed their own proficiency to "common sense". As staff increased in technical knowledge and status, so their accounts of food-work became focussed on resources, structures and procedures operating beyond the '30-40cms' between patient and plate. We suggest that whilst food-work is recognised as being fundamental to adequate nutrition for older patients, investment in this work is overlooked by policymakers, clinicians and researchers.

Heaver, E. Wainwright, D., Keogh, E., Eccleston, C.

University of Bath

### **THE SOCIAL NEGOTIATION OF SICKNESS CERTIFICATION FOR CHRONIC PAIN PATIENTS**

The UK government is committed to reducing sickness absence and recently introduced a number of initiatives in pursuit of this aim, including replacement of the sick note with a 'fit note' that focuses on capacity for work, and a training programme to persuade GPs that most patients would do better at work. The policy is based on a knowledge deficit model and assumes that once GPs are acquainted with the evidence base on the benefits of return to work they will exercise their gatekeeper role more effectively. Preliminary findings from a qualitative study of patients and GPs and an extensive literature review, suggest that the negotiation of sickness absence is a more complex process, particularly for chronic pain patients whose symptoms often do not coincide with clear evidence of pathology. How do doctors assess the magnitude of pain, or decide at what point it warrants absence from work? What happens when doctor and patient disagree over the seriousness of the problem or the necessity of sick leave? Drawing on symbolic interactionism and Grounded Theory, this study explores the social construction of the chronic pain patient and the negotiation of sickness certification. Key themes emerging from the data include: the dual role of the GP as gatekeeper and patient advocate; social norms relating to compassion in relation to human suffering and entitlement to benefits; the contestability of chronic pain. Findings from the study are interpreted in relation to Bourdieu's notion of habitus and sociological concepts of illness behaviour and sick role.

**2<sup>nd</sup> September 2010**

Preventive Health

**09:00 - 09:30**

Engineering 101

*Hedlund, M., Landstad, B.J., Aglen, B.*

*University College of Nord-Trøndelag*

### **THE CONSTRUCTION OF SELF-HELP AS A HEALTH PROMOTING STRATEGY**

Modern welfare states like the Norwegian one, are now reorienting and withdrawing their support and welfare system. One change appearing in Norway is a focus on using self-help and self-help group as a health promotion strategy. Self-mastery and self-help groups as a health promoting strategy represent a fairly new strategy in the Norwegian context. However, self-help can be seen as being aligned with self-mastery and user involvement, which do have a long history. Patient organizations, next of kin organization, or organizations for people with disabilities have for years made claims for co-operation with public health care and welfare state services sector to legitimate users' experience and the knowledge and insight of users and patients. However, this work and user influence have not been recognized or been organized as self-help knowledge or self-help strategies, neither by the public or the organizations. This paper aims bringing knowledge and critical reflections about these issues, such as to what extent self-help groups and participants of self-care activities promote experience of sustainable and positive health experiences for people struggling with mental and psychological capacity or lower capacity due to chronic diseases or disabilities? The study is based on analysis of documentary sources of public documents referring to self-help as a health promoting strategy, using the approach of intertextuality and critically analysis what meaning making are brought to the concept of self-help as a health promotion strategy.

ESRC and MRC (RES-339-25-0009).

**1<sup>st</sup> September 2010**

Lifecourse: Chronic Conditions

**13:00 - 13:30**

Calman, Rosemary Cramp

*Henderson, L., Seers, K., Tutton, E.*

*University of Oxford*

### **'WHO NEEDS TO KNOW?' THE ROLE OF DISCLOSURE IN THE MANAGEMENT OF LONG TERM CONDITIONS: A GROUNDED THEORY STUDY**

#### Background

A high proportion of people in the United Kingdom are living with a long-term condition. Government Policy has placed emphasis on supporting individuals to self-care. It has been argued that disclosure of illness may in itself be a self-care strategy. However, to date individuals' experiences of disclosure of long-term conditions are neither clearly defined nor its role in managing a long-term condition fully understood. The aims of the study were to explore the role of disclosure in the management of a long-term health condition.

Setting: The study drew on constructivist grounded theory (Charmaz, 2006) undertaking thirty-five in-depth qualitative interviews (fifteen people living with epilepsy, and twenty people living with type 1 diabetes) recruited from patient support groups and clinical nurse specialist's clinics.

#### Findings

"Learning about disclosure" is an integral part of living with a long-term condition. Three key disclosure roles were identified: (1) access to self-care and social support, (2) non-disclosure (concealment) of the condition to protect one's identity from stigma. (3) redressing myths about the condition in advance: to avoid perceived stigma.

#### Conclusions

The findings provide important insights that could enable health care professionals to develop more of an emphasis on including disclosure as an issue when talking to patients about managing type 1 diabetes and epilepsy and this is also relevant to a broad spectrum of long-term conditions. These findings build upon existing work in the field of the sociology of health and illness by illustrating the challenge of the ongoing nature of disclosure, a concept relatively overlooked in the literature.

**2<sup>nd</sup> September 2010**

Lifecourse: Ageing, Death & Dying

**11:20 - 11:50**

Calman, Rosemary Cramp

*Higgs, P. Jones, I.R.*

*University College London*

### **THE DEBATE ON ANTI-AGEING MEDICINE, PROGRESSIVE CRITIQUE OR CONSERVATIVE METAPHYSICS?**

Anti-ageing medicine has become a lightning rod for many debates around ageing in recent years. The fiercest critics of anti-ageing medicine are to be found among the gerontological community who wish to distance themselves from the anti-ageing movement. For this group, anti-ageing medicine is a kind of 'Frankenstein science'; a deviant form of health-care that is promoted by quacks, charlatans and corporate medicine whose interests lie with profits and market expansion rather than research and treatment aimed at understanding and improving health in later life. These criticisms have parallels in other fields such as psychiatry and sexual health where scholars and practitioners have highlighted the dangers of disease construction.

However, Anti-ageing medicine has also been criticised for denying people the 'right' to age 'naturally', instilling desires that cannot be fulfilled, placing the emphasis on youth rather than health as well as promising limitless life-extension. Vincent among others articulates a number of counter arguments for an 'anti-anti-ageing' movement which include, inter alia; the undesirability of bodily perfection, the loss of old age identities, the social importance of death and the debt owed to future generations. While those who take an explicitly 'anti-anti-ageing' approach may view themselves as the true progressives in the debate on the future of human ageing, in this paper we question the extent to which this is justified. Despite the stated radicalism of anti-anti-ageing, in its present guise we argue, it cannot avoid a retreat into an implicit conservative metaphysics.

2<sup>nd</sup> September 2010

Individual, Collective & Global Risk

11:20 - 11:50

Calman, Arnold Wolfendale

*Hilton, S. Hunt, K.*

*Medical Research Council*

**UK NEWSPAPERS' REPRESENTATIONS OF THE SWINE FLU PANDEMIC (MARCH 2009 TO FEBRUARY 2010)**

A/H1N1, more commonly referred to as swine flu, emerged in Mexico in spring 2009, before infecting hundreds of thousands of people internationally. The World Health Organisation's (WHO) declaration in June 2009 that H1N1 was a global pandemic heralded the first influenza pandemic in over 40 years. Swine flu attracted huge media attention as public health officials and scientists tried to predict and communicate the emerging health risk to the public. In summer 2009 'worst case' predictions suggested 30% of the UK population might be infected and 65,000 killed, and a 'best case' scenario predicted 5% contracting the virus and 3,100 deaths. However, swine flu was less lethal than initially feared, accounting for less than 500 UK deaths during two peaks of swine flu cases, in July and October 2009. We present an analysis of UK newsprint coverage of the pandemic to examine how the emerging public health threat was reported within a broader socio-political context. We selected 8 UK newspapers with high circulation figures and a range of readership profiles. A search for articles using the electronic database LexisNexis identified 5647 articles, of which 2374 met our inclusion criteria defined as A/H1N1 being more than 50% of article content. During the first peak in swine flu there were many newspaper articles but much fewer in the second peak. We show how the reporting around risk changed over a one year period. These findings may have implications for future communication strategies around pandemic health threats.

2<sup>nd</sup> September 2010

Lay-professional interface

10:10 - 10:40

Calman, Kingsley Barrett

*Hislop, J., Ziebland, S*

*University of Oxford*

**NEGOTIATING AMBIGUITY: GP AND PATIENT PERSPECTIVES OF HRT IN PRIMARY CARE**

From the 1970s HRT was heavily promoted for symptomatic relief of menopausal symptoms and prevention of osteoporosis and heart disease. Two landmark studies linking HRT with an increased risk of breast cancer and heart disease, however, have had a significant effect on prescribing practices in primary care and on the uptake of HRT. This paper explores how these findings and subsequent publicity have created an environment of ambiguity which impacts on doctor-patient relationships in primary care.

The paper draws on data from a qualitative study of UK women's experiences of the menopause (N=46) and telephone interviews with GPs (N=10) from three primary care trusts. Data were transcribed and analysed using NVivo 8.

In terms of symptom relief, HRT remains a popular treatment. Yet the awareness of risks associated with its use has made both doctors and patients wary. Our findings suggest that this creates tensions around responsibility as GPs try to balance the individual needs and preferences of their patients against ambiguous evidence and guidelines. In the absence of effective alternative symptomatic treatments, women are left to negotiate the complex issues surrounding HRT use without the benefit of clear, unambiguous information and advice.

The fall from grace of HRT as the medicine of choice for menopausal women has contributed to an atmosphere of fear in which adverse publicity, conflicting evidence, competing interests and ambiguous guidelines have impacted on doctor-patient relationships. In this environment the tasks of giving advice and making an informed choice are in danger of being compromised.

2<sup>nd</sup> September 2010

Randomised Controlled Trials & Evidence-Based Medicine

16:20 - 16:50

Calman, Kingsley Barrett

*Hughes, D. Doheny, S.*

*Swansea University*

**DELIBERATING TARCEVA: A CASE STUDY OF HOW NHS MANAGERS DECIDE WHETHER TO PURCHASE A HIGH-COST DRUG IN THE SHADOW OF NICE GUIDANCE**

This paper examines data from meetings in which NHS managers deliberate whether to buy high-cost drugs for individual patients. It investigates the work of a Welsh individual patient commissioning panel responsible for sanctioning the purchase of 'not normally commissioned' treatments for exceptional cases. The case study presented highlights the changing rationales used for approving or denying a cancer drug during a period when NICE first suggested it was not cost effective, but changed its position after a new technology appraisal recommended use where the cost did not exceed that of alternative products. We describe how the IPCP based its deliberations on the central notions of efficacy and exceptionality, and discuss the tensions that emerged when managers tried to use NICE information on cost effectiveness to inform deliberations on efficacy (clinical effectiveness). Until the release of the new NICE guidance, the IPCP consistently declined to fund referrals for Tarceva on grounds of the claimed efficacy of the drug or the exceptionality of the patient. The new NICE guidance presented a challenge to the panel because it suggested that Tarceva was effective and exhorted the drug manufacturer to reduce its cost. This implied that the IPCP had been making erroneous judgements, and forced panel members to reconstruct the drug as effective and move their deliberations on to the issues of exceptionality and funding.

**2<sup>nd</sup> September 2010**  
Experiences of Health & Illness

**10:45 – 11:15**  
Engineering 005

*Jenkins, N., Hallowell, N., Farmer, A., Holman, R., Lawton, J.*

*University of Edinburgh*

**PATIENTS' AND HEALTH PROFESSIONALS' EXPERIENCES OF INTENSIVE INSULIN THERAPY: TOWARDS A 'THREE-DIMENSIONAL APPROACH' TO UNDERSTANDING (NON-)ADHERENCE**

Conrad argued that, in order to understand patients' 'non-compliance' with treatment regimens, it is necessary to move beyond a 'doctor-centered perspective' and consider the meanings patients attribute to medications and their usage. Subsequent studies have also highlighted the importance of patient-health professional interaction in promoting and maintaining 'adherence'. Whilst these factors are important, less attention has been paid to patients' day-to-day experiences of taking medications, and to exploring (non-)adherence as an habituated health behaviour. Drawing on qualitative interviews with patients (n=45) and health professionals (n=21) who participated in a trial comparing three intensive insulin regimens (the 4-T trial), we will outline the three dimensional approach which we developed to understand the treatment (non-) adherence which occurred amongst our participants. This approach combined an exploration of: the meanings patients attributed to their insulin; how the 'rules' governing insulin use were negotiated between patients and health professionals; and how patients experienced having to incorporate insulin regimens into their everyday lives. We will argue that Schutz's theories offer fertile ground for developing a three dimensional approach to adherence, as they highlight that adherence is a constantly evolving practice, which is re-enforced, modified and revised as patients and health professionals operate within their life-worlds. Hence, exploring the social contexts in which adherence is (and is not) reproduced is of paramount importance. We will conclude by considering future avenues for research into treatment adherence, which utilises the three dimensional approach.

**2<sup>nd</sup> September 2010**  
Lay-Professional Interface

**14:35 - 15:05**  
Engineering 005

*Jones, D.*

*Glyndwr University*

**'SHE'S THE ONE: LISTENING TO MIDWIVES' ACCOUNTS OF 'RISK' SURROUNDING ANTENATAL SCREENING FOR CHROMOSOME ABNORMALITIES'**

Where does the midwife 'fit' between expert 'intrusions' into the body and 'lay' forms of knowledge about risk? Do midwives have any autonomy over the presentation of 'risk knowledge' produced by the medical profession, in their communications with pregnant women and their families? Or do they form part of a community of experts, attempting to rationally 'make sense' of uncertainty and fear?

Drawing on my current research into midwives' perceptions of risk surrounding antenatal screening for chromosome abnormalities in pregnancy, this paper will discuss some of the emerging themes from the interviews that I am currently conducting (March-June 2010). Initial findings seem to suggest that to see risk discourses as fitting into a simplistic 'top-down' model of risk transmission may be overly simplistic. Emerging findings seem to suggest that subjects in fact reproduce a variety of discursive strategies in which to communicate screening results to women. Nonetheless, as Beck (2004) argues, such discursive strategies may do little more than reinforce the anxieties that such tests are designed to alleviate. At the time of the presentation, the research will have been completed, and the paper will be able to present where it is felt midwives' discursive accounts 'fit' into the production of risk discourses in pregnancy more completely.

**1<sup>st</sup> September 2010**  
Inequalities

**14:10 - 14:40**  
Calman, Arnold Wolfendale

*Jones, I.R. Higgs, P.F.D.*

*Bangor University*

**CLASS AND RETIREMENT: HOW DO WE STUDY SOCIAL CLASS RELATED HEALTH INEQUALITIES IN LATER LIFE?**

Research on health inequalities in later life has produced ambiguous results. Researchers focus on two competing hypotheses. The cumulated disadvantage thesis suggests that the level of health inequality related to socio-economic status (SES) in a cohort will increase as a cohort ages. In contrast, the 'divergence/convergence' hypothesis or 'age as leveller' hypothesis suggests a widening of inequalities up to early old age and a decrease in inequalities thereafter. Research in this area is increasingly important because of population ageing and because of the gaps in our knowledge of the determinants of health in later life. However, much socio-epidemiological research treats class as a variable within standard log-linear models. While these studies offer important insights there has been a relative neglect of wider debates about class and class culture and how this relates to the changing nature of later life. This is an important absence because the generations in affluent countries entering retirement today are those who experienced the social changes that have led to debates about the salience of class in wider society. This paper considers debates about the salience of class in relation to later life and asks how can it be conceptualised in a population that may have been out of the workforce for many decades? The paper concludes by examining the implications of such questions for research on inequalities in health in old age.

<b>2<sup>nd</sup> September 2010</b> Health Policy	<b>16:55 - 17:25</b> Calman, Rosemary Cramp
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*Jones, L., Exworthy, M., Frosini, F.*

*London School of Hygiene and Tropical Medicine*

**'WHY WOULD ANYONE DISAGREE WITH US? AN ETHNOGRAPHIC STUDY OF HEALTH SERVICE RECONFIGURATION POLICY IN ENGLAND**

In England there has been increasing interest by policy makers in health care service reconfiguration as a means of bringing about improvements in the efficiency and effectiveness of the health system. However, plans to reconfigure health services have often met with significant community resistance, especially if they involve the closure of a local hospital. This study considers how health care policy 'works' as an instrument of power. It reports from an ethnographic study of reconfiguration policy in England undertaken between November 2006 and March 2009. The study found that reconfiguration policy draws on a clinical discourse that frames decisions to reorganise health services as based on the evidence and necessary to ensure safety. We interpret this discourse as a rhetorical strategy for implementing organisational change in the context of community resistance to service closure and a concomitant policy emphasising the importance of public and patient involvement in the planning of services. Although the persuasive power of the discourse was limited, a more insidious form of power was identified in the way the discourse disguised the political nature of the issue by defining it as a clinical problem. We conclude by discussing how the clinical discourse constrains patient and public participation in decisions about the delivery and organisation of healthcare and restricts the extent to which alternative policy responses can be considered.

<b>1<sup>st</sup> September 2010</b> Lifecourse: Chronic Conditions	<b>14:10 - 14:40</b> Calman, Rosemary Cramp
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*Kapadia, D., Vassilev, I., Blickem, C., Fullwood, C., & Cording, H.*

*The University of Manchester*

**WORLDS OF DIFFERENCE: THE SOCIAL EMBEDDEDNESS OF HEALTH BEHAVIOURS**

Living with long term conditions (LTCs) requires substantial lifestyle changes including modifications to diet, exercise, relaxation, and adherence to a medication regimen. The dominance of professionally and individually centred accounts of long term condition management (LTCM) means that such changes are primarily interpreted as the ability and willingness of individuals to change (overemphasising self-efficacy and health behaviours). In contrast, we argue that LTCM should be discussed as a social process where actors within an individual's social network are strongly implicated in the illness 'work' (Strauss 1985; Corbin & Strauss 1988) and this additional work must be socially embedded or 'normalized' (May & Finch 2009) for successful management.

Here we explore the processes implicated in lifestyle changes specifically associated with LTCM. We argue that specific types of illness work (Strauss, 1985), relate differently to everyday life for people with long term conditions and thus pose different types of challenges, both for the individuals and also for the members of their social network. For example, it could be hypothesised that diet, in contrast to exercise, is closely associated with everyday family practices, such as mealtimes, shopping, cooking and thus is related to a set of shared practices directly influenced by the capabilities, preferences, and habits of others.

Using both qualitative, framework analysis (Ritchie & Lewis 2003), and quantitative, social network analysis (Scott, 2000), we present a preliminary analysis of findings from a pilot study on the types of work done within the social networks of people with LTCs.

<b>3<sup>rd</sup> September 2010</b> Mental Health	<b>10:10 - 10:40</b> Maths 107
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*Kayali, T. Iqbal, F.*

*University of Cambridge*

**MAKING SENSE OF MELANCHOLY: THE ROLE OF PERCEIVED TRIGGERS IN WOMEN'S EXPERIENCES OF DEPRESSION**

This research set out to investigate whether aspects of women's experiences with depression, diagnosis and treatment relate to the ways in which they describe depression in relation to their self and how they describe medication's role in their recovery. Based on an empirical study involving qualitative interviews with 37 women diagnosed with depression, the data indicate that women who considered most of their episodes to have been triggered by events or circumstances in their lives were more likely to believe that their depression could in future be overcome, whereas those who did not consider the majority of their episodes to have been triggered were more likely to believe their depression to be chronic. The analysis indicates that in depression, perceptions of control and identity are interlinked. Moreover, this study suggests that the distinction between those who perceived triggers for their depression and those who did not is even more meaningful for women's own narratives of identity (particularly whether depression is a temporary or permanent part of their lives) than the clinical distinctions of unipolar and bipolar depression. Women's conceptions of the extent of personal control that is possible within their depression also has implications for how they perceive the role of treatment, which could be taken into account when making treatment decisions. This research thus demonstrates the value of sociological investigations for both our understanding and treatment of depression.

**2<sup>nd</sup> September 2010**

Lifecourse: Ageing, Death & Dying

**10:45 - 11:15**

Calman, Rosemary Cramp

*Kelly, M.*

*Queen Mary, University of London*

**EVALUATING HEALTHCARE EXPERIENCE: IDENTITY WORK IN INTERVIEW ACCOUNTS ABOUT TERMINAL CARE**

Interviews are frequently used to elicit the views of 'the consumer' and the data are used to influence policy and practice initiatives. This paper examines the way in which lay people talk about healthcare in the process of describing their experiences of terminal cancer care in research interviews. Membership categorisation device analysis (Sacks 1992) has been applied to the interview data to investigate the complex moral work undertaken by the interviewees. The interviewees set up lay and professional identities, and associated roles and responsibilities, in describing the course of the illness and death of their spouse. This includes negotiation of the identity of caring spouse within the husband/wife relationship such as prompting a spouse to seek professional help, and regarding lay-professional roles such as the right of a spouse to be present at the death. The analysis displays how these social relationships are drawn upon in order to evaluate their experiences. Implications for the role of lay carers and the way in which evaluations of healthcare can be understood are discussed.

**2<sup>nd</sup> September 2010**

Embodiment & Emotion

**14:35 - 15:05**

Calman, Derman Christopherson

*Kessler, I., Heron, P., Dopson, S.*

*University of Oxford*

**FRONTLINE CARE AND THE MANAGEMENT OF EMOTION: DEATH AND THE HEALTHCARE ASSISTANT**

Dealing with death as a routine part of working life creates distinctive challenges for the employee in the management of emotions. The emotions generated are likely to be intense, invoking genuine feelings and placing strain on institutional display rules. Indeed, the worker might well be required to deal not only with their own feelings but those of others with a more direct affective investment in the situation. This paper explores how the healthcare assistant (HCA) in secondary healthcare confronts these challenges. Typically overlooked in the literature on emotional labour, the HCA is increasingly taking on the care responsibilities formerly performed by the nurse with implications for the HCAs' relationship with patients and for the emotional fall-out from the patient's death. As a non-professional role, often undertaken by women with few formal qualifications but typically with broad life experiences, questions arise about how HCAs engage with and manage the emotional intensity associated with death. In the absence of professional training and norms, does the management of emotion emerge as problematic for the HCA? Or can the HCA draw upon tacit skills, perhaps developed outside the workplace, to cope with efficiency and effect? These questions are addressed by drawing upon interviews with 81 HCAs in four hospitals. The paper argues that the HCAs' emotional experience of death is heavily contingent on the personal and situational circumstances that surround death, and on a range of coping strategies revealed as regulating the management of their emotions and those of patient friends and family.

**3<sup>rd</sup> September 2010**

Theory

**09:35 - 10:05**

Engineering 005

*King, C.*

*University of Edinburgh*

**THE IMPORTANCE OF KNOWING: AN ANALYSIS OF POWER/KNOWLEDGE DISCOURSES IN HEALTH VISITING WORK**

In 2003 a change in health policy influenced how health visitors work with families. Health visitors are now asked to target support to the most vulnerable, whereas before they worked with all families. A research partnership was formed to investigate the impact of this policy change. Sixteen health visitors and nineteen mothers took part in research interviews. Social workers, speech and language therapists, community staff nurses, midwifery representatives and policy makers from government and the NHS also took part. The emerging findings suggest that targeting health visiting services is problematic. There is a risk of marginalising some families who are identified as vulnerable, and at the same time of failing to support other families who have not been recognised as in need. The works of Michel Foucault have been used in a number of studies about health visiting and the surveillance of child health (Bloor and McIntosh 1990; Wilson 2001; Peckover 2002). Often presented as a neutral concept, child health surveillance is contested and framed differently in these analyses in terms of disciplinary power. In this paper I aim to present for discussion my analysis of the health visitor accounts which will draw on the works of Michel Foucault and the understandings to date presented in this literature.

<b>2<sup>nd</sup> September 2010</b> Experiences of Health & Illness	<b>11:55 – 12:25</b> Engineering 005
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*Kokanovic, R.*

*Monash University*

**'A LITTLE GREY MONSTER THST SITS ON MY SHOULDER' – STORIES OF PEOPLE WHO HAVE BEEN DIAGNOSED AS 'DEPRESSED'**

"This paper explores how lay people describe the experience of being medically diagnosed as depressed. Diagnosis is both a category and a process; it is the "set of categories agreed upon by the medical profession to designate a specific condition it considers pathological, and the process, or deliberate judgement, by which such a label is applied" (Blaxter 1978 quoted in Jutel 2009). With regard to 'mental illness', control over diagnosis is closely linked to the categories contained in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM). Sociologists have investigated the social processes underpinning the production of DSM diagnostic categories, challenging the purported scientific objectivity of psychiatric diagnosis and exploring the consequences of medicalising emotional experiences of distress and silencing alternative understandings of emotional distress. It has been suggested that lay people often challenge the idea that depression is an illness, preferring to see it as a part of 'everyday life and its vicissitudes', but at the same time, Pilgrim suggests depression has strong lay credibility as a diagnostic category (2007). In this context, a better understanding of how lay people describe, experience, negotiate and participate in processes of diagnosis is needed. This paper provides a narrative analysis of 10 in-depth interviews conducted in Australia with people who have been diagnosed as 'depressed'.

<b>2<sup>nd</sup> September 2010</b> Lay-Professional Interface	<b>15:10 - 15:40</b> Engineering 005
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*Lannie, A., Barbour, R., Corlett, J.*

*University of Dundee*

**THE SOCIAL CONSTRUCTION OF THE OLDER PERSON WITH CANCER: REFLECTIONS ON FOCUS GROUP DISSEMINATION SESSIONS WITH HEALTH CARE PROFESSIONALS**

This paper reports on the final stage of a qualitative study that seeks to compare patient and health care professionals' perspectives and experiences of cancer care for the older person. The research design (employing focus groups and interviews) centres around comparison of a general and a specialist ward in one hospital –exploring the challenges involved, depending on whether the focus is on the older person or the disease. It also highlights the tensions that may arise – both for patients and professional carers, as they negotiate the potentially contradictory demands of the 'social' and the 'clinical'.

Dissemination sessions provided an overview of preliminary findings, and were organized around the following themes: 'the ward as a half way house', 'etiquette', 'emotion work' and 'hope'. Discussing findings of this study with participants has a dual purpose: to inform participants of the preliminary findings, to generate further data to establish whether these findings have relevance for them.

This presentation reflects on further insights obtained through four focus groups carried out on the two wards (general and specialist) which were used as study sites. Importantly this allowed for the original sample to be augmented (by including new categories of staff and individuals with a remit to work across both wards, who were not involved in the first set of focus groups and interviews). Integrating analysis of original study transcripts and data generated in dissemination sessions also allows for further interrogation of theoretical frameworks that seek to elaborate the intersection of the clinical and social.

<b>2<sup>nd</sup> September 2010</b> Randomised Controlled Trials & Evidence-Based Medicine	<b>15:10 - 15:40</b> Calman, Kingsley Barrett
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*Lee, A.*

*Queen's University*

**RENEGOTIATING OBJECTIVITY IN CLINICAL MEDICINE: DEBATES SURROUNDING EVIDENCE BASED MEDICINE AND THE COCHRANE COLLABORATION**

Evidence-based medicine (EBM) is a statistical model of science that emphasizes the use of randomized control trials to inform healthcare practice decisions. Since its inception in the early 1990s, many consider EBM the 'gold standard' of epidemiological decision-making, displacing other epistemes that incorporate information gathered from individual clinical encounters.

The Cochrane Collaboration is an international organization that systematically reviews the totality of international research on any given health care issue. These meta-analyses represent a complex process of scientific knowledge production. The project embodies the paradigmatic virtue of EBM because it is a realization of scientific ideals concerning objectivity.

From a sociology of science perspective, Cochrane reviews are the products of the scientists who create them and their specific epistemological commitments, or 'ways of knowing' (Daston and Galison 2007). Cochrane reviewers are the most immediate knowledge arbiters, deciding what evidence is best, which scientific models to use and so on. At every level of knowledge making, from bench scientist to reviewer, contributors implicitly access epistemological frameworks and shape/re-shape medical knowledge with each clinical trial they choose or do not choose to value.

This paper explores the Cochrane Collaboration's genesis. It will locate its development within the context (and as an embodiment) of the paralleled establishment of EBM as a dominant scientific paradigm, which displaced other epistemes that relied on the authority of individual clinicians. Importantly, this paper represents a timely social scientific engagement with medical knowledge that enables cross-discipline connections between the social and natural sciences by exploring scientific knowledge claims.



<b>2<sup>nd</sup> September 2010</b> Ethnicity & Migration	<b>11:20 - 11:50</b> Maths 107
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Lee, J. Y.

Nottingham University

### **FOUCAULDIAN UNDERSTANDING OF KOREAN MIGRANT WOMEN'S INITIAL CONTACT WITH THE NHS**

This presentation is part of a PhD thesis which looks at how the concepts of health and illness of Korean migrant women have changed since their arrival in the UK, using a Foucauldian theoretical framework. It focuses exclusively on their initial medical encounters with the NHS when they had light illnesses such as cold, fever and headaches. These early contacts with the GPs served as an alarm that instilled in them a sense of responsibility for their own health – whether as a form of conforming to or resisting against the British ‘healthy citizen’ model of medical subjectivity. As a result, the Korean women’s efforts to re-define their concepts of health and illness as immigrants will be discussed.

<b>3<sup>rd</sup> September 2010</b> Lifecourse: Reproductive Health	<b>09:35 - 10:05</b> Calman, Rosemary Cramp
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Letherby, G. Stenhouse, E.

University of Plymouth

### **INFANT FEEDING, DIABETES AND ‘GOOD MOTHERHOOD’: KNOWLEDGE, CHOICES AND EXPERIENCES**

For women whose pregnancy is complicated by diabetes research has highlighted the health benefits of breastfeeding for mothers and infants and this has led to the active promotion of breastfeeding. However, a plethora of social science research argues that the ‘Breast is Best’ message has ideological overtones which suggests that if ‘breast is best’, formula feeding is second best. By association the suggestion is that mothers who successfully breastfeed are better than mothers who do not. Many women with diabetes find it difficult to initiate and maintain breastfeeding and this has implications for women’s choices and experiences of breast and formula feeding and feelings of self-worth with reference to motherhood.

In a project focusing on mother/daughter relationships during pregnancy for women with pre-existing diabetes, respondents spoke to us about their views, intentions and experience of infant feeding, including the influence of midwives and other healthcare professionals and the significance of partner and familial support. Pregnant and new mother respondents’ talked of the complexity surrounding infant feeding choices and experiences including the lack of sufficient antenatal information regarding infant feeding and the lack of support to enable them to breastfeed if they wanted to. They felt anxious and defensive about their choices and the perceived and actual pressure they were put under by others to make the ‘right’ feeding choices.

<b>3<sup>rd</sup> September 2010</b> Inequalities	<b>10:45 - 11:15</b> Calman, Arnold Wolfendale
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Lorant, V., Bhopal, R.

Université catholique de Louvain

### **ETHNICITY, SOCIO-ECONOMIC STATUS, AND HEALTH : INSIGHTS FROM AND IMPLICATIONS OF CHARLES TILLY’S THEORY OF DURABLE INEQUALITY**

Ethnic inequalities in health status and health care remain substantial in Europe and addressing them is becoming a priority for European policies. However, the best way to respond to such a challenge is, as yet, unclear. The research community is grappling with the contribution of socio-economic discrimination to ethnic inequalities. We present a new theoretical analysis, based on the landmark work of Charles Tilly on ‘Durable Inequality’ and we apply it to the public health goal of reducing ethnic health inequalities. Tilly claims that, for organisational reasons, ethnic categories and socio-economic categories are tied together. The theory of Durable Inequality claims that the matching of ethnic categories with socio-economic categories helps to enforce exploitation, leading to inequalities. We present the theory, and focus on its main components (categories, exploitation, opportunity hoarding, emulation, adaptation) and discuss the implications for health inequalities by ethnic group. In essence, the theory provides four main implications. Research should compare different organisational and institutional settings, and study how ethnic categories aid organisational aims; it should put the emphasis on altering networks and social routines and not so much on beliefs and attitudes, including racism; the theory call for examining how ethnic minorities themselves utilise opportunity hoarding to create niche economic opportunities; finally, the measurement of ethnicity should be made with paired categories defining the access to valuable resources. Our paper opens a debate to refine these ideas prior to empirical testing.

**3<sup>rd</sup> September 2010**

Sleep

**11:55 - 12:25**

Engineering 102

*Luff, R., Venn, S., Arber, S.*

*University of Surrey*

### **SOCIAL AND HEALTH INFLUENCES ON THE SLEEP QUALITY OF OLDER ADULTS LIVING IN THE UK**

The Pittsburgh Sleep Quality Index (PSQI) was designed to measure subjective sleep quality over the previous month and to discriminate between poor and good sleepers. The PSQI includes indicators of sleep latency, sleep duration, sleep disturbances, use of sleep medication, subjective sleep quality and daytime dysfunction. This paper examines how health and social factors interact to influence the quality of sleep of older adults.

A self-completion questionnaire which included the PSQI was completed by 1085 older people (575 males and 583 females), from South East England, aged over 65 who were living in their own homes. It was found that about half of older adults scored 6 and above on the PSQI, indicating they experience poor quality sleep. Logistic regression using a range of socio-demographic and health predictor variables was undertaken.

Gender, social economic status (SES) and health problems were all significant predictors of poor sleep. In particular, older women reported poorer sleep than men, and those who had been in professional occupations reported better sleep than those in most other SES groups. Greater numbers of health problems were associated with poorer sleep, with cancer and muscular/skeletal conditions specifically relating to higher PSQI scores. There was no effect of age once health problems were entered into the model, suggesting poor sleep amongst older people is not purely age related, but is influenced by more specific health and social factors.

We acknowledge support from the New Dynamics of Ageing initiative, a programme supported by AHRC, BBSRC, EPSRC,

**2<sup>nd</sup> September 2010**

Cancer

**17:30 – 18:00**

Engineering 101

*MacArtney, J.*

*London School of Economics*

### **HEALING THEMSELVES: COMPLEMENTARY HEALTHCARE AS A BALANCED WAY OF LIVING**

"In this paper I explore one of the ways that people with cancer, who use complementary medicines, have found to manage the biographical (Bury, 1983) and agnatomological (Proctor, 1996) tensions that their diagnosis brought. Complementary self-help approaches have been widely criticised for, amongst other things, duping individuals (Goldacre, 2009; Ehrenreich 2010), inducing self-helplessness (McGee, 2007) and disciplining the therapeutic subject (Foucault, 1982).

This paper draws on my ethnographic fieldwork in two complementary cancer support centres in England. During the fieldwork I also conducted 15 in-depth narrative interviews. In my analysis I argue for an embodied sociology by using Frank's (1991) 'thinking with narratives'. Instead of theorising the subject as the foundation of practices and discourses, "[s/]he remains on the level of how subjects appear to themselves as subjects of possible actions" (author's italics, McGushin, 2007: 11). This allows the subject a relation to oneself that 'resists' codes and powers as subjectivation attempts continue creating itself by folding power and knowledge so that "the relation to oneself is continually reborn

**2<sup>nd</sup> September 2010**

Lifecourse: Reproductive Health

**16:20 - 16:50**

Engineering 102

*Machin, L., Brown, N. and McLeod, D.*

*University of York*

### **FRAMING CORD BLOOD BANKING: A QUESTION OF RIGHTS AND CHOICES?**

Since the first cord blood (CB) transplant in 1988, CB has been viewed as an alternative source of stem cells to bone marrow and has been typically discussed within the context of blood, organ and tissue donation. The early 1990s saw an increase in the collection of CB through the establishment of banks, which make CB units available for either societal, personal or familial use. In 2007, a third way of banking was presented when Virgin Health Bank was established, whereby 80% of the CB unit is stored for public use and the remaining 20% is stored privately for the woman paying for the collection. However, the collection of CB in the UK is not widespread. Donating to the public bank is restricted by the location of the collection sites, as well as the sexual health history of the woman donating. Private banking is also constrained by individual NHS Trust policies on CB collection. Increasingly, CB is being framed within the discourse of reproductive rights. In turn, this creates a novel situation whereby being able to donate is being discussed as a 'right' and, in the case of Virgin bank, is something that is to be paid for. In this presentation, findings from a two year, ESRC-funded project on the political and moral economy of cord blood banking will be reported, with extracts from interviews conducted with members of public and private banking sector and those storing CB included.

<b>2<sup>nd</sup> September 2010</b>	<b>09:00 - 09:30</b>
Lay-professional interface	Calman, Kingsley Barrett

*Mackichan, F., Britten, N., Paterson, C.*

*Peninsula Medical School*

### **BOUNDARIES OF HEALTH CARE: SELF CARE FOR LONG TERM CONDITIONS**

People with long term health problems engage in a significant amount of 'illness work', and enhancing self care has become a key component of health policy in recent years. This paper presents findings from a mixed method study investigating both the use of self care by people experiencing long term conditions and the potential for self care support. A cross-sectional postal survey (n = 578) investigated the use self care and other forms of care in relation to six long term health problems. Interviews (ongoing) were undertaken with 24 adults purposively sampled from survey respondents.

Self care was widespread, although there were variations both in the type (e.g., over the counter medications, rest, positive thinking) and total number of self care strategies used according to the specific health problem. The number of self care activities utilised was predicted by factors including trust in a greater number of sources of health care information, and having received a diagnosis. Interviewees discussed the location of self care within their experience of living with a persistent health problem; self care was viewed as a moral obligation and as just part of everyday life. Perceived constraints (e.g., time, cost) led interviewees to consider that provision of self care support from the orthodox sector might not be achievable, or even desirable. Findings are discussed in the context of existing theory and empirical literature, drawing on concepts of responsibility and legitimacy, medicalisation and the shifting boundaries of different sectors of health care.

<b>2<sup>nd</sup> September 2010</b>	<b>16:55 - 17:25</b>
Health Service Delivery & Organisation	Calman, Ken Wade

*Mackintosh, N., Sandall, J.*

*King's College London*

### **STRUCTURING AND MEDIATING BOUNDARIES WITHIN THE ACUTELY ILL PATHWAY: IMPLICATIONS FOR PATIENT SAFETY**

A significant proportion of cardiac arrests are perceived to be preventable, amenable to earlier detection and intervention. In the last ten years, the social construct 'failure to rescue', has emerged as a legitimate arena for policy and professional scrutiny. Current risk management and safety strategies focus around regulation of routine assessments and the governance and control of the trajectory of the acutely ill patient.

This paper will examine how 'deterioration' is socially framed and negotiated within medical settings and the impact of safety strategies designed to facilitate early detection and management of complications in the acutely ill patient. Ethnographic methods were used to explore the social organisation of the landscape of the 'acutely ill pathway'. Data will be presented from observations and interviews with a variety of staff in two acute NHS trusts.

We consider the distributed decision making, multiple viewpoints and conflicting knowledge bases that influenced the 'brokering' process around deterioration. We utilise the concept of the 'boundary object' which expands understanding beyond boundaries as conditions for separation and exclusion, to communication, exchange, bridging and inclusion (Lamont & Molnár, 2002). We examine how safety artefacts such as early warning scores and protocols demonstrated professional power and authority, acting as material and social resources, and helping structure relations between occupational and professional groups providing legitimacy and license for junior staff to escalate. Importantly, safety artefacts and strategies were not uniformly applied across the two trusts, but were shaped by organisational patient safety macro-systems.

<b>3<sup>rd</sup> September 2010</b>	<b>11:20 - 11:50</b>
Genetics & Experiences of Health & Illness	Engineering 101

*Marques-Brocksopp, L.*

*The Guide Dogs for the Blind Association*

### **A PSYCHOSOCIAL ANALYSIS OF EMOTIONAL WELLBEING IN VISUALLY IMPAIRED CHILDREN.**

Vision loss can have a profound effect on the emotional and functional wellbeing of children. Indeed, functional disabilities have a strong reciprocal relationship with mental health, and are a key risk factor for the onset of depressive symptoms. Consequently, emotional problems may result in an increased risk for both physical illness and functional disability. As such, emotional wellbeing is an important factor when considering the overall health of visually impaired children.

There is a lack of theoretical and methodological consensus concerning the impact of childhood vision loss. One of the principle debates surrounds the use of sighted children as a yardstick when measuring "normal" emotional wellbeing, and thus ignoring the ways that visually impaired children use different routes and styles of emotional and social development.

This paper therefore calls for a more heterogeneous and holistic understanding of vision loss and wellbeing. Using a biopsychosocial framework, it will consider how vision loss affects emotional and functional wellbeing of children, analyzing factors such as the aetiology of visual impairment, a child's self-concept, coping strategies, peer and parental influences, social networks and environment.

Fundamentally, a paradigm shift is needed to challenge the homogeneity that currently exists in this area of research. A multifactor framework is required that embraces various psychological and sociological factors, and informs specific emotional wellbeing education for children and their families. Such initiatives are currently being piloted by the Guide Dogs for the Blind Association, which ultimately aim to improve the emotional and functional wellbeing of visually impaired children.

**2<sup>nd</sup> September 2010**

Health Policy

**15:45 - 16:15**

Calman, Rosemary Cramp

*Martin, G., Learmonth, M.*

*University of Leicester*

### **A CRITICAL ACCOUNT OF THE RISE AND SPREAD OF 'LEADERSHIP' IN HEALTH CARE DISCOURSE**

This paper considers the rise of the notion of leadership in discourses relating to the British National Health Service, and the application of the term to an increasingly heterogeneous variety of actors. Drawing on discourse analyses of (i) interviews with NHS chief executives performed in the late 1990s, and (ii) key policy documents published in the period since, the authors highlight how leadership has become a term of choice among policymakers, with positive cultural valences which previously predominant terms such as administration and leadership now lack. They note in particular how leadership is increasingly conferred not only on those in positions of formal power in the health service but on frontline clinicians, patients and the public, and how not just the implementation but the design of policy is now constructed as being led by these groups. Such constructions of the distribution of power in the health service, however, conflict with the picture drawn by academic work. The authors suggest, therefore, that part of the function of leadership discourse is to align the identities of health-service stakeholders with the intentions of policy, making their implementation not just everyone's responsibility, but everyone's common aim, and even sense of self. Given the realities of organizational life for many of the subjects of leadership discourse, however, the extent to which this function is realized—and to which 'leadership' retains its current positive associations and ubiquity in policy in the future—remains to be seen.

**2<sup>nd</sup> September 2010**

Lay-Professional Interface

**16:55 - 17:25**

Engineering 005

*Martindale, A-M.*

*University of Liverpool*

### **FOOD FOR THOUGHT: LAY HEALTH TRAINERS, LOCAL AND OBSTINATE BODIES.**

Lay Health Trainers (LHTs) appeared suddenly in policy documents in 2005. By 2007 they were being hailed as a success and rolled out nationally. Their aim was to prevent life-style diseases, such as obesity and to improve health generally. Trained local people would offer support to motivated individuals who were at risk from coronary heart disease (CHD) and crucially, would succeed in bringing CHD rates down, where conventional methods had failed. There are political and financial incentives to reduce the rates of CHD, a healthy and productive workforce are desirable, and by default, the use and cost of NHS services are reduced. In spite of the potential benefits of the service, Lay Health Trainers have had limited success to date.

This paper will explore the underlying assumptions made about the 'good' citizen and by extension the 'good' body (Foucault, Margaret Shildrick) within LHT discourses. The enrolment of non-medically qualified individuals, such as LHTs, to carry out government policy, is an interesting extension to the role of citizens. The current medical, cultural, and psychological obsession with bodies, and specifically the attainment of the healthy body, is transformed into a financial liability when it resides outside medical norms.

The paper will, perhaps, ask more questions than answers, such as what are government expectations surrounding health and how are these made by social actors, professional or otherwise? How can challenging public health issues, such as obesity and smoking be usefully framed?

**3<sup>rd</sup> September 2010**

Patient & Public Involvement

**11:20 - 11:50**

Calman, Derman Christopherson

*Mason, G.*

*King's College, London*

### **INVOLVING FAMILY CARERS IN MENTAL HEALTH RESEARCH**

Why do we involve service users and carers in research, and what are the benefits of public involvement in terms of improving research, and for service users and carers themselves? Locating carer involvement in the context of Department of Health policy, I draw on a critique of government expert advice from DEMOS (2006), and mental health service user literature which identifies imbalance of power between scientists, doctors, health professionals, and the public as leading to acquiescence and limited engagement. The INVOLVE report on the impact of public involvement in research (2009) contrasts the many descriptions of processes with a lack of evidence on outcomes of involvement. In practice, there is disagreement about what counts as user and carer involvement; I argue that the need to evaluate leads to a subtle shift of outcomes away from benefits to research towards benefits for those who are involved, and a blurring of the line between processes and outcomes. I describe carer involvement in the IMPaCT programme of research on improving physical health and reducing substance use in severe mental illness, running on the NIHR Mental Health Research Network. MHRN assists with recruiting participants and involving family carers through FACTOR – Families/friends And Carers Together in Research. We had regular discussions with research clinicians on how service users could be motivated to change to healthier lifestyles. Through FACTOR, carers edited a newsletter and two health manuals for care coordinators and service user participants, and a carer group intervention was included in the research design.

<b>2<sup>nd</sup> September 2010</b> Lay-Professional Interface	<b>16:20 - 16:50</b> Engineering 005
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*Matsushige, T., Tsutsui, T., Otaga, M.*

*National Institute of Public Health*

**FROM ‘PURPOSE-ORIENTED’ TO ‘CONNECTEDNESS-ORIENTED’ MEDICINE: A STUDY OF HOME MEDICAL CARE IN JAPAN AND FRANCE**

Today the shift ‘from hospital to community’ is a trend in healthcare shared by many countries. ‘Community’ means, in many cases, service users’ home or home-like settings as a place of healthcare delivery. Home medical care used to be only for those with non-severe conditions. Today, however, some countries have begun to provide a wider range of medical treatment at patients’ home. For example, Onomichi city in Japan established ‘Onomichi system’ in the last decade, where a healthcare team, which consists of primary care physician, hospital doctor, nurse, social worker, patient, family member and others, is arranged depending on the patient’s conditions. The team provides services integrating health and social care for patients with terminal cancer, childhood cancer, consciousness disturbance and other serious diseases. In France, the government institutionalised ‘Hospitalisation à Domicile’, where patient’s home is assumed to be ‘an extension of hospital ward’ and the treatment is provided for patients in all post-acute conditions except for mental disorder.

Although the way in which home is positioned as a place of healthcare delivery may vary by region, the shift in the place of care delivery seen in many nations may be understood as part of ‘care transition’. However, little is known about structural and qualitative changes in service provision as a result of the shift. How can sociology explain the shift and its impact on patients’ day-to-day living? We consider this question based on the empirical field research in some advanced cases of home integrated care in Japan and France.

<b>2<sup>nd</sup> September 2010</b> Individual, Collective & Global Risk	<b>10:45 - 11:15</b> Calman, Arnold Wolfendale
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*Maunula, L.*

*University of Toronto*

**PROTECT YOURSELF! EDUCATING THE PUBLIC ABOUT PANDEMIC INFLUENZA**

In order to reduce infection and death during influenza pandemics, public health bodies worldwide have developed comprehensive pandemic public education campaigns. The Canadian pandemic public education plans strongly advocate individual and family practices to prevent infection and stop further transmission, such as hand-washing, vaccination and respiratory etiquette. From a social and political perspective the focus on individual infection control techniques is problematic, particularly as the social and structural factors behind influenza pandemics go unmentioned. Thus, the ways in which pandemic flu is represented in official pandemic education messages shapes the way we view the pandemic scenario and ourselves, collectively and individually, within it.

In this paper I provide an overview of the goals for pandemic public education outlined in several Canadian pandemic plans, and examine how infection control is invoked within those texts. Drawing from Foucault’s notions of governmentality and technologies of the self I then engage in a theoretical critique of those public education strategies. This study contributes to understanding of how pandemic preparedness and infection control is represented in Canadian pandemic plans, how public health shapes pandemic messages for the public, and the implications of those messages for subjectivity and notions of citizenship.

<b>2<sup>nd</sup> September 2010</b> Preventive Health	<b>11:55 - 12:25</b> Engineering 101
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*Maurice, A.*

*INRA (Institut National de Recherche Agronomique)*

**“EVERYONE THEIR OWN FRUIT”, A PUBLIC HEALTH ACTION AIMED SPECIFICALLY TOWARD UNDERPRIVILEGED FAMILIES IN FRANCE**

This presentation will display the French nutrition education policy and its effect on the French population. Noting certain insensitivity from the underprivileged populations towards nutrition education policies, local actors seek to set up projects targeting specifically these groups. It is within this framework that the project called “Everyone their own fruit” has its origin, under direction of a local authority. In order to carry out the study for the feasibility of this project, we have met families of secondary school students in ZEP (ZEP: Priority Education Zone, which means that these schools welcome mostly socially disadvantaged pupils). By studying their dietary habits as well as their perception of their own nutrition education, we were able to note a significant social differentiation. Other results show that, in general, the parents accept the project, giving great importance to the nutrition of their children. We also noticed that the adolescents’ opinions and desires are very often taken into account in family eating choices. Moreover, the children seem to have a closer connection than their parents to the instruction of the current standards. We witnessed certain interactions between parents and children which revealed the moralizing role that some children play. This presentation will also focus, through the example of France’s PNNS (National Program for Nutrition and Health), on how a national health policy can be adapted in order to create a local public health action targeting adolescents. Finally, it will show how a given piloting team can achieve this while respecting the families’ expectations.

<b>2<sup>nd</sup> September 2010</b> Methods	<b>10:45 - 11:15</b> Calman, Derman Christopherson
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*Mazanderani, F.*

*University of Oxford*

### **DATING WITH HIV: THE INTERNET AS MORAL MEDIATOR**

The internet has become an increasingly popular technology for the initiation of romantic and sexual relationships. Based on qualitative interviews with 40 HIV positive African women living in London on their uses of the internet in relation to health, this paper explores online dating as part of broader practices of being 'healthy' while being HIV positive. Through an analysis of narratives of successful and unsuccessful online dating experiences I examine how digital technologies mediate gendered and culturally specific 'acceptable' partner-seeking practices. Of particular interest is use of the internet as a means for filtering potential partners while simultaneously enabling the protection of oneself through control over disclosure of personal information in the context of fear of stigma and rejection. Within this I focus on the tension between the pursuit of romantic and sexual relationships as an important element of being 'healthy' while living with a stigmatised sexually communicable virus. What emerges through this analysis is that, in addition to being a functional facilitator for finding new relationships, the internet is enrolled as moral mediator in the establishment of relationships that involve negotiations around being both 'at risk' from others and 'a risk' to them. By examining how the mediatory role of the internet changed as relationships developed over time and shifted to other mediums, this paper shows to what extent the use of digital technologies, alongside other technologies, such as biomedical ones, shape the relationships and experiences of people living with HIV.

<b>3<sup>rd</sup> September 2010</b> Sleep	<b>10:10 - 10:40</b> Engineering 102
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*Meadows, R.A.L., Dregan, A.*

*University of Surrey*

### **TELIC DEMANDS AND THE LIMINALITY OF SLEEP: A QUANTITATIVE INVESTIGATION**

When sleep overcomes us 'the body is no longer ecstatic, that from which I perceive and act, but a being recessed from my command and awareness. As I no longer perceive from my body, neither can I perceive to it' (Leder 1990: 58). This means that, upon waking, we cannot directly audit our sleep quality. In turn, this inability to directly audit our sleep quality raises questions as to how we infer the quality and quantity of our sleep, how we infer causes and reasons for 'poor' sleep (a hermeneutical component of any telic demand) and how we act towards the body in the hope of finding relief (a pragmatic/creative component of any telic demand).

The paper analyses data from the UK Psychiatric Morbidity Survey (PMS; 2007). This survey includes the CISR battery, which asks those who have indicated that they have a sleep problem whether or not they know the 'reason' for it. Over 800 people (26% of those with a sleep problem) do not know the 'reason' for it. Logistic regression models were fitted to explore how respondents who can give a reason differ from those who cannot.

Results suggest that age, income and social functioning all have a complex relationship with the presence of a reason. Whilst discussing these findings, we also reflect on the small portion of variance explained by the model and the need for more sophisticated testing of survey instruments.

<b>2<sup>nd</sup> September 2010</b> Lifecourse: Reproductive Health	<b>14:00 - 14:30</b> Engineering 102
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*Mellor, R., Cleland, J., Slaymaker, E.*

*London School of Hygiene & Tropical Medicine*

### **MEN'S RESPONSIBILITY IN SWITCHING TO A 'FEMALE-CONTROLLED' CONTRACEPTIVE METHOD, FROM THE COUPLE PERSPECTIVE**

Context: In the UK prevalence of switching contraceptive method is high, as is the proportion of women ambivalent about their pregnancy. Switching between methods can leave a gap in contraceptive protection and can result in unintended pregnancy; moreover switching from barrier to non-barrier methods eliminates protection from STDs.

Aim: This research examines men's responsibility for switching to a 'female-controlled' method, from the couple perspective.

Methodology: In-depth interviews were conducted with fifteen heterosexual couples, partners interviewed separately. Couples had switched method in the last year and were theoretically sampled to get a range of ages, length of relationships and methods switched between. Couples were recruited from waiting rooms of contraceptive clinics in one ethnically and economically diverse London borough.

Results: Respondents defined being responsible for contraception primarily as acting to prevent pregnancy. In terms of switching to a 'female-controlled' method, there were several acted steps: deciding to switch, researching methods, choosing a new method, obtaining the method, and using the method. Couples perspectives of men's responsibility in these steps varied. In the step choosing a new method, responsibility was spilt between women being responsible, joint responsibility (with men wanting involvement or forced into involvement) and one instance of the man being responsible. There was not always agreement within couples as to who was responsible for the switch. Responsibility was linked to women's 'bodily ownership' and justified through their being contraceptive 'knowledge holders'.

Conclusion: Men's responsibility for switching method varies and is not always in accord with the desires of their partner.

3<sup>rd</sup> September 2010

Sleep

09:35 - 10:05

Engineering 102

*Moloney, M.*

*University of North Carolina*

**THE MEDICALIZATION OF SLEEPLESSNESS AT THE LEVEL OF PATIENT-PHYSICIAN INTERACTION: A MIXED METHODS PERSPECTIVE.**

Sleeplessness – a universal experience with a variety of causes – may be increasingly re-conceptualized, diagnosed and treated, or “medicalized” as insomnia. I investigated the medicalization of sleeplessness at the level of patient-physician interaction.

Using the National Ambulatory Medical Care Survey a nationally representative dataset of U.S. physician office visits, I analyzed trends (1993-2007) in insomnia complaint, diagnoses and prescription of non-benzodiazepine sedative hypnotics [NBSHs]. To contextualize quantitative findings, I interviewed 8 primary care physicians working in a university-affiliated practice and a sub-sample of their patients prescribed NBSHs (N=27).

Over 15 years, insomnia complaints doubled from 3.2 million to 6.6 million while diagnoses grew from 870,000 to 6.5 million. NBSH prescriptions increased 30-fold from 550,000 to 16.3 million. Slope changes for these trends were positive and statistically significant.

Physicians interviewed were critical of the medicalization process, but their bias against sleep drugs was mediated by time constraints, consumerism and pre-existing prescriptions. Patients reported fears of NBSH dependence and acknowledged insomnia was not typically a medical problem, but rather a symptom, part of aging or a reaction to stress.

Disparities between self-reported attitudes (“It’s not a disease”) and behavior (“If I could take [Ambien] every night...I would.”) provide support for the medicalization hypothesis that life problems are increasingly treated with pharmacologic solutions. Additionally, prescriptions of NBSHs in the U.S. have increased exponentially over time, and are not concomitant with slower-growing complaint and diagnoses. Taken together, these qualitative and quantitative findings provide evidence of the medicalization of sleeplessness at the level of patient-physician interaction.

2<sup>nd</sup> September 2010

Experiences of Health & Illness

10:10 – 10:40

Engineering 005

*Moore, L., Britten, N., Paterson, C.*

*Peninsula Medical School*

**HAVE I GOT THE JOB? SKILLS, ATTRIBUTES AND PRESENTATION OF SELF IN SELF-MANAGEMENT FOR THE OLDER PERSON**

As part of the modernisation of the National Health Service (NHS) and in response to an increasing older population, self-management policy has presented opportunities for patients with long-term conditions to improve their health and wellbeing by becoming partners, decision-makers and active agents in their care in collaboration with professionals and lay educators. However, the ‘work’ of self-management for patients appears to be packaged in the form of essential and desirable skills, attributes and personal characteristics required in order to participate.

This paper presents early findings from a doctoral research study employing diary-interviews with older patients diagnosed with coronary heart disease and interviews with professionals in three contrasting general practices in the South West of England. The analysis is informed by a model of self-management developed from a literature review, which identified four concepts including active, responsible, efficacious and competent. It also draws on features of Grounded Theory.

Preliminary findings suggest that self-management is a complex and elusive concept for some participants. Skills and attributes may be influenced by personal circumstances, self-knowledge and health beliefs. Although personal responsibility for health is presented by NHS policy as a prerequisite for self-management, there are tensions for older people with respect to parallel responsibilities for their ‘dependents’. Moreover, although some individuals have refined skills associated with body listening, problem solving and negotiating, others employ ‘covert’ health behavior or present themselves as ‘cured’ ‘fixed’ and ‘in denial’ which appear to run counter to the ideas associated with ‘actively’ managing coronary heart disease.

3<sup>rd</sup> September 2010

Theory

11:20 - 11:50

Engineering 005

*Moreira, T.*

*Durham University*

**THE MARKET, THE LABORATORY AND THE FORUM: REGIMES OF HEALTHCARE GOVERNANCE**

The past three decades have seen enormous changes in the organisation of health care in contemporary technological societies. Most attempts to analyse these changes have been either descriptive or underpinned by theoretical perspectives that tend to overlook the role of knowledge and technology in those processes. The paper suggests that three overriding ideals have been proposed as alternatives to the clinical regime as it was established during the 19th-20th centuries. Conceived as regimes of knowledge making and technologically mediated action (Moreira, 2005), these ideals have been deployed in the transformation of health care systems as follows:

a) the market: attempts to embed principles of economic rationality and/or efficient use of resources in the shaping and delivery of health care;

b) the laboratory: reforms that emphasise the value of science, experiments and ‘evidence’ in the management of research, practice and policy;

c) the forum: the application of deliberative procedures and other forms of public consultation to health care decision making.

Using the case-studies from the United States and Britain, drawn from primary research or published literature, the paper explores how the implementation of these ideals in different contexts has had different consequences for the capacities and identities of individuals or groups involved in health care.

**2<sup>nd</sup> September 2010**

Lifecourse: Reproductive Health

**15:45 - 16:15**

Engineering 102

*Murphy, F., Philpin S.*

*Swansea University*

**EARLY MISCARRIAGE AS 'MATTER OUT OF PLACE'**

Background - Early miscarriage has been conceptualised as loss and bereavement where practitioners are urged to provide sympathetic, psychological care for women. However, the reality of women's experience is also about blood, 'dirt' and failure and this tends to be ignored in the literature.

Aim - This paper will draw on anthropological theories of transition (van Gennep, 1909) and pollution (Douglas, 1966) to argue that the miscarried foetus can be considered as 'matter out of place'.

Methods - An ethnographic approach consisting of 20 months participant observation working alongside gynaecological nurses in a United Kingdom gynaecological unit. In-depth interviews were also conducted with a purposive sample of 8 women experiencing early miscarriage and 16 health professionals.

Results - The vaginal blood loss associated with miscarriage emerged as highly significant for both women and nurses. It was observed that nurses were constantly noting and recording the amount and type of vaginal blood loss that women had. Women feared the blood loss as it signalled the end of the pregnancy. For both, there was a link between this blood loss, menstruation and elimination of bodily fluids.

Discussion - This exploration of how women were managed in a hospital setting reinforced the notion of the ambiguous nature of miscarriage, the anomalous status of the foetus and supports the position that miscarriage may be considered as atypical bereavement (Frost et al., 2007). Furthermore, an analysis is offered of the significance of the vaginal blood loss as polluting and offers insights into how nurses manage this ambiguity.

**3<sup>rd</sup> September 2010**

Gender

**10:45 - 11:15**

Calman, Kingsley Barrett

*Newlove, C.*

*Teesside University*

**BOYS DON'T CRY AND MEN DON'T GO TO THE DOCTORS: AN EXPLORATION OF GENDER AND CLASS IN MEN'S CONSTRUCTIONS OF HEALTH**

Proponents of the new "men's health movement" have tended to argue that masculinity is damaging to men's health. The key proposition of this paper is that this approach not only downplays the role of class in determining health outcomes but also presents an oversimplified version of gender relations; with concepts such as men being used interchangeably with masculinity. The paper explores issues of gender relations, class and autonomy in men's constructions of health, drawing on data collected from thirty semi-structured qualitative interviews. The sample contained men with a varied age range and all of the participants were unemployed at the time of data collection. Findings indicate that participants are aware of the structural barriers to health outcomes. However structural barriers were also understood in relation to individual choice in shaping health. Participants displayed views on gender that reflect "hegemonic masculinity" (Connell 2000, 2005); particularly asserting the role of "evolutionary" and biological explanations for gender differences in relation to health.

**2<sup>nd</sup> September 2010**

Lifecourse: Reproductive Health

**17:30 - 18:00**

Engineering 102

*Nordqvist, P.S.*

*University of Manchester*

**RISK, TRUST AND SPERM DONATIONS: LESBIAN COUPLES' REPRODUCTIVE PRACTICES IN SELF-ARRANGED DONOR CONCEPTION**

This paper aims to contribute to an understanding of the social practices embedded in the life-changing and life-shaping event of conception by exploring the reproductive practices and concerns of lesbian couples who conceive together outside reproductive health clinics, in self-arranged donor conception. Self-arranged conception is not recognised by the UK regulative framework of the Human Fertilisation and Embryology Act 2008 and compared to clinical donor conception, which now has been explored to some extent, we know almost nothing about what this route entails. Seeking to shed light on the practices, considerations and concerns embedded in these conception processes, this paper draws on a qualitative in-depth interview study including 25 lesbian couples in England and Wales. The paper explores how lesbian couples engage with the issues that arise in self-arranged conception, for example, how to negotiate the parental status of the donor and the mothers, how to manage and control sexual health and how to manage handing the fluid of donated sperm, a bodily fluid from a possible stranger. Exploring issues around risk and trust embedded in these practices, and shedding new light on the changing world of what it means to become and be family, the paper utilises the framework of 'ontological choreography' developed by Thompson (2005), as well as Douglas's (1966) and Twigg's (2000) work around bodies, dirt and disgust.



2<sup>nd</sup> September 2010

Ethics

17:30 - 18:00

Calman, Arnold Wolfendale

*O'Dwyer, M., Monaghan, L.F, Gabe, J.*

*University of Limerick*

**SEEKING RESEARCH ETHICS APPROVAL: THE EMBODIED IRRATIONALITIES OF A 'RATIONALISED' PROCESS**

Medical sociology is increasingly being regulated by Research Ethics Committees (RECs), in ways that render research(ers) more or less vulnerable. While we recognise ethics are of paramount importance through all stages of the research process, we would question whether the REC 'approval' process is as rationalised as proponents might imagine? Are there (unanticipated) embodied irrationalities associated with these bureaucratic and putatively rationalised processes?

In seeking to further sociological debate on RECs, our paper does two things. Firstly, we present an overview of the general multi-ethical dimensions of RECs remit amidst contestation and the resultant problem of uniformity in their decisions. As qualitative researchers interested in the sociology of children's health, we would question how the team efforts of RECs 'contributes to the process of acquiring and disseminating a consensus of informed morality based upon some appreciation of expertise' (Weisstub, 1998: 66). Secondly, we offer our reflexive insight into and analysis of the lead authors' personally taxing experiences of REC procedures, by cataloguing the emotional costs of engaging with formal and somewhat indeterminate bureaucratic processes. In short, our paper demonstrates that the rules of such engagement, 'which our codes and declarations embody' (Fulford et al, 2002:3), impact the researcher's affective 'lived body' in unanticipated and unwelcome ways. One issue for us, then, is that RECs should be concerned not only with safeguarding against bad researcher practice, but also with the facilitation of good practice – including their own practice of governing health-related research by and with 'vulnerable' bodies.

2<sup>nd</sup> September 2010

Methods

11:55 - 12:25

Calman, Derman Christopherson

*O'Neil, S., Kaner, EFS., May, C., Baker, R and Shucksmith, J.*

*Newcastle University*

**'I MIGHT ACQUIRE A TASTE FOR MORE SOPHISTICATED DRINKS WHEN I'M A MORE MATURE MAN...'  
EXPLORING DRINKING BELIEFS AND BEHAVIOUR AMONGST YOUNG PEOPLE IN NORTH EAST ENGLAND.**

While the overall proportion of UK young people drinking alcohol appears to have decreased, those who do drink a larger amount and more frequently. Young people aged 15- 16 rank third in Europe for the highest average level of alcohol consumption on their latest drinking day; being drunk in the last 12 months and 30 days. Regionally, 63% of 11-15 year-olds in North East England report drinking regularly compared to 11% in London. Early initiation (age 11-14) is an important precursor to later misuse; drinking alcohol can increase probability of harm (e.g. fights, drug use, regretted sexual behaviour). With this in mind, Safe, Sensible, Social identified young people as a priority group for alcohol harm and CMO guidance recommends an alcohol-free childhood.

Findings from a major systematic review suggest, given their finite resources, young drinkers are more sensitive to price changes. However, more recent analyses suggest young people may be more affected by pricing policies that affect on-trade settings (e.g. regulating prices in pubs or clubs) rather than the off-trade context (e.g. via minimum price per unit). These analyses define young people as a homogeneous group of individuals under 25 years. It is essential to explore young people's views about the influence of the commercial environment on their drinking behaviour. This project uses novel methods (in-depth interviews and Q methodology) to identify extrinsic factors (e.g. price, promotion and availability) and explore how these factors interact with intrinsic factors (e.g. role of family and social networks) in shaping drinking beliefs and behaviour. Preliminary findings from both phases are presented in this paper.

3<sup>rd</sup> September 2010

Patient & Public Involvement

10:45 - 11:15

Calman, Derman Christopherson

*Orr, L., Barbour, R.S., Elliott, L.*

*University of Dundee*

**CARER INVOLVEMENT WITH DRUG SERVICES: MAKING THE POSSIBLE, MORE PROBABLE**

Drawing on focus group discussions and in-depth interviews with informal carers, service providers and policy makers who live and work in one Scottish region, this study compared participants' accounts of carer involvement with drug services. Two main - but potentially contradictory - narratives emerged from the data - firstly, that carer involvement with drug services is achievable, necessary, and worthwhile, and, secondly, that carer involvement with drug services is difficult, optional and potentially tokenistic.

Carers, service providers and policy makers both individually and collectively recounted stories, contextualising and justifying their own and others' actions. In-vivo codes were used to organize their stories on a variety of themes - including 'walking the line'; 'the good, the bad and the ugly'; and 'hitting rock bottom.' By examining how these stories were told, what language was used and what constructs the participants appealed to, the study exposes how tensions in relation to carer involvement arise. It will be argued that, while participants' stories define and empower those telling the stories, they also frame and constrain carer involvement by reinforcing stereotypes and perpetuating stigma - perhaps even fuelling unhelpful self-fulfilling prophecies.

The multiple accounts elicited in this comparative study emphasise the challenges that exist in drug contexts when attempting to involve carers as equal partners. However, this research also reveals commonalities in the accounts provided by the three sets of participants and draws on these in order to identify circumstances in which carer involvement with drug services becomes not only possible but more probable.

**2<sup>nd</sup> September 2010**

Preventive Health

**09:35 - 10:05**

Engineering 101

*Parke, H., Seale, C.*

*Queen Mary, University of London*

### **THE PUBLIC IMAGE OF HEALTH INCENTIVES: A STUDY OF UK MEDIA**

Whilst incentives to encourage 'healthy' behaviour are not an entirely new concept, they are currently being employed in a variety of novel contexts. In this study, popular and professional media coverage of UK-based initiatives to provide (usually financial) incentives for health-related behaviour change has been explored. Media coverage exercises an important influence on the public acceptability of health policies. Searches on the Lexis database and other media archives identified 210 articles for inclusion in the study. Thematic content analysis allowed comparisons to be made between different health incentive schemes and between popular and professional media. A coding scheme was developed to identify the overall tone of articles, the arguments used in debates about health incentives, and the use of different 'sources' in the media coverage. Health incentive initiatives received rather mixed coverage in the media, reports being neither clearly supportive nor opposed to such schemes. A cash incentive to encourage pregnant women to eat more healthily was the notable exception; the only scheme to receive a majority of positive coverage. Incentive schemes targeting more stigmatised groups tended to receive more negative media coverage. 'Sources' were split into two broad interest groups; those supporting incentives (such as academics) and those against their use (such as political lobbyists). Sources in favour of incentives gained the most media coverage. The study concludes by outlining ways in which those promoting incentive schemes for recipients who might be regarded as 'undeserving' can improve the ways in which such schemes are portrayed in the media.

**2<sup>nd</sup> September 2010**

Lifecourse: Ageing, Death & Dying

**11:55 - 12:25**

Calman, Rosemary Cramp

*Philpin, S.M.*

*Swansea University*

### **MEMORIES, IDENTITY AND HOMELINESS: THE SOCIAL CONSTRUCTION OF MEALTIMES IN OLDER PEOPLE'S CARE HOMES**

Meeting older people's nutritional needs in care homes remains a serious concern (BAPEN, 2007). Whilst nutritionally important, food and drink are also imbued with social meanings and are used to express and create relationships between people. Mealtimes in care homes provide structure to the day and are fundamentally social occasions, affording opportunities for conversation and companionship. They are also important indicators of 'time, place and normality' (Pearson et al, 2003).

This paper explores how care home residents' experiences and understandings of mealtimes are influenced by their social and spatial environment and also by their personal memories, identities and histories.

The paper reports on particular findings from a qualitative study which investigated factors which influence nutritional care provided to residents in two different types of residential care settings. Data were generated through focus group interviews with relevant staff (n=15), individual interviews with care home managers (n=4), residents (n=16) and their family caregivers (n=10), observation of food preparation and meal times and documentary analysis. A steering group involving service users and informal carers informed the research process. Data were analysed using thematic analysis.

Residents' mealtime experiences were influenced by various social and environmental factors, such as the home's geographical location, physical lay-out and ambience. Mealtimes also structured the rhythms of both daily life and annual cycles in the care homes. Moreover, the shared meaning of mealtimes for residents, carers and staff was drawn from each group's socio-cultural background, family experiences and memories and engendered residents' sense of normality, community and identity.

**3<sup>rd</sup> September 2010**

Mental Health

**11:20 - 11:50**

Maths 107

*Pilgrim, D.*

*University of Central Lancashire*

### **INNOVATIONS IN MENTAL HEALTH SERVICES: LESSONS FROM TWO REALISTIC EVALUATIONS**

This paper will offer lessons derived from conducting two large realistic evaluations about mental health service innovations. The first, commissioned by the National Endowment for Science Technology and the Arts (NESTA), involved a meta-evaluation of eleven projects in England and Scotland, divided between the NHS and the third sector. The second involved evaluating three English sites deploying a pilot project about supporting young people with mental health problems, commissioned by the charity Rethink (previously the National Schizophrenia Fellowship). A brief outline of realistic evaluation is given, followed by a longer presentation of the lessons learned about mental health innovations across the two projects. In line with the methodology, these lessons are presented in terms of context-mechanism-outcome linkages. From a sociological perspective, a number of discussion points are then raised in relation to: the role of entrepreneurial 'product champions' and their supportive or constraining networks in health policy innovation; tensions between normative rule enforcement in statutory services and aspirations for voluntary support in the third sector; and the contradictions the latter are now generating about 'personalisation' and 'recovery' in current mental health policy in practice. The presentation concludes that although 'resources' are often alluded to, with some good reason, to account for why more person-centred mental healthcare is not achieved, this reductive explanation diverts us from addressing the other contradictions exposed in these service evaluations.

<b>3<sup>rd</sup> September 2010</b>	<b>10:10 - 10:40</b>
Patient & Public Involvement	Calman, Derman Christopherson

*Pollard, K., Bheenuck, S., Dalrymple, J., Evans D., Fletcher, I., Miers, M., Moule, P., Thomas, J.*

*University of the West of England*

**PRECONCEPTIONS, POWER AND POSITION: RESEARCHER REFLECTIONS ON PUBLIC INVOLVEMENT IN RESEARCH**

In the United Kingdom, the Department of Health and many funding bodies require public involvement in health and social care research. However, members of the public are still mostly engaged in research as subjects/participants, or in a limited consultative capacity. Although little has been published about researchers' attitudes, it is known that some resist greater public involvement in research, through fears articulated in terms of control and quality maintenance. Including non-professionals and non-academics as full team members invariably impacts on how research is conducted, and demands that researchers 'do' research in ways with which they are not necessarily familiar or comfortable. In particular, researchers may need to re-examine constructions of 'research' and the researcher role, and the relationship between 'expert' (professional/academic) and 'situated' (non-professional/academic) knowledge. Over the last two years, the University of the West of England, Bristol (UWE) has developed a system through which service users, carers and/or members of the public can actively contribute to the conception, design and conduct of research. This paper presents eight UWE researchers' reflections on the impact of public involvement on their role, drawing on their experience across three projects with substantial public input. These include a national evaluation for the Department of Health and a project supported by the Higher Education Innovation Fund. Key aspects of these reflections include researchers' recognition of their own preconceptions about public involvement in research; their perceptions of academic-public power relationships within the research process; and positions they have adopted with a view to optimising research outputs.

<b>3<sup>rd</sup> September 2010</b>	<b>10:45 - 11:15</b>
Mental Health	Maths 107

*Pollock, K. Coveney, C., Moore, J., Armstrong, S.*

*University of Nottingham*

**'A STICKING PLASTER ON A MORTAL WOUND': PERSPECTIVES ON MATCHING SUPPLY AND DEMAND FOR EMOTIONAL SUPPORT WITHIN A NATIONAL SUICIDE HELPLINE SERVICE**

Samaritans was established in 1953 as an 'emergency service' providing emotional support to callers experiencing despair and distress, especially where this involved suicidal thoughts and feelings. The organisation offers callers the security of an anonymous, confidential and non-judgemental setting in which to disclose and explore such feelings, and a commitment to round the clock availability, seven days a week. It is hoped that volunteer support at a critical juncture will enable individuals passing through crisis to realise alternative options to ending their lives and, consequently, reduce the incidence of suicide. However, as with other helplines, many callers fall outside the service remit or define the nature of Samaritans service and their capacity to benefit from contact, in different terms. A paradox emerges where the offer of unlimited availability and unconditional support is tempered by policies to restrict and bound callers' use and access to the service. This paper reports findings from a mixed method, two year investigation of Samaritans emotional support service. It focuses on organisational and volunteer strategies to shape caller compliance with Samaritans terms of service, and caller responses and strategies to shape this in terms of their own requirements and self-defined needs. In orienting primarily to suicidal callers, Samaritans overlooks the considerable benefits the service provides for many people who call for help in dealing with the ongoing challenges of emotionally arduous and unhappy lives. This paper contributes to a greater understanding of the role of voluntary sector helplines in promoting mental health in contemporary societies.

<b>1<sup>st</sup> September 2010</b>	<b>13:35 - 14:05</b>
Health Technologies	Calman, Kingsley Barrett

*Porter, J.*

*King's College London*

**GOLD STANDARD OR FOOL'S GOLD? MANAGING EXPECTATIONS AND CONTROVERSIAL SCIENCE - THE CASE OF INTERSPECIES STEM CELLS IN THE UK**

Using stem cells, scientists hope to discover possible treatments for degenerative diseases. The best-known example: embryonic cells are, however, problematic due to the use of human eggs. To circumvent potential problems, UK scientists in January 2006 proposed a new research method: inter-species stem cells - removing the genetic material from an animal egg and replacing it with a human cell. This new model would help researchers to overcome the limited availability of human eggs and speed up the research process. These proposals, though, were met with sensationalist headlines like "Frankenbunnies", threatened with a ban from the Department of Health, and the licensing decision was deferred to Parliament. Mobilising the scientific community, researchers went on a media offensive to combat opposition slurs of "Nazi science". After a two-year campaign, licenses were approved. Yet, unlike other classic studies in the sociology of expectations, the research never secured any funding and quickly disappeared. The whole debate raises a series of questions: why, when all the obstacles had been removed, were the scientists declined funding? Why did scientists go down this route in the first place? And why did the debate take the form that it did? Drawing on interviews with the key scientists involved, and using documentary evidence from parliamentary debates, this paper illuminates how this case study speaks to a changing management of controversial science, the emergence of differing (and competing) expectations in doing science, and the role that ethics played in (and how it was translated across) this whole drama.

<b>1<sup>st</sup> September 2010</b> Methods	<b>14:45 - 15:15</b> Engineering 102
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*Purcell, C.A.*

*University of Edinburgh*

### **TALKING TOUCH: THE CASE OF HOLISTIC MASSAGE**

Complementary and alternative health practices continue to have a significant presence in everyday life. However, sociological examinations of these practices have tailed off in recent years. Moreover, existing studies which treat these diverse practices as a cohesive group are often problematic. Instead, it is proposed that an approach examining each practice individually is more appropriate to understanding the variations and complexities in this field. The research presented here draws on the specific case of Holistic Massage. This paper is based on interviews conducted for a doctoral research with ten Holistic Massage practitioners in early 2009. The study utilised a narrative inquiry methodology – where narrative inquiry is understood as an overall orientation to research – informed by phenomenological sociology. The paper outlines the contours of what the practice of Holistic Massage actually involves, while critically reflecting on the value of the over-used term ‘holistic’ in the context of body work practices such as massage. In so doing the paper also examines the way in which touch is talked about, and the ‘enunciatory challenges’ it poses for practitioners who ‘do’ touch as a form of work. The paper concludes by reflecting on the methodological tensions inherent in talking about touch.

<b>2<sup>nd</sup> September 2010</b> Randomised Controlled Trials & Evidence-Based Medicine	<b>17:30 - 18:00</b> Calman, Kingsley Barrett
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*Reid, B.*

*Newcastle University*

### **PHYSIOTHERAPY: BETWEEN MEDICINE AND OTHER HARD PLACES**

Among sociological work on health professions, relatively little attention has been paid to physiotherapy. Nicholls and Cheek (2006) gave a fascinating account of the birth of physiotherapy in 1894 as a medically-endorsed profession for women, resulting from a confluence of discourses of sexual governance and masculine power. In contemporary times, physiotherapy remains a predominantly-female profession, occupying a sensitive social location: the ‘physio-terrorists’ of NHS-folklore are sometimes seen as embodying a denial of sensuality in healthcare – a niche filled instead by the emergence of e.g. Touch-Therapy. This project, a discourse-analysis of Evidence Based Practice (EBP), considers the ambivalent position of physiotherapy in contemporary healthcare. In a context where EBP has arguably sharpened the borders between health professions (Rycroft-Malone 2006), physiotherapy is perceived to be threatened from above (by medicine), below (osteopathy, chiropractice) and sideways (nursing, occupational therapy), and yet to have interests in common with these sources of threat. EBP literature reveals a further threat from within, where there are persistent themes of self-abasement and shame.

The analysis goes on to consider the possibilities for reformulating the socio-political basis of physiotherapy practice, simultaneously establishing similarity with and difference from other professions. One option would be to draw on Parsons’ Sick Role, with physiotherapy contributing to an institutionalised exit-strategy. But there are other possibilities that would potentially allow for a more a symbiotic relation between health professions, as opposed to the conflictual accounts which are dominant within sociology of health and illness.

<b>3<sup>rd</sup> September 2010</b> Patient & Public Involvement	<b>09:35 - 10:05</b> Calman, Derman Christopherson
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*Renedo, A., Marston, C.*

*London School of Hygiene and Tropical Medicine*

### **HEALTHCARE PROFESSIONALS’ ROLE IN CREATING ‘PARTICIPANT’ IDENTITIES: IMPLICATIONS FOR PATIENT INVOLVEMENT INITIATIVES.**

**BACKGROUND/OBJECTIVES:** For over a decade, the UK Department of Health has called for involvement of patients and the public in health care research and service development (PPI). Yet there remain multiple barriers to successful PPI, little evidence of its impact, and disagreement about exactly what role public participants should play. Professionals’ and involvees’ ideas about the role of public participants affect the processes and implementation of PPI initiatives.

In this paper, we examine discourses about PPI among healthcare professionals, and study how participants negotiate these discourses when making sense of themselves as public participants. We examine how these processes can affect how PPI works in practice.

**METHODS:** This qualitative study uses in-depth interviews with public participants and professionals involved in PPI and non-participant observation of PPI activities in Northwest London.

**RESULTS:** Professionals’ understandings of PPI contain discourses about the identity of the participant (i.e. who he/she is, how he/she should behave). These permeate relationships with participants, shaping their self-understanding and experience as participants, and crystallising in behaviours that can undermine or enhance PPI processes and outcomes.

**IMPLICATIONS:** It is vital to understand how ‘public participant’ identities are developed. We show how professionals’ representations of PPI can constrain or facilitate this identity formation. Participants make sense of their role, and feel able to influence decision-making through and against professionals’ discourses about PPI. We identify how enabling identities for PPI can be fostered in practice, and reflect on the obstacles to the development of effective PPI.

<b>1<sup>st</sup> September 2010</b> Preventive Health	<b>14:45 - 15:15</b> Engineering 101
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*Robinson, J.E., Amos, A., Ritchie, D., Greaves, L., Cunningham-Birley, S.*

*University of Liverpool*

### **EXPLORING BOUNDARIES, CONTROL AND PARENTAL HOME SMOKING**

The concept of therapeutic landscapes emphasises how individual, familial, and cultural factors as well as the physical dimensions of space and place relate not only to healing and recovery but also to the maintenance of health and wellbeing of individuals. Theories around place identification stress the emotional ties people have to a particular place, and also how an informal and private space, such as a home, can reflect shared ideas, interests and values. This paper explores how the concept of the home as a therapeutic landscape relates to reported home smoking behaviours in Scotland. The socio-political debate around smoking has emphasised the need to regulate public spaces to improve population health, yet despite an increased knowledge of the risks and harms of exposing children to secondhand smoke, people still smoke in homes where babies and children live and/ or spend time. Drawing on data from two studies conducted in Scotland in 2007 from 24 households where resident parents and carers smoke and live with children, we found that adults' home smoking behaviour often influenced the social and physical boundaries that governed and shaped everyday social life within the homes and importantly, the creation of non-smoking zones within the household did not always reduce or eliminate children's exposure to smoke. Also the strategies parents developed to 'protect' their children at times negatively impacted on the social cohesion within their homes as they exerted their power and control over shared space to dominate communal areas, effectively marginalising children and non-smokers.

<b>1<sup>st</sup> September 2010</b> Preventive Health	<b>14:10 - 14:40</b> Engineering 101
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*Rowa-Dewar, N., Amos, A., Cunningham-Burley, S.*

*University of Edinburgh*

### **DEFENDING SMOKING PARENTS; CHILDREN'S MORAL DISCOURSES ON SECOND-HAND SMOKE (SHS) IN THE HOME AND CAR**

Despite the smoke-free legislation in public places many children continue to experience high levels of second-hand smoke (SHS) exposure in their homes and cars. Children from socio-economically disadvantaged households are at particular risk as their parents are more likely to smoke and less likely to enforce smoking restrictions in the home. This paper discusses one of the key findings of a qualitative PhD study exploring 38 children and young people's views and experiences on SHS and how these interact with wider social norms in communities with contrasting socio-economic profiles.

The wider moral discourses in the media, health promotion and the academic literature surrounding smoking, particularly smoking around children, are powerfully resisted in children's accounts. Rather, children frame their parents as considerate smokers protecting others from SHS. These framings vary between communities, however. Children's contrasting experiences of and involvement in decisions around SHS exposure in the home and car appear heavily influenced by wider community norms. Specifically, the social stigma of smoking and smoking in the home and car featured more prominently in accounts of participants from the advantaged community. This paper will also discuss the how different methods, data and the social dynamics within peer groups encouraged or suppressed such accounts.

<b>1<sup>st</sup> September 2010</b> Methods	<b>14:10 - 14:40</b> Engineering 102
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*Russell, S., Barbour, R. S., Brady, M., Morris, J.*

*University of Dundee*

### **USING A MIXED METHODS DESIGN TO STUDY THE PROCESS OF REINTEGRATION FOLLOWING STROKE**

The disruptive event of a stroke can transform the lives of survivors. Subsequently, "reintegration" (re-entering society as an active social participant) can be an essential goal for stroke survivors. To explore the factors likely to influence reintegration this study utilises a theoretically informed mixed method design, aiming to explore the relationship between social, cultural and economic capital and health related quality of life (HRQoL). Possible impacts on reintegration after stroke may include the ability to maintain, or accumulate social, cultural and economic capital and how these capitals are utilised as a resource, if at all, by the long-term stroke survivor.

The design is sequential - preliminary quantitative methods in a principally qualitative study. The first phase, a postal questionnaire, will furnish a sampling pool for the following phase, in-depth interviews. Within the survey each respondent has a score for economic, social and cultural capital as well as HRQoL. Respondent profiles will inform selection of interviewees to illuminate the ways in which different types of capital are linked. Preliminary analysis has identified some interesting respondent profiles, suggesting, for example, that strong bonding networks are not necessarily associated with high social support or HQoL scores. Such a sampling method not only facilitates exploration of the mechanisms that link economic, social and cultural capital and HQoL but also provides opportunities to explore such anomalous findings.

Such a sequential design is an underused approach to mixing methods. Therefore this paper will outline both the challenges and benefits of a theoretically informed mixed methods design.

**2<sup>nd</sup> September 2010**

Health Service Delivery & Organisation

**17:30 - 18:00**

Calman, Ken Wade

*Sandall, J. Rance, S. Mackintosh, N. McCourt, C. Rayment, J.*

*King's College, London*

### **DOING PATIENT SAFETY' IN MATERNAL HEALTH CARE**

The increasing focus on patient safety in health policy is accompanied by recent debates articulating the contribution of sociological approaches to 'safety' in healthcare, following a major focus on 'risk' in the past decade. Maternity is a 'high-stake' clinical setting, identified as a priority in a number of patient safety policy initiatives in the UK and internationally by the Institute for Health Improvement and WHO. The environment is undergoing substantial and rapid reconfiguration in service delivery, particularly involving change in workforce roles and responsibilities and a changing primary-secondary care interface. A key issue in distributed care systems is how 'safety' is perceived and enacted at a frontline and organisational level.

To explore these questions, we draw on empirical data from case studies within a programme of work at King's Patient Safety Research Centre looking at organisational aspects of safety in maternal health care in England using ethnographic methods.

Drawing on Vaughan's work on the 'dark side of organisations', we focus on multiple ontologies in the 'doing of patient safety' and on the question of which practices of 'doing safety' are being enacted by service users and professionals, and what the consequences may be for service users, providers and organisations. In particular, we focus on the role of service users contribution to safety. Within the debates on the value of a sociological perspective in patient safety research, we argue that a realistic analysis of healthcare must reflexively manage its social and professional, cultural and political, scientific and technical facets.

**2<sup>nd</sup> September 2010**

Health Service Delivery & Organisation

**14:00 - 14:30**

Calman, Ken Wade

*Sanders, C., Rogers, A., Bowen, R.*

*University of Manchester*

### **COHERENCE AND PRACTICE IN THE IMPLEMENTATION OF TELEHEALTH: A STUDY OF TRIAL PARTICIPANTS AND NON-PARTICIPANTS**

Coherence is a key component of implementing, embedding and integrating practices according to normalization process theory (NPT, May and Finch, 2009). In this paper, we draw upon NPT to examine how telehealth (TH) interventions make sense or fail to make sense for trial participants and people declining the trial. We also used a longitudinal case study approach to examine how the technology worked in practice for those entering the trial. Qualitative interviews were combined with observation for 58 people who were purposively sampled from 3 trial sites (East London, Kent and Cornwall); including people with diabetes, heart failure, COPD or social care needs. Semi-structured interviews were also conducted with 19 people who declined to take part in the trial. Interviews were recorded and transcribed, and data organised with aid of Atlas.ti. Observational field notes were made and explored alongside interview data to elicit key themes within narrative and situational contexts. Whilst policy assumes coherence regarding workability and benefits of these interventions, the views and experiences of recipients and potential recipients in this study often demonstrated a high degree of uncertainty. Interventions were sometimes presented as threatening identity, independence and existing management. Lack of coherence resulted in some people declining or withdrawing from the trial. However, amongst trial participants, uncertainty was in most cases settled over time and the technology embedded into routine practice. Consistent with NPT, the dynamics of establishing coherence (or failing to) were somewhat contingent upon participative activities and organisational factors that were context specific.

**2<sup>nd</sup> September 2010**

Health Service Delivery & Organisation

**15:10 - 15:40**

Calman, Ken Wade

*Sanders, T., Ong, P., Foster, N.*

*Keele University*

### **IMPLEMENTATION OF A NEW SYSTEM FOR ASSESSMENT AND MANAGEMENT OF BACK PAIN PATIENTS: THE ROLE OF COHERENCE**

Health care interventions aimed at changing the behaviour of clinicians have had limited success. Behaviour change may not solely depend on demonstrating to clinicians the proven effectiveness of a clinical intervention; contextual as well as occupational and professional factors, such as doctors' desire to retain their autonomy over clinical decision-making may be critical to any attempts at introducing innovations in health care. We report findings from a qualitative interview study of GPs' attitudes towards the use of a new system for the management and assessment of back pain, to examine the dynamics of implementation. This paper highlights some of the contextual factors affecting the implementation of a healthcare intervention in general practice; including such issues as organisational, inter-personal and practice-based obstacles that have received limited research attention. In particular, we examine the process of 'sense-making' by GPs and how the acceptance of a social practice, in our case the collective adoption of a new system of assessment and management, becomes defined as meaningful (or 'coherent').

Conclusion: Clinicians are frequently divided between the demands of their organisation in the expectation that they follow the best practice recommendations and by an occupational desire to draw on their own clinical expertise. However, there is a third possibility with neither evidence-based guidelines nor clinical judgement necessarily playing a dominant part; instead 'routines' underpin daily clinical work and potentially present a significant obstacle to implementation. The implications for the implementation of health care interventions are discussed.

**2<sup>nd</sup> September 2010**

Ethics

**16:20 - 16:50**

Calman, Arnold Wolfendale

*Sasaki, K., Reed, J., Bell, D.*

*Chelsea and Westminster Hospital*

**IS E-HEALTH OUR HOPE FOR THE FUTURE? PUBLIC UNDERSTANDING OF THE DEVELOPMENT OF ELECTRONIC MEDICAL RECORDS IN THE UK**

This presentation demonstrates the social, political, and ethical implications of the current NHS policy to develop electronic patient records. The anticipated benefits of this policy include enhancing the quality of medical services and of research. However, this development also raises ethical and political questions with regard to citizens' rights over their own medical data, namely the matter of 'informed consent' in medicine. Who can access a computer-based personal medical record for that patient's medical treatment? On what terms and in what ways will the data extracted from the e-database and then anonymised be used for medical research? Furthermore, questions have been raised regarding the security of the e-database, and its socio-political implications in relation to the development of other databases that hold personal information (e.g. Facebook, Oyster cards, Credit cards). In view of this, we consider in what ways and on what grounds these social, political and ethical questions have so far been articulated. This presentation argues that the issues arising from this policy encompass a range of important socio-political, socio-medical and bioethical contexts in the UK.

**3<sup>rd</sup> September 2010**

Genetics & Experiences of Health & Illness

**09:35 - 10:05**

Engineering 101

*Saukko, P.*

*Loughborough University*

**FROM PSYCHOLOGICAL BELIEFS TO SOCIOLOGICAL DYNAMICS: THE CASE OF PREVENTIVE GENETICS**

Health psychological research has focused on variables, such as causal beliefs, that are suggested to mediate outcomes in, for example, preventive genetics. So, the question has been whether understanding lifestyle-related diseases as genetic would motivate or discourage healthy habits, and this research approach has also been adopted in qualitative sociological research. This presentation argues for moving from examining causal variables--frequently associated with mental states, such as beliefs--to exploring "dynamics" generated by the interaction between diverse elements that shape outcomes. Drawing on actor-network-theory the elements producing the dynamics may include understandings, technologies, treatments, embodied sensations, interpersonal support and social structures. The presentation discusses how the notion of dynamics helps to make sense of a qualitative follow-up study on individuals at risk of heart disease, who participated in a family history trial. In this study positive family history could discourage, motivate or have no bearing on preventive actions depending on the broader dynamic. The focus on dynamics not only helps to break away from an individualistic focus on beliefs but also undoes the unproductive juxtaposition of individual and social determinants. It helps to ascertain how particular elements, such as new technologies or social circumstances, may be relevant in particular situations but not in others. Thus, the approach does justice to the diversity and complexity embedded in preventive health that cannot be captured by linear, predictive models. It would also be particularly lamentable if social scientists were stuck with linear predictive models in genetics/genomics, where natural scientists are moving towards comprehending complex interactions.

**1<sup>st</sup> September 2010**

Inequalities

**13:00 - 14:05**

Calman, Arnold Wolfendale

*Scambler, G.N.*

*University College, London*

**'GIVE CLASS A CHANCE': RECOVERING MARX FOR HEALTH INEQUALITIES RESEARCH**

It is argued that the sociology of health inequalities lacks ambition, and that this is related to its neglect of classic macro-sociological theory. A brief account is given of a critical realist-based neo-Marxist approach focusing on: the contradictions of capitalism; the potential for crises of legitimation; a new class/command dynamic; and a culture-ideology of consumption. A summary is then given of the recent WHO Commission on the 'Social Determinants of Health' and of the 'Marmot Review'. The earlier Marxist perspective is then used: (1) to offer a sympathetic but radical critique of these reports; (2) to outline a genuinely sociological theory of health inequalities; and (3) to argue the case for further extension of this theory to provide for a global rather than national reach. The final paragraphs revisit the longstanding but largely dormant debate between 'reformists' and 'revolutionaries' to commend an approach and agenda for change.

<b>1<sup>st</sup> September 2010</b>	<b>14:45 - 15:15</b>
Lifecourse: Chronic Conditions	Calman, Rosemary Cramp

*Scambler, S., Newton, P.*

*King's College London*

**AN ANALYSIS OF THE EFFECTS OF LONG-TERM ILLNESS ON CAPITAL ACCUMULATION AND TRANSACTIONS**

The work of Pierre Bourdieu uses the concepts of field, habitus, and capital accumulation to show the processes of interaction between individual agency and structure. This paper uses the work of Bourdieu and the concept of transaction, to chart the impact on the lifeworld of long-term illness taking as an example the field of Batten disease which is a rare, neurodegenerative metabolic disease resulting in profound multiple disability and a limited life expectancy. Data from qualitative interviews with families of children and young adults with Batten disease are used to illustrate the devaluation and de-legitimation of VARIOUS forms of capital upon entry into the biologically determined, and biomedically policed, field of Batten disease. The ability of families within this field to accumulate and transact with legitimated capital is explored alongside the development of a new, instrumental and temporal form of 'personal' capital specific to the field. The paper concludes with some thoughts on how theoretically informed analysis of this kind can give us tools to better understand the multi-layered implications of long-term illness on families.

<b>1<sup>st</sup> September 2010</b>	<b>14:45 - 15:15</b>
Health Technologies	Calman, Kingsley Barrett

*Scamell, M.*

*University of Kent*

**MIDWIVES - AGENTS IN THE INTENSIFICATION OF THE MEDICAL CONTROL OF BIRTH? AN ETHNOGRAPHIC ANALYSIS OF BIRTH PERFORMANCE IN THE UK**

Why, despite both international and national policy initiatives aimed at curbing the routine medicalisation of birth, does birth continue to be managed within a pathological model of care in the UK? Furthermore, why, when midwives - the purported experts of normal birth - are the most senior practitioners present at the majority of births in this country, is our normal birth rate still on the decline, while our Caesarean Section rate continues to rise?

This paper assumes that the unnecessary medicalisation of birth is a form of political and physical violence against women and sets out to interrogate the role midwives take in this process. Ethnographic data, taken from a three year, ESRC funded PhD investigation into of midwifery talk and practice in relation to risk, will be presented to examine midwifery agency. The empirical evidence, which was collected while working and talking to midwives (n34) practicing in labour care settings in the South East of England, will be used to question the assumption that the midwifery commitment to normality operates to confine the discourse of risk by restricting medical intervention within the performance of birth.

The question this paper aims to address is: Are midwives agents in the intensification of the medical control of birth?

<b>2<sup>nd</sup> September 2010</b>	<b>09:00 - 09:30</b>
Ethnicity & Migration	Maths 107

*Scammell, J., Olumide, G.*

*Bournemouth University*

**WHITENESS AS A SOURCE OF POWER IN THE RECONSTRUCTION OF RACISM WITHIN EVERYDAY NURSING PRACTICE.**

This paper will present selected findings from an investigation of Internationally Recruited Nurse mentor and White student encounters in one nurse education department in England. The research aim was to analyse mentorship relationships, focusing on examples of interaction in which perceptions of racialised difference are in play. Whilst there is an increasing body of evidence that racism occurs, much less is known about how it gets constructed and reconstructed on a daily basis.

The research approach draws upon the principles of qualitative ethnography. Data were collected through focus groups, semi-structured interviews, participant observation and documentary analysis. Using purposive sampling, 10 Internationally Recruited Nurses, 25 nursing students, 2 university lecturers and 5 placement-based staff development nurses participated.

The findings revealed that essentialist constructions of different 'cultures' were used not only to explain and justify differences, but often to portray these as inferior. The reality of racism (that is to say attributions of behaviour to racial difference) was ignored or denied, indicating a failure of nurse education. Whiteness as a source of power was shown to be influential in the reconstruction of racism within everyday nursing practice. There are few studies which show the micro processes through which institutional racism is performed through small and frequently repeated acts. As such this study contributes to a furthering of understanding of the term 'unwitting', which is often found in Government reports and clouds knowledge of how institutional racism actually operates. Without this understanding, eliminating institutional racism within the NHS cannot successfully progress.



**2<sup>nd</sup> September 2010**

Lay-professional interface

**11:20 - 11:50**

Calman, Kingsley Barrett

*Schoeb, V., Staffoni, L., Parry, R., Pilnick, A.*

*University of Applied Sciences, Western Switzerland*

### **GOAL SETTING IN MUSCULOSKELETAL PHYSIOTHERAPY: A CONVERSATION ANALYTIC APPROACH**

**Introduction:** Physiotherapists' task is to help maintain or improve patients' functional abilities. Like many other health professionals, physiotherapists are guided by standards of practice recommending including patients in decisions regarding their health. Goal setting is seen as a key moment to involve patients. The aim of this paper is to explore how physiotherapists and patients with musculoskeletal problems initiate the goal setting process in an outpatient setting.

**Methods:** 40 interactions between patients and physiotherapists are videotaped and analysed using conversation analysis. This qualitative research method provides insight into the way participants accomplish activities and how they produce actions and make sense of the other's actions. Two different settings are selected: private practices and hospital-based outpatient clinics. The first three to five sessions are recorded, sequences relevant to the research question selected, transcribed and analysed.

**Results:** 13 sequences are found where physiotherapists initiate formally the goal setting sequence, whereas in other sequences goal setting activities are initiated by patients or picked up by physiotherapists during patients' narratives. Direct questions regarding expectations can create interactional difficulties, especially if it is unrelated to previously discussed topics. Patients, however, expand on their responses in order to provide more details or to explain their functional capabilities.

**Conclusion:** The goal setting activity in physiotherapy can be initiated by therapists or made explicit by patients. Any appreciation by physiotherapists to the proposed patients' goals is rare in our data, and negotiation does not take place. This empirical study might contribute to formulate standards appropriate for physiotherapy practice.

**2<sup>nd</sup> September 2010**

Ethics

**15:45 - 16:15**

Calman, Arnold Wolfendale

*Seale, C.*

*Centre for Health Sciences*

### **MASS MEDIA REPORTING OF RESEARCH ON END-OF-LIFE DECISIONS**

Assisted dying is a major pre-occupation of mass media, journalists and politicians and periodic efforts are made in the UK to enable legalisation. Cases involving 'mercy killing' by relatives, journeys to Switzerland for assisted death, and medical assistance with dying all receive a great deal of publicity, so that it has become difficult to do research on end-of-life care without the results being interpreted as saying something about these issues. I will report on the media treatment of two surveys of end-of-life decisions in the UK, reflecting on what this tells us about how journalists report statistics derived from social scientific studies and what we can learn about the extent to which authors of research studies bear responsibility for the wider reception of their work. The case study draws on analysis of the content of media reports in newspapers and the internet, and emails and other written communications such as press releases lying behind the reporting. The ways in which particular phrases and statistical presentations in the original research reports were transformed so that in some cases they produced media effects that were different (and usually more sensationalised) than the original versions will be traced. The impact of this in public debates about ethical issues and legislative and health care reform will be shown. In a broader sense, the study contributes to a growing body of sociological knowledge about the media 'framing' of health and ethical issues.

**2<sup>nd</sup> September 2010**

Randomised Controlled Trials & Evidence-Based Medicine

**16:55 - 17:25**

Calman, Kingsley Barrett

*Segar, J.*

*University of Manchester*

### **COMPLEMENTARY AND ALTERNATIVE MEDICINE: EXPLORING THE GAP BETWEEN EVIDENCE AND USAGE**

Debates over the efficacy of complementary and alternative medicine (CAM) are highly polarised and have received much publicity of late. While 'believers' in CAM campaign for its integration into the NHS, 'sceptics' call for the withdrawal of any public funding for such services. These debates take place in the context of a steady rise in CAM usage both in the UK and abroad.

Critics of CAM often point to the lack of scientific evidence demonstrating its efficacy. In particular the lack of evidence gathered by means of randomised controlled trials is often used to make the claim that CAM is no more effective than placebo. This paper examines some of the debates surrounding the use of evidence based medicine to assess the efficacy of CAM. It also explores a number of issues pertaining to CAM and the placebo response including the moral questions surrounding the knowing use of placebo as therapy.

The rest of the paper presents material from a qualitative study on the understandings of CAM efficacy. The material shows that CAM therapists and patients do not reflect the polarities evident in the public debate in their own understanding and usage of CAM. Rather they are pragmatic pluralists with clear ideas about when CAM treatment is appropriate. They have an understanding of evidence based medicine and often have sophisticated insights into the placebo response.

The paper concludes with a brief discussion of the implication of these findings for future work in the growing field of CAM research.

<b>2<sup>nd</sup> September 2010</b> Ethnicity & Migration	<b>10:45 - 11:15</b> Maths 107
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*Sim, J., Grieg, Y., Gorman, D., Katikireddi, V., Ulanika, A.*

*NHS Lothian*

**MIGRATION, MATERNITY CARE AND THE CONCEPTUALISATION OF CULTURE IN 'CULTURAL COMPETENCE'**

Sociologists have contributed distinctively to research on ethnicity, migration and maternal health, including explorations of how racism and stereotyping play out in practice through pregnancy and childbirth (Bowler, 1993); and providing a theoretically-informed critique of how cultural childbirth practices and 'traditions' are constructed as British health services strive for cultural competence (Culley, 2006; Bourdieu, 1990). In recent decades, however, pregnancy has increasingly medicalised across the globe, but in different ways in different places, and the consequences of this for migrant users and health services providers in the UK have received relatively little sociological attention.

This paper will use findings from three linked qualitative research studies with migrant women and maternity care staff from Lothian, Scotland, to argue that, for many migrant women, conflicts arising from expectations between pregnancy care in the UK and their countries of origin cannot be mapped onto differences between lay and professional perspectives, where lay perspectives are equated with 'traditional' practices. Rather, such conflicts are often rooted in differences in medical cultures. The paper will argue that sociological insights into patients as active agents in increasingly medicalised worlds (Williams and Calnan, 1996) have much to contribute to debates about cultural competence, and that the concept of 'culture' be broadened to encompass recognition of the global diversity of medical cultures and practices. It will examine the consequences of the ways in which highly globalised networks are drawn into women's attempts at negotiating the care they want; and how migration can bring in its wake specific challenges to contemporary medical authority.

<b>2<sup>nd</sup> September 2010</b> Cancer	<b>14:35 - 15:05</b> Engineering 101
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*Sime, C., Hunt K, Buston K*

*Medical Research Council, University of Glasgow*

**WHEN THEY CALL ME MRS I SAY 'NOT MRS, MR.' A COMPARISON OF MEN AND WOMEN'S EXPERIENCES OF HAVING BREAST CANCER.**

Breast cancer in men is rare and under researched, particularly in relation to men's experiences of the disease. To date, no studies have compared men's and women's experiences of having breast cancer.

This paper describes a primary analysis of the healthcare experiences of men with breast cancer, and, through secondary analysis of data on women collected using the same methods, the similarities and differences between men's and women's experiences. Participants were 50 years or older and sampled throughout the UK.

The findings suggest that men felt that a lack of clinical research on men limits the therapeutic options available to them. They also felt their presence at breast cancer clinics drew unwanted or insensitive attention from both patients and staff. Most men reported contact with breast care nurses during treatment and few searched for additional information following diagnosis. Unlike the women, who reported a wealth of sources of information, the men struggled to find anything that was appropriate and felt alienated by leaflets advising them about soft bras and gynaecological side effects of hormonal treatment.

The men said that most of their support came from their close family, although some would have liked to attend support groups or meet other men who had had breast cancer to compare experiences. However few were offered, or felt able, to use these alternative means of support. The men appeared to adopt a traditional, stoical approach to their illness to maintain their masculinity and identity within the feminised culture of the breast cancer environment.

<b>1<sup>st</sup> September 2010</b> Preventive Health	<b>13:35 - 14:05</b> Engineering 101
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*Skafida, V.*

*University of Edinburgh*

**MUMMY KNOWS BEST: ASSESSING THE IMPACT OF PARENTAL KNOWLEDGE OF HEALTHY EATING ON THEIR CHILDREN'S DIET**

UK health policy aiming to improve children's nutrition relies heavily on informing and educating parents about the importance of healthy eating. This paper assesses whether differences in parental 'nutrition knowledge' actually explain differences in toddlers' diets in Scotland when controlling for socio-economic confounders. It also explores the different sources of eating advice which parents access and evaluates their relative significance in explaining children's nutritional patterns. The research employed binary logistic regression models using data from the Growing Up in Scotland longitudinal survey.

Results show that children of parents who claimed to know more about cooking and healthy eating were significantly more likely to have a healthier diet (i.e. more fruits and vegetables, fewer crisps, sweets, fizzy drinks). This effect was significant even after controlling for the effects of household income, maternal education and social class. Having sought for advice from other mothers, family and friends, or the internet was associated with significantly better dietary outcomes for children.

Paradoxically, having sought for advice from health professionals, such as GPs, midwives or health visitors, did not seem to significantly predict dietary differences. On closer inspection, parents who consulted other sources for advice were better off in terms of education, class and income, while parents who consulted health professionals were more likely to be disadvantaged. The results suggest that, although health professionals encourage healthy eating, the parents most likely to ask for their advice are at the outset more disadvantaged and less likely to have children with optimal diets in the first place.

2<sup>nd</sup> September 2010

Cancer

16:20 - 16:50

Engineering 101

*Smith, E., Hilton, S., Hunt, K.*

*University of Glasgow*

### **TEENAGE GIRLS' PERCEPTIONS OF THE HPV VACCINE AND CERVICAL CANCER AWARENESS: A FOCUS GROUP STUDY**

In September 2008, the Human Papillomavirus (HPV) vaccine, Cervarix, was introduced into the routine vaccination programme in the UK for school girls aged between 12 and 18 years. The vaccine has the potential to prevent 70% of cervical cancer, but will not eliminate the risk of cervical cancer so screening for it will still be necessary. The Health Scotland awareness campaign accompanying the launch of the HPV vaccination programme featured teenage girls speaking candidly about getting the vaccine to prevent cervical cancer. Similarly the English Department of Health campaign depicted teenage girls with the tagline 'arm against cancer'. The introduction of the HPV programme coincided with the diagnosis with, and death from, cervical cancer of the television star Jade Goody. We conducted 18 focus groups (Scotland n=9, England n=9) with girls aged between 12 and 17 years from various socioeconomic backgrounds to explore their views on the HPV awareness campaigns, understandings surrounding HPV infection, HPV vaccination, cervical screening and to investigate whether Goody's illness featured in their accounts. Participants were recruited through newspaper advertisements, community groups and snowballing. We found that girls understood the vaccine was to protect them from cervical cancer. However, they were not knowledgeable about HPV, that it was a sexually transmitted virus, how HPV infection could develop into cancer, and the importance of future cervical screening amongst women who had been vaccinated. Many recalled the media adverts about the HPV vaccination, but not the official information leaflets, and most were aware of Jade Goody's cervical cancer.

2<sup>nd</sup> September 2010

Cancer

14:00 - 14:30

Engineering 101

*Solbjør, M., Skolbekken, J-A., Sætнан, A.R., Hagen, A.I., Forsmo, S.*

*Norwegian University of Science & Technology*

### **MAMMOGRAPHY SCREENING AND TRUST: THE CASE OF INTERVAL BREAST CANCER**

Women who are invited to public mammography screening participate to a large extent. Though women are aware of potential flaws of mammography screening, they trust it to save them from serious cancer. In this paper we investigate what happens with trust in mammography screening for those who experience the occurrence of interval cancer. Interval cancer is cancer detected in-between screening rounds among participants in a screening programme. In the Norwegian Mammography Programme, about two out of 1000 screened women are diagnosed with interval cancer. We conducted qualitative individual interviews with 26 women who had interval breast cancer.

Our preliminary analyses show different ways of adjusting trust to the interval cancer diagnosis. While some women continue to trust mammography screening, others experience distrust and doubts towards different parts of the screening programme. Trusting is explained in terms of their own experiences being exceptions to the rule, interpreting their own situation as independent of the screening. Others have lost trust in mammography screening. They feel that mammography screening has provided false safety, and find it frightening that symptoms can be overlooked.

Paradoxically, the women who present themselves as having lost trust in mammography screening say that they will continue to participate in the screening programme. We ask why these women want mammography screening to continue when they have disclosed it as providing a false security. Maybe it is simply not an acceptable option to envision ourselves as in a state of total uncertainty?

2<sup>nd</sup> September 2010

Embodiment & Emotion

15:45 - 16:15

Calman, Derman Christopherson

*Sommerbakk, R., Tjora, A.*

*Norwegian University of Science and Technology*

### **CARING FOR THE DYING: NURSES' EXPERIENCES, RESPONSES, AND PREPARATIONS**

Nurses' intense emotional experience of caring for dying patients is still an under-researched area in Norwegian medical sociology. While dealing with patients and their families who express emotions ranging from anger, sorrow, depression and denial, nurses need to handle their own emotional responses. On basis of semi-structured interviews with ten nurses in one palliative and one medical ward, this paper investigates nurses' reflection on emotional aspects of caring for the dying as well as coping mechanisms they apply to deal with this challenging aspect of their work. Additional interviews were conducted with two teachers at two different schools of nursing to examine how the educational institutions prepare nurses for working with dying patients. The findings suggest that although there has been an increased focus on these issues in schools of nursing the past twenty years, it is still a challenge to prepare nurse students adequately for the actual experience of death that they will be confronted with in hospitals, and further; that a more detailed elaboration of how nurses experience situations of patients dying is needed to develop better coping strategies.

<b>1<sup>st</sup> September 2010</b>	<b>13:35 - 14:05</b>
Health Service Delivery & Organisation	Calman, Ken Wade

*Staniland, K.M., Dingwall, R.*

*University of Salford*

### **CLINICAL GOVERNANCE: QUALITY AND CEREMONY IN ENGLISH NHS HOSPITALS**

The medical sociological study of hospitals as organizations has declined significantly in the last thirty years. As Davies (2003) has noted, however, hospitals have changed a great deal and, instead of constantly recycling classic literature, research is urgently needed to analyse their contemporary forms. In response, there has been a sustained attempt to promote new connections between organisational studies and medical sociology, and reinvigorate studies of the settings in which health care is delivered (Currie, 2007). This paper draws on that synthesis. It begins by reviewing recent NHS quality initiatives, with particular focus on clinical governance and the impact of ideas, such as knowledge management, drawn from organizational studies. This social movement is then re-examined through the sociological frame of 'new institutionalism' in an ethnographic study of a large English general hospital rated as a leader in the field. Is clinical governance promoting excellence, imposing control, or simply producing a symbolic image of the organization that reflects changing environmental notions of legitimacy (Meyer & Rowan, 1977)? Although this analysis shows that the outcomes are primarily symbolic, with the clinical governance system failing either to promote excellence or control everyday practice and standards of care, it also explains why ceremonial success is of real value to the hospital. In doing so, it contributes to understanding the system failures represented at Mid-Staffordshire NHS Foundation Trust, where a hospital, also highly rated for its financial and quality management, was found to have delivered consistently unacceptable standards of patient care (Department of Health, 2010).

<b>2<sup>nd</sup> September 2010</b>	<b>09:00 - 09:30</b>
Health Service Delivery & Organisation	Calman, Ken Wade

*Stevenson, F.A.*

*University College London Medical School*

### **PROFESSIONAL ROLES IN CONSULTATIONS CONDUCTED IN MORE THAN ONE LANGUAGE**

Perceptions of professional role are likely to affect the way professionals describe their role as well as interactions between them. This paper focuses on consultations in a pharmacy in which the pharmacy assistant acted as an interpreter for both the pharmacist and the customer. Acting in this way has the potential to alter the traditional hierarchical dynamic between pharmacists and pharmacy assistants.

Twelve video recorded consultations and four focus groups, two conducted with pharmacists and two with pharmacy assistants, are used in order to consider perceptions of professional role and how roles are enacted in consultations.

The role presented by pharmacists in focus groups is one in which information is given to customers and customer understanding is checked. Pharmacy assistants are portrayed as ideally working to support the pharmacist's objectives. In their focus groups pharmacy assistants reported adopting a subordinate, passive role in order to assist the pharmacist. Video recordings of consultations however suggest that in practice pharmacy assistants do not always act as a passive interpreter, but rather adopt a more active role in which advice may be given directly to customers. Thus unsurprisingly the roles observed in recorded consultations differed from the 'ideals' presented in focus groups.

The paper argues that the value of the different data sources is not to establish the 'reality' of interactions in pharmacy settings, but rather that by focusing on points of difference we are able to present an account which more accurately reflects the complexity of interactions in a pharmacy setting.

<b>2<sup>nd</sup> September 2010</b>	<b>09:00 - 09:30</b>
Individual, Collective & Global Risk	Calman, Arnold Wolfendale

*Stjerna, M-L. Olin Lauritzen, S.*

*Stockholm University*

### **LIVING WITH RISK: FOCUS GROUPS INTERVIEWS WITH PARENTS OF CHILDREN WITH A FOOD ALLERGY**

Being a parent of a child with chronic illness can be difficult in various ways. In this paper we address the case of food allergy. It is well known that parents of children with this condition experience anxiety due to the constant vigilance and the daily management that is necessary to cope with this condition. In addition, some of these children run the risk of having a severe anaphylactic allergic shock, which could ultimately lead to death, when confronted with 'dangerous' foodstuff. Further, food allergy is an area which is characterized by medical uncertainty. All together this amounts to complex everyday decisions and a stressful life for families with food allergic children.

Of particular interest is how food and eating, which is part of everyday life, becomes associated with risk. To explore this issue, a focus group study was carried out with parents of children, who were diagnosed with food allergy at a children's hospital in Stockholm. The analysis focuses on three major themes; the parents understanding of the allergic condition, the environment as risk as well as a safeguard, and the parents' management of the children's food allergy - all related to the more general issue of how parents understand risk as related to food allergy. We will also discuss some methodological questions concerning the analysis of focus group material, in our case how shared understandings of risk emerge in the interaction between parents in the focus group interviews.

**2<sup>nd</sup> September 2010**

Lay-professional interface

**09:35 - 10:05**

Calman, Kingsley Barrett

*Stokken, R., Barstad, J.*

*Helse Sunnmøre*

### **CHALK AND CHEESE OR TWO PEAS IN A POD, ON THE RELATION BETWEEN SELF-HELP AND PATIENT EDUCATION IN NORWAY**

Helping people to care for themselves is a natural part of Norwegian Health Policy. Self-care has gained strong interest and support from the government, and the idea is for instance embedded into both the Patients' Rights Act and the Special Care Act.

The Norwegian approach to self-care has pushed patient educative initiatives in direction of self-care initiatives, and away from being patient schools aiming at compliance. This development makes the distance between self-help and patient education smaller in Norway than in many other countries. At the same time it also blurs what kind of activity that is to be considered as patient education, and what to consider as self-help. This pose challenges to both hospitals and self help clearinghouses.

To look into the commonalities among, and differences between, self-help and patient education, we take on a theoretically informed empirical approach where we investigate four projects: a preoperative information day at a hospital, an online self-management programme, a professionally led self-help group for obese and a 12-step initiative. All initiatives are examined from the perspective of leaders/mentors/seniors.

We approach these initiatives as educative initiatives, and turn to a three dimensional view of learning that see learning as change of cognitive, psychodynamic and social processes. Through this, we point at processes that are at work in the four initiatives, and deduct features that distinguish between self-help and patient education in a Norwegian context.

**2<sup>nd</sup> September 2010**

Mental Health

**15:10 - 15:40**

Maths 107

*Sweeting, H., Hunt, K., Bhaskar, A*

*Medical Research Council*

### **IS MATERIALISM BAD FOR YOUNG PEOPLE'S MENTAL HEALTH?**

It has been suggested that certain aspects of modern Western culture are hazardous for mental health. Studies suggest materialistic values are related to lowered well-being and life satisfaction; the commercialisation of childhood has been associated with reduced well-being and behavioural problems. Very few such studies have been conducted in the UK. We examine how materialism is associated with well-being and anger in contemporary Scottish teenagers

Data, obtained early in 2010, via a schools-based self-completion survey of ~2,800 Scottish 12-14 year olds, included a series of items representing consumer involvement and a list of material possessions (e.g. 'Xbox 360, PS3 or Wii', 'ipod touch or iphone'). Analyses to date suggest four consumer involvement factors: dissatisfaction (e.g. 'feel like other kids have more stuff than I do'), image awareness ('like clothes with popular labels'), consumer orientation ('usually have something in mind that I want to buy or get') and anti-consumerism ('don't mind what kind of car my family has'). Among both males and females, and after adjustment for age group and family affluence, number of material possessions was unrelated to well-being (represented by the 12-item General Health Questionnaire and Rosenberg Self-esteem scale), but positively associated with anger. The consumer involvement factor 'dissatisfaction' was associated with poorer well-being and greater anger, and 'anti-consumerism' with higher self-esteem. Greater 'image awareness' was associated with better well-being among males, but poorer well-being and greater anger among females. Results, including this gender difference, will be discussed in relation to more general societal concerns about young people's well-being.

**1<sup>st</sup> September 2010**

Health Service Delivery & Organisation

**14:45 - 15:15**

Calman, Ken Wade

*Tarrant, C.C., Dixon-Woods, M.*

*University of Leicester*

### **REGULATING DOCTORS: MOTIVES AND TRUST**

We aimed to explore the meaning of public trust in doctors, and the relationship between the regulation of the medical profession, trust and confidence, through interviews with senior stakeholders in the field.

Semi-structured telephone interviews were conducted with 14 stakeholders including members of the GMC, doctors, patient representatives, members of regulatory agencies, policy-makers and social scientists.

Participants attributed recent changes in regulatory approaches primarily to recent medical scandals, and all agreed that changes were needed. However, there was a shared concern that external regulation that was too preoccupied with demonstrating compliance with objective performance standards would undermine public trust in doctors, through a shift in attributions of motive. Trust in doctors may be undermined by beliefs that doctors' behaviour will be driven by the need to meet standards and demonstrate performance, rather than by their motivation to act in the best interests of the patient.

We argue that the medical profession is currently facing challenges that can be understood as a taking the form of 'biographical disruption' in the career of the profession. Defining features of the profession (including the taken-for-granted assumption that doctors can be trusted to self-regulate based on their professional moral and ethical values) have been disrupted, requiring the profession to renegotiate its identity and future. A particular challenge in renegotiating identity is the need for the profession to develop new vocabularies of motive.

<b>1<sup>st</sup> September 2010</b>	<b>13:00 - 13:30</b>
Health Service Delivery & Organisation	Calman, Ken Wade

*Tattersall, R.*

*University of Sheffield*

### **THE WITHDRAWAL OF VIOXX: JUST WHAT THE DOCTOR ORDERED?**

Writing a prescription is one element of the complex and multi-faceted prescribing process in which there are a variety of stakeholders. Prescribing involves complex networks of relationships between these stakeholders - from consultations between doctors and patients to state regulation of medicines to the market strategy of pharmaceutical companies. Previous research has explored different aspects of this process, but little is known about the perspective of doctors, who in most cases have responsibility for making prescribing decisions and issuing prescriptions. Research is needed to expose the heterogeneity in what is seen as prescribing and where, if at all, prescribing fits into notions of medical power or medical dominance.

This paper conceptualises prescribing as more than simply the issuing of a prescription and asks how doctors make prescribing decisions. It draws upon empirical research (in-depth interviews with doctors) about the voluntary withdrawal of Vioxx™ (rofecoxib - a novel anti-inflammatory painkiller) by its manufacturer in 2004, amidst concerns about the drug's safety. It explores how the withdrawal affected individual prescribing practice and prescribing relationships and what this reveals about prescribing more generally. Doctors were found to hold simultaneous, but often contradictory, views on the withdrawal and these were selectively exercised according to the context in which the doctors were acting. It is concluded that the withdrawal of Vioxx represented a clear challenge to prescribing practice and may be used, furthermore, as a starting point to explore a theory of prescribing governance.

<b>2<sup>nd</sup> September 2010</b>	<b>10:10 - 10:40</b>
Patient Organisations & Support Groups	Engineering 102

*Teppan Vik, K.*

*University of Tromsø*

### **THE HEALT-RESORT: A CHALLENGE TO THE PUBLIC HEALTH CARE SYSTEM? A STUDY OF THE IDEOLOGICAL BASIS 'HEALTHY HOLIDAYS'.**

In Norway, an increasing number of resorts offer "healthy holidays", consisting of services and goods that are marketed as improving the customer's appearance, coping, physical condition, diet and general lifestyle.

This paper is based on a fieldwork at "The Sunny Hill Hotel" (TSHH). Located in rural surroundings, TSHH offers a thorough "package deal" consisting of a constricted diet combined with daily sequences of group-organised activities managed by certified instructors. Based on qualitative research interviews with guests at TSHH, I investigate interpretations and expressed ideals on health by analyzing the manner in which they reflect on their stay. By employing a constructionist perspective on these interviews, I argue that the guests prefer with certain ideals and interpretations after the following structure: 1) Guests tend to conceptualise health as a result of making individual choices. 2) Guests tend to imply a comprehensive social concept of health; making a variety of events, persons and consumption relevant to their health considered.

Based on these findings, I argue that the health-resort can be considered as an expression of challenges to the public health care system: 1) A comprehensive social concept of health – as visible in the interviews - affects the trust in the curativeness and relevance of Western medicine. 2) A conception of health as a result of making individual choices may complicate the continued economical and political support of the Norwegian public health care system.

<b>2<sup>nd</sup> September 2010</b>	<b>15:10 - 15:40</b>
Ethics	Calman, Arnold Wolfendale

*ter Meulen, R.*

*University of Bristol*

### **DEMENTIA: ETHICAL ISSUES**

There is no 'miracle cure' just around the corner for dementia, and our rapidly ageing population means that the number of people with dementia is likely to double in the next forty years. People with dementia and their families, as well as healthcare staff and care workers, face difficult ethical dilemmas on a day-to-day basis.

The Nuffield Council on Bioethics set up an expert Working Party in 2007 to examine the ethical issues raised by dementia. Following a public consultation, a deliberative workshop with members of the public, and meetings with stakeholders including people with dementia, carers, health professionals and other members of the public, a report was published in October 2009<sup>1</sup>.

The report concludes that we need to do more as a society to enable people to live well with dementia. Currently, they are not getting the support and respect that they need. The report presents an ethical framework to help those who face dilemmas in connection with the everyday care of someone with dementia.

This talk will explain the rationale behind the ethical framework presented in the report and use examples from everyday care to highlight key recommendations to policy makers in the following areas:

- promoting autonomy and well-being through an ethical approach to dementia care
- including people with dementia in society
- a legal framework for making decisions about the care and treatment of people with dementia
- dealing with day-to-day ethical dilemmas in care
- recognising the needs of carers
- research funding and participation

**3<sup>rd</sup> September 2010**

Gender

**09:35 - 10:05**

Calman, Kingsley Barrett

*Theberge, N.*

*University of Waterloo*

**GENDER, DIFFERENCE AND THE POLITICS OF INCLUSION IN RESEARCH ON MUSCULOSKELETAL HEALTH**

One of the major developments in health research has been a move toward inclusivity. Socially significant categories such as gender "have taken on a new salience within modern medicine" (Epstein, 2007). While this has helped to overcome historical gaps in understanding women's health concerns, it poses the danger of naturalizing gender differences and deflecting attention away from the social bases of health. One area of research that particularly reflects the challenges of "gender profiling" is musculoskeletal (MSK) health, where gender differences in anthropometry interact with social differences in exposure to health hazards and specifically the risk of injury. Two settings in which MSK health issues are prominent are the labour force and sport, where the risk of injury is an inevitable outcome of the physical practice of work and athletic competition. This presentation will explore the major themes in current research on women's injuries in sport and work as a basis to examine how the issue of difference has informed the discussion. Research in occupational health is marked by an explicit effort to elucidate the biological as well as social bases of risks and the interaction between the two. Research on women's sport related injuries has concentrated to a greater extent on biological risk factors, leading to criticism of the very fact of gender profiling. The conclusion suggests that differences between these bodies of research derive from differences in the social organization of sport and work and the broader literatures on health and safety in each setting.

**2<sup>nd</sup> September 2010**

Health Policy

**15:10 - 15:40**

Calman, Rosemary Cramp

*Thompson, A., France, E., Wyke, S., Ziebland, S., Hunt, K., Entwistle, V., Jepson, R.*

*University of Edinburgh*

**THE MIRAGE OF CHOICE: NOW YOU SEE IT, NOW YOU DON'T**

Choice has become a fundamental organising principle in public services reform in England and elsewhere. Health services have been in the vanguard of this consumerist development, vigorously pursued by New Labour since 2000, embodied most obviously in requirements that patients are offered choice between hospitals, including private suppliers. Arguments in favour of choice have included increased patient responsiveness, improved health system performance and promotion of equity. However, insufficient is known about whether recognition of, interest in, and ability to make choices is equally distributed. The extent to which users/carers perceive or value choices and how they are socially differentiated is key to how they fit the governmental project engineered for them.

We present a mixed methods project using qualitative secondary analysis of interview transcripts followed by a national quantitative interview survey about information that users/carers needed, preferred and used in various types of decision. We focus on perceptions of choice involving specific decisions within three very different health issues: antenatal screening, treatment for lymphoma, and caring for someone with dementia.

We found the identification of choices, decisions, or dilemmas varied considerably by issue. Perceptions of choice in antenatal screening differed between 'routine' screening and diagnostic testing. Carers of people with dementia often associated sudden changes in health status with a loss of control and removal of choice. People with lymphoma (a potentially life-threatening condition) were less likely to perceive or want treatment choices, preferring their doctor to guide them. Education, age, gender and deprivation provided partial explanation of some differences.

**1<sup>st</sup> September 2010**

Experiences of Health and Illness

**14:10 - 14:40**

Engineering 005

*Thompson, B., Rapley, T., Broderick, W., Kay, L., May, C*

*Newcastle University*

**MAKING (NO) SENSE OF A DIAGNOSIS OF ANKYLOSING SPONDYLITIS: VULNERABLE PATIENTS**

Ankylosing spondylitis (AS) is a type of inflammatory arthritis which causes pain and restriction of movement of the spine. It often presents in young men, and despite recent advances in drug-based therapy, AS causes disruption to life and health. After an initial shock of discovering they have AS, most patients come to terms with the diagnosis, and learn how to manage their new life with AS. In part this is achieved through learning about their illness alongside learning how to manage encounters with health and social care services. However, not all patients cope with this transition, and this paper explores their struggle.

We conducted serial qualitative interviews with 10 people with a new diagnosis of AS. These were undertaken at time-of-diagnosis, 6 months and 12 months post-diagnosis. We then used theoretical sampling in order to test and refine emergent issues and ideas and interviewed a further 12 patients, who had all lived with a diagnosis of AS for at least a year. We focus on how a group of patients did not engage with medical services or information sources in ways that the organisation of health and social care might expect them to. We outline the characteristics of these patients and explore the consequences for their health and healthcare. We suggest some ways that professionals' recognition of these 'vulnerable' patients might improve and suggest how to improve the resources available to them.

<b>3<sup>rd</sup> September 2010</b>	<b>11:20 - 11:50</b>
Gender	Calman, Kingsley Barrett

*Till, C.*

*University of Leeds*

### **IS ANOREXIA NERVOSA A USEFUL SOCIOLOGICAL CONCEPT?**

Critical sociological approaches to understanding Anorexia Nervosa (AN) from a feminist and Foucauldian perspective (Brain, Gremillion, Hepworth, Lester) have problematised the use of AN for its association with psychiatric assumptions. By emphasising the significance of patriarchal social relations as being constitutive of AN, such work undermines the individualising and essentialising tendencies of psychiatric and medical approaches by building on core critiques of sociology of health and illness. Through an analysis of twentieth century psychiatric texts describing AN it is suggested that femininity itself has come to be associated with weakness, illness and dependency at the same time as further abjectifying these concepts. Furthermore, it will be suggested through the work of Elias and Mannheim) that the use of a concept such as AN strips complex social phenomena of evaluative elements or common meaning and only enables us to talk of them in individualising and objectifying terms. It will be further proposed that the psychiatric approach may be incapable of conceptualising AN without feminising due to its association with masculine notions of rationality and rationality. The only way that this can be avoided is with a more radically sociological ontology that emphasises social relations and historical analysis rather than subject/object and individual/culture splits. The usefulness of AN as a historical category of analysis will thus be questioned as it may be impossible to use the term without reifying such dichotomies and reproducing patriarchal and individualising relations of power.

<b>2<sup>nd</sup> September 2010</b>	<b>11:20 - 11:50</b>
Methods	Calman, Derman Christopherson

*Tjora, A.*

*Norwegian University of Science and Technology*

### **THE COMPLEX AGENCIES OF DIGITAL PATIENTS**

Despite of an easily identified political and technological push towards electronic communication in the healthcare sector, traditional relations between service providers and user interaction is fairly well maintained. In Norway, various healthcare sector reforms have failed to release the expected potential of ICTs. By drawing on contributions in a newly released edited book titled "Digital Patients" (edited by Tjora & Sandaunet 2010) this paper elaborates on ICT-related changes and maintenance of patient roles through perspectives of consumption, communication, community, and responsibility. It is found that publicly financed and professionally initiated projects tend to objectify and activate patients (or users) while patient-initiated projects, such as private blogs and other Web 2.0 applications, create potential for more active involvement. The paper reflects on how various types of agencies are shaped by and shapes "digital patients", i.e. patients communicating and/or being communicated electronically.

<b>2<sup>nd</sup> September 2010</b>	<b>14:00 - 14:30</b>
Randomised Controlled Trials & Evidence-Based Medicine	Calman, Kingsley Barrett

*Tomlin, Z., de Salis, I., Toerien, M., Donovan, J.*

*Cardiff University*

### **NURSES, RCT RECRUITMENT AND IDENTITY: CLINICIAN-ADVOCATES OR RESEARCHER-RECRUITERS?**

This paper reports on findings from an interview study of nurses participating in five randomised controlled trials (RCT) and explores their views and feelings about the task of inviting patients to consent to randomization. The nurses felt committed to the trials, expecting them to produce scientifically validated 'knowledge,' but at the same time had concerns for sub-groups of patients. They often undertook nuanced personal assessments of the suitability of technically eligible patients for trial participation, paying attention to the patient's lifeworld as well as clinical features and sometimes developing informal, idiosyncratic eligibility criteria. Anxiety over less-intensive trial arms (doing 'less' for the patient) was combined with anxiety over more intensive arms (burdening the patient). While equipoise (uncertainty) is thought to provide ethical legitimation to experimental health research, it is proposed that the nurses were able to carry out the recruitment task not because they were in equipoise (many were not) but because they had adapted to the tension created by inhabiting two social worlds, that of clinical practice and that of science, and had, on the whole, reconciled the demands, agendas and ethics of the two. As part of this process of adaptation, they promoted their identities as responsible clinicians and protective advocates and downplayed their roles as trial recruiter. It is suggested that the emphasis on clinician identities provided confidence and reassurance that they would not compromise the welfare of their patients for the sake of research.



**1<sup>st</sup> September 2010**

Lifecourse: Chronic Conditions

**13:35 - 14:05**

Calman, Rosemary Cramp

*Tomomatsu, I.*

*Barts and The London, School of Medicine and Dentistry*

**JAPANESE HEART TRANSPLANT RECIPIENTS' EXPERIENCES AND THE STIGMA IN JAPANESE CULTURE**

**Aim:** This study aims to explore Japanese heart transplant recipients' experiences, in particular, how their sense of self might be redefined through the experience of heart transplant.

**Method:** To achieve the aim, the following people were interviewed face to face and in follow-up e-mails: 20 heart transplant recipients, 14 heart transplant recipients' families, 3 recipients of other organs, 2 families of recipients of other organs, 1 donor family, 4 doctors, 4 people from patient support groups and 4 journalists.

**Findings:** Many more Japanese people have had heart transplants abroad than in Japan. More than half the patients who went abroad needed fund-raising support to have the surgery. Japanese heart transplant recipients and their families experience 'stigma'. The nature of that stigma differs between recipients who are self-funded and recipients who rely on fund-raising. The experience of stigmatisation is also influenced by how long the recipient had to wait for his or her transplant. While waiting, potential heart transplant patients imagine how they will be stigmatised, and find strategies for managing the stigma. Therefore, a recipient who is on the waiting list for a short period experiences a stronger stigma.

**Discussion:** The stigma derives from the Japanese cultural notion of 'shame', which creates profound sensitivity to what other people think. In relation to heart transplants, this study focuses on how the recipients perceive people's responses, and how they disclose information to other people about their transplant experience.

**2<sup>nd</sup> September 2010**

Ethics

**14:35 - 15:05**

Calman, Arnold Wolfendale

*Turkmendag, I.*

*Newcastle University*

**PROVIDING AND ACQUIRING HUMAN REPRODUCTIVE TISSUE FOR STEM CELL SCIENCE: SCRUTINISING THE SOCIO-ETHICAL ISSUES**

Reproductive tissue (e.g. eggs, embryos, fetal material) is crucial to developments in stem cell science. The balance between achieving effective protection of the providers of that tissue and achieving scientific goals has been subject to growing socio-ethical consideration (Haimes and Taylor, 2010).

Many of the issues are also central to medical sociology; for example, the impact of acquiring tissue (which mainly occurs through IVF clinics) on the clinic-patient relationship and the potential conflict of interest between treatment and research (Wainwright et al, 2006). Other, emerging, issues in this field are equally important to scrutinise through the lens of medical sociology, such as: 'intercorporeality' (Weiss, 1999) and fragmentation of the body; the contestability of the ontological status of human embryonic stem cells (Eriksson and Webster, 2008); the meanings and status of "reprotissue" and of new biological entities created by stem cell science (e.g. parthenotes, pseudocloning, cybrids, Watt, 2007); the relationship between embodiment, emotion and tissue (Shaw, 2008); questions about the global bio-economy in human tissue (Waldby, 2008). This paper explores how medical sociology can enhance our understanding of these issues and also how these issues both challenge and contribute to medical sociology.

This paper is from an ongoing project, 'IDARTSS' (Interdisciplinary Approaches to the Uses of Reproductive Tissue in Stem Cell Science) which is a constituent of a wider international research network, PARTS (Provision and Acquisition of Reproductive Tissue for Science).

**2<sup>nd</sup> September 2010**

Randomised Controlled Trials & Evidence-Based Medicine

**15:45 - 16:15**

Calman, Kingsley Barrett

*Turner, A.*

*University of Nottingham*

**HAS A COHERENT IDEA EMERGED AFTER NEARLY TWENTY YEARS OF LITERATURE ABOUT EVIDENCE-BASED MEDICINE?**

The term EBM was coined in 1991, and grew out of arguments that have their roots in clinical epidemiology. In 1996 David Sackett and colleagues set out to describe what EBM is, and isn't, in their seminal paper in the British Medical Journal. Those classic arguments for the EBM view are relatively clear: trust the results of high-quality clinical trials, rather than the judgement of experts or mechanistic reasoning from biophysiological theory.

How these arguments have been spelt out more fully is much less clear. Indeed in the nearly twenty years that the term EBM has been employed in the medical literature the range of views about what EBM is, and what it entails, has multiplied to the point where the literature can seem deeply unclear, if not contradictory. Moreover the proliferation of the prefix 'evidence-based' throughout the medical specialties and allied sciences has created a discourse with yet more unclear or problematic links to the original arguments.

The sociology of health and illness has a longstanding interest in the nature of medical knowledge and a recent interest in EBM in particular (see for example: Green (2000), Mykhalovskiy & Weir (2004), Lambert (2006), Traynor (2009)). This paper will detail how the arguments at the heart of the EBM movement have evolved over time and examine whether the development of EBM embodies a coherent idea about what it should be. The paper will present data from a citation and text analysis of a corpus of articles from the EBM literature.

**2<sup>nd</sup> September 2010**

Ethnicity & Migration

**10:10 - 10:40**

Maths 107

*Vaughan, S., Sanders, T.*

*University of Manchester*

**THE RECIPE FOR SUCCESS: ETHNIC MINORITY MEDICAL STUDENTS' EXPERIENCES OF THE MEDICAL FIELD**

Future doctors enter the field of medical education from increasingly diverse backgrounds as a result of ongoing attempts to widen participation. Access, however, does not equal smooth integration and existing research highlights inequalities in the experiences and achievement of some minority students. There is now a convincing body of evidence to show ethnic minority medical students are less likely to achieve the academic success of their white counterparts, implying there may be processes at play disadvantaging these young doctors. Using students' perspectives gained in 15 semi-structured interviews and 5 focus groups, this study explores how medical students' identities are created as they move across intersecting fields of community and medicine, each a socially delimited space in which different forms of knowledge hold value. Dependent on their position, and the accountability they feel to the practices of a field, students engage in an ongoing struggle to change or maintain its boundaries. For some, the social spaces that produced them allow a pre-recognition of the requirements for success in their new field, however for others a sense of mismatch characterised their experiences. Understanding these processes help explain inequalities that so far remain unanswered by previous research but also challenge current discourse around integration; without first affecting change, simply increasing the number of minority medical students may only serve to increase the inequity of success.

**3<sup>rd</sup> September 2010**

Inequalities

**11:20 - 11:50**

Calman, Arnold Wolfendale

*Vedoy, T.F.*

*The Norwegian Institute for Alcohol and Drug Research*

**PERCEPTION OF ADDICTIVENESS OF SMOKING AND EDUCATION: HAS THE RELATIONSHIP CHANGED OVER TIME?**

This paper examines the relationship between education and the perception of addictiveness of smoking (PAS) in 1968, 1989 and 2007. This period has seen dramatic changes in the percentage of daily smokers in most European countries and education has played an ever increasing role in determining smoking behaviour. As smoking is a major cause of health problems, the impact on social inequalities in health is great. According to previously published work, the perceived risk associated with smoking affects smoking behaviour. Likewise, smoking status affects the perceived risks associated with smoking. The way people perceive this risk is likely to vary with tobacco control policies, but also with increased awareness of smoking as harmful, addictive and unglamorous. We will examine two hypotheses: (1) The importance of education for PAS will increase from 1968 to 2007. (2) The relationship between education and PAS is different among smokers and non-smokers. Using data from three cross sectional surveys from Norway ('68, '89 and '07) we find that while education did not predict PAS in 1968, regardless of smoking status, higher education was associated with reduced PAS in 1989 and 2007. In 2007 however, this was only the case for non-smokers. These results may indicate that people with primary education overestimate the addictiveness of tobacco. The lack of an educational effect among smokers in 2007 may indicate that the physical experience of addictiveness weighs heavier than knowledge of risk and that this has become more important over time.

**3rd September 2010**

Sleep

**11:20 - 11:50**

Engineering 102

*Venn, S., Arber, S.*

*University of Surrey*

**UNDERSTANDING OLDER PEOPLE'S ATTITUDES TO POOR SLEEP, SLEEP MEDICATION AND SLEEP REMEDIES**

**Introduction**

Sedative hypnotics have traditionally been prescribed to older people who report difficulty sleeping, although alternative solutions are being sought for poor sleep as it is recognized the benefits of hypnotics are outweighed by the potential risks, such as an increase in falls. This paper offers an understanding of older peoples' perceptions surrounding medications and remedies for poor sleep through in-depth qualitative interviews (n=62) with older people living in the community\*.

**Results**

All respondents had a PSQI (Pittsburgh Sleep Quality Index) score of > 5, an indicator of clinically poor sleep. However, most older people would not consider going to their doctor for help with their sleep, partly because of a perception that poor sleep is not an illness, but also because of a fear of being prescribed sleeping medication. Those who did go to their doctor, and were prescribed sleeping medication, rarely took it, or discontinued use after a short time, largely because of (a) concerns about the effects of the medication on their ability to continue with daily activities, and (b) a fear of reliance. Alternative, more 'acceptable' medications included painkillers, antihistamines, or over the counter solutions, such as herbal remedies.

**Conclusions**

Older people place great emphasis on being in control of their everyday lives, so they may only seek professional help when they consider their poor sleep interferes with their ability to undertake daily activities. Raising awareness of alternative, non-pharmacological, solutions to poor sleep may encourage older people to seek professional help for their sleeping problems.

**2<sup>nd</sup> September 2010**  
Lay-Professional Interface

**17:30 - 18:00**  
Engineering 005

*Visram, S., Clarke, C., White, M.*

*Northumbria University*

**'IT'S NOT A TEXTBOOK THING, IS IT?' THE VALUE OF LAY KNOWLEDGE IN THE NHS HEALTH TRAINERS INITIATIVE**

Health Trainers represent a new public health workforce role (DoH 2004). The aim is to reduce inequalities by offering a range of approaches to helping people make healthy lifestyle choices, as well as providing employment opportunities for those living in disadvantaged areas. The largely grass roots development of Health Trainers has been ad hoc, resulting in a diversity of local models that lack sound theoretical or empirical basis. At the same time, the role has implications for debates about subjectivity from both sociological and psychological traditions, and provides an opportunity to enhance understanding of the needs of marginalised groups. This paper will report findings from a qualitative study aiming to investigate the processes involved in the NHS Health Trainers Initiative. The sample of clients (n=26), Health Trainers (n=13) and managers (n=5) has been drawn from 3 contrasting models of local service delivery, and in-depth serial interviews are being conducted over a 12-month period. Drawing on debates about lay knowledge as a 'privileged' form of expertise about health, this paper discusses the way in which Health Trainers pose an epistemological and political challenge to the institutional power of professional knowledge (Popay et al 1998; Popay 2006). In practice, the individualist, paraprofessional approach of the Health Trainer role creates a number of potential risks and tensions to be addressed. A key challenge is to achieve a balance between local knowledge and organisational imperative, in terms of meeting the needs of both the target communities and the NHS.

**2<sup>nd</sup> September 2010**  
Mental Health

**14:00 - 14:30**  
Maths 107

*Wainwright, D.*

*University of Bath*

**THE LIMITATIONS OF THE CONCEPT OF WORK STRESS**

The concept of work stress has considerable traction in academic research, policy making and the popular imagination. Psychological accounts of the phenomenon are largely ahistorical and naturalised, implying that work stress is a physiological response to objective working conditions and job characteristics. Central to this approach is the assumption that the demands of work have pushed individuals beyond the limits of psychological and physical endurance. Interventions based on this approach often emphasise individualised stress avoidance or coping skills. The purpose of this presentation is to debunk the discourse of work stress and reveal its historical and cultural specificity. It will be argued that work stress represents the medicalisation of problems at work that were previously addressed through political or trade union activity. The ontological and epistemological assumptions of the concept of work stress will be questioned, including recent attempts by epidemiologists to salvage the concept by the adoption of new methodological techniques. It will be concluded that rather than attempting to stretch the concept of work stress to answer its critics, it is time for a paradigm shift towards a social model of work and wellbeing that emphasises human agency and resilience.

**2<sup>nd</sup> September 2010**  
Health Service Delivery & Organisation

**11:20 - 11:50**  
Calman, Ken Wade

*Waring, J., Bishop, S.*

*University of Nottingham*

**LEAN HEALTHCARE: RHETORIC, RITUAL & RESISTANCE**

This paper presents an ethnographic account of the implementation of Lean service redesign methodologies in one hospital operating department. It is suggested that this emerging and popular management 'technology', with its emphasis on creating value streams and reducing waste, has the potential to transform the social organisation of healthcare work. The paper locates this change agenda within wider debates related to the standardisation of clinical practice, the re-configuration of occupational boundaries and the stratification of clinical communities. Drawing upon the 'technologies-in-practice' perspective the study is attentive to the interaction of both the intent to transform work and the response of clinicians to this intent as an ongoing and situated social practice. In developing the analysis the paper explores three dimensions of social practice to explore the way Lean is interpreted and articulated (rhetoric), enacted in routine social practices (ritual) and experienced in the context of prevailing lines of power in the organisation of healthcare work (resistance). Through these interlinked analytical lenses the paper suggests the interaction of Lean and clinical practice remains contingent and open to negotiation as clinicians and managers work through and around the processes of interpreting and implementing service improvement. The paper concludes that Lean might not be the easy remedy for making both efficiency and effectiveness improvements in healthcare.

**2<sup>nd</sup> September 2010**

Lifecourse: Ageing, Death & Dying

**10:10 - 10:40**

Calman, Rosemary Cramp

*Watts, J., Cavaye, J.E.*

*The Open University*

### **DEVELOPING UNDERSTANDINGS OF COMMUNICATION IN END OF LIFE CARE**

Communication is perceived by both educators and policymakers to be a core component of quality end of life care and is frequently referred to in recommendations as an area for improvement (DoH 2008). Communication emerged as a significant theme in a broader literature review of death education within nurse training. This paper focuses on the ways in which communication helps shape the care and illness experience of people with a terminal diagnosis. Findings suggest communication skills have a strong focus within professional programmes (Dickinson et al 2008). Missing from the literature, however, is recognition that spiritual embodiment is an important feature of non-verbal communication with this conveyed through empathetic connection and behaviours such as touch, being wholly present, giving time and the kindness of smiles. The evidence suggests that communication training should be developed to take a more holistic view to incorporate both verbal and non-verbal elements. Furthermore, effective communication skills training needs to frame the patient as an individual within a whole life perspective. A stronger emphasis on values-based education that highlights the importance of empathetic sensitivity on the part of health professionals to develop the qualities of warmth, compassion and genuineness is proposed. These personal attributes of healthcare professionals are highly valued by patients receiving end of life care and contribute to the development of positive relationships between patients and health professionals (Johnston and Smith 2006). They also require ongoing attention and nurturing and cannot be assumed or taken for granted.

**1<sup>st</sup> September 2010**

Experiences of Health and Illness

**13:35 - 14:05**

Engineering 005

*Watts, K., Richardson, J.C., Ong, B.N.*

*National Primary Care Centre*

### **FITTING PAIN INTO A DAILY ROUTINE**

For individuals living with arthritis managing and living with their pain is an everyday activity. For some it may be all consuming while for others it is just part of their routine. This paper presents some findings from an ongoing study re-examining data from a range of projects on musculoskeletal conditions. The analysis offers a comparative overview of how people evaluate and prioritise their daily routines. In utilising data from multiple pain sites it is possible to develop a conceptual overview of a large and complex area of conditions, and allow a multifaceted set of experiential narratives to be united through specific comparisons.

This analysis contributes to our understanding of the importance of a daily routine in attempting to control pain. Detailed descriptions of

schedules that enable both recreational and functional activities provide insight into the lives of people with chronic painful conditions. This is important in understanding how people live with painful conditions for which there is no 'cure', such as arthritis.

Using data focusing on different pain conditions, there is the potential for developing an overall theory of the relationship between routine and the experience of living with a chronic painful condition.

**2<sup>nd</sup> September 2010**

Lay-professional interface

**11:55 - 12:25**

Calman, Kingsley Barrett

*Webb, H., Vom Lehn, D.*

*King's College London*

### **'SOMETIMES I JUST CAN'T SEE THINGS PROPERLY' CHARACTERISING VISION AND EYE HEALTH DURING VISITS TO THE OPTICIAN**

Visits to the optician are a regular event for many of us. We attend appointments to have a check-up or to report a perceived problem with our vision or eye health. In either case we are required to describe the status of our eyes to the optician, who uses this information to proceed with the consultation. As in any healthcare setting, characterising our own subjective experience of the body and bodily symptoms can be a complex and difficult task. This paper uses data from an ongoing project to describe how these characterisations are produced in the particular setting of the optician consultation.

The paper reports on an ongoing project, "Assessing eye sight and ocular health". The project involves the video-recording of consultations in a range of eye care settings, including over 40 consultations in 'high-street' optician chains. The recordings are analysed using insights from ethnomethodology and conversation analysis (CA) to observe how the consultation unfolds and identify recurrent patterns of interaction.

Our findings demonstrate that in characterising their eye health and vision patients do not refer to the quality of their eyes alone. Instead they invoke their everyday environment and their ability to perform actions within it. In this way, 'normal' activities such as reading or driving can become transformed into significant problems. These characterisations are enabled by practitioner questions and so are inherently interactional. These findings build on research into patient descriptions of health and also demonstrate the analytic benefit of conducting sociological research into the practice of optometry.

<b>1<sup>st</sup> September 2010</b> Health Technologies	<b>14:10 - 14:40</b> Calman, Kingsley Barrett
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*Weiner, K., Will, C.*

*University of Nottingham*

### **DE-SCRIBING EXPERT PRESCRIPTIONS – ACCOUNTS OF PLANT STEROL USE**

Foods containing plant sterols are currently marketed on the basis that they actively lower cholesterol. On introduction, these elicited a range of clinical concerns which were distilled in clinical guidance on CVD prevention and food labelling regulations. These act to prescribe correct and proscribe illegitimate types of users and uses. Experts also recommended that clinicians take responsibility for advising consumers about these foods.

In this paper, we analyse users' own accounts of these products, considering how far they conform to expert prescriptions or suggest alternative views and practices. The analysis is based on 40 in-depth interviews with self-identified users of plant sterol products.

We find that accounts were mainly framed in terms of normal habitual eating practices. Users in this sample were relatively immune to guidance on dosage, which is part of the labelling of all such products in the UK, rarely making reference to this. Furthermore, plant sterols use was not seen as a matter of interest to health care professionals, even for those users also taking statins under medical supervision. Nevertheless, there was a narrative of compliance with medical prescribing.

Our analysis suggests that plant sterol products are placed largely in the realm of foodstuffs and that attempts to prescribe habits relating to them do not fit with users' expectations relating to these kinds of foods (particularly margarines). This could perhaps be understood as resistance to the (further) medicalisation of food.

<b>2<sup>nd</sup> September 2010</b> Individual, Collective & Global Risk	<b>10:10 - 10:40</b> Calman, Arnold Wolfendale
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*Weir, L.*

*York University*

### **INTEGRATING SECURITY INTO GLOBAL PUBLIC HEALTH**

The sociology of public health needs to be revitalized. One obvious remedy would be to examine current transformations in global and national infectious disease control, a neglected sociological topic. Between 1995 and 2005 a new global public health regime was fashioned around the early detection and containment of infectious diseases and other emergencies.

Empirically this paper focuses on the security aspect of this regime, specifically the integration of international security into the work of the World Health Organization (WHO) in infectious disease control. At the level of theory I focus on the place of security in an emergent form of global biopolitics.

Throughout the twentieth century international public health was legally and institutionally separate from international security, but this changed with the passage of the International Health Regulations (2005) (the main international health law). During the revision of the Regulations in 2004-2005, North-South debates occurred among WHO members about how extensive WHO's security mandate should be. Drawing on archival, document and interview research at the WHO (Geneva) and the Public Health Agency of Canada (Ottawa), I argue that the WHO's resulting securitization was restricted to preparedness and response to transborder acute health emergencies, including weapons use. A new concept of global public health security has been formulated that combines international communicable disease control with some aspects of international security. In this process international infectious disease control has been displaced and reconstructed as global public health security, a deep transformation in global biopolitics.

<b>2<sup>nd</sup> September 2010</b> Preventive Health	<b>11:20 - 11:50</b> Engineering 101
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*Wright, C., Avis, J., Fisher, P., Gifford, C., Locke, A., Swindells, S.*

*University of Huddersfield*

### **HEALTH, WELLBEING AND ACTIVE CITIZENSHIP**

This paper is based on a current research project at the University of Huddersfield's Institute for Health Citizenship. The research is exploring the understandings of health, wellbeing and citizenship by analysing the discourse of trainee further education (FE) lecturers. Initially, a literature review of policy documents was undertaken to identify dominant discourses in relation to health, wellbeing and inclusion. Two exploratory focus groups were held: one with a group of pre-service trainees and one with in-service trainees. The policy literature suggests that ideas around health and wellbeing are being discursively repositioned. Whilst previously regarded as a fortunate state of being or condition, the dominant discourses now tend to construct health and wellbeing as contingent on individual behaviour – behaviour that is inextricably tied up with a particular model of citizenship and personal accountability. Put another way, the 'good and active citizen' must 'choose' to be healthy. Despite this individualisation, issues of health and wellbeing appear to be embedded within systems of surveillance, carried out by various state agencies, organisations and charities, including the further education sector. However, this surveillance and intervention is not straightforward. Initial findings from the focus groups suggest that trainee lecturers draw on conflicting discourses of health and wellbeing, and have developed counter discourses that resist or provide alternatives to the dominant model of 'active citizenship'. This paper begins to disentangle the complexities between active citizenship, health and wellbeing and government public health policy, and how these directives are practised and understood at ground-level.