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Reviewer: Pamela Pitman Brown, PhD
Editorial

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Welcome to this last issue of MSo under the editorial direction of the OU team. This is also the final issue in the MSN/MSo series of publications that began over 40 years ago and thus this issue feels very much like a landmark in the way that ideas and news are communicated within the medical sociology community.

During the 3 year period of our editorship we have endeavoured to continue some of the traditions of previous editorial teams by including a mix of commentaries, research articles as well as news items and book reviews. A new initiative, however, has been the development of the archive of MSN/MSo publications that is now fully available on the MSo web pages. We see the electronic compilation of the archive as a significant legacy for current and future medical sociologists.

In looking back across the archive, what has been particularly noticeable has been the diversity of topics covered together with different styles of commentary, debate and reflection. The good humour and bonhomie of medical sociologists is also evident with early editors using cryptic headings such as "Brief and to the point editorial" in volume 9.1 followed by "The smallest one of all" in volume 9.2. Readers can explore for themselves the meanings of these but a hint - just to encourage you to explore further - is that the latter is not about the size of the issue, but rather a very well-known medical sociologist!

The archive reflects the growing popularity of medical sociology as a discipline. It serves as a fascinating history not only of medical sociology, but also of medical and health policy developments since the first issue of MSN was published in autumn 1973. The continuing currency of some of the archive items is also very striking and it, therefore, seemed fitting that this last issue of MSo should primarily take a retrospective focus. The main contents are thus formed of some highlights selected from the archive. The choice has been difficult because the quality and richness across more than 40 years of MSN/MSo is such that it would have been easy to have included many more articles.

The issue opens with a piece by Anne Murcott written in 1974 that critically discusses the place of sociology in both the teaching and practice of medicine. As medical education continues to develop, the case for some sociological input to the curriculum that gives clinicians a stronger understanding of the personal and social context of their practice is still being made. The issue of whether or not medicine is the client of sociology remains contested.

The next four items beginning with the piece by Robert Harris in 1978 debate the utility of quantitative methodologies in the study of schizophrenia as proposed by George Brown. The four commentaries comprise a debate between the two men that involves each challenging and responding to ideas about the nature and veracity of positivist quantitative scientific methods that are subject to standpoint and interpretation. Reference to 'common sense judgements' masquerading as scientific fact is a theme of this debate. This is a fascinating dialogue that, with the onset of blogs and other electronic platforms, is now rarely seen in this form.
David Hunter's 1986 commentary casts the spotlight on healthcare management arguing that sociology can bring new perspectives to aid understanding of the complex nature of managing healthcare delivery within the NHS. Hunter's focus on organisational structures that he sees as a matrix of relationships involving funders, consumers and managers holds contemporary resonance as the NHS continues on its path of ongoing reform and change.

The theme of NHS organisation is continued by David Marsland in his 1993 critique of the NHS Review that discussed potential innovations and changes to the operation of the NHS to include a stronger public/private partnership approach. The implicit ideological 'drivers' of Marsland's commentary are highlighted by Gareth Williams and Jonathan Gabe in the piece that follows. They specifically call for Marsland to acknowledge his ideological standpoint to situate his scholarship. Marsland's response to his critics centres on the defence of his values, the innate 'left-wing' prejudice of many academics wedded to the status quo and the imperative for NHS reform to ensure its survival. Robert Dingwall joins the debate to point out that 'the market' and models of efficiency in healthcare are contested concepts even amongst those such as health economists who might be expected to be strong advocates of this business model. It is Marsland, however, who has the final word in the debate with his commentary first published in December 1993 that reports on the progress of the new reforms. These five pieces make fascinating reading particularly in light of the current 'crisis' narrative that frames much reporting of the NHS.

Gillian Bendelow and Simon Williams focus on a very different topic in their 1994 article about emotions and the body. Putting emotion firmly in the sociological frame (rather than just in the psychological domain), they draw out the relevance of emotion and feelings for the sociological study of health and illness. In the years following the publication of this article, emotion has also come to be recognised as an important component of research experience and the reporting of findings.

Martin O'Neill's article 'Tales from the Natives' first published in 2000 raises ethical and methodological questions that have ongoing relevance for medical sociological research. In the years since this was written we have seen a significant increase in the use of ethnography within medical sociology and O'Neill's call for a stronger emphasis on reciprocal approaches within ethnography in this field reminds us that participants in our research can reasonably expect to get something from their contribution.

Current debates about the rights of and provision for disabled people prompted the inclusion of the article by Patricia de Wolfe that is concerned with the link between incapacity benefit and medical sociology. First published in 2001 the article sets out the 'mechanics' of how incapacity benefit is assessed and awarded and the psychological and social impacts on claimants. References to Foucauldian analyses involving surveillance, loss of power and the subjection of claimants to ongoing scrutiny by the 'authorities', remain highly relevant today.

In introducing the final archive article, I should declare my standpoint. Feminist theory has been central to my research and scholarship and I was thus much engaged by the arguments in Ellen Annandale's commentary on the connection between feminism and medical sociology. This plenary paper, presented at the 2005 BSA MedSoc group conference, calls for a reinvigoration of gender analys es within health sociology that Annandale argues has been 'forgotten' by feminists. An anchoring in feminist thought is essential, Annandale argues, to fully account for health-related change.

The last three pieces in this final issue report on a group symposium, a successful PhD and a recently published book. There is much for readers to enjoy and reflect on and we hope
that you will be inspired to dip into the archive to explore further highlights from over 40 years of MSN/MSo.

My final remarks are those of thanks to the BSA and the MedSoc group committee for their continued support and to Charlie Cavaye, the MSo administrator, for his efficient running of the publication, social media and the MSo website. We have greatly enjoyed the last three years!
Some Remarks on the Dialogue between Sociology and Medicine

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26th July, 1974

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The comment I offer here is in the way of an item on the aide-memoire of those of us who are engaged - or should be engaged - in the dialogue with the medical profession to which Margaret Reid referred in her editorial of the Newsletter (No. 1.4).

It would indeed seem that those in the medical profession favourably disposed to sociology's inclusion in the medical teaching effort champion sociology's respectability on the basis of a vulgar positivistic view of the discipline. So when meeting medical challenges about what we think we're contributing in our teaching we find that we confront at least two styles of reaction. One is that blanket hostility, the 'impenetrable armour of medical professional culture' which stereotypically medical sociologists have incorporated into their own professional sub-culture. The other is the (initially) unexpected support offered in terms which Margaret Reid reminds us is exemplified in the Todd Report's view of the operation. We break off the main offensive, in order to re-build the bridge with these signatories to the alliance. For those allies are surprised and hurt when we round on them to deny that sociology is a science, at least according to their views of science. Which brings us to domestic matters. For in entering the dialogue we have yet a number of things to sort out amongst ourselves.

Rodney Coe presents the following characterisation of the part we are to play in the dialogue:

"Since medical sociology is an applied field, it is incumbent upon sociologists to demonstrate their value by solving problems which result in a product with a clear practical utility for their 'client' — in this case the medical profession."¹

I see this as counter-productive. For it accords with and builds upon precisely that medical perception of sociology which as Margaret Reid rightly points out ignores the virtues of recent revivals and developments within the discipline.

First, I take issue with the designation of medical sociology as an applied field. That Coe is explicitly writing a text in the sociology of medicine is I think significant. For while Straus's distinction when stated has an immediate appeal, it becomes decidedly blurred at all sorts of edges when elaborated. (When operating as a sociologist in medicine, do we ignore all the insights of work in the sociology of medicine, or at least Bowdlerise them? Are we to keep a kind of index of dangerous ideas which might corrupt those we are attempting to help teach, or those with whom we are research collaborators? Like good Longfords all, we could justifiably be accused of protestations that conceal a fear for our own (professional) comfort were the dirt to become public). Clearly Straus's distinction is but another expression of that between pure and applied sociology. It is because this distinction is spurious that I consider Coe's remark misplaced. Sociology is a discipline in process. A static model of pure on the one hand, to be applied later, on the other, may be appropriate in the natural sciences, but represents one of the very features of the view of sociology here considered problematic. In
the nature of social existence, theories and their application are telescoped to become coincident, such that we have to think of what we do in terms of a relationship between theory and practice which in actuality exist simultaneously, albeit at different categorical levels. Quite simple, however, it emerges from that truism that we are capable of thinking about what we do. As sociologists, we do sociology as we teach and as we research - and as we live and work, for our lives become imbued with the insights derived from our work dealing as it does with the very stuff of life.²

An integral part of our work as sociologists is not only continually to make sense of social action from the cultural point of view of the protagonists, but also to exercise continued vigilance, reflexively, of our acculturated selves at work. We have also to ask whether the view of our work held by others does not in part derive from the efforts of those within our ranks. If we do not accept the scientistic view of sociology, then what is incumbent on us is to work out, publicly, how and why we do not accept it and embark an the difficult task of developing an account of ourselves that more closely portrays our preferred mode of operations.

As a small start in this direction I return to the quotation from Rodney Coe. A major theme of medical sociology’s examination of its place in the world, is its continued, although sometimes muffled, refusal to accept categories defined for it by the medical profession.³ We mistake our purpose if we take as unproblematic, a5 Coe seems to do, the designation of the medical profession as our “client”.⁴ Sociology has a (notorious) tradition of championing the underdog; a tradition often is a serious danger of romanticising and sanctifying the downtrodden. The poor, the misfit. the deviant is often such because he cannot fight back; he cannot fight back against the investigative curiosity of the sociologist either. That the deviance of Poulson and Watergate emerge not in the course of sociological enquiry but as national scandals reflects nothing more nor less than power. Our relationship with the medical profession, both as we experience it, and as our own literature testifies, is one in which they have more power than we have. Disconcerting as it is, we must not allow this to divert us to a view of that profession as our clients. They are no more our clients than are people at risk of accident crossing the road, than nurses, than hospital secretaries, than patients, than people who smoke… Freidson admits the moral entrepreneurship of sociology’s view of medicine. Incautiously, perhaps, I submit he is too apologetic. For if there is any meaning to the utility of sociology, it must lie in precisely its own view of the world, however discomfiting, however revelatory, however congratulatory. Sociology persists, as part of its enterprise in refusing to accept others’ taken-for-granted.

Let me be not misunderstood. I am no more advocating the cause of the (medically) downtrodden, than rejecting the claim to our exclusive attention of the point of view of the powerful. If we have anything to learn from the labelling perspective of deviance, it is that we cannot view the deviant in isolation from those who so designate him, and those who succeed in making their designation stick. We have to focus on the processes and consequences of the interaction between all parties.

A consultancy view of the task is doubly misleading. Clearly it is readily available, since in one way or another, we are employed by, sponsored by, or at least need the acquiescence of the medical profession, or its agents. We should strive not to let this cloud our sociological judgement, such that we fail to see the situation as one of a conjunction of professional cultures of unequal power. It is misleading further, for thereby we fail to see that the designation of any category as client is yet a version of an expression of medical sociology as applied to sociology.
In some sense, the injunction I imply, namely to have worked out an identification of purpose, is prior to the actual engagement in dialogue, if only to avoid feeling swamped. However, identities develop in interaction. We can start to develop the alternative view of ourselves which we seek to promote if we attempt to bear in mind the kind of themes I have dealt with, not only in domestic discussion in Newsletter, but in the range of context in which we find ourselves face to face with members of the medical profession.

1 Rodney Coe: Sociology of Medicine, McGraw Hill, 1970, p.23
2 We are socialised into the sociological culture no less so than doctors who as we are so fond of reminding students, are taught not only pre- and clinical- sciences at medical school, but also the manner of behaving of the medical profession.
3 Obviously this is a fundamental feature of all sociology, no matter the substantive area.
4 Nicknames stick. We identify ourselves variously as medical sociologists, sociologists of medicine, etc. Let us watch that we do not start accepting our own emergent taken-for-granted which allows us to forget the task. This task, cumbersomely and programmatically, is to be expressed as the sociology of any social situation in which the designation of health and illness (terms themselves problematic) is an issue.
WHY I AM BROWNED OFF WITH QUANTITATIVE METHODOLOGY

A comment on Brown, Birley, Wing (1972) and Vaughn and Leff (1976)

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Recently, two papers have appeared in the British Journal of Psychiatry which together claim to have established a new fact to which psychiatrists are enjoined to pay regard when making discharge decisions (Brown, Birley and Wing, 1972; Vaughn and Leff, 1976). The first of these studies purports to have found a causal relationship between the nature of the affective environment of discharged schizophrenics and their readmission to hospital. The second is a replicative study which substantiates what the authors call the unequivocal nature of the results of the first. On the face of it the results do indeed appear quite convincing. However, more detailed examination reveals that what the authors have demonstrated is a common-sense observation which I suspect has always been recognised by psychiatrists’ and others concerned with the discharge and readmission of psychiatric patients.

Of course if researchers wish to spend their time scientising common sense judgements that is entirely their own affair. It becomes a matter of debate when their findings are presented as scientific facts which should be taken into account by practitioners when deciding upon disposal options. Furthermore, when a common-sense judgement masquerades as a scientific fact, it gains a spurious authority which cannot be gainsaid by available put-downs such as ‘that’s just an opinion’, or ‘that is generally true, but it doesn’t apply in this case’ and so forth. My personal commitment in addressing the following comments towards these studies is that I regard the form of scientism which they represent to be a positive hindrance to our understanding of schizophrenics and their families. Vaughn and Leff’s study stands or falls on the merits of the earlier research carried out by Brown et al. My remarks, therefore, are directed entirely to this. The principal findings reported by Brown et al. is shown by the following 2 x 2 contingency table. I address to this table two questions: 1. How was it produced? 2. What does it mean?

<table>
<thead>
<tr>
<th>Expressed emotion of relatives</th>
<th>No Relapse</th>
<th>Relapse</th>
<th>% Relapse</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>19</td>
<td>26</td>
<td>58</td>
</tr>
<tr>
<td>Low</td>
<td>47</td>
<td>9</td>
<td>16</td>
</tr>
</tbody>
</table>

P<.001

(From Brown et al. 1972, p. 246)
The table shows a statistically significant direct relationship between the level of emotion expressed by members of a household group living with a discharged schizophrenic patient towards that patient and the patient’s relapse. The higher the expressed emotion, the more likely is the patient to relapse. Relatives’ expressed emotion is an overall index arrived at by combining three indicators of emotional response towards the discharged patient. Assessment of the relative strength of these indicators were made by analysing data produced in a lengthy family interview. The three indicators are: critical comments, hostility and the emotional over-involvement of the relative. Relatives were categorised as expressing high or low emotion according as to whether or not they made seven or more critical comments about the ex-patient, expressed or did not express hostility about him or showed marked or low emotional over-involvement with him.

The most significant of these indicators in demonstrating high expressed emotion is the first, i.e. seven or more critical comments. This accounted for 35 of the relatives in that category. Hostility accounted for two and emotional over-involvement for five. The three remaining numbers of the high EE group were added following a joint interview, i.e. an interview where the patient was present. The criteria for allocating relatives into the high or low EE groups following this interview were different from those used following the joint interview. In particular, two or more critical comments were sufficient for allocation into the high EE group. This criterion added one relative, marked over-involvement added two, and hostility none. Hence 37 out of 45 patients lived with relatives who were assessed as being critical or hostile towards them.

Thus half of the answer to my first question, 'how was the association produced?', is as follows: Certain discharged patients and their relatives were interviewed. What they said at the interview and how they said it was judged to show hostility, over-involvement and criticism. If there was judged to be any hostility or marked over-involvement or seven or more critical comments the relatives were said to be expressing high emotion. To complete the answer to the first question we need to know how relapse was measured. Brown simply says that relapse was judged using all available information. Presumably this includes interview material and in the case of readmitted patients, hospital records. Twenty nine out of thirty five relapsed patients were readmitted. So much for how the table was produced. Let us now consider what it means. First of all, what do Brown and his colleagues think it means? They are in no doubt:

"...a high degree of expressed emotion is an index of characteristics in the relatives which are likely to cause a florid relapse of symptoms, independently of other factors such as length of history, type of symptomatology or severity of previous behaviour disturbance" (Brown et al. p 242. My emphasis)

Brown and his colleagues believe they have discovered a causal relationship between EE and relapse. Furthermore, EE is a measurement of characteristics in the relatives. It is thus a psychogenic variable. Later on in the same paper, however, Brown and his colleagues speak of the level of EE as ‘an enduring potential characteristic of the relative's behaviour towards the patient’ (p 246). I am not at all sure that I know what they mean by an enduring potential characteristic of behaviour. Perhaps they mean that EE in an index of personality characteristics which dispose or cause the relative to behave in a particular way towards the patient. This interpretation accords well with the first statement quoted above. However, my interpretation does imply that the second statement is elliptic and that this ellipticism obscures the model of relatives’ behaviour on which Brown's study appears to be based. The implicit model seems to be this: Relatives have inside them certain characteristics. When exposed to a certain stimulus - the patient - these characteristics are activated. Once
activated they cause the relative to behave in a particular way which, in turn, causes the patient to relapse. Diagrammatically Brown’s model of relatives’ behaviour seems to be this:

![Diagram]

As has been frequently pointed out explanations like this deny the volitional aspects of human action and for that reason alone must be rejected as satisfactory explanations of that action. There in no denying the fact, however, that the strong statistically verified relationship shown in the table above remains. If Brown’s explanation for the relationship, i.e. one based on a mechanistic view of man, is inadequate, then what might be a more adequate explanation?

An alternative way of accounting for the association between EE and relapse is given in diagram 1. This diagram is not to be seen as a flow chart if by that is meant a sequential series of stages. Rather it is an attempt to render intelligible, a process (schizophrenic relapse) by seeing it as the praxis of relatives and patients and others with whom they come into contact, particularly psychiatrists. This way of seeing is, of course, that recommended by Laing and Esterson (1971).

As Brown himself states, 'expressed emotion has a highly negative connotation' (p 253). In other words, when Brown assesses a high level of expressed emotion he is saying, in effect, that the relatives don’t like the patient very much. They are critical of him and hostile towards him.

Brown relies upon his own and his interviewers’ common-sense ability to recognise hostile and critical comments when they hear them, to see hostility in gestures and hear it in tones of voice. There is nothing exceptional in this ability. We all have it and we use it. However, neither we in our everyday lives nor Brown and his interviewers in their research activity are invariably right in judging that A dislikes B. The first point to notice then is that when Brown assesses high or low EE he may be wrong or right. That is to say, relatives may, in fact, like the patient when Brown assesses that they don’t and vice-versa. I assume that within the families studied by Brown there is a state of affairs recognised by them by which Brown may be said to be right or wrong. It seems to me to be silly to deny that our common-sense judgements of relationships may be incorrect. Insofar as Brown believes his methodology to be valid (which he does) he is denying that he may be wrong. In a separate paper (Rutter and Brown, 1966) devoted to the issue of the reliability and validity of the research instruments used in the study discussed here, Brown and his co-author describe in great detail the procedures followed to ensure validity and reliability. For him, therefore, expressed emotion (dislike) exists entirely **in and through the methodical practices by which it is recognised and described** (Garfinkel, 1967).
Brown Assesses Expressed Emotion of Relatives

1. He is more likely to be right since we can recognise dislike when we see it. Note that intuitive judgements and feelings disallowed.

2. No reported cases in Brown’s series.


4. Crucial assumption that a diagnosis of relapse is more likely following re-admission.

5. No relapse but not because low E.E. Such cases though assumed to support Brown’s theory.

Thus, I accept that for Brown, relatives’ dislike of patients exists in and through his methods of recognising and describing it. I do not accept that these methods constitute the totality of the affective components of the households he studies. In short, Brown may be wrong. He is, though, I submit, more likely to be right than wrong. This is not because of the excellence of his research instruments as Brown believes, but simply because both he, his co-authors and his ‘hired hand’ researchers are ordinary, competent members of society who can, as a matter of fact, recognise, a criticism when they hear it. But while Brown relies on common-sense to recognise a critical comment, at other points in his research design common-sense is thrown out of the window as being unscientific. For example, in treating critical comments as ordinal data he assumes that one critical comment carries as much censure as any others. Again, he denies the ambiguity of family relationships and characterises them as either hostile or not hostile. His interviewers were counselled against allowing their ‘feelings’ to interfere with their judgements of the affective aspects of the households they visited. All these offend common-sense. Thus, although Brown is likely to be right in his assessment of dislike as long as he relies on common-sense, insofar as he rejects common-sense, he is
more likely to be wrong. **The more scientific he is, the more wrong he is likely to be.** For reasons which will become plain as we proceed, I believe that the strong association between EE and relapse is due entirely to the greater likelihood that Brown is right when he assesses that a patient is not liked very much.

Let us assume that Brown is right when he assesses that a patient is not liked very much. Further, let's try and see the family situation from the point of view of the patient by imaginatively taking his position. If we are in a situation where we are not liked we may reach a point where we try to escape from it. Escape may involve physical removal from the situation or social withdrawal. The second is effective only as far as the others allow you to withdraw. Both forms of withdrawal require a level of command over scarce resources, namely accommodation, either a separate and private room in the household home, or accommodation outside the household home. We need to ask, therefore: Has the disliked patient somewhere to go apart from hospital? If the answer is 'Yes' the patient leaves the situation in either of the above senses. If the answer is 'No', we then have to ask: Does the patient resist readmission? If the answer is 'Yes' we have then to ask two questions. Firstly, what resources are available to the patient to resist readmission and remain sane in the household? Whatever the available resources, among them is likely to be one of the major tranquillisers routinely prescribed for discharged schizophrenics. Secondly, what is likely to occur in a household in which the patient is disliked and refuses to leave? My commonsense hunch would be that the level of conflict in the household is likely to increase. We would not be surprised, therefore, to find some cases of high dislike, relatives' reports of severe disturbance in the patient, the patient following the medical regimen (he takes tranquillisers because he himself defines his need for them) and no relapse (if he relapses the patient knows he will be readmitted). And this is precisely what we do find among Brown's data. Since Brown's implicit theory effectively denies human volition he regards this state of affairs as a paradox. We now see it not as paradoxical at all but as a state of affairs brought about by specifically human action.

The disliked patient, however, may not resist readmission and may indeed, actively seek it as a means of egress from the household. Should he be readmitted I hypothesise that either he will be assumed to have relapsed, or any assessment of his behaviour will be biased towards a finding of relapse once the patient has been readmitted. I regard this hypothesis as plausible on three counts: Firstly, relapse was assessed by Brown using all available information. Presumably this includes relatives' reports of the patient's behaviour. Relatives who dislike the patient are more likely to define the patient's behaviour in a way that renders it perceivable as symptomatic as a means of extruding him from the household. Secondly, the patient himself may mimic psychiatric symptoms as a means of escaping from the household (Braginsky and Braginsky, 1969). The belief of medical and nursing personnel that psychiatric patients can act insane is documented in the literature and the simulation of psychiatric symptoms is a recognised syndrome in clinical psychiatry: the Ganser syndrome. Thirdly, other research has shown psychiatric diagnosis to be manifestly influenced by social context. The patient's presence in the hospital requires psychiatric legitimation. A finding of relapse is, therefore, likely.

An important feature of this rendition of Brown's significant association is that the problem of cases which don't fit Brown's hypothesis disappears. Cases which deviate from Brown's hypothesis are cases either where his assessment of dislike is wrong or the patient has somewhere to go or the patient resists readmission.

It might of course, be argued that even allowing the plausibility of my rendition of Brown's research I have not disproved his hypothesis. This is perfectly true, but do we really need research of this kind to convince us that discharged patients living with people who don't like
them are more likely to be readmitted than those who live in a more sympathetic emotional atmosphere? If we do, we seem in great danger of substituting a mystifying welter of reified statistics for our common sense.

References


Science and Common Sense: A Reply

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Harris’s article in the January number of *Medical Sociology News* criticising the London research on schizophrenia depends throughout on a dichotomy between ‘common sense’ and ‘science’ which are at no point defined or explained. Moreover its attack is sometimes based on the argument that the work is common sense masquerading as science but elsewhere it is seen as rejecting common sense. This makes a reply difficult and only in his last sentence do we get a hint that his doubts stem from a suspicion of quantitative expression - ‘a mystifying welter of reified statistics’.

Since at heart doing science consist of a persistent effort to seek as honestly as possible answers to particular questions about the world, it is the procedures used, not the answers obtained, that distinguish it from common sense. Moreover science does not expect to obtain a completely valid description of the world or a final understanding of it. A scientific study merely sets out to measure the world well enough to arrive at a plausible answer to questions. Measurement has only got to he good enough to achieve this. It is therefore silly for Harris to say that he does not accept our measures ‘constitute the totality of the affective components of the households’ we studied. Who ever claimed that they were? We claim no more than that they are relevant and valid enough to test whether the emotional atmosphere in the house influences the course taken by a schizophrenic disorder. The statement ‘insofar as Brown believes his methodology to be valid (which he does) he is denying that he may be wrong’ illustrates the depth of the confusion here. The term belief is used pejoratively: the appropriate idea would he a struggle to believe. Methodology consists of procedures and arguments that can at best influence, positively or negatively, a confidence in one's results. This is always a matter of degree - confidence can never be absolute. To repeat, methodological considerations are not concerned to achieve totally accurate or comprehensive measurement (an impossible task) but to arrange measurement in such a way that, given a particular set of results, the investigator can rule out as implausible interpretations of the results other than the one he believes to be correct. There is no question of claiming at any point infallible knowledge. Indeed, scientific knowledge is often best viewed in economic terms: given that effective research is expensive in terms of money and time, is the pursuit of a question justified? Should we go on and if so, in what way? The study under discussion is the third of a series and now over twenty years since the start of the programme, work on the role of expressed emotion (EE) is currently being carried out in the UK, USA, Denmark and India. When this work is complete we will be more sure or less sure of what we know: it is unlikely that our knowledge will remain unchanged.

Harris early in his paper seems to be convinced that our conclusions are no more than common sense and, I infer, that the work need not have been done. This is a historical and an intellectual misjudgement. When I first thought in terms of the influence of home atmosphere twenty years ago there was no question of the idea’s general acceptance. There was a widespread belief in an inevitable endogenous process in schizophrenia and the extraordinarily disturbed and unusual condition of many chronic schizophrenic patients did not make this view absurd. Second, he ignores the plausible alternative interpretation of our
results and our long struggle to rule it out. This is that there is no causal link between degree of expressed emotion (EE) and relapse: that the patients’ disorder determines both EE and relapse and the apparent causal link is spurious:

To ignore such major methodological questions is to trivialise the research and to underplay grossly the need to test ideas.

Harris is also muddled about the idea of causality. He questions the relevance of our interpretation because it denies ‘the volitional aspects of human action and for that reason alone must be rejected as satisfactory explanations of that behaviour.’ This again posts a dichotomy the elements of which are unexplained. We, in fact, make clear that those involved are not without some personal influence. The patient can, of course, take drugs. We also demonstrate that the schizophrenic patient when returning to the ‘wrong’ sort of home can, by reducing the amount of face-to-face contact in the home, much reduce its adverse effects. But this is not the same as saying that a patient necessarily realises the full implication of what he or she in doing. One young woman told us how she no longer lingered after a dance to make love behind the local hall, as she had learned that this brought back the voices in her head. This degree of understanding in probably uncommon but it is possible, and one consequence of developing knowledge of aetiological processes is the chance of incensing such self-awareness. But the general point is that in sociological research we can never assume we know the degree to which ‘volitional’ and ‘deterministic’ components are involved in a situation: it in an empirical issue to be settled for every situation anew. What we can be sure about is the uselessness of a general assertion of the kind made by Harris.

The matter in inherently complex. Having plans in not the same as being able to put them into effect; putting plans in to effect in not the same as achieving them and achievement will not necessarily lead to the emotions that we hoped would flow from the successful realisation of our plans. At best we are only partially and episodically in control of our experience. It is a travesty of this view to claim it is mechanical. I should add in this context that I am at a loss to understand his discussion on page eight where he discusses patients returning to a high EE home, who have been seriously disturbed before admission, who take drugs after discharge and who do not relapse. In interpreting this in so-called volitional terms he seems to suggest that the patient does not relapse because ‘if he relapses the patient knows he will be readmitted.’ This might be intended to mean that this is why they took drugs and this is the reason for them not relapsing. If so this is entirely consistent with our position; or it might be meant to suggest that patients can decide whether or not they will relapse. Our view is that schizophrenic patients do not have this control in the sense they can decide
whether or not to catch a bus. But they certainly do have potential for doing things that will lessen the chance of their getting into a situation where their experience of schizophrenic symptoms gets out of control. And I have no doubt that patients to varying degrees develop and utilise such 'knowledge'. If we assume that a phenomenon in entirely 'determined' or entirely 'voluntaristic' we will not only almost certainly be wrong, we are almost bound to rule out the development of effective social theory. Such theory in essence is about constraints and the degree to which they may be 'overcome'.

A more general point can be made. The argument illustrates a common fallacy - that of confusing procedures employed for methodological purposes with ideas held by investigators about the nature of the phenomenon they study. It is an though a scientist were accused of denying the existence of colour because he based his research on black and white photographs. Of course, it is possible that some are led astray - that they do doubt the existence of colour. But this cannot be used to impugn the method; the correct deduction in that we must work to obtain and retain a self-awareness of the status of our methods. Simple-minded dichotomies of the kind made by Harris obscure this vital issue.

Confusion seems in part to arise from his ideas about what we have measured. I quote: 'For him, therefore, expressed emotion (dislike) exists in and through the methodic practices by which it is recognised and described.' Once again Harris’s argument rests on the assumption that science claims to encapsulate totally its subject - a straw man. And furthermore that if one’s methods play a role in shaping one's results, this constitutes a reason for the blanket rejection of results. That by nuking operational assumptions one will inevitably be wrong. For example, that using ‘critical comments’ as though they were equivalent to each other must lead us astray. (In fact in our earlier papers on measurement we describe an overall measure of criticism not making this assumption - this gave much the same result in predicting relapse as the count of individual critical comments). This again implies a view that science is either right or wrong - a straw man epistemology. It also follows from such a view that only exhaustive description could avoid being wrong. Yet to invoke Garfinkel (as he does), every description has to be finite and limited in its selection of reality. The world exists only insofar as we are able to develop categories that describe it. We, of course, still need to deal with the accuracy of our measures and whether the process of abstracting has produced casual links where there are none. And given our measures survive such tests we need to go on to question the status of any theoretical interpretations that we have made.

I will deal with the issue of measurement inaccuracy and error first. Harris notes that 'intuitive judgements and feelings are not allowed' in our measurement of EE. We make it clear that they are. If we use observers to measure emotion there is no other way to proceed. While we systematise such judgements, we have never doubted that for this we use tacit knowledge and skills, developed and used in everyday life. There is evidence that we have managed to do this reasonably well (see Brown and Rutter, 1966; Rutter and Brown, 1966). Our belief that our results are not artefacts is strengthened by the measurement of expressed emotion before any relapse. I, in fact , know of nothing about our measurement procedures that suggests that the links we have obtained are not casual: that returning to a certain kind of home atmosphere often leads to a relapse that would not have otherwise occurred. But ideally experimental confirmation in still required.

The second issue of the theoretical status of what we were measuring and the interpretation of the reasons for the link between EE and relapse is more open. Harris seems unaware, however, that many of the theoretical concepts and measures in the social sciences involve dispositional concepts: constructs that indicate that a person in likely to act in a certain way given a certain set of conditions. We believe our measure of EE most likely reflects a disposition of the relative to act in a certain way towards the patient under certain conditions.
While this interpretation at present is speculative, Harris again manages to trivialise the matter. He, for example, equates high EE with dislike of the patient. But we already know enough to be confident that such a general interpretation will not do. For instance, extensive dissatisfaction with the patient was common; and yet unless dissatisfaction was associated with seven or more 'critical comments' it was unassociated with an increased risk of relapse. This result held however marked the dissatisfaction. Moreover, high emotional involvement was associated with relapse irrespective of criticism or hostility.

Harris also at this point ignores our broader theory about schizophrenia - that schizophrenic patients are particularly sensitive to too little or too much stimulation. That with too little stimulation they can develop the signs of extreme withdrawal, poverty of speech and even muteness, to be seen in old style chronic mental hospital wards; and that with too much stimulation they can develop florid symptoms, the latter developing in response to the experience of any marked emotion including joy and excitement. Although he may not agree, it is misleading to reduce our work to 'coping with dislike' without dealing with these theoretical ideas about the nature of schizophrenia.

There are many other criticisms I could make. But I will restrict myself to one more: about the nature of schizophrenia. Implicit in Harris's interpretations is the wish to deny the existence of schizophrenia and its manifestation in characteristic florid symptoms and disordered behaviour. His opening insistence on the common sense nature of our results appears to derive from this. For him relatives who dislike the patient are more likely to define hint behaviour in a way that renders it perceivable as symptomatic, the patient may mimic psychiatric symptoms, the patient's presence in hospital can lead to the definition of symptoms as a means of legitimising his presence. In other words any interpretation other than one accepting that schizophrenic phenomena exist, cause great distress and present a major medical and social problem.

Recent community studies have been, as far as I am aware, completely in accord about the extent and seriousness of the symptoms and handicaps of discharged schizophrenic patients. If there is not a core of characteristic symptomatology at the heart of the disturbed behaviour of schizophrenic patients, I am at a loss to conceive of an explanation of what has been documented in these studies. That someone may be able to mimic a schizophrenic disorder in order to fool a hospital psychiatrist is irrelevant for this issue (and whether this has been done is in any case in some doubt - see Spitzer, 1976). My experience of schizophrenic patients has been that the majority have arrived in treatment only after persistent efforts by relatives and friends to deal with them as though there were little or nothing wrong. I would not wish to undervalue the effectiveness of such an attitude. It may help patient and family to cope. But to persist in such a view – that nothing essentially is wrong that everyday responses cannot put right - can lead to distressing, if not tragic consequences. Harris may well consider the implications of David Reed's account of his wife's schizophrenic illness in his book *Anna*.

I will make a final and more general point. Underlying invective of the kind that Harris pours on science appears to be a rejection of attempts to sum up the complexity of the human condition in abstract, and perhaps numerically expressed, principles. This is a false fear. As Toulmin has made clear, even for the physical sciences, the actual complexity of the real world can defeat any straightforward practical use of its principles. Although Newtonian and later physics gives us a satisfactory explanation for the phenomenon of tides, the only way to predict the tides at Southend is to go there and measure them. Likewise, at best we may obtain principles of relevance to the course of a schizophrenic disorder. These will be fallible not only because to some degree they are bound to be inadequate but because we cannot possibly predict (or control) the contingent factors likely to impinge on the patients' life. A
patient may return to a 'perfect' home according to our principles, but an unexpected occurrence (say the return of the landlady's son from sea) may transform the situation. This is why we will always need 'clinicians' to 'translate' any scientific principles we acquire; and this is why there will always be a place in the social sciences for intensive descriptions of the individual and his life. But to confuse either with the building of broader principles - and fallible knowledge - is pitifully misguided.

REFERENCES
SCIENCE AND COMMON SENSE: A rejoinder to Professor Brown

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I thank Professor Brown for his lengthy reply to my article in the January edition of Medical Sociology News. However, for all its length, Professor Brown has not answered satisfactorily my main criticism which is that his research boils down to the observation that discharged schizophrenic patients living with relatives who do not like them are more likely to be readmitted to mental hospital than are those patients discharged to families where they are liked. Brown simply states that in equating High EE with dislike I manage ‘to trivialise the matter’.

My criticism was, and remains, that in calling criticism, hostility and emotional over-involvement ‘expressed emotion’ and according this manufactured psychogenic variable a causal status in ‘relapse’ Professor Brown manages to reify the matter.

The crux of the contention is whether I am justified in regarding High EE as basically an indicator of dislike. Suppose during a conversation the person you are talking with makes several critical remarks about an absent third person and/or indicates strong hostility towards that person. It would seem to me that you would have strong grounds for concluding that the person you were talking to did not like the other person very much.

Professor Brown reminds us that ‘high emotional over-involvement was associated with relapse irrespective of criticism or hostility’. Indeed it was, but this indicator of High EE added only 7 out of 45 families to the High EE subgroup. Moreover, the predictive power of this indicator was much less than 7 or more ‘critical comments’. The association between High EE and relapse was therefore created predominantly by the families who were critical about the patient. To make the matter clearer suppose, for example, than an England football team were to win the World Cup by fielding a side containing nine Manchester United players*. Would we not conclude that this indicated the overall strength and depth of Manchester United rather than English football as a whole? And would we not suspect special pleading if a commentator played down the contribution of the Manchester United players compared with the two from elsewhere? The analogy must not be pushed however, for while 11 football players constitute what is recognisably a team, Professor Brown's High EE is a reified device which serves to mystify the relations between people.

Since ‘marked emotional over-involvement’ did not materially affect Professor Brown's results we might justifiably ask why he retained it in his ‘overall index of EE’. Could it be that had he left it out he would have been clearly seen to be wearing no clothes?

This particular research conducted by Professor Brown would probably best be left buried in the pages of the British Journal of Psychiatry were it not for the fact that a recent collection of ‘Basic readings in medical sociology’ (Tuckett and Kaufert 1978) gives pride of place to an article by Brown and Rutter which describes the methods used in the study I have criticised and another by Vaughn and Leff which replicates Professor Brown's research on EE, warts and all. Both articles are to be found in the opening section of the book under the heading 'Sociology as a Science', where presumably they are intended to stand as examples of the best scientific work available within medical sociology. Thus, the pretentions of those who
count, while losing sight of what it is they are counting, are enshrined, legitimated and objectified for consumption by the next generation of students.

* I am grateful to Bill Bytheway for suggesting this analogy.

REFERENCE
David Tuckett and Joseph H. Kaufert (ed.) Basic Readings in Medical Sociology, Tavistock 1978.
In his rejoinder to my reply ‘Science and Common Sense’ to his original statement in the January number of Medical Sociology News, Harris has ignored my points and turns from broad criticism to a specific issue concerned with analysis of data. Since he shows here an equal penchant for seeing only what he wants to see, I am writing a brief and final reply.

He claims that the EE (expressed emotion) index is no more than a measure of dislike. He notes that only 7 of the 45 families high on EE are ‘added’ when high emotional over-involvement is taken into account and uses this to argue for the overwhelming importance of ‘dislike’ in the EE index. However, he fails to note that emotional over-involvement only produced relapse for patients returning to live with parents - a point emphasised in our paper. For these patients returning to parents the emotional over-involvement measure makes a quite sizeable contribution to the index. But this is not all. It is misleading to refer to patients ‘added’ to the index in the context of his argument as what is added depends on an arbitrary decision of what measure is considered first. If, in forming the index, we had first considered emotional over-concern rather than criticism and only ‘added’ criticism at the second stage, double the number of patients would have been contributed by emotional concern measure to those high on EE. Of patients returning to high EE homes, 48% were included for criticism alone, 24% for emotional over-involvement alone and 28% for both criticism and over-involvement. There is therefore no justification in any theoretical interpretation of these results for giving priority to criticism. Harris confuses this point by selecting for his illustration mutually exclusive categories - you either play for Manchester United or someone else. Once this is accepted the issue of importance cannot be sorted out along the common sense lines advocated by Harris: and clearly over-concern is not the same phenomenon as dislike.

Harris by talking in general about dislike also manages to obscure another issue – that of categorising degree of dislike. It was when only a particular number of critical comments were exceeded that criticism predicted relapse i.e. seven comments. Even if dislike is an important component of our measure (as it probably is) just how much and of what kind has still to be established.

Harris has largely rested his case again systematic measurement in social research by setting up a straw-man account of scientific activity. I earlier argued that his account is grossly misleading and I will not return to this. However, irrespective of the merits of my argument about scientific activity there is no doubt that much sociological measurement is inadequate. Harris appears to be concerned to denigrate the London measures because, without such work, it would be easier to equate these widespread shortcomings with a scientific approach. I am convinced that they have in fact nothing to do with science as such. They result largely from ignorance and the need to measure things on the cheap.

Since Harris has failed to sustain either the case against science or against our measures, he might, I suggest, consider the implications of his failure for current research in medical sociology.
MEDICAL SOCIOLOGY AND HEALTH CARE MANAGEMENT

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The conceptual, empirical and methodological approaches that are the stock-in-trade of medical sociologists contain much of value for practising health care managers in furthering an understanding of the management process and its concern with policy formation and implementation. Yet I wonder if many medical sociologists or health care managers would agree that this is so.

Medical sociologists are most at home studying perceptions of symptoms, social class and inequalities in health, lay referral systems, the sick role, professional socialisation and a host of other similar issues. Without denying the importance of any of these for health managers and others, medical sociologists may have more to contribute than they realise to the study and development of health care management itself. My firm belief in this view took shape while engaged on a review and assessment of research relevant to the management role in the Scottish Health Service commissioned by the Chief Scientist’s Health Services Research Committee. The conclusion I reached is that the social sciences in general and medical sociology in particular, can bring new perspectives to the study of the organisation and management of health care.

Without becoming embroiled in an unproductive argument about what medical sociology is (I view it as an eclectic assemblage of interests and skills), it is apparent that the boundaries within the social sciences are becoming increasingly blurred. It is a development to be capitalised upon in terms of theoretical and empirical work on health care management without losing the basic integrity of each discipline. My concern is that medical sociology may be excluded, or may exclude itself, from making its own unique, albeit partial, contribution.

Improving management in the NHS has been a constant theme in its development and the Service is currently emerging from a further upheaval, one that has been hailed as the most far-reaching, for it is aimed at changing the management culture and not merely the structural apparatus.

The more the structure of the Service is rejigged, the less it appears to change. The failure of successive reforms across the public sector, including the NHS, over the past decade or so stems in large measure from the inadequacy of the approach adopted and the virtual absence of adequate empirical evidence that particular reforms and theories are soundly based and workable. Changing institutions in order to change behaviour is always likely to fail as a reform strategy, unless attention is given to the participants and their behaviour. The neat portrayal of organisations like the NHS in ‘charts and boxes’ bears little resemblance to their complexity.

Organisational research and analysis, in which medical sociologists can play a prominent part, can be of practical value in demonstrating how complex organisational life really is. Out of ignorance and a misguided faith in a conception of rationality that is at odds with practice, reformers have failed to recognise the NHS’s power structure, the capacities of groups to
bargain and influence and the importance of historical legacy for the shape and character of organisational arrangements.

Health care policy and management issues rarely occur as simple economic, sociological, political, psychological or epidemiological problems, but as variants of all of these. The study of organisations ought to be approached from an interdisciplinary base. There is, I believe a danger of the medical sociologist not figuring in this disciplinary mix. Even if it is the case that 'applied' disciplines, like economics, are more comfortable doing research on issues of public policy importance, the situation is not immutable. There is a need to ensure that valuations, other than economic ones, are produced.

Medical sociology will not provide exact formulas or precise prescriptions to aid day-to-day decisions, nor should it. Its contribution is in providing illumination in order to sensitize managers to the reality (or realities) they confront. By providing knowledge and a critical perspective, or searchlight, the medical sociologist can make a useful contribution to the management of health care and to raising the level of public debate about health policy.

There is much to be done. To begin with, there is the activity of management itself. What is management in a health context? What is successful management? Who are the managers? What have been the achievements (and failures) of successive managerial reforms? Answers to these questions are not as straightforward as the questions themselves. A growing body of literature, most of it American, has sought to explain what it is that managers do and to identify the ingredients of successful companies, managers and leaders. What emerges are organisations that operate quite differently from the dominant conception of the effective organisation. Our health care arrangements have not been subjected to such a searching inquiry. Medical sociologists are well placed to take part in an exercise of this nature, providing they genuinely want to, and invest in establishing relations with health managers.

Without allowing counsels of despair to dominate, one must not expect too much from medical sociology research. As in other areas of social life, social scientists' findings in the sphere of health policy and management can be uncomfortable and may pose a threat to the existing order. Nevertheless, a contribution remains valid and one that will extend the traditional concerns of medical sociologists cited earlier.

Health care managers are presently confronted by a series of ambiguities, contradictions and tensions which go to the roots of what the NHS exists to do. These centre on the ability of the Service to adapt to changing demands and priorities; to innovate and implement change; to restructure internal relationships as the organisation is re-shaped to tackle the changed nature of its environment, e.g a shift from institutional to community care, an altered demographic profile, the public-private mix in health care provision.

At least five key issue areas in contemporary health policy may be identified as meriting attention from medical sociologists.

**Environmental forces.** The NHS cannot be detached from its social, political and economic setting, although it is invariably looked at in isolation.

**Improved management performance.** Before we can talk seriously about improved performance, we need to learn more about what it is that managers do, or think they do.

**Medical technology and innovation.** The use of technology is not merely a technical matter but also a major policy issue with social implications. Little is known about why some innovations are successful and why others fail, particularly in regard to the organisation and provision of services.
Internal organisational relationships. Within health care, there exists a whole range of important issues surrounding the management of services, e.g. relations between clinicians and managers, between consumer groups and managers and between organisations involved in the provision of care. Without a sound understanding of the current dynamics of health care management and of the assumptions, views and behaviour of the participants, attempts to effect change can founder.

Intra-UK comparisons. It is not widely appreciated that the NHS operates differently in each of the four countries making up the UK in ways which might affect management performance. There is scope for comparative work aimed at assessing the significance of these differences.

In tackling this incomplete agenda of research issues, medical sociologists have an important input to make. But unless this is actively acknowledged, it is almost certain that the research endeavour will be dominated by other disciplines which will neither serve as effective substitutes, nor compensate for the loss of a unique critical perspective.

References
1 Hunter, D.J. Managing the NHS in Scotland: Review and Assessment of Research Needs, Scottish Health Service Studies No 45, Scottish Home and Health Department, Edinburgh, 1985.
The following six related articles, commencing with Professor Marsland's piece in MSN Volume 14, Issue 2 in April 1989, and concluding with his report in MSN Volume 19, Issue 1 in December 1993, are published here, together, for the first time.

PROGRESS IN HEALTH CARE: A SOCIOLOGICAL APPRECIATION OF THE NHS REVIEW AND ITS POTENTIAL BENEFITS

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Reactions to the NHS Review seem so far to be wearisomely predictable. The opposition parties in Parliament, their media allies, the left en bloc, the health unions from the BMA downwards, and orthodox opinion in the social sciences have condemned it in its entirety. One might be forgiven for thinking that the Review were recommending an equivalent to Dean Swift's ironically intended final solution to the Irish problem - eating babies. One might imagine to judge from the self-righteous hysteria provoked in the health establishment by the Government's modest and cautious proposals that the NHS were beyond improvement, and as unimpeachably sanctified by history and tradition an Magna Carta.

Challenges to this chorus of negativism have so far been few and far between. One interesting and important exception, however, was provided by Chris Ham of the King's Fund Institute, writing - where else - in "Marxism Today" (March, 1989). Headlined "Kenneth Clarke: far reaching and imaginative proposals", he rejects opposition allegations that the Review is a prelude to privatization, and suggests that introduction of incentives for doctors and hospitals will produce services which are more responsive to patients. "In tandem", he says, "competition between providers will be used to stimulate greater efficiency in the use of resources". He counsels a "discriminating response" by "those on the left", and argues that "outright rejection of the White Paper would be both wrong and a missed opportunity". While advising of possible dangers, he provides what is unambiguously a positive evaluation of the Review overall, admitting weaknesses in the NHS which have for too long been irresponsibly denied, and urging solutions to these problems along the broad lines recommended in the Review. Thus:

"The NHS clearly has a number of weaknesses that need to be tackled, including a lack of responsiveness to patients, the wasteful use of resources, and the lack of accountability of doctors. Where the Government's proposals offer the prospect of addressing these problems, they should be welcomed".

I would broadly agree with this analysis, which finds further support in a new study of consumer preferences by Peter Saunders and Colin Harris ("Popular Attitudes to State Welfare Services", Social Affairs Unit, 1989). I would seriously advise colleagues involved in research and policy analysis in the health sphere to reflect carefully on the deficiencies in existing health care arrangements and the scope provided by the Review for real improvements in the quality of service offered to the mass of ordinary people before they join the unthinking chorus of condemnation. It goes without saying that serious reform - any serious reform - always involves risks, always imposes costs, and usually leads to at least
some major mistakes which will need correcting. But without serious reform we face in health, as in every other sphere, stagnation and decay.

**Reviewing the Review**

There seems to be eight major topics in the reforms proposed by the Review. I shall briefly comment on each of these separately, indicating the major lines of criticism and the counter-arguments. In this I shall limit myself to practical and policy considerations.

In each case I shall add some further specifically sociological observations designed to open up technical debate among readers of this journal. In this aspect of my analysis I am drawing in part on the critique of orthodox modern British sociology which I have presented in my book “Seeds of Bankruptcy” (Claridge Press, 1988) and elsewhere.

For Medical Sociology seems to me at least as much prone as other sub-fields of the discipline to fundamental errors in theory and methodology. In the sphere of health, sociological errors and confusions have produced a contradictory mixture of hysterical critique and craven flattery of existing health care institutions. Perhaps the Review will provide the opportunity for Medical Sociology to review itself and thus to amend and strengthen its analysis.

**Self-governing hospitals**

The Review proposes the establishment of NHS Hospitals Trusts which will allow major hospitals to become self-governing. Criticisms are of three kinds. First the danger of self-government becoming privatised independence; secondly the risk that local provision of essential services may be threatened; and thirdly the challenge posed to supposedly essential large-scale planning. On the first, the Review and the Government are clear and firm: no privatisation is intended. Similarly the Review unambiguously guarantees that essential local services will be protected. The third criticism goes to the heart of this first proposal. The basic assumption underlying it - which I find entirely persuasive - is that bureaucratic planning has failed, and proved itself thoroughly counter-productive. Major hospitals need the freedom and flexibility which only self-government can offer if they are to serve the complex, changing needs of patients well.

The sociological issues posed by this first proposal - how to optimise effectiveness in complex organisations, how to provide coherent services while avoiding bureaucracy, how to provide for planning without impeding initiative are all standard themes in general sociology, but somehow curiously neglected in recent medical sociology.

**Re-structured health authorities**

The role of the health authorities will be substantially changed by the Review’s proposals concerning self-government, funding, management, and family doctors. There was in any case much dissatisfaction, internal and external, with their operation even before the Review was contemplated. It seems a little curious therefore to find critics rushing to the defence of the RHAs.

The proposed changes are intended to make them more professional and more efficient, and to reduce politicisation. All of these are surely proper and sensible objectives, likely to be resisted only by those with a vested interest in political interference in health care management.

For sociologists extremely interesting and important issues are raised about the relations in a democracy between the central state, the local state, organised labour (particular professional labour), and specialised institutions and their senior managements. Querulous
one-sided complaints about centralization hardly seem a plausible approach to investigating such complex issues with the dispassionate care they call for.

Flexible funding
RAWP and its associated elaborate formulae and procedures are to be replaced by simpler methods of resource allocation and an internal market. This seems to me potentially one of the most radical proposals in the Review. Critics object mainly in terms of “thin end of the wedge” argument about markets, and out of what looks to me very simple prejudice against any serious use of monetary criteria in welfare services.

On the issues involved sociologists ought to be capable of providing useful guidance. In any large-scale organization - and the NHS in as big as any - internal resource allocation decisions are inherently problematic. The choice - which commonly turns into arbitrary oscillation between de-centralised competitive procedures and authoritarian centralised systems regularly turns out to be a "Devil and the deep blue sea" scenario. An internal market, recognising real cost, profit, and efficiency centres, perhaps offers a way through this deep-seated dilemma.

Modern management
The Review heavily emphasises the need for improved management capable of providing value for money and handling the more complex tasks posed by the other proposed reforms efficiently. The over-bureaucratised structure currently in place in to be streamlined to allow local management "to get on with the task of managing".

In the main, criticisms have focused on the supposed threats to union pay negotiating strength. Of course these anxieties must be attended to, but in principle there seems to be no reason why more localized authority, including even pay flexibility should not be advantageous to the majority of health service personnel. And in broad terms - in which for once sociologists might concur with the man and woman in the street - it is surely desirable to make a serious effort at reducing bureaucratic over-management and giving managers at all levels the discretion they need to do their essential job well?

More consultants
At least one proposal in the Review which should escape criticism in for a significant increase in the number of consultants. This should at the same time reduce waiting lists and improve career prospects for junior doctors. However, alongside this increase in resources, the Review promises a new and more effective form of medical audit, confidential and peer-controlled, but nevertheless seriously equipped with teeth.

This whole package, which also includes reform of merit awards, seems to me sensible and overdue. It acknowledges consultants' crucial importance and indispensable value, while at the same time seeking to limit any possible abuse of their considerable power.

Medical sociology has tended by and large simply to treat senior doctors an villain-chieftains of the so-called "medical model". Perhaps we may now hope to see more careful attention to the real complexities of the work and careers of specialist senior medics?

Healthcare at the front line
As I write, a large-scale "mutiny" among GPs in the face of the Review's proposals is brewing. This is predictable and understandable. At first blush the main thrust of the Review is to set cash limits and require GPS to pay more attention to their costs than has been usual.
However, it seems to me a short-sighted reaction. The Review acknowledges generously the key role of family doctors in health care which is likely to increase still further as the emphasis shifts from treatment to prevention and health promotion. Larger practices are to have their own budgets and the capacity to spend it on the patient’s behalf wherever they can get the best deal in terms of quality and price. Savings can be ploughed back into improvements in the practice.

This redresses the balance between doctors and hospitals significantly. At the same time these proposals are likely to reduce drug prescribing - a change which nearly everyone concerned about health care has been pressing for.

No doubt some doctors will be anxious about their capacity to handle their new freedom and responsibility, and critics have argued that attention to budgets will distract doctors from quality care. There may be need for some adjustments to this segment of the Review’s reform proposals. But this has been anticipated from the start by the - supremely pragmatic - Minister, and in seems to me equally likely that the pay-off to patients in terms of improved quality of service will be higher from this part of the reform proposals than from any other.

Hopefully sociologists will be joining actively in careful, objective evaluation of the consequences for patients.

**Patients first**

The whole Review is focused on improving the quality of care and service for patients. It is a health consumers' charter. More specifically the Review calls - not before time - for appointments systems, improved waiting rooms and family facilities, information about facilities and services, better complaints procedures, etcetera.

All this seems to me absolutely commendable. One of the gravest weaknesses of the NHS has been the tendency for patients' interests as consumers to be ignored. Even a state monopoly is after all a monopoly. I find it surprising and disappointing that in general sociologists have done so little by way of acknowledgement and exploration of this serious deficiency.

**Towards the future**

The eighth and last aspect of the Review I shall deal with concerns the private sector. Here the left were anticipating a dreadful lurch away from basic NHS principles, while the right were sullenly resigned to their demands for a serious reconsideration of 1940s thinking being ignored altogether.

As it turns out, the Review Charts a moderate path which seems to have perplexed left and right alike. Tax relief on private insurance has been offered to the over-sixties and various suggestions for collaborative partnership between the independent sector and the NHS have been proposed.

Of tax relief the Nursing Times (Vol. 85 No 6 February 1989) says plausibly enough that it "will generate enormous ideological debate, but in short and medium terms at least its direct effects are likely to be very limited". For sociologists the Review's considered allegiance to the status quo in this ideological debate - that is to say a positive partnership between public and private, with the former substantially predominant - should provide an opportunity for more dispassionate and open-minded analysis of private sector provision than has been typical hitherto.

Even the most careful studies, such as Joan Higgins' "The Business of Health Care" (Macmillan, 1986), have tended simply to presume that the private sector's contribution to health care is unnecessary, regrettable, and overdue for termination. We might now show
ourselves at least as pragmatic and open-minded as the Review, and assess the public/private balance on its merits.

Saunders and Harris conclude their analysis of popular attitudes to state welfare services as follows:

“If this analysis is correct, then the choice for those concerned with public policy is clear. They can attempt to suppress the growing demand for the right to exit from the state System, or they can start to restructure the system of state support so as to enable consumers to express their preferences effectively. State monopoly provision in kind is being rejected by increasing numbers of people, but the state still has an important role to play as a facilitator rather than a provider. Policy-makers would best be advised to work with the change that is coming by enabling people to purchase the services they want, rather than attempt to stand out against the tide”.

This tide is not to any substantial extent reflected in the White Paper, which largely concerns itself with improving the capacity of a better organised and more effectively managed NHS to provide good quality, value for money, care for patients. Not, however, does it exclude movement in a more liberal, less monopolistic, direction in the future, supposing popular demand were to shift as Saunders and Harris predict.

Perhaps sociologists will manage - despite the persisting influence in medical sociology of such work as Navarro’s, and our tendency to treat the NHS as an index of welfarist virility rather than as a practical instrument for delivering certain important services effectively to achieve at least the White Paper’s level of honest pragmatism. What matters most, surely, is that our excellent doctors and nurses should have the administrative systems, management structures, and resources available to them which will allow them to give their patients the best of care.
THE NHS REVIEW: THE NEED FOR A CRITICAL SOCIOLOGICAL ANALYSIS

Gareth Williams and Jonathan Gabe

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David Marsland (Medical Sociology News, April 1989) is right to say that medical sociologists need to develop a critical analysis of existing health care arrangements. In most other respects, however, his advice seems to us to be woefully wide off the mark. His assessment of the substance of the Government's review of the NHS, Working for Patients, provides little more than an additional gloss upon a document that is glossy enough already and can perhaps be treated as just an exercise in apologetics. However, in passing, Marsland attempts to prescribe what a proper sociological analysis should do and to develop a characterization of recent developments in medical sociology. We would like to make a few comments about these matters before taking up some specific points he makes about the White Paper.

Marsland makes much of the need for dispassionate study and objective evaluation, viewing most criticism of the White Paper as little more than 'an unthinking chorus of condemnation'. Yet his own commentary is replete with value judgements about 'the Government's modest and cautious proposals', 'the supremely pragmatic Minister', 'a large-scale "mutiny" among GPs', and 'our excellent doctors and nurses' (the last two being illustrative, respectively, of just the 'hysterical critique' and 'craven flattery' for which he lambastes medical sociology!). How do such statements square with his commitment to value-freedom? Although it may be difficult for a long-time devotee of Talcott Parsons to grasp (Ramazanoglu, 1987), the value-laden language reflects the inescapable ethical and political underpinnings of any sociological and political underpinnings of any sociological analysis. Marsland should come clean and acknowledge his strong attachment to the neo-conservative ideology informing the Review.

Marsland’s criticisms of medical sociology are blunted by his somewhat eccentric reading of the history of the subject. What evidence is there, in the history of medical sociology, of ‘the persisting influence … of work such as Navarro’s? And on what basis can he argue that the discipline has ignored the interests of patients as consumers? It seems to us that both these claims are false. Indeed, Marsland’s claim can be inverted. What is striking about the history of medical sociology in Britain, in contrast to the United States, is the absence of an avowedly Marxist perspective on health care and the popularity and influence of studies of patients’ views of different aspects of the health service – the studies of Stimson and Webb, Cartwright and her colleagues, and Jefferys and Sachs are just some of those that spring immediately to mind.

In relation to the White Paper itself, Marsland develops two main points first; that the Review should not be seen as a prelude to privatization (we have Kenneth Clarke’s assurances on this, after all); and secondly, that many of the proposals offer the possibility of real improvement in the quality of health care delivery to the mass of ordinary people. These points are then examined, or at least reiterated, in relation to the major initiatives proposed in the White Paper. Let us look at a few of them.

Marsland believes that under the new proposals that health authorities will become more professional and efficient and less political. This is a curious interpretation of a document which, in response to the perception that District Health Authorities are ‘neither truly
representative nor management bodies’ (Working for Patients, p64), proposes to eliminate elected representatives altogether! How can a system in which the Secretary of State ultimately determines the composition of health authorities at both regional and district level be seen as a reduction of ‘political interference in health care management’? Moreover, it is hardly surprising that many GPs are sceptical of the Government’s claims to be working for patients when the proposals specify that the number of GP appointees to Family Practitioner Committees be reduced to just one, with no obligation to include among the five lay members representatives from the local community. As for the patients, it is unlikely that Community Health Councils (CHCs) will adequately reflect the needs of ‘consumers’ when they are given no place on decision-making bodies and, for all his expressions of concern for the consumer, Marsland seems to have ignored the criticism that consumers’ representatives themselves have produced in response to the Review (e.g Gaffin, 1989).

Looking at the opportunities presented by the proposals for hospitals to become self-governing, Marsland maintains that this is nothing to do with privatization and that local services will be protected – though he provides no arguments to support these contentions. By what mechanisms will the health care needs of local communities be assured? Surely once a hospital opts out of the control of the District Health Authority (albeit remaining within the ambit of the NHS, and begins to enter into contracts for the services it offers, the only way in which core services will be protected for the local population will be through the introduction of cumbersome regulation procedures (Paton 1989). It is unlikely that the new profitable trusts will be happy to do this and it therefore increases the probability of a move to full privatization, with any non-market obligation to the local community being abandoned altogether.

Marsland also claims that the cash limits proposed for GPs will have major benefits for patients in terms of improved quality of service, but he fails to ask, ‘for which patients’? It is likely that fixed budgets for larger practices, together with the proposal to increase the proportion of practice income derived from capitation, may act as an economic disincentive to the enrolment of those categories of patient (e.g the elderly) who have the greatest health care needs. Any attempt to identify in advance high risk categories of patient and adjust the capitation fee paid accordingly is fraught with difficulty, as Flemming (1988) has demonstrated with regard to the current capitation fee structure.

These points cast doubt upon Marsland’s grasp of the significance of key proposals in specific areas. But there is a more general intellectual lacuna. Marsland takes at face value concepts of efficiency, consumer preference and value for money, reflecting not at all upon either the complex meanings of the terms, or the structural realities which they purportedly describe. The fact is that the use of these terms signals a shift in the whole system to one geared to buying and selling, with cost reduction coming before the treatment of patients; and such a structural shift will act to destabilize the NHS (Robinson 1989). This will benefit the acute rather than the chronic sick, the wealthy rather than the poor and the hospital rather than the community; benefits which, on any ‘objective’ analysis of present and future health care requirements, is just what our society does not need. How, and for the benefit of whom, will an internal market resolve the problematical decisions of internal resource allocation? It will certainly not benefit, for example, the elderly person with arthritis (Haslock 1989).

Whatever the Secretary of State says, the reforms set in motion a process of change which will enable the NHS to be dismantled when the opportunity presents itself (Petchey 1989): a conclusion reinforced by the record of the present Government in other areas of economic and social policy. Marsland argues, with touching innocence, that serious reform always involves risks and costs. But who decides the level of risk and upon whom the risks are to be
foisted? These are questions about political power which any critical sociological appraisal of the NGS Review has to ask. Marsland would have us assess the Government’s intentions for the NHS by taking their proposals item by item, on their merits. What kind of sociological analysis is that? It makes no sense to look at their proposals for the NHS out of relation to the wider strategy upon which Mrs Thatcher has been engaged – with some tactical variation – for almost a decade. This is not a form of ‘hysteria’, but an attempt to understand specific policies in the wider economic, political and ideological context. Such policies are part of a coherent attempt to move from a mixed to a market-orientated economy. This has involved an assault on the power of the professions such as medicine, along with a sophisticated attempt to reconstruct the ideological terrain so as to emphasise personal responsibility for health. Seeing the NHS Review in this context leads us to believe that Kenneth Clarke is involved in duplicity.

We do not castigate Marsland for holding his particular beliefs or values, but feel it is beholden on him to be more reflexive about the way in which they inform his writing. This sensitivity is a necessary component of a critical mode of sociological analysis. For our part, we have offered a perspective on the Review which draws on a different tradition within sociology – one which acknowledges the need for health policy to be examined within the wider context of economy, politics and ideology, confronts the reality of structured inequality and power relations and their consequences for health policy, and is wedded to the notion that health care provision should be equitable.

July 1989

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Parliament and the people are debating the Government’s proposed reforms of health care, so why shouldn’t medical sociologists join in? I was delighted, therefore, to read the response to my own analysis (Medical Sociology News, April) by Gareth Williams and Jonathan Gabe in the August issue. Before the reforms are enacted and the practical tasks of implementation are entered on constructively by all concerned, I have one last opportunity, for which I am grateful, to continue the debate.

My critics raised many interesting and important questions which will require more space for adequate response than I have here. I focus, therefore – leaving other more particular issues to be addressed in other arenas – on the two fundamental criticisms they deployed. These concern, first my alleged naivety about the concepts of “efficiency, consumer preference and value for money”, and second, the methodological role of values in social analysis.

Service for whom?

It seems to me wonderfully ironic that I should be accused of “taking concepts at face value” by critics who – in defending the status quo of an unreformed National Health Service – demonstrate their own willingness to take the thoroughly elastic concept of “service” entirely at face value. After forty years of social and medical change, the necessity of reform in British health care is now widely acknowledged. Admission that the hopeful promises of those who legislated the NHS have been less than wholly fulfilled implies no reneging on principled commitment to high quality health care for all. All that is entailed by acknowledgement of the necessity for reform is an honest, open-minded attempt at improving service quality, at turning the failed ideal of service into a reality.

In this attempt, the concepts of efficiency, value for money and consumer preferences are indispensable instruments of analysis. Despite Williams’ and Gabe’s strictures, each of these three concepts is clear, operational and practical. They provide bench-marks which can be applied coherently to any and all of the multifarious policies, programmes and procedures which comprise the health care system. If we measure the NHS, rigorously and across the board, in terms of efficiency, value for money and consumer satisfaction, we shall be on our way towards ensuring delivery of quality health care and genuine service throughout Britain.

Hidden agendas

While I am grateful to be spared “castigation” (Williams and Gabe, page 10) for my values – which are not dissimilar, as it happens, from those of rather large numbers of my fellow citizens – I was surprised that my critics should suggest that I need to be more open and explicit about them. I would have thought my scepticism about socialist and other collectivist principles and my resistance to sociological bias against markets, business, freedom and individualism had been set out thoroughly and explicitly in all my recent published work (please see references for examples).

My reading of British medical sociology (including Medical Sociology News) and the sociology of health more broadly suggests that the boot is on the other foot. If only medical sociologists had admitted explicitly in their relation to their analyses of the NHS, the medical
profession, health inequalities and all the rest, the extent of their own commitments to socialism, collective provision, centralised planning and union power! If only student readers of our text books had been made aware of the role of authorially hidden agendas in the elegant marshalling of arguments, and of unexplicated values in the judicious selection of evidence!

What is essential, surely, is that sociological analysis of current health care reforms should be explicit, and reflexive, about a range of values – with objectivity, validity and practical relevance being pursued through wide-ranging debate and competitive testing of a variety of perspectives. The range of value-perspectives brought to bear in medical sociology in recent years, and in analysis of the current NHS reforms specifically, seems to me to have been clearly too narrow. Those who support NHS reform have no need to apologise for attempting to widen it just a little.

Protesting too much

It seems to me that over the intervening months, Chris Ham’s recommendation to “those on the left” (which I referred to in my earlier paper) of a “discriminating response” and his advice that “Outright rejection of the White Paper would be both wrong and a missed opportunity” have been sadly ignored. There is widespread conviction that the millions of pounds spent by the BMA on doctrinaire resistance to reform of the NHS have been mis-spent and counter-productive.

Reform of the NHS is essential. Our elected Government has brought forward its reform proposals for consideration in all the relevant arenas and made significant adjustments and concessions, given Parliamentary approval, the whole reform package will be implemented. If resistance persists, it will be justifiably interpreted as a product of dogmatic opposition to the whole idea of innovation and reform in health care. In a word – reaction.

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RESEARCH INTO HEALTH CARE

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Reactions to the White Paper “Working for Patients” and to the Government’s Bill now going through Parliament have demonstrated that there are very few academics, journalists or social policy researchers who are not substantially prejudiced in favour of the status quo in health care.

Apart from the Health Reform Group, the Institute of Economic Affairs and the Adam Smith Institute, Kenneth Clarke has been able to rely on precious little support in his brave efforts from intellectuals in Britain. Even these exceptional cases are outside public higher education, where the bulk of research funding is spent on health care. Indeed, even from the sadly few universities where there are important centres of innovative thinking in relation to health care, there seems to have been very little by way of public support for NHS reform since the Bill was published.

ESRC-funded research projects in the sphere of health care seemed likely, to judge by recent conference papers, to produce yet more critical material, rather than anything which could provide positive assistance in the implementation of NHS reform. Social scientists generally remain thoroughly sceptical about – not to say prejudiced against – any serious role for markets (external or internal) in the health sphere; about objective scrutiny of current health care costs; about strengthening the hand of devolved management; about genuine attention to consumer perceptions and dissatisfactions; or about allowing the proper emphasis on efficiency, which along with care, is essential in a modernized, dynamic NHS.

Even the sociology and social policy now routinely taught to doctors and nurses in training is largely, if we may judge from the textbooks typically used, impregnated with prejudices incompatible with genuine reform of health care.

Lack of support for health care reform from the academic community cannot simply be dismissed as a trivial, predictable nuisance. The agenda of debate in the media and the atmosphere of public discussion are shaped to a powerful degree by “merely” academic and intellectual influences. Unless something is done to encourage a more balanced and more objective approach in research and analysis, it seems unlikely that serious reform of health care in Britain will be successfully accomplished.

In private sector research, it would generally be considered foolish to commission studies from sources who were known to be opposed in principle to the service or commodity being researched. It would not be regarded as in any way prejudicial to place research with investigators who were believed likely to approach their task open-mindedly and in a spirit of honest practicality. Why should it be any different in the public sector?

It seems to me there are two distinct constituencies with a real interest in attempting to amend and improve the condition of research into health care:-

1. All those seriously concerned about current levels of costs and efficiency in the NHS, and anxious – for the sake of patients, staff and taxpayers – to see improvements.
2. All those with a broader interest in welfare reform as one fundamental aspect of the modernization of Britain. If reform is blocked or stalled in health care, moves in other spheres against bureaucracy, collectivism and inefficiency will be considerably weakened.

There are several important tasks which people who identify with either or both of these constituencies might usefully take on:-

- Monitor academic publications, especially those used in teaching health care personnel and those which are taken up by the media, for the extent of their open-mindedness and objectivity in relation to NHS reform.
- Systematically monitor the conclusions and public statements arising from research on health care funded from the public purse and publish the results.
- Identify researchers in higher education who are other than prejudiced against health care reform.
- Seek ways of strengthening funding for research undertaken by such people. Both public and private sources of funding will need to be tapped.
- Develop networks of contact between, on the one hand, academics of good reputation who are sympathetic to reform, and the media on the other.
- Establish a programme of invitation seminars over the next two years designed to examine the practical task of implementing health care reform. Key media people to be included as observers. Press releases to be attractive and professional.

Since 1945, and more particularly since the expansion of the social sciences during the nineteen sixties, there seems to have been a tendency for the research community to be more than somewhat partial in its ideological inclinations. Even among economists, but especially among social historians, sociologists and social policy analysts, the tendency has been:-

- To underplay and even denigrate the potential positive role of markets, competition, enterprise and incentives.
- To over-estimate the scope for effective central planning.
- To lay greater emphasis on generalized principles of presumed social justice than on the particularities of individual consumers’ wants and satisfaction.
- To underestimate costs and to downplay their significance in policy development.
- To sympathize with the concerns of trades unions and professional associations at the cost of ignoring the requirements of efficient management.
- To presume on some general trend of history towards increased state control and away from active participation by private, independent and voluntary producers and suppliers of commodities and services.

These tendencies have been apparent in most fields of social policy research, including housing, pensions, education, training, employment advice and placement, and not least health.

It seems to me unlikely that an intellectual context shaped by these tendencies can provide effective support for the radical reforms needed as much in the health sphere as in other sectors of social policy. Those who are seriously committed to reform ought, therefore, to be
giving attention to measures designed to amend the one-sided inclinations of social research. This Working Paper is designed as a stimulus and encouragement to such efforts.
RESEARCH INTO HEALTH CARE – PARTISANSHIP OR SCIENTIFIC INQUIRY
A Reply to David Marsland

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Professor Marsland’s contribution to the last issue of Medical Sociology News (August 1990, pp. 12-15) raises a number of serious matters. Some of his criticisms should be well-taken by medical sociologists. Others, however, reveal a considerable ignorance of the literature produced over the last twenty-five years, while a few reveal an aspiration to intellectual autocracy which seems inconsistent with Professor Marsland’s own philosophical roots.

Where does Professor Marsland have a point? There is some justice in his charge that sociologists have been unduly neglectful of efficiency questions, although this may not necessarily be the highest priority in a health care system that spends a proportion of GNP comparable to other Western countries (looking at purchasing power parties), but which incurs much lower administrative costs. Although there may be specific distributional problems, the NHS has, by international standards, been a relatively efficient provider of health care. However, as current thinking in the management schools reminds us, direct money costs are not everything. We also need to be concerned with effectiveness, with staff morale and with consumer satisfaction. The optimal solution to the problems of delivering any personal service will be found only by a complex balancing act between costs, quality, user-friendliness and employee welfare. There is little virtue in delivering a cheap service which is ineffective, hostile to consumers and indifferent to staff. It may well be worth paying a premium over the cheapest solution to construct an organization which provides a quality service, attracts customers, satisfies employees and has some prospect of long term survival. The ‘fourth generation’ evaluation studies which are now being conducted in the US have recognised the subtlety of the judgements involved in the inappropriateness of the kind of preoccupation with cost reflected in Professor Marsland’s contribution. When it comes to issues of quality, consumer satisfaction and staff morale, one is dealing with areas where sociologists have long made a distinctive contribution.

Professor Marsland is on stronger ground with his suggestion that medical sociologists have romanticized the role of trades unions in health care, although not, surely, to the extent of David Green’s lyrical account of their role before 1911. It seems bizarre, however, to accuse sociologists of an excessive sympathy for professional associations. If there has been a dominant obsession in medical sociology for the last twenty-five years, it has surely been ‘doctor-bashing’, even where this has involved a Procrustean treatment of the empirical evidence. The BMA, the GMC and the Royal Colleges have been repeatedly depicted as villains, whose power needs to be broken in precisely the sort of consumer interest advocated by Professor Marsland. What is more noteworthy is the absence of any serious attempt to understand their problems and internal dynamics in the way that, for example, Halliday has done for the Chicago Bar Association. Likewise, far from neglecting consumerism, this must be seen as one of the major influences on the field, despite Margaret Stacey’s powerful caution against its limitations as a model. In avoiding the
language of the market, Sixties libertarianism may differ in its justifications from Thatcherism but its practical effects may sometimes be little different. Besides, Professor Marsland’s consumerist solutions raise their own empirical difficulties: why has it been so difficult for American women to influence obstetric care when they were theoretically its direct purchasers, at least until the spread of HMOs? Might this not suggest that there are real problems with simple application of consumer sovereignty? Can markets always regulate supplier-induced demand?

The point is, as health economists generally recognize, that health care is not a good case for market solutions. Even Adam Smith acknowledged this in exempting physicians from his general critique of occupational monopolies. The unavoidable informational asymmetry between doctor and patient, coupled with the highly consequential nature of the decisions being made, create serious problems in equalizing the position of buyers and sellers in the way assumed by neo-classical economics. When this is coupled with the difficulties of creating a satisfactory system of insurance because of the problems of the increasing certainty of risk of uptake of the service as a result of the ageing process, of adverse selection and of moral hazard, the market provision of health care involves such torturing of logic as to appear unworthy of much expenditure of intellectual energy.

This becomes evident when one looks at the present Government’s proposals. Professor Marsland criticises the reluctance of scholars to come on board and it is remarkable how isolated the Department of Health’s position has become even among health economists who might have been expected to be the greatest enthusiasts for the internal market. Indeed, its alleged inspirer, Alain Enthoven, has professed himself unhappy with many aspects of the proposals and called for limited and carefully evaluated pilots to establish that there will indeed be a change for the better. The problems of these proposals, however, have nothing to do with the ill-will of scholars and everything to do with their sheer intellectual incoherence. Even for those of us who share the view that financial and management information in the NHS is inadequate, there are still plausible reasons to see the reforms as an expensive charade which depends upon a massive centralisation of power in the Department of Health and an extension of costly and unproductive regulation, financed by a transfer of resources from patient care to administration, which will aggravate rather than relieve the funding problems of the service. In the circumstances, the reaction of many in the academic community may be more comparable to the reluctance of seamen to enlist on a leaky tub than any fundamental ideological animus.

Professor Marsland’s response, however, lacks the seriousness he finds wanting in others. If the community of scholars will not come on board, he will reintroduce the press gang. This response has already disconcerted a number of other libertarians like Professor Kedourie, who recognize that the logic of their own position calls for the sustenance of free thought and inquiry and that these are threatened by the demand for political commitment as the price of public support. As Hayek rightly observed, we cannot foresee the future in detail and part of the policy of any state must be the deliberate fostering of a diversity of perspectives offering politicians and public a variety of options for conduct under whatever environmental conditions prevail. If the market fails to provide this choice, because of its emphasis on the here-and-now rather than on the medium and long term, then this failure may legitimately provoke Government action. Some part of this is undeniably the latter-day equivalent of the servant retained by the Roman Senate to whisper in the ears of triumphal Caesars that they too are mortal. Professor Marsland may choose to disregard the message but in shooting the messenger he is trampling on the very democracy he claims to represent.
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IMPLEMENTING HEALTH CARE REFORM: FROM POLICY TO PRACTICE

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_A paper presented to the Panel on Progress in Health Care Reform at the 25th Annual Conference of the BSA Medical Sociology Group, York University, September 1993._

_The other members of the Panel were Dr David Armstrong (Department of General Practice, UMDS Guy’s Hospital); Professor Robert Dingwall (School of Social Studies, University of Nottingham); and Dr Jennie Popay (PHRRC, Salford). The Chairman was Dr Nicholas Mays (Director, Health & Health Care Research Unit, Queen’s University of Belfast)._  

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In the three decades between the establishment of the NHS and 1979, expenditure on health care expanded dramatically and the size of its staff grew explosively, while the number of patients treated and the amount of actual health care work accomplished stood more or less still (Gammon, 1987).

This is a typical picture of any nationalised industry: squandered investment, a manpower budget out of control and poor productivity. All this is despite the exceptional calibre of our medical research, the international reputation of our doctors and the traditions, discipline, commitment and high quality of British nursing.

The founding intelligentsia of the NHS proclaimed and promised – implausibly enough, one might have thought, even in the innocently idealistic climate of the nineteen forties – that, after high initial costs, future expenditure on health care would be reduced in absolute terms, as people were brought into a healthy condition by the new system. As it has turned out, costs and expenditure have consistently escalated to a level which both major political parties and most sensible people agree must be controlled.

Widespread dissatisfaction with the NHS

On top of all these objective problems with the NHS, there was also by the nineteen eighties considerable dissatisfaction with its performance:-

- On the part of professional staff objecting to irrational resource constraints and bureaucratic interference in their day-to-day work by the health authorities;
- On the part of innovators and radicals who found it resistant to new ideas and new challenges and fixated on outmoded objectives, methods and procedures;
- On the part of Governments, of whichever party, for whom the NHS seemed to comprise a reliable source of unexpected and embarrassing difficulties;
- And not least, on the part of the general population, on account of its negligent paternalism, its impersonal lack of attention to patients as people and their growing feeling that standards of health care were not rising in parallel with improvement in other aspects of the standard of living and the quality of life in modern Britain.
By the mid-eighties, it was evident that, despite continuing ritual acclaim of the NHS as a potent symbol of politically correct aspirations, the objective quality of health care in Britain had been overtaken in many other countries. It was widely acknowledged that radical reform was essential (Scrivens, 1991 and 1993).

**Reporting progress**

Since the reforms were inaugurated, their progress has been reported by the media and by most social scientists of health as if by the peace party in a period of war – with every next military disaster gleefully exaggerated and imminent surrender enthusiastically anticipated. Weaknesses and failure going back years, some of them apparent since the inception of the NHS, are routinely mis-attributed, with cavalier inattention to the evidence, to the reforms and to the Government.

My view is different. So far, so good. We must press on in the face of predictable resistance. I enter two caveats:

- First, it is still too early to make definitive judgement about the overall success or failure of the reforms. Critics and proponents alike are eager to find confirmation of their prejudices. But these are wide-ranging, radical reforms of a massive, complex, entrenched system. It will take at least as long to establish fully and reliably their negative and their beneficial impacts as with comprehensive schooling, nationalisation, the nineteen sixties transformation of the criminal justice system or the nineteen eighties reform of trades unions.

- Secondly, as these examples suggest, the interface between objective evaluative judgement and ideological commitment – where matters are properly adjudicated by the people at elections rather than by the advancing knowledge of experts – is treacherously difficult terrain.

It seems to me that the relevant criteria for evaluating Government reforms, at least in a liberal democracy, are the Government’s own objectives – not the Opposition’s, still less the utopian dreams or irrational worries of agents and agencies privileged to avoid reality-testing entirely.

In these terms, my assessment is of mixed but fair success so far. I will mention the successes as I see them on the basis of the evidence so far in and some remaining difficulties.

**The Trusts**

The Trusts have grown at a rate which their enemies claimed was impossible – almost 300 already, and a further large tranche anticipated in 1994, bringing coverage to more than 90%. They have become already normalised. The intended effects of their new status, of their autonomy, and of their enforced self-reliance in a competitive environment are coming through rapidly (Times, 21 August, 1992).

They are shaping up organisationally, sorting out their budgets and their manpower, addressing purchasers confidently and orienting to patients as people and as consumers. Most are improving their standard all round. Some may need new leadership. A few will go the wall. Overall, the Trusts are proving a triumphant success.

The morale problem – which is hardly new in the hospitals – will take time to solve. The trades unions and the professional associations, whose reactions to change powerfully influence staff morale, may need yet another Conservative electoral victory before they yield. The BMA stood out longer and more toughly, we should remember, against contraception
and indeed against the NHS as such. The Trusts will not in the end be sabotaged and the productive impact of competitive autonomy will continue.

**GP fund-holders**

Here, the movement has been slower and resistance more organised. But the trend is set and the numbers will expand until this second key element of the reforms is as normalised as the Trusts. Already more than 6,000 GPs are involved, covering one in four of the population. A fourth wave from April 1994 will increase this substantially.

The beneficial impact of GP fund-holding is even more evident than with the Trusts – as the clamorous complaints about a two-tier system demonstrate (survey in *Doctor* magazine, 7 October, 1993). Enforced equalisation of standard guarantees levelling down and the lowest common denominator. Competitive autonomy is creating a dynamic multi-tiered system, with standards of care, expertise, management, facilities and attention to patients as people improving across the board, and inadequates squeezed out.

**Purchasing**

Purchasing, other than by doctors, is still inchoate and inadequate. I would not expect otherwise at this stage. Purchasing in general is a more difficult art within the market enterprise than selling. The forms of organisation and the personnel involved in the Authorities were designed for a command economy of health care, rather than for the subtleties of an internal market.

More structural changes, more learning and more changes in personnel will be needed. Dr Mawhinney’s recent speeches on purchasing are having a powerful effect. “Purchasing”, he has said, “is the engine which drives the reforms”. “From first to last”, Mrs Bottomley argued at a recent NAHAT conference, “it is purchasers who should be in control. They pay the piper. They must call the tune”.

If this ambitious claim is to be fulfilled, the activities of the health authorities as agencies of state purchasing may require some independent competitive stimulus. Why not introduce incentives for big companies, which have the experience, skills and systems required for effective purchasing, to purchase health care for their employees and their families through the workplace?

**Funding and the market**

Until the purchasing component of the market equation is brought up to the strength of the new provider element, it is difficult to judge the dynamics of the whole system fairly. I would expect Government to relax central and regional controls gradually, to restrict its interventions to serious crises and to release the internal market to operate much more freely.

This will no doubt provoke problems and protests from time to time – the London situation being a peculiarly awkward and difficult example. But the process will continue to go forward, until even a Labour Government would not be able, or in the end willing, to reverse the process and return to centralised planning. Nostalgic pleas by academics and by health correspondents in the media for “tighter management” – i.e. subversion and sabotage – of the market should be ignored (Conservative Research Department, 1993).

**Public expectations**

The reforms have already had a dramatic effect on public expectations in relation to health care. Among politicians, in the media and among the people, expectations have risen, and
deferential tolerance of inadequacies has fallen away. This was intended; the Charter is designed to strengthen it and is unarguably a positive gain (Department of Health, 1991).

But it has to be steered responsibly if we are to avoid what one might call "post-communist syndrome", where unrealistic demands, combined with unwillingness to take on individual responsibility, produce a neurotic reaction into antique authoritarianism. Thus, independent health care should grow gradually and in positive collaboration with the NHS as the effects of the reforms on expectations and demand unfold. Journalists and social scientists should draw attention just occasionally to the responsibilities of individuals for their own and their families' health care in terms of life-style decisions and spending priorities.

Sources of concern

In concluding, I will mention two concerns of mine.

The concept underlying "The Health of the Nation" seems to me valuable and timely (HMSO, 1992). It portends a long overdue shift from treatment to prevention and health promotion and from the hospital to the community as the centre of gravity in health care. However, the implementation of its message worries me.

It might provide the ground on which forces antagonistic to health care reform can re-group and work for the restoration of levelling paternalism. Rather than risk a growing army of missionary zealots to the general population, primed with generalised health promotion formulae dreamed up in Alma Ata of all places, I would prefer a less ambitious, more sharply targeted, more local, more practical approach aimed at clearing up the concrete health problems of the genuinely disadvantaged (Le Fanu, 1993).

My second worry is on information. The reforms require a massive upgrading in the quantity, quality and transparency of information of all sorts. Reliable financial epidemiological and evaluative information will be needed for operational management purposes, to steer the internal market and to apprise the public of variations in offerings and standards. Improvements are being made, but there is a long way to go (Marsland 1993)

CONCLUSION

Radical reform is inherently difficult, which is why it is usually avoided (Marsland, 1992). The reforms of health care seem to me courageous and broadly correct. In a remarkably short period, their implementation has gone forward strongly. I think this will continue, despite resistance and problems, until the overall thrust of reform is positively accepted by everyone except incorrigible recidivists in the collectivist lobby. Within ten years, efficiency and equity alike in the provision of health care can be substantially improved.

In his introduction, the Chairman was kind enough to say how pleased he was to welcome "a varied and distinguished Panel". I suspect I was invited to represent the variation rather than the distinction. As a dissident among social scientists involved in research into health and health care in supporting the Government's NHS reforms, I urge the research community to practice the open-minded, dispassionate stance which we preach to our students. The reform programme is working.

Bibliography


Emotions and the Body: Raising the Issues for Medical Sociology

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Emotions lie at the juncture between mind and body, culture and biology and are crucial to our survival by their ‘signal function’ in relation to danger. Yet despite their cultural significance, and the obvious implications for the study of health and illness in particular, social science research in this area has remained predominantly under the psychological rubric until very recently. Echoing an earlier call in this newsletter (Olesson 1990), this brief paper emphasises the importance of the sociology of emotions for medical sociology and relates these approaches to other highly significant and newly emerging realms of study; namely, the sociology of the body and pain.

Although there may be an implicit recognition of the importance of emotions and feelings within health and illness, the Western medical model could benefit from the philosophies and practises of alternative healing systems. For example, traditional Chinese medicine sees health as a state in which the energy of the mind, body and spirit are in harmony. Here an instructive guide is The Barefoot Doctor’s Manual (Revolutionary Health Committee of Human Province 1978). As well as “body make-up” and “physical conditions”, the section on “How to analyse causes of disease” lists the following factors as equally significant: (i) nervous and emotional make-up; (ii) external factors such as radiation, civil war, etc.; (iii) chemical factors; (iv) external biological factors such as pathogenic viruses, tapeworms etc., and; (v) climactic factors such as: wind, cold, heat und humidity which are thought to affect the body’s resistance (1978:25-26).

This model contrasts vividly with the more mechanistic dualist model adopted by Western medicine, which is unable to systematically address the aetiological role of social or emotional factors in the same way. Practitioners such as Lynch (1977), for instance, have demonstrated the links between cardiovascular disease and emotionally distressing life events, using examples such as electro-encephalographic (EEG) patterns which show dramatic improvements when a nurse holds a patient’s hand. Yet the ‘faulty-machine’ approach remains deeply embedded. Moreover, the Cartesian divide between mind and body resonates through to reason and feeling with the consequence that scientific culture regards emotions with much distrust and suspicion: even within the discipline of psychology.

As Davitz (1969) points out, apart from a few notable exceptions such as Freud and James, most academic researchers have hidden behind the argument that emotional experience is outside the realm of ‘scientific’ investigation:

*If one wants to learn something about the experience of guilt, anxiety or joy one might turn perhaps to Dostoevsky, Kierkegaard or Wordsworth, but certainly little is to be learned in this area from even the most careful study of Thorndyke, Hull. Skinner, or any of the other major figures of academic psychology (Davitz, 1969:88).*
The tendency for social scientists to avoid discussing feelings, presumably in order to increase the respectability of their scientific endeavour, has led to the neglect of the remarkable potential of emotions to transcend the mind-body dualism, as recent sociological work in other areas has successfully attempted. For example, the body of work around the medicalisation of childbirth, particularly the contribution of feminist sociologists such as Oakley (1980, 1993) has advanced the quest to integrate the physical, emotional and existential dimensions of our being.

It could also be argued that emotions have always been an implicit, if not explicit, theme within sociology: consider, for example, Durkheim's work on anomie and suicide (1897) and Marx's concept of alienation (1867). However, it is really only within the last decade that a distinct body of work identified as the sociology of emotions has emerged. One of the major advocates of this work is Arlie Russell Hochschild (1979, 1983) whose theories of emotional labour and emotion work have been instrumental in establishing emotions are socially, as well as personally, faceted. Here she highlights two strongly held notions which act to confuse and cloud our understanding of emotional processes:

1. An emotion such as anger or jealousy is seen to have an independent presence or identity, often given a bodily location or residency in a person or through time (e.g. love in the heart, envy in the bile; we talk of 'expressing' or 'storing' emotions which acquire an identity - 'that old jealousy' etc.);
2. When 'possessed' by emotion we act irrationally and our perceptions are distorted - love is something we fall in or out of, we are in a thrall: we are taken over or consumed by anger, gripped by fear and so on. The implication is usually negative, and our cultural policy towards our emotional life is to watch out for this and manage it. However, such an attitude negates the positive and rational aspects, such as comforting a crying child (Hochschild 1983: 202-203).

Hochschild outlines two models regarding theories of emotion, the organismic and the interactionist. The organismic model draws on the works of Darwin, Freud and James and their investigation of the origins of emotion and sees emotion as an essentially biological process, so that the manner in which emotions are managed or labelled is seen as extrinsic and of less interest than how they are 'motored by instinct' (as in the James-Lange theory and the work of Ekman (1988)). Here there is an inherent assumption of emotion having a prior existence distinct from introspection, and one which is passive and fixed. A third model could be seen to be the social constructionist perspective, as, for example, developed in the work of Harre (1986), which sees emotions as culturally invented and contextually relative, so that biology becomes irrelevant.

As Kemper (1990) has shown, the study of emotions itself transcends many divides - micro/micro; quantitative/qualitative; positivist/humanist; prediction/description – and has many perspectives. However, it is the interactionist model which has the potential to transcend the mind-body divide superseding the more reductionist features of the organismic model. Hochschild draws upon the proposition that emotion consists of an indefinite number of 'instinctive' activities organised into interests responding to each situation and shows how the role of social factors is given weight by Gerth and Mills (1964). Using a combination of theories of interaction from Mead, motivation from Freud and structural ideas from Weber and Marx, they conclude: 'Social interaction of gestures may thus not only express our feelings but define them as well' (Gerth and Mills 1964:55). Hochschild then makes links with the dramaturgical theories of Goffman (1959), focusing on the interaction between the institution and the individual, with particular reference to stigmatisation and emotions of guilt and embarrassment. Goffman turned the biological focus on its head by maintaining that
feelings contribute to interactions via the social self. Subsequently suppression, repression or expression of feeling is not necessarily unconscious, but can be consciously controlled and open to rules and norms which can be identified within routine social interaction. Thus, the management of feelings implies actively altering our emotional state using emotional labour and developing ‘status shields’ (1983:173) in order to protect attacks on our self-esteem. Having one’s feelings ignored or termed as irrational has the subsequent impact of one’s perceptions being invalidated, of being ‘less than a person’. For instance, the feelings of a person of lower status are given less attention and weight than those of higher status, so they have fewer status shields with which to protect themselves.

Emotional displays consist of both bodily and cognitive components and are a significant determinant of the way in which a person is evaluated socially, as deviation from what is ‘socially appropriate’ may meet with disapproval from others. Emotion work involves having to change the quality of felt emotion to conform to social expectations, which in turn are affected by characteristics such as gender, social class, ethnicity and age. The gendered pattern of the division of emotional labour, both at work and at home, is emphasised by James (1989), with the inherent assumption that emotion work is ‘natural!’ for women.

As has been emphasised already, emotional management has repercussions for the body and the relevance of a sociological approach to emotions in the study of health and illness is emphasised by Freund (1990). He maintains that the Durkheimian legacy of the non-reducibility of ‘social facts’ to biological ‘facts’ has resulted in a lack of acknowledgement of the body in sociology. To understand that biology can be socially constructed leads to a unification of the cognitive and the physical aspects of emotions, giving rise to:

An existential-phenomenological perspective which emphasises subjectivity and the active expressive body [which can be] used to bridge the mind-body-society splits that characterise both fields... a focus on the emotionally expressive, embodied subject, who is active in the context of power and social control, can provide a useful approach for studying distressful feelings, society and health (Freund 1990:452).

Denzin (1987), however, insists that ‘scientific’ study of emotions is not possible and stresses the term ‘emotionality’, which he defines as the process of being emotional. He draws on the philosophical works of Heidigger, Sartre, and Merleau-Ponty in order to show how this ‘lived quality’ and intersubjectivity is of paramount importance, locating the person in the world of social interaction in which all emotional experiences involve reflection, feeling, cognition and interpretation. However, no emotional experience is ever exactly the same and is open to constant reinterpretation and meaning depending upon the particular social and cultural experiences which shape them. Moreover, Denzin asserts that the study of ‘emotionality’ requires a conception of the human body as a structure of ongoing lived experience (1987:3); a suggestion which is equally relevant to the study of pain as an embodied experience.

As Turner (1992) argues, a phenomenology of the body or ‘embodiment’ has particular importance for medical sociology as it provides us with a sensitive and sophisticated perspective on issues such pain, disability and death. As he points out, (his phenomenological approach to the ‘lived body’ has been influenced by a diversity of traditions, including Lebensphilosophie, philosophical anthropology and existentialism. For example, in his book Phenomenology of Perception, Merleau-Ponty (1962) developed a conception of human embodiment which attempted to overcome this duality between mind and body. Merleau-Ponty argued that it is not possible to talk about human perception without a theory of ‘embodiment’ as the ‘perspective’ from which observation occurs (Turner 1992). That is to say, our perception of everyday reality depends upon a ‘lived body’: ‘Man
taken as a concrete being is not a psyche joined to a organism, but a movement to and fro of existence, which at one time allows itself to take corporeal form and at others moves towards personal acts' (Merleau-Ponty (1962), quoted in Turner 1992:56).

From this perspective, human beings can be seen to have a dual nature; one which is succinctly captured within the German language between the terms Lieb which refers to the animated living, experiential body (i.e. the body-for-itself), and Körper which refers to the objective, exterior, institutionalised body (i.e. the body-in-itself) (Turner 1992). This also resonates with similar distinctions made by writers such as Plessner (1970) and Berger and Luckman (1967): namely, that each of us is a body and has (i.e. experiences) a body.

In developing this phenomenological perspective on the body, Leder draws attention to the ways in which our bodies are normally phenomenologically absent from view. As he explains:

Whilst in one sense the body is the most abiding and inescapable presence in our lives, it is also characterized by absence. That is, one's own body is rarely the thematic object of experience… the body, as a ground of experience… tends to recede from direct experience (Leder 1990:1).

Yet as Leder goes on to point out, this normal mode of bodily disappearance tends to be profoundly disrupted in the context of factors such as pain, disease and death. Here the body becomes a central aspect of experience, albeit in an alien and dysfunctional manner. In other words, in contrast to the ‘disappearances’ that characterise ordinary functioning, the body, in the context of pain, suffering and death, dys-appears. That is to say:

The body appears as a thematic focus of attention, but precisely in a dys state - dys is from the Greek prefix signifying 'bad', 'hard' or 'ill', and is found in English words such as 'dysfunctional' (Leder 1990:84).

Like emotions, pain unites nature and culture, although the dominant conceptualisation of pain has focused upon sensation over emotion with the subsequent inference that it is able to be rationally and objectively measured. The fact that mind and body are fully interfused in pain also points to another fundamental issue: namely, that physical experience is inseparable from its cognitive and emotional significance. It is for this reasons that pain can be used to describe not only physical agony but emotional turmoil and spiritual suffering (Leder 1984-5). As Schepers-Hughes and Lock (1987) argue, emotions affect the way in which the body, illness and pain are experienced and are projected in images of the well and poorly functioning social and body politic: 'Insofar as emotions entail both feelings and cognitive orientations, public morality and cultural ideology, we suggest that they provide an important “missing link” capable of bridging mind and body, individual, society and body politic’ (1987: 28-29). In this respect, explorations of sickness, madness, pain, disability and death are human events which are literally ‘seething with emotion’ (Schepers-Hughes and Lock 1987). Thus emotion is seen as the mediatrix of the three bodies - phenomenally experienced, social and the body politic - which Schepers-Hughes and Lock (1987) identify, and which they unify through the notion of the ‘mindful body’. Thus grief, for instance, is an example of emotional pain which is inseparable from its ‘gut churning, nauseating experience’, whilst physical pain bears within it a ‘component of displeasure, and often of anxiety, sadness, anger that are fully emotional’ (Leder 1984-5: 261).

However, as Leder notes, whilst the study of pain demands the dissolution of dualities and draws attention to the relatedness of self and world, mind and body, a phenomenology of pain must also confront and account for the enduring power of such categories. In this respect, the alienating and privatised nature of pain seems to shatter the self into a series of
lived oppositions. As Leder states: ‘Whereas in day-to-day events we are our body without hesitation, suddenly pain renders the body disharmonious with the self. Such times, along with those of hunger, exhaustion, disability and approaching death, can be seen as experiential antecedents to dualism’ (1984-85: 262). Here the painful body emerges as ‘thing-like’; it 'betrays' us and we may feel alienated and estranged from it as a consequence. Thus whilst, at an analytical level, the study of pain may demand a transcendence of dualistic thinking, at the phenomenological or experiential level it may perpetuate these very dualisms.

Historically, we should have learnt the lesson that potentially serious implications stem from the separation of reason and feeling, not only for medical practice, but for human culture in general. Instead of the hopes of a new and better world based upon reason which Descartes envisaged - one which signified an end to ignorance and superstition - the ultimate implications of rationality can be seen in more sinister light:

*It was an idea that at first sparked off great hope and optimism in the West. Yet it was also a blind hope which was crushed forever in the madness of the sheer rationality of Auschwitz, where the mathematical idea of a final solution bore witness to a terrible flaw in the philosophical foundations of modern Western civilisation (Lynch 1985:309).*

Bauman (1989) reaches similar conclusions in Modernity and the Holocaust, arguing that rather than seeing the holocaust an aberration, it represents the fullest expression of modern rationality in all its repugnant glory.

In summary, the main thrust of this brief paper has been to argue that feelings and emotions must be regarded as crucial to our embodiment and as central aspects of experiences such as pain and suffering, as well as sexuality, pleasure and desire. As Turner states:

*If we recognise pain as an emotional state then we immediately consider the idea of the person as an embodied agent with strong affective, emotional and social responses to the state of being in pain… [this draws] …attention to a neglected aspect of the sociology of health and illness for which a theory of embodiment is an essential prerequisite for understanding pain as an emotion within a social context (Turner 1992:169).*

In this respect we have attempted to suggest some possible links between the sociology of emotions, and other newly emerging areas such as the sociology of the body and pain in order to provide a more holistic understanding of these phenomena as social, embodied experiences; an approach which aims to transcend the dualistic thinking which has hitherto dogged Western thought.

In order to explore these issues further, the B.S.A. study group on Emotions is proposing to hold a one-day conference on the theme ‘Emotions and the Body’ in July 1994. Anyone who is interested in presenting a paper and/or coming the day should contact Gillian Bendelow at the address below…
REFERENCES


Tales from the Natives: Declining Response Rates and the Promise of Participatory Methods

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In recent years there has been a growing unwillingness by the general public to participate in social research. (Purdon and Nicolas 2002) This tendency has been attributed to a general disenchantment, particularly within the most disadvantaged in society, with the whole consultation/research process. Research fatigue has often become the norm as people feel that although they may have taken part in the past the results have often led to a situation where there is still a large gap between what they need and want and what they actually receive, which in turn, leads to ‘democratic despondency’ [Macaskill 2002]. The result of this for social research has been that there have developed large sections of society that it is becoming increasingly difficult to research using conventional methods and when such methods are used sampling strategies are skewed as rather than being a representation of the general public it is increasingly becoming an unrepresentative sample of those who agree to participate in research. In an attempt to counter this escalating disillusionment with the social research process more collaborative approaches have been utilised, such as participatory action research, which seeks not only to answer the questions of the researcher but also attempts to address some of the issues faced by those who are collaborating in the research enterprise.

The model of participatory research advocates putting research capabilities in the hands of those who are traditionally the focus of social research so that they may identify ways themselves of transforming their lives. It is a means of preventing an élite group i.e. social scientists from exclusively determining the interests of others, in effect transferring power to those groups. Therefore, this approach blurs the distinction between the researcher and the researched and indeed as both collaborate, as equals, in the investigative process; choosing methods, analysing data, and sharing options for action, maybe such role distinctions are redundant. However, this increasing trend toward developing more participatory approaches both to social research methodology and to the development of social policy poses some interesting considerations for some of the central tenets of the social sciences.

**Going native**

One of these central tenets, which is an inherent feature of all social sciences, is best illustrated by the anthropological concept of ‘going native’. This term refers to the situation where the researcher identifies too strongly with the values and perspectives of those they are researching and therefore loses sight of their “objectivity”. This fear of the researcher ‘going native’ is based on the belief that it is not the researcher’s role to gain insight into another culture by ‘going native’. But rather, their role is to appreciate the values of other cultures through systematic academic techniques of observation and analysis.

However, the term ‘to go native’ does not have its origins in social science but was originally a term used by the British military as they administered their colonial empire. During this period often a small post of British soldiers oversaw a large geographic area and population, removed from British military and culture. To counter any threat of these colonial
administrators ‘going native’, the army had strict rules and regulations for these isolated officers that included shaving each day, dressing in full uniform and following a rigid schedule of duties etc., this was to ensure that there would be no loss of the ‘civilizing’ regimentation and discipline of British culture and by extension British rule.

The link of this notion to academic study was brought about by early anthropologists, who were often closely linked to colonial administrations, typically taking for granted the superiority of their own Western Colonial cultures. Therefore, covertly embedded in the concept of ‘going native’ is an assumption of the inferiority and domination of the native’s perspective. ‘Going native’ in the context of social research means losing one's footing in the dominant culture of government or university and dangerously toying with adopting the ways and perspectives of the inferior people. Inherently, at the least, the term still retains some of its ‘othering’ connotation which is contrary to the ethos of a participatory research approach which is seeking to establish a consensus approach, based on equality of status.

Again, intrinsic to a more participatory approach to the research process is that it attenuates the boundaries between researchers and the researched. Adopting more participatory approaches entails turning ‘lay’ people into researchers a role previously within the domain of the professional. However, by commissioning research subjects, or natives, to actively co-operate in the research process there is an integral element of going native built into the very research design. Although such research can offer the promise of access to social networks and knowledge that more traditional approaches would take years to develop, embedding the ‘researchers’ in the world of the native also brings to the process a number of tensions or possible pitfalls not associated with more traditional methods. For example research partners live in the communities which they research on a full time basis and continue to live there after the research has ceased. This, in turn, has ramifications for how such native researchers manage their identity both during the research process and after. Managing these in-built tensions, between the requirements expected of these two roles, is a continual challenge due to the multiple agendas of research partners.

Particularly from the end of the twentieth century and into the beginning of the twenty-first social scientists are realising that we live in a different world from that inhabited by those that established the discipline. Their perspectives often do not fit a world where social and technological changes have led to an attenuation of boundaries of time and space and where the whole categories of what constitutes them and us have become blurred. In many instances researchers are in an environment where they share cultural capital with those who are the focus of the research. Indeed, it can be argued that there is always a degree of this in any social research setting as we are all humans. More recent theorists of the research process, such as Rosaldo (1993) and Jenkins (1992), realise so-called natives do not ‘inhabit’ a world completely separate from the one researchers ‘live in’. In relation to research that seeks to be participatory and empowering, with its ethos of joint problem solving, it is ever more difficult to ascertain who is the researcher and who is the researched or native. If such an approach is to be adopted it is important to contest such established boundaries and fears of going native and encourage people to reflect on and incorporate both the promises and drawbacks of both perspectives. The notion of going native needs to be reconsidered in this context. If the inherent power bias imbedded in this notion is contested then if the researcher is to be critiqued for ‘going native’ then the next consideration should be, native to what culture, that of the local community or that of the university, government or funders?
Toward a new conception of natives’ perspectives

Participatory approaches seek to attain a position where the aims of the researchers and the researched coalesce. However, in the more macro research environment this is a complex position to attain. For example, for all the grand theorizing of the post-modern turn in social research that has led to the call for more participatory multi-vocal methodologies, ultimately an academic’s career is dependent on the amount of publications they produce. The production of academic papers however is often of little consequence to those outside the academic community - their desired outputs tend to be more immediate and material. Also, there may be other agencies who have other agendas that they wish to satisfy via the research process. Funders, for instance, require research reports produced in language which may well mean very little to other research partners who have participated in their production.

It is probably impossible to attain a situation where all these multiple agendas can be replaced by one participatory schema that all parties can work toward but adopting a mutual approach to managing these different agendas has the possibility to result in a mutually enlightening experience for all those concerned. Participatory approaches offer great promise for overcoming the very real challenge of the declining interest in and response rates to social research. Adopting these more participative reciprocal approaches, however, will entail a more fundamental reconsideration, on the part of social scientists, of some of the mainstays of what it means to do ‘proper’ research, one of which will be what value has the natives’ perspective in relation to others.

References


Incapacity Benefit and Medical Sociology: A Missing Link?

Patricia de Wolfe

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On July 4th 2001, Alistair Darling, the Work and Pensions Secretary, announced a crackdown on illegitimate claimants of incapacity benefit (IB), and suggested that some 70% of IB claimants could return to work. His statement, supported by the Prime Minister and Cabinet, but unsupported by evidence, evoked indignation amongst representatives of disability groups and a significant number of MPs. No comment, to my knowledge, was forthcoming from sociologists of health and illness - possibly because of their lack of awareness of the impact of benefit-related issues on the lives of the chronically sick. In this article, I suggest that there is a large Benefits Agency-shaped gap in medical sociology, which could profitably be filled.

First, a comment on the recent controversy: it is notable that both Darling’s statement and the way in which it was initially reported were grossly misleading. Darling claimed that the new regulations were aimed at rectifying a situation in which people were able to claim IB, unchecked, for an indefinite period. Two days later, however, his department was forced to admit that IB claimants are currently subject to a regime of medical checks more, not less, frequent than the three-yearly tests he proposed for new claimants. It is inconceivable that Darling did not know this when he made his original announcement. It is also puzzling, given that IB has been the subject of repeated public debate in recent years, that the quality press should have followed his line so slavishly. The Times (Sherman 2001; Times 2001), the Telegraph (Sparrow 2001), and, more surprisingly, the Guardian (Wintour 2001) all referred to a situation in which people could claim IB, unchallenged, more or less indefinitely. That even the Guardian should swallow this inaccuracy wholesale is perhaps symptomatic of the suspicion which now bedevils anyone claiming state benefits on grounds of incapacity to work.

The basis on which IB is awarded, and the stresses involved in obtaining it, are probably unfamiliar to most readers. A brief account of these matters therefore follows.

Who receives Incapacity Benefit?

IB is payable to people who become incapable of work. There are three rates, the long-term rate (normally applicable after 52 weeks) being the highest - higher than jobseekers’ allowance. Entitlement ceases at pension age: 65 for men; 60 for women. IB itself is contribution-related, but some of those lacking the necessary contributions receive other benefits, or national insurance credits, on the same basis, and are counted as IB claimants. In February 2001, there were 2.3 million claimants according to a broad definition (Department of Work and Pensions 2001a: 5; 23-24). Of these, almost 1.9 million had been claiming IB for over a year, and almost a million for over 5 years. Men over 50 constitute 35% of IB claimants (ibid.). The number of IB claimants has more than trebled since around 1980 (Beatty and Fothergill 1999: 8-10; White 2001). There are many possible reasons for this other than a collapse in the health of the nation. Most significantly, the Tory government encouraged the transfer of large numbers of redundant people - mainly men - to sickness-related benefits, to keep unemployment figures low (Beatty and Fothergill 1999; Toynbee 2001). Research points to high levels of hidden unemployment (claimants registered as sick, but, despite genuine health problems, able and willing to do at least some work) in traditional industrial areas where jobs are now scarce (Beatty and Fothergill 1999). (This research
suggests no deliberate abuse of benefits; and a recent survey by the Department for Work and Pensions (2001b: 3) found the incidence of fraud amongst IB claimants to be low.) If this is indeed the case, the government may find that a tougher stance on IB opens a new can of worms, exposing the extent of involuntary unemployment.

A further probable cause of the increase in IB claimants is the rationalisation of many workplaces, and the increasingly pressurised pace of work in all sectors of the economy (academia is just one example amongst many). Employees who lose the capacity to work at full tilt are less likely to be accommodated than they were 20 years ago. The deterioration of public transport may also play a part, as it becomes harder for people with limited mobility or strength to reach a potential workplace. All this shows that, for some people at least, (in)capacity for work is not a quality which inheres in the individual, but is a matter of interaction between individual and environment.

It may be older male claimants who, because of their numbers, are the government’s main target. However, the difficulties of relying on the state have a profound effect on other sick and disabled claimant populations, such as the members of the M.E. group amongst whom I conducted my research (de Wolfe 1999). Most (although not all) of my research subjects were female, white and middle-class; most had been in the labour force before becoming ill, but now seemed unfit for work under any economic circumstances. Their experience brings to light many of the problems of establishing eligibility for IB.

**Testing for incapacity**

Anyone claiming IB for longer than 28 weeks is subject to the Personal Capability Assessment (PCA), formerly known as the All Work Test. This assesses the claimant’s capacity to carry out a range of functional activities: walking; manual dexterity; climbing stairs; lifting and carrying; sitting; rising; bending and kneeling; reaching; standing; speech; hearing; vision. The self-assessment questionnaire (IB50) issued to claimants also asks about incontinence problems and seizures. Within each broad functional area, there are specific activities to which points are allocated according to severity of impairment. (Mental illness and learning disability are assessed differently.) There is a space for additional comments at the end of the form, and the claimant’s GP is also asked to supply information (Paterson 2001: 67-77). In recently - some 50% to 70% of cases (Comptroller and Auditor General 2001: 22), the claimant will then be examined by a Benefits Agency doctor, or rather, a doctor employed by SEMA, the private agency to whom medical examinations are outsourced.

Undergoing the test for incapacity is gruelling for everyone, since livelihoods are at stake. Even people with disorders which fit well into the parameters of the questionnaire may have difficulty in proving the extent of their disability. Further, the test treats fitness for work as a property of the claimant, ignoring availability of suitable work. But for people with chronic illness, there is a further problem with the PCA: it makes no allowance for being ill. No points are available for feeling drained, unsteady, or even running a fever - or rather, points are available on these grounds only insofar as they affect capacity to perform the tasks specified above. Oddly - and this confirms the impression that the test is aimed at manual workers - there is no question which enables claimants to gain points on the grounds that they rapidly become too tired to think straight. M.E. is, of course, a contested condition, but organisations representing people with better legitimated diseases such as arthritis (Betteridge 2001) raise similar objections. Where sick people are subject to a test which accords no legitimacy to the symptoms of illness, the task of establishing incapacity for work assumes a Kafkaesque quality. It is, in the words of one harassed claimant, like trying to prove you have a soul.
The purpose of physical medical examinations is to confirm information supplied on the form. From claimants’ accounts (Pearce 2001; personal communications), their content and quality seems immensely variable. They may consist purely of questioning about daily activities, or they may include a clinical examination. Tasks may be set: the doctor may throw a piece of paper on the floor and ask the examinee to pick it up (Pearce 2001). Some claimants report fair and polite treatment, others discourtesy: the largest single category of complaints about medicals concerns doctors’ manner (Comptroller and Auditor General 2001: 36). Some examinees complain of entrapment: someone who, on their IB50, has pleaded inability to manage steps may, on arrival, be directed up a staircase; or someone who reported limited strength be pointed towards a heavy door. In a situation of great tension, it takes courage and presence of mind to request assistance rather than struggle to comply (ibid.; Earnshaw 1999). The process may be experienced as humiliating, and the outcome as inequitable. Trivial activities (in one case, reading a daily newspaper) may be pronounced to establish fitness for work. (This claimant’s IB was reinstated on appeal.) SEMA doctors have immense power over examinees in this situation - and they may or may not turn out to act respectfully and reasonably. In fact, being a claimant entails an ongoing sense of helplessness and uncertainty.

If declared unfit for work, claimants have no idea when they might be retested. Contrary to Darling’s statement, fewer than a quarter are permanently exempt from reassessment (Department of Work and Pensions 2001a: 11). Re-evaluations, supposedly conducted at intervals specified by the Benefits Agency, tend in practice to occur irregularly. People may be assessed twice within months, and then hear nothing for years. A virtually housebound patient may be retested more often than one who is less restricted. There also seems to be no consistency in the decision-making process which results in some claimants, but not others, being summoned to a medical following the completion of an IB50. Most importantly, people may be baffled as to why their account is not believed, and IB refused - about 20% of cases (Department of Social Security 2000).

The strain of the PCA is compounded by the delay in hearing appeals - at which over 40% of claimants disqualified after medical tests are said by disability groups to have their IB reinstated (White 2001). Waiting time has now been reduced to about three months, but could until recently be much longer. IB is withdrawn pending appeal, although other benefits are available (usually at a lower rate) in the interim.

These delays, understandably, cause intense anxiety. Some of the sickest or most disabled may also be claiming Disability Living Allowance, payable to those who need care and have mobility problems; this has its own rules and system of assessments, and is equally likely to be stopped or reduced, generating a further set of uncertainties, appeals and delays. If stress impairs health, being a claimant cannot be good for the chronically sick.

**Sociology and Incapacity Benefit**

What has all this to do with sociology? This becomes clearer if one examines aspects of the sociological literature. Research on the experience of chronic illness in the UK and USA, addresses, inter alia: disruption of normal life and expectations, and damage to sense of self (Bury 1982; Charmaz 1983); the balancing of tasks and goals in the face of unpredictability (Pinder 1988); the transformation of pre-existing concepts and experiences of body, self and society (S. Williams 1996); the (felt) stigmatisation of specific conditions (Scambler and Hopkins 1990). Recent sociological interest in narrative has led to an emphasis on sufferers’ accounts as storied attempts at the restoration of order (see G. Williams 1996: 201-203; Bury 2001). The experience of claiming state benefits, however, barely features in this literature. Texts aimed at students (Nettleton 1995: 68-99; Locker 1997) discuss a range of
emotional and practical issues confronting the chronically sick, but are silent about being a claimant.

In the course of my own research, the subjects of which were nearly all claimants of sickness-related benefits, I found that fear of having these benefits withdrawn hung over people like a dark cloud. They complained of ‘brown envelope syndrome’: the panic which overwhelmed them at the sight of an official-looking letter lying on the doormat. Problems with and anxieties about welfare benefits were one of the dominant topics of conversation in the self-help group whose meetings I attended. Admittedly, by no means everyone reported difficulties with their claim; but everyone knew someone whose application for benefits had been apparently unreasonably disallowed. People are, therefore, haunted by worry, and also by resentment that this worry should be inflicted upon them, further impairing what are already spoiled lives.

There would be much in the conditions and experience of being a claimant for social scientists to study, from a range of theoretical stances. The suggested themes which follow emerge from my own research; investigation of the concerns and experiences of, for example, former industrial workers might produce a different set of proposals.

Sociologists with an interest in presentation of self and the social construction of subjectivity could note the effects of long-term dependence on social security, beyond ongoing financial uncertainty, and, for those with no other resources, poverty. Many IB claimants feel permanently under suspicion - a feeling fuelled by the repeated public attacks on their integrity. They therefore experience a constant niggling fear of being discovered in breach of (often ill-defined) limits, and, at worst, reported to the Benefits Agency. They also experience a sense of disjuncture. Those with some capacity for activity may feel obliged to conceal their status as ‘normal’ social actors (who may occasionally drive a car, go on an outing, or undertake light gardening) from anyone aware that they are claimants; and their status as claimants from those who witness them acting ‘normally’. Media questioning of their legitimacy may even affect claimants’ own perception of their bona fides. In particular, people with fluctuating conditions (MS, M.E., arthritis) may, when in partial remission, themselves come to question whether they are really unfit for work. (One claimant, in the grip of such self-doubt, telephoned an agency which helps disabled people into work, and was - politely - laughed out of court when she described her state of health.) Applications for benefits and medical examinations may themselves contribute to a sense of leading a double life, as - contrary to customary strategies of ‘making the best of things’, and concealing symptoms for social purposes - claimants are obliged to describe and present their symptoms in their full severity (Pearce 2001).

The notion of the biographical disruption caused by illness (Bury 1982) could also be extended in the light of dependency on the state. Becoming a claimant involves a kind of infantilisation: a loss of control over one's own financial affairs, and an inability to plan for the future. Further, the 'parent' on whom the claimant depends is perceived as wayward, unresponsive and miserly. For many, the unreliability (as well as the level) of welfare benefits increases dependency on partners and/or family - compounding the dependency which may already have arisen out of the physical depredations of the illness. This unforeseen financial dependency may give rise to a sense that moral, as well as physical competence has been lost. It may also cause tensions in, and contribute to breakdowns of, relationships.

Along different lines, there is scope for Foucauldian analyses. People who claim sickness-related benefits experience themselves as being subject to surveillance, but this particular form of surveillance is, again, notably absent from the literature (Shildrick and Price 1996 is
a rare exception). If IB claimants were to read Foucault, they might recognise in their situation a means through which the effects of power gain ‘access to individuals..., to their bodies, their gestures and all their daily actions’ (Foucault 1980: 151-152). Foucauldian claimants might also recognise the image of the Panopticon, rendering everyone a potential object of surveillance (Foucault 1977: 195-228). The omission of this line of enquiry is particularly striking when one considers the widespread theorisation of medicalisation as surveillance - and hence, implicitly, as oppressive. From the point of view of sick people, however, medicalisation has a lot going for it. It does, at least, promise - and occasionally deliver - relief from physical suffering. Medical examinations carried out for social security purposes, however, have no therapeutic aim. To be the recipient of Benefits Agency attention is to be scrutinised, not cured or cared for or comforted.

From both modernist and poststructuralist stances, government rhetoric on (supposedly unjustified) claims to IB could be studied for its constitution of long-term disabling illness as shameful or as non-existent, hence contributing to the marginalisation of the sick, whether or not they are claimants. This rhetoric is liable to magnify the sense of dislocation, already considerable, which besets people when they first become ill with an incurable disease - and when many first move from financial independence to dependency on the state. It is also interesting to speculate on the motivation behind government attacks on the legitimacy of the sick - on whether this is purely cost-led, or whether it is part of an ideological agenda, and whether the government believe, and are justified in believing, that their tough stance will play well with large sections of the electorate4.

Obstacles exist to the pursuit of some of these lines of enquiry. Anyone wishing to investigate the quality of medical examinations is unlikely to find that a welcome is extended to observers. The effect on public attitudes of government discourses on sickness-related benefits is diffuse, and hard to research empirically. As to the motives of those in power, ministers will not admit to any goals other than targeting benefits to those in real need and extending help to those eager to return to work.

It is also possible that some claimants might be reticent, fearing breaches of confidentiality. On the other hand, many of those long-term IB claimants who feel they are struggling against great odds, only to be subjected to inappropriate forms of testing and to aspersions of malingering, might be eager to tell their story to researchers. The voices of chronically sick people, especially those dependent on welfare benefits, carry little social weight, and they have little opportunity to make themselves heard. Unlike some of their disabled counterparts, few are able even to take part in demonstrations to put their case. It would be heartening if, in future, when a government minister makes an unsubstantiated statement about the capacity of IB claimants for work, sociologists of health and illness were able and willing to respond, documenting the profoundly detrimental effect which such pronouncements have on many claimants’ lives.

Notes

1. The Benefits Agency is now an executive agency of the Department for Work and Pensions, which was formed in June 2001 from the former Department of Social Security and part of the former Department for Education and Employment.

2. Government statistics distinguish between ‘claimants’ in this sense, and the narrower category of ‘beneficiaries’. The latter receive contribution-related IB and number 1.5 million, 44% of them men over 50 (Department of Work and Pensions 2001a: 5; 16).
3. The change of name in April 2000 signalled ‘a new focus on ability rather than disability’ (Department of Social Security 2000). The method of assessing entitlement to IB remains unchanged, but, in pilot areas, examining doctors now produce a second report, which focuses on the claimant’s capabilities.

4. Perhaps ministers foresee a fall in IB claims, which can be presented as a vindication of their ‘toughness’: many IB claimants will have reach pension age before the next election, losing their entitlement to the benefit, and are unlikely to be replaced in similar numbers.

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References


Missing Connections: Medical Sociology and Feminism

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INTRODUCTION

We only need to cast our minds back to the 1970s to find a strong connection between medical sociology and feminism. Health and illness was of vital concern to feminists and medical sociology, then in its ascendency as a new sub-disciplinary field, drew on feminist insight. They shared a common disciplinary project which was to distinguish the biological from the social – in feminist terms, sex and gender – and claim the social as their own. Today - 30 years on, the connections between feminism and medical sociology are at best peripheral and, at worst, totally absent. It is difficult to find much, if any, direct reference to health in sociological accounts of gender and social change in the western world. In a raft of otherwise excellent books published over the last decade by feminist sociologists, education, work, the family, sexuality, identity and political representation all figure highly, but health fails to get more than a passing mention - if that (see, for example, Aapola et al. 2005, Charles 2002, Delamont 2003, Hughes, 2002, Marshall 1994, Pilcher 1999, Walby 1997). Within theoretical writing the absence is even more marked (e.g. Evans 2003). It may seem inappropriate to say that health is missing in feminist writing when there has been an explosion of work in areas such as the body, genetics and new reproductive technologies, but more often than not, attention stops either at the body’s surface (in terms of appearance, for example) or probes the body’s interior in a highly reductive manner (Birke 1999, Klein 1996). Psychoanalytic feminism is especially guilty. I particularly like this remark from John Wiltshire, referring to Julia Kristeva’s work

in this feminism, mortality is suspended – that is part of its exhilarating quality, no doubt: the implied female subject in such writing is young, bold and free, menstruates regularly and without discomfort, never suffers from lower back pain or ulcers, and not even her reading of Derrida and Lacan can give her a headache.

(Wiltshire 1997: 16)

Prominent feminists like Judith Butler, Donna Haraway and Elizabeth Grosz have no interest in health and illness (Kuhlmann & Babitsch 2002, Shildrick & Price 1998). This is light years away from the 1970s and early 1980s when feminist sociology effectively developed through an interest in health and health care.

But what of the other side of the coin - medical sociology; is it fair to say that medical sociologists have lost their connection with feminism? On first glance it seems simply wrong to say this – after all, a scan of journals such as Sociology of Health & Illness, Social Science Medicine and Health will quickly reveal scores of really interesting articles on gender and health: on topics such as health inequalities, the experience of illness, reproduction, the delivery of health care, and so on. There is then no shortage of research and no shortage of publications on gender and health within sociology and the wider social sciences. The problem as I see it is that gender is everywhere and it’s nowhere. Although it would be imprudent to stretch the point too far, ‘gender’ has become somewhat taken-for-
granted. So much so that we seem rarely to reflect critically upon what concepts like gender, patriarchy – even feminism itself - mean for us anymore. When medical sociologists use the term ‘gender’ in reference to women’s health it typically connotes potential or actual disadvantage (the same often now applies, of course, to the growing body of men’s health research). But the reasons for how and why this disadvantage comes about are often rather murky. All too often, research focuses only on a cluster of proximate causes (be they quantitatively or qualitatively defined) and the relationship between gender and health loses its structural moorings. Without these moorings we are left with similarities and differences in women’s and men’s health status, and similarities and differences in their experience of health and illness, for which we have no real explanation beyond a generalised sense that they are related to women’s and men’s positioning within society.

As I will discuss in more detail later, as what has conventionally been thought of as ‘biological sex’ and ‘social gender’ become less fixed and more fluid, the traditional distinctions between male and female experience are breaking down and being reconfigured in new, more complex and highly problematic ways with significant implications for patterns of health and illness and for the qualitative health experience of individuals. It is my argument that in order to fully understand these changes medical sociology and feminism need to be brought closer together.

Thinking about sex and gender

The story of how and why medical sociology and feminism came together, how they parted, and how they might be brought back together can be told through changing conceptualizations of the relationship between sex and gender. As far back as the seventeenth century, women writers were acutely aware that mind/body dualism had enabled men simultaneously to define themselves as rational agents, while equating women with a defective biology that excluded them from agency. It therefore made perfect sense for feminists, centuries on, to challenge this biological determinism with a new dualism of their own: the distinction between sex and gender. This distinction enabled them to argue that women’s oppression is socially caused, rather than biologically given. The conceptual distinction between sex and gender, the biological and the social which took off in the 1970s, has proven unshakeable. Even those who appeal for an appreciation of the interdependence of sex and gender in the production of health and illness persist in using the terms and, in effect, try to parcel out when sex (biology) is most important, when (social gender) is most important and, when they are equally important (e.g. Krieger 2003). Effectively, researchers are calling for greater precision in the use of these concepts, rather than a fundamental questioning of them.

The sex/gender distinction is as equally well embedded in the wider consciousness of society as it is in social scientific thought. This means that it is an object of enquiry as well as a conceptual tool. It is the lens through which debates on women’s oppression and liberation have been refracted for many years (and increasingly the focus for understanding men’s health in gendered terms). In this respect it is important to appreciate that the meanings attributed to ‘sex’, to ‘gender’ and to their inter-relationship have varied over time. I wish to suggest that they are intimately tied to particular configurations of patriarchal capitalism.
Patriarchy has traditionally operated by conflating sex and gender (that is, sex equals gender) - through what I will term the ‘old single system’ of patriarchal capitalism. Within industrial capitalism, production and consumption were predicated on a relatively fixed binary difference between men and women (that is, male ‘biological sex’ maps onto male ‘social gender’ and female ‘biological sex’ onto female ‘social gender’). This ‘old single system’ benefits patriarchy insofar as it is male sex and its associated social gender that enjoys the benefits of political and economic primacy. Gender follows directly on from sex and women’s inferiority is a natural product of her (inferior) biological make-up. The heyday of this old single system in the West was probably the 1950s when production and consumption depended on a relatively fixed binary difference between men and women. Men were the producers, women the consumers. Products and services were targeted to a segmented gender market, but it was women who were incited to do the purchasing and servicing for the household. Slicing through the tight connection between sex and gender (that is, arguing that sex does not equal gender) provided what I will loosely call ‘second wave’ feminisms of roughly the 1970s onwards, with the conceptual wherewithal to challenge the old single system of patriarchal capitalism. It enabled them to argue that women’s relatively poor health is the result of social (or gender) oppression, not biological inferiority. The sex/gender distinction was truly a conceptual treasure trove for sociological research on health and health care, spawning influential work in areas such as reproduction and childbirth and gender equalities in health.

Problems with the sex/gender distinction

Notwithstanding the wealth of groundbreaking insights that emerged, two inter-related problems followed in the wake of the ‘second wave’ distinction between sex and gender. First (sex)biology came either to matter too much (for example in radical feminist influenced work on reproduction) or not to matter much at all (for example in liberal feminist inspired work on health status) and the interplay between the biological and the social was neglected. The second and related problem was a tendency to draw a firm divide between male and female experience, be this on biological or on social terms. While on the face of it, (social) gender is treated as a variable against sex (which is more fixed), in reality gender effortlessly maps back onto a binary biological difference. Researchers still read gender through sex (or biology) as assumptions are typically made about which social/cultural/ political/economic

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**Fig 1: Patriarchy, capitalism and feminist conceptualisations of sex and gender:**

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<thead>
<tr>
<th>OPERATION OF PATRIARCHY</th>
<th>OPERATION OF CAPITALISM</th>
<th>FEMINIST APPROACH</th>
<th>RELATIONSHIP BETWEEN SEX/GENDER</th>
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<tbody>
<tr>
<td>‘old single system’</td>
<td>binary difference</td>
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<td>relatively fixed</td>
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<tr>
<td>‘new single system’</td>
<td>sex and gender</td>
<td>3rd wave ‘diversities approach’ (differences-within)</td>
<td>sex and gender (multiple forms)</td>
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<tr>
<td></td>
<td>more fluid</td>
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A Journal of the BSA MedSoc Group

Missing Connections: Medical Sociology and Feminism

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factors are relevant for male, and which are relevant for female, experience of health - often in advance of empirical research. Health and illness are irrevocably drawn towards opposition as part of this process. An unfortunate consequence of the binary logic that flows from the sex/gender distinction is that positively valued health is typically attached to men, and negatively valued illness to women. The ironic consequence is that feminism can end up entrenching women’s ill-health, effectively colluding with patriarchy by not letting them be well. And, of course, as a corollary, construed as well by comparison, men (in general) cannot be ill (Annandale and Clark 1996).

These difficulties of second wave feminism reflect a more fundamental underlying problem: that of trying to treat gender as variable, when sex (male/female biological difference) is taken to be fixed and dichotomous. This suggests that perhaps ‘social gender’ can only fulfil its initial feminist promise and be truly variable, when it is no longer necessarily associated with either men or women, when it is no longer tightly bound to the sex(biology) dichotomy? Or, we might say that fulfilling the ‘gender’ promise requires feminists to mount a two-headed attack whereby both (biological) sex and (social) gender are seen as malleable and carrying multiple meanings? It could be argued that patriarchy loses its moorings when diversity (i.e. differences within women’s and within men’s experience) replaces binary differences between them.

Operating as a critique of second wave feminism, this kind of approach - typically identified, of course, with ‘third wave’ or postmodern feminism of the mid-1980s onwards - disrupts the conceptual strait-jacket of the second wave ‘difference’ approach, since when sex and gender both become more fluid, men can no longer be identified so readily with positive health and women with negative health. Rather, the experience of health and illness can more appropriately be seen to cross-cut gender in complex ways. Insofar as the process of individualization which many sociologists argue characterises contemporary social life generally and the experience of health and illness specifically (e.g. Beck and Beck-Gernsheim 2002) resonates with the postmodern feminist vision of both sex and gender as multiple and malleable entities, it could be said to appropriately reflect the contemporary social world in which men and women live out their lives.

The ‘new single system’ of patriarchal capitalism

Not only traditional gender roles (‘the social’), but also distinctions between sexed (or ‘biological’) bodies are diminishing through what Rosemary Hennessy (2000) dubs the continual tooling and retooling of the desirous subject. It has been argued that capitalism ‘shapes biology in its own image’ (Dickens 2000). It also shapes the way we think about the relationship between the biological and the social, sex and gender. Social scientists, as well as some biologists (including feminist biologists such as Lynda Birke, 1999), have recently drawn our attention to openness as a counter to biological determinism. It is pointed out that, as self-actualising agents bodies have agency in relation to their environment as they constantly interact to change, both inside and out. And, as Emily Martin (1999) and others have shown, within society at large, people are moving away from a fixed mechanical view towards a conceptualisation of the body as fluid, flexible, and ever-changing.

As discussed earlier, during the old single system of industrial capitalism, sex (as biology) and (social) gender were seen as dimorphic with biological sex determining social gender. Typically men earned the family wage, while women, when not drawn into the workforce as a reserve army of labour, worked unpaid in the home. But this dichotomy doesn’t make sense for late capitalism which relies heavily upon fluid and malleable identities formed equally, if not more, in the sphere of consumption as the sphere of production. The social body is being reformed as the once steadfast roles of male breadwinner, female homemaker and all that
accompanied them in attitudinal and behavioural terms are being torn apart by far-reaching changes in employment, education, family and household structure, leisure and consumption (although of course this varies enormously by factors such as ‘race’, social class and age).

The opening up of the biological body (as described by social and natural scientists) and the opening up of the social body in the manner just described, means that sex (biology) is no longer so directly tied to gender in the traditional manner of the ‘old single system’ of patriarchal capitalism. The mapping of what has traditionally been thought of as male sex onto male gender, and female sex onto female gender, has begun to give way to a more flexible, or open, system. This is not to say that (biological) sex and (social) gender are no longer connected – as mentioned earlier, it is still not possible to think about one without the other - but rather that they are being drawn into a new, more complex, shifting and arguably more pernicious relationship. A new sex/gender tapestry is being woven. A ‘new single system’ wherein (biological)sex and (social)gender depend on each other for understanding just as much as before, but where the meaning of biological sex and the meaning and enactment of social gender, as well as the connections between them, are far more fluid (Annandale 2003).

The ‘new single system’ of patriarchal capitalism profits from the new markets that an increasingly ‘diversified’ gender economy operates. The self-culture of late modern capitalism is an extremely fertile ground for the commodification of sex and gender (and the body) as malleable entities. Indeed, sex/gender isomorphism has been readily seized upon, indeed advanced by, the marketing industry. Celia Lury (2002) argues that features which might once have been considered natural such as one’s sex or ‘race’ have acquired the ‘mutability of culture’. A good illustration of this is the Benetton clothing company which makes diversity its brand-identity. Brand iconography reveals, for example, that in the Benetton world ‘race’ is not about one’s skin colour, physical characteristics and so on, but about style. And people are not shackled by outmoded ideas of what is appropriate for men and women. But corporations like Benetton cleverly play on both sides of the fence – keen on the one hand to profit from the fissures between sex and gender, but also keen to deal in traditional gendered images. This became very obvious earlier this year (2005) when Benetton joined forces with corporate giant, Mattel to launch the ‘Barbie loves Benetton’ girls’ fashion range. Branded with a pink heart logo, four dolls called Paris, London, New York and Stockholm Barbie trade in traditional female stereotypes. Thus ‘diversity’ exists alongside binary difference.

Destabilised sex/gender identities have become an indispensable condition for the cross-marketing of products and lifestyles that were previously more or less confined to either men or to women, such as cigarette smoking and cosmetic surgery, with dubious or nebulous benefits to health and well-being. Marketing and the media position women (and increasingly men) in diverse and contradictory ways. In the case of alcohol, for example, in Britain women have been problematized as ‘ladettes’ and sexual aggressors who are losing their femininity and also viewed as liberated women living in an increasingly gender-neutral world:

_The ladette takeover: ‘a generation of women are hitting the bottle harder than men, fuelling fears of a timebomb linked to alcohol abuse.’ (Daily Mail 2004)_

_Gender neutrality: ‘There has been a convergence of taste and consumption: ‘women get tattoos, like football, watch strippers, buy erotic fiction and go on lone holidays while men learn to use cosmetics, do aerobics, cook and read magazines.’ (Guardian 2000)_
Media and corporate representations of the ladette are of a young woman who only appears to have it all. Here the vicissitudes of the ‘new single system’ of patriarchal capitalism are transferred to individual consumers who are positioned as inherently unstable themselves. The young female drinker is volatile and unreliable, and needs to be constantly reminded of this lest she forget. For example, the Christmas 2004 campaign of the Portman Group (which represents the UK drinks industry) was targeted at women and dubbed, ‘If you drink, don’t do drunk’. It portrayed women as voluble Jekyll and Hyde characters. The television advertisement features a young woman sitting at her desk in an office. As the ad campaign puts it, ‘she looks like butter wouldn’t melt, dressed as she is in her smart business suit’. But, as the copy continues; when the interviewer asks her what she likes to do at the weekend, we see an altogether different side as Ms Jekyll turns into Ms Hyde. Along with her two friends, she is seen getting very drunk and – again, as the campaign copy puts it, ‘putting herself and others into increasingly embarrassing and risky situations starting with vomiting in the nightclub toilets and ending up in the gutter holding on to one of her friends for support’. This is captioned with the comment: ‘Not a pretty sight’. More widely, drinking is positioned as a male undertaking that women take on at their peril. If they do so, they risk subverting natural female virtues such as modesty and their looks. So, as the Observer newspaper put it in 1999, ‘if she [a woman] drinks like a man she may start to look like one.’

It is not just young women who are implicated. Women are construed as irresponsible whatever their age and circumstances. In a recent survey Mintel Marketing Intelligence identifies, ‘two new types of women behind’ what they call the bad behaviour trend among thirty- to forty- somethings: on one side is a new group of women who are single or divorced, who are fed up that they can’t find a partner or have just left one and are saying ‘to hell with the whole thing and rewarding themselves with things they enjoy like alcohol and cigarettes’, and on the other side are married women for whom the pressure of work and home life is growing all the time. These are the women who it is said are struggling to live up to media icons like Nigella Lawson who is seen to have a top career and a home life. A no-win situation then: women are in dire straits whatever their circumstances. The clear message is that liberation has let them down and in the process generated a lucrative market of unstable identities and individual women who need to be shown the light. My argument is that this fluidity of identities is actively fostered through the new single system of patriarchal capitalism. The drinks industry for example, actively positions women in multiple contradictory ways. Mintel currently values the UK drinks industry at £38 billion and identifies women as a fast rising consumer group. Although young people remain the key market drivers, persons in their mid 50s to mid 60s are identified as a vital rising market too – the very age cohort of women whose health (as I will discuss later) appears to be suffering a downturn relative to men. The recent World Health Organisation’s report, Women and the Tobacco Industry (Samet and Yoon eds. 2001) makes clear that tobacco companies need to recruit 4,000 new smokers a day worldwide to maintain their current market size. Selling tobacco products to women currently represents the single largest product marketing opportunity in the world.

The impact on morbidity and mortality

As mentioned earlier, within feminism discussion about the remaking of sex/gender has typically been concerned with the body’s surface. Yet the changes associated with this protean ‘economy of differences’ of the ‘new single system’ of patriarchal capitalism, self-evidently extend beneath the surface. They reach deeply into the interiors of the body and change traditional health profiles. As health problems that were once largely the province of men begin to increasingly affect women (for example, lung cancer), and vice versa (for
example, melanoma), the materiality of the body is modified and takes on characteristics more typical of the so-called ‘opposite’ sex (the damaged lung, skin lesions and so on).

At the population level, traditional patterns of male/female morbidity and mortality appear to be shifting in the west. For example, the widening gender mortality gap favouring women which characterised the period from around 1870 to the early 1970s has been closing in many nations.

Table 1: UK Life Expectancy

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<tr>
<td>Males</td>
<td>67.8</td>
<td>69.1</td>
<td>70.8</td>
<td>73.2</td>
<td>75.7</td>
<td>76.2</td>
<td>8.4</td>
</tr>
<tr>
<td>Females</td>
<td>73.6</td>
<td>75.3</td>
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<tr>
<td>Males</td>
<td>64.4</td>
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<tr>
<td>Females</td>
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* United Kingdom, ** Great Britain Source: Social Trends 35, table 7.1 (2005)

Table 1 shows improvements in life-expectancy for both men and women, but a gradual chipping away of the female mortality advantage, as reflected in the reducing gap. In fact, the main contribution to longevity for both men and women comes from accelerated improvement at older ages, and it is here that men have fared especially well in recent years. This trend is mirrored in many other countries such as Australia, Sweden, Germany, France and the USA.

Somewhat ironically then, the ‘old single system’ of patriarchal capitalism may have conferred a mortality advantage to women. Binary difference may have kept them away from the dangers to life and limb that cut male lives short. Now, as differences between men and women attenuate and inequality is reconfigured, women appear to be losing out and men gaining. Interestingly, very little popular attention has been given to men’s improvement at older ages. Ironically, the tendency of the UK men’s health lobby to draw attention to the historically invisible character of men’s ill-health may unwittingly have contributed to this.
Figure 2: Major mortality

**Lung cancer**

- Male rates still higher. But since mid-1970s, rise for women, decline for men in many western countries (e.g Griffiths & Brock 2003).
- Opinion that women are ‘in the throes of an epidemic of tobacco-related disease’ which is yet to reach its peak (US Surgeon General, 2001).

**Heart Disease**

- Coronary heart disease (CHD) is major cause of death of women and men in UK (UK women amongst highest rates in world). Concern that CHD is incorrectly perceived to be a ‘male disease’ (British Heart Foundation 2003)

The major contributors to changing patterns of morbidity and mortality are heart disease and cancer. There is ongoing debate over whether women and men have a different biological vulnerability to heart disease and cancer, but it is generally recognised that social factors are very important. There is a lag effect whereby health behaviours linked to cancer and coronary heart disease such as cigarette smoking, alcohol consumption and diet initiated 20 or so years ago show up in later statistics. The commonsensical explanation for changes in mortality in the west is, as I have explained, a social one: that men and women are becoming ‘more similar’ in their health behaviours and particularly that women are ‘paying the price for liberation’. It is common to hear that young women are setting off an illness time-bomb that will go off in 20 or so years’ time as they ‘become more like men’. Thus, writing in the British Medical Journal very recently, Madeleine Brettingham (2005:656) concludes that, ‘the historic gap between men and women’s life expectancy could vanish as more and more women accustom themselves to the work hard-play hard culture of modern Britain.’

As was discussed earlier in respect of media representations, explanations are typically couched in attitudes and beliefs such as heightened health consciousness amongst men and the taking up of damaging health behaviours, notably cigarette smoking – which is generally considered a major cause of women’s declining mortality advantage - by women. This explanation is mirrored within the medical and social sciences, where the ‘state of the art’ view is also that change is afoot. Mel Bartley, for example, remarks

> We might guess that, as the home and work situations of women and men become more similar (as women become more likely to have full-time jobs of similar status to men, and as work, marriage and children are combined in more similar ways), any remaining health differences between men and women may disappear’ (Bartley 2004:139-140)

Similarly, Jacques Vallin *et al.* (2001) claim that there has been a convergence in life expectancy due to a ‘convergence of behaviour patterns between men and women’. Researchers point out that the so- called ‘gender paradox’ whereby women live longer, but are apparently sicker than men throughout their lives, has been a product of blinkered thinking, a product of research designs which set out to find male/female differences (a point made earlier in this paper). Recognising the complexity, McDonough and Walters remark that
Rather than fixed paths, we see multiplicity and diversity in the relationships among gender, stress and health that call for more refined conceptualisation of ‘gendered reality’. The research challenge is to explore the ways in which gender continues to be an important representation of inequality, while recognising the diversity of experiences within genders (2001: 556, 557).

There is nothing intrinsically wrong with these summaries. Rather, the difficulty is that we seem to have a problem in search of a theory. Without this we can unwittingly lapse into accepting popular representations of change (such as those already discussed) rather than providing a critical commentary on them. With their vision of both sex and gender as multiple and malleable entities, many ‘third wave’ or postmodern feminisms tilt precariously in this direction. They come painfully close to endorsing the flourishing academic and more popular ‘new feminist’ literature of authors like Rosalind Coward (2000), Naomi Wolf (1994) and Katie Roiphe (1993) who claim that feminism’s very success means that it is no longer needed. As Beverly Skeggs (1997) and Imelda Whelehan (2000) aptly remark, this ‘new feminism’ offers a markedly individualistic kind of radicalism, one that feeds easily into the rhetoric of individualism where the way forward for women is lifestyle choice and self-determination largely unfettered by the erstwhile constraints of sex and gender.

I wish to suggest that if we make the ‘new single system’ of patriarchal capitalism as the object of our study, this provides us with the conceptual wherewithal to interpret the new biological embedding of experience reflected in changing patterns of morbidity and mortality and the experience of illness as direct and visible representations of how, to paraphrase Rosemary Hennessy (1993) (who gives no attention to health and illness), the common experience of health-related oppression is produced differently, and experienced differently, through systematically driven processes of sex/gender fragmentation.

Heart disease is a good concluding illustration of this. Although deaths from heart disease are falling for both men and women, heart disease is the leading cause of premature death for both men and women in the UK (typically occurring some 7 to 10 years later in women than in men) and the number of people living with cardiac morbidity is increasing. But it is only recently that popular opinion has begun to shift away from heart disease as a ‘male disease’. Quite a lot has been done very recently to debunk this myth. For example, the British Heart Foundation (2003) has made women’s awareness a focus of attention and so-called ‘gender sensitive’ health policies have sought to draw attention to the differential presentation of symptoms in men and in women. It might be argued that as perceptions of male female differences attenuate, it will become much easier for the general public to think of heart disease as a female (as well as a male) disease. This perceptual shift has been the source of some attention in the corporate world. In the USA for example, the National Heart, Lung and Blood Institute (which is part of the partnership with, among others, cereals giant General Mills. The new Berry Burst Cheerios boasts a ‘circle of healthy hearts programme’ for women. In Britain, Nestle has equally positioned Shredded Wheat – traditionally geared to men’s health - to the women’s heart health market. In 2003, for example, ex-gymnast and TV sports presenter Gabby Logan told us in a television advertising campaign that men and women are not as different as they seem: so ‘women need to take care of their hearts too.’

The drug Zoroc Heart-Pro, the world’s first over the counter statin is niche marketed to a range of target consumers. The message is geared to a segmented market of males and females and different age groups. Heart-Pro is considered to be a key industry test case because it is now sold over the counter to healthy people as a preventative medicine. A suite of magazine advertisements has been directed to women. One such advertisement shows a woman holding up a 55th birthday card. The wistful look on her face suggests that the occasion is as much worrisome as it is a cause for celebration as the copy advises that she
is now of an age when she needs to think about taking Zoroc Heart-Pro to prevent a heart attack (even if she doesn't have risk factors like high cholesterol or high blood pressure). Even if she exercises and eats healthily, it can still help her.

**Conclusion**

If I can then return to my starting theme: the missing connections between medical sociology and feminism. Back in the mid-1980s, Ellen Lewin and Virginia Olesen (1985) felt confident in claiming that more than any other domain of life, ‘health embodies almost all the crucial elements necessary to achieve an understanding of ...society itself’. ‘Health permits the revelation of most of the elements of western cultures which bear most directly on the construction of gender and its consequences for women, men, and the larger social order’ (p. 19). While other domains - such as religion or the law - provide insights, Lewin and Olesen make clear that none take us as far as health does, precisely because health is so all encompassing. Many feminists seem to have forgotten this and pushed health and illness out of view. Medical sociologists in their turn seem perplexed by the increasingly complex social relations of gender in the west, and unable to fully account for health-related change, in good part - I would argue - because they have lost their original anchor in feminist thought. They often work with vague derivatives of feminist theory, failing to appreciate the significant differences between them, and the implications of this for their research. I therefore argue that there is a need to bring feminist theory and gender-related research on health and illness within medical sociology much closer together than they are at present.

Contemporary health-related changes are highly complex and reach deeply into the interiors of the body. They are part of what Teresa Ebert (1995) - writing outside of the domain of health - refers to as ‘an economy of differences’. What we know as social (gender) and (biological) sex are drawn into a new symphysis within the ‘new single system’ of patriarchal capitalism. Within this new single system the common experience of health-related oppression is produced differently, and experienced differently, through systematically driven processes of sex/gender fragmentation. Together, medical sociology and feminism provide us with the wherewithal to reflect critically on this process.

1 The term gender was in use before this time. Feminists and feminists fashioned their own use of the distinctive use of the term as a social counterpoint to biological (sex).

2 Although of course this leaves aside the important question of whether longer life is a good thing anyway.

**References**


Applied Qualitative Health Research Special Interest Group Symposium

Wednesday 14th May 2014, Newcastle University

A great turnout for the AQHR in Newcastle with over 60 people in attendance for the one day event at Newcastle University.

Helen Eborall et al, Leicester University - "Development of the PROPELS mobile health (mHealth) intervention: a case study"

Qualitative research is increasingly used as part of the process of developing complex interventions. Helen described how the often unique and lone voice of the qualitative researcher is highly important, and more than simply "piloting" but formative in the development.

Laura Sheard & Claire Marsh, Bradford Institute for Health Research - "How can we use qualitative data to make sense of what happens in a randomised controlled trial?"

Laura and Claire explained how a range of qualitative research methods were used to track if and how complex patient safety interventions led to an improvement in patient safety. There was great interest from the audience in the use of fieldworker diaries, observation and interviews to understand the barriers both practical and cultural that are faced when implementing change in hospital settings.

Andrew Mordon et al, Keele University - "Using qualitative social science in developing, delivering and evaluating Evidence Based Medicine Interventions"

Including a narrative of lived experience of health and illness of patients is key to helping clinicians reflect on their practice. Andrew concluded by inviting the audience to push for using social theory to add explanation in addition to using social research methods.

Louise Locock et al, University of Oxford - "Testing Accelerated Experience-based Co-design: qualitative study of using a national archive of patient experience interviews for rapid patient-centred quality improvement"

Louise helped illustrate how powerful the accounts of patient experience can be in inclusion and co-design of future health practice. Using video clips as ‘touch points’ to stimulate discussion and debate between patients and clinicians it proved to be highly evocative in forcing reflexivity.

Jenny Dalrymple et al, Glasgow Caledonia University - "A qualitative study of late middle aged heterosexual adults’ negotiation of partnerships within the context of risks for sexually transmitted infections"

Late middle aged heterosexual adults whom may be newly single face a new cultural environment in terms of negotiating their sexual behaviours and relationships. Jenny talked the audience through her use of social research methods and sociological explanations to understand the accounts of those she interviewed in terms of age, gender and cultural influences with regards to their sexual behaviour. She gave some fantastic quote from her data that led to lively discussion.

Ann Hutchinson et al, Hull York Medical School - "In search of a rich description - Experiences of carrying out linked interviews"
The experience of breathlessness can present due to a number of different underlying causes in different patients. The focus for Ann was, what effects the decision of the patient to go to A & E, and how are they treated there when they do? In discussing her sampling methods, ethical challenges and experience of using linked interviews she highlighted how qualitative research can help pin point the root of an issue and recommend where best it is confronted, such as with GP’s.

**Keynote speaker Professor Carl May, University of Southampton - "Applied Qualitative Research in Healthcare; What can we do with it?"**

Introducing his keynote presentation by admitting that in his early career he was asking inappropriate questions, Carl had the audiences’ full interest and enthusiasm for the work that all have an interest in. In questioning the separation of applied and theoretical interests our research can do a disservice to both and can stop qualitative health researchers getting involved with the big problems of our era. Often little cited is the political and social engagement of some of the biggest names of sociological theory such as Parsons and Foucault. As medical sociologists often working in health settings and with practitioners we should not fear using social theory. Grounded theory, which historically grew from influential empirical qualitative research, is widely referenced when discussing analysis of data, yet often misunderstood. Social theory provides a window and framing of the social world we seek to understand. In a rallying call to arms, we should not be afraid to engage actively with “intellectual conviviality and collegiality” in order that we use applied findings to frame and explain social phenomena that contribute and shape theoretical understanding.

**Sally Brown, Durham University - “Using focus groups in naturally occurring settings”**

Sally presented her use of focus groups in naturally occurring settings, as a way to generate more natural talk and interaction. With discussion in families or friendship groups it can be highly insightful as the underlying power structures that may influence health behaviour and/or discussion of it can be identified through non-verbal indicators. One way that this can be exemplified was through the colour-coding of transcript to demonstrate the amount and type of talk done by different members of the group. This generated a great deal of discussion of how this could be applied to many focus group transcripts.

**Judy Richards, Newcastle University - “Researching sensitive issues: Reproductive Loss from a Multiple Pregnancy”**

Researching sensitive issues is rightly widely discussed, but less so is the experience and effect on the researcher. In sharing her experience of conducting interviews with those whom had lost a baby due to multiple pregnancy, Judy highlighted the many issues that it raised as ‘emotion work’ for her as researcher. Having appropriate support and learning to manage your feelings as the research develops was key to maintaining self-care.

**Sarah Chew, Pam Carter, et al, Leicester University - "Ethics in theory and pseudo-ethics in practice"**

Provoking much thought and discussion Sarah and Pam outlined their concerns around ethical standard and safeguards which are often dominated by bio-medical research practices. This can lead to a mismatch of ethical procedure and regulation on paper and practice in the field. Discussion gave many different views and experiences of undertaking Good Clinical Practice training which some found beneficial and others worried was a waste of resources.
‘Ourfoodstories@e-mail.com’: An Auto/Biographical Study of Relationships with Food

Julie Parsons
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Abstract
Popular discourses and current government policy focus on the need for individuals and families to make healthy food choices, without acknowledging the social and cultural milieu in which these are embedded. A neo-liberal focus on responsible individualism is part of a middle class habitus that ensures foodwork and foodplay are located within distinct heteronormative cultural fields. In my thesis I explore narratives from seventy-five mainly middle class respondents who engaged in a series of asynchronous online interviews over nine months beginning in November 2010.

The themes that emerged aligned with public policy debates on the family, healthy eating, eating disorders, ‘fat’ bodies and elite foodways. Hence, feeding the family ‘healthy’ meals ‘prepared from scratch’ was considered a means of acquiring social, symbolic and cultural capital. ‘Fat’ talk and ‘lipoliteracy’ or learning to read the body were ways of performing femininity, whilst elite foodways were utilised as forms of hegemonic masculinities. Hence, in a challenge to the individualisation thesis my research demonstrates the complexity of food relationships beyond individual consumer choice.

Throughout I adopt an auto/biographical approach that stresses the interconnectedness of biography and autobiography, focuses on researcher reflexivity and is sensitive to respondent subjectivities. Respondents used a common vocabulary of individuality, whilst simultaneously embedding themselves in family and kinship relations. Indeed, family, gender, and class, were the means of anchorage in a sea of remembering that engendered a sense of ontological security.

Foodways are, thus, part of a habitus that is gendered, classed, temporal and historical. Women in the study conformed to cultural scripts of heteronormative femininity, whilst men resorted to hegemonic masculinities to distance themselves from feminised foodways and care work. These identities were not part of a negotiated family model, but located in cultural fields that reinforced and naturalised gendered divisions, they were bound by gender and class.
Book Review

Lesley Doyal, with Len Doyal

Living with HIV and Dying with AIDS: Diversity, Inequality and Human Rights in the Global Pandemic
Ashgate, UK, 2013, Paperback
ISBN: 978-1-4094-3111-4
264pp

Reviewer: Pamela Pitman Brown, PhD
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The book is one of the newer titles in the ‘Global Health’ book series presented by Ashgate Publishing, and edited by Nana K. Poku. The series provides global health-focused texts, which construct health issues from socio-cultural, a socio-economic, and a moral political standpoint rather than a more medically based perspective. This text is one of six offering research projects or literature reviews on HIV/AIDS, having the distinction of being the only one published within the past 3 years. As the author, Lesley Doyal writes in the introduction, the central theme of the text purports “the value of bringing social sciences into the study of HIV and AIDS, especially when that is based on interdisciplinary collaboration.” The text conveys how the HIV epidemic cannot be deliberated within a global north ideological position of personal responsibility, but offers up how the HIV epidemic is enmeshed within the larger global economic sphere, where poverty and socio-structural violence amplifies the disparity of survival between the have and the have-nots of essential resources.

The initial chapter of the text, Posing the Problem, references Randy Shilt’s And the Band Played On including statistics from WHO, UNAIDS, and UNICEF. Additionally, Doyal inserts a precise explanation of the biological underpinnings of the HIV epidemic, including information on the various stages and progression of the illness. This narrative is one of the most simplistic, nevertheless accurate explanations that I have encountered on the HIV epidemic. The aforementioned, along with the introduction of four created case studies, sets the tone of the text to one of teaching to and not teaching down. This is most important when instructing students at the undergraduate/graduate level who do not have the historical or biological background on the origins of the HIV epidemic; they can become enlightened and not bored with pages of incomprehensible terms.

Of particular interest to me is Chapter 2, Mapping the Pandemic, as Doyal mentions the oft neglected group of those who are aging (over 50) with the illness, stating estimates of those cases from both a global and country specific perspective. Doyal’s dialogue on the globalised differences of transmission routes of HIV references groups such as MSM, IDU, and sex workers is enlightening, and additionally a conversation on China and their HIV epidemic is included. She also uses quite a few pages to discuss the topic of intersectionality concerning women specifically. Doyle interjects the concept of the limited, homogeneous, and summative descriptives of those with HIV, without acknowledging the usually
heterogeneous and multiplicative characteristics we find as researchers for those who are HIV positive. This intersectionality within the text’s foundational framework is Doyle’s contribution to how these individuals’ who are HIV positive are renegotiating their local and/or global environment and their negotiation of daily life.

As I moved into Chapter 3 I realized how much extant knowledge of HIV would be needed during the reading for students. Additionally, it became obvious that many undergraduates would not benefit from the text, as additional sociological mastery, and more medical and global understanding (particularly for Chapter 4) was required to continue reading. Moving into Chapter 5, Challenging Livelihoods, Doyle appears to have begun to come back to the level where undergraduates can then understand how sociological factors such as lack of paid work, gender inequalities within paid/unpaid care work, and gender roles within families who are dealing with the challenges of the HIV epidemic, influence economic and social circumstances. Additionally, Doyle addresses the tragic intergenerational responsibilities pressed upon the oldest and the youngest of the caregivers, the mothers and the children of the infected. Chapter 6, Changing Sexual Lives, will be one of the most useful tools in the text for health educators of HIV+ individuals, Doyle not only discusses abstinence policies but body dysmorphic, power differentials when one partner becomes positive, and the issues of condom use among MSM, including the lack agreement of status disclosure.

Chapter 7 discusses reproduction as HIV+ individuals and alludes to the differences between those in rich countries, who have technological means to hinder the virus from passing to the child, and those in sub-Saharan Africa. Additionally the chapter discusses the choices, intentions, and decision-making processes individuals consider for parenthood desires. Chapter 8 on Human Rights is an excellent chapter for any student to read and understand principles and challenges of the universality and the move forward to protect others. The final chapter, Back to the Future, focuses on HIV/AIDS research issues, as well as the challenges of funding, linked to resource allocation, reminding us that HIV includes the word “human.”

I would suggest using this text within an advanced sociological course on HIV/AIDS or Medical Sociology, but would refrain from using it as a sole text, encouraging instructors to supplement with current news or journal articles, bringing in the global North’s HIV research as well.