The Biographical Turn and the ‘Sociolization’ of Medicine

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I should perhaps begin by apologizing for the proof-reading problems engendered by my use of the term ‘sociolization’ and to attempt to define what I mean by this. It refers to what I wish to argue is the process through which sociology has come to shape the profession of medicine, partly, but not exclusively, through what I’ve called ‘the biographical turn’.

I’m using the licence afforded by this plenary to take a biographical turn of my own and to revisit the thinking that informed my own PhD, carried out in the late 1970s. This was concerned with charting the professional socialization of social work students and drew on the literature relating to the sociology of the professions – particularly the work of Eliot Freidson (1970a), who published his influential book Medical Dominance: The Social Structure of Medical Care in 1970 (b) which, of course, built on the work of Everett Hughes (1958).

Freidson – and, indeed, other commentators – viewed medicine as the quintessential profession, deriving its authority through its claims to possession of a distinctive and complex body of knowledge; its control over selectivity with regard to admission; and the requirement of a lengthy training period – in other words, via its ‘attributes’. Freidson’s analysis introduced a conflict view of the acquisition and maintenance of professional power and acknowledged the power struggles both within medicine as the ‘prototype’ profession (Conrad, 2007) and with close contenders. Medicine was seen also as occupying a superior power position vis-à-vis other occupational groups concerned with providing health care. In the spirit of that time I, too, viewed social work as one of the semi-professions (Etzioni, 1969) and speculated as to whether it would ever become a fully fledged profession.

At this point in time social workers on the ground – if not their senior managers and associations – remained largely ambivalent with regard to attaining full professional status and sought to resist the all-pervasive drive to professionalization identified by theorists such as Wilensky (1964). I concluded in my PhD thesis that social work claimed legitimacy through appeals to a somewhat different cluster of attributes, which privileged the possession of ‘people skills’ and emphasized its value base. In a similar vein, Kleinman (1981) differentiated between professions which relied on an established skills set and those concerned with “making professionals into ‘persons’”. The arena of ‘people skills’, I argued, was not the terrain on which medicine deigned to wage battles for professional dominance, contenting itself with its manifest success in relation to fulfilling ‘harder’ and more easily observable claims as outlined earlier.

However, since that time both society and the medical profession itself have changed and, alongside a more generalized ‘humanization’ of society, medicine has, I would argue, sought to cultivate recognition in respect of these ‘softer’ skills, whilst retaining its traditional power base underpinned by its unchanging attributes. Rather than social work and other so-called semi-professions seeking to emulate medicine, it would appear that the movement has, at least some of the time and in some quarters, been in the opposite direction. Sociology – and, in particular, medical sociology – has also had a significant influence on the ways in which the medical profession, at least in some of its incarnations, has responded and sought to
move with the times in terms of developing its ‘softer’ face.

The late 1970s were also characterized by growing concerns with regard to the process of medicalization, which, it as argued, involved medicine in extending its influence, through turning social issues into conditions requiring medical treatment. This argument was, most notably, advanced in relation to pregnancy and childbirth. To sum up, these critiques of medicalization highlighted medicine’s technical gaze; its episodic focus, its mechanistic rather than holistic approach and its concentration on the physical to the neglect of the psych-social. While such processes are undeniably still a feature of many encounters with the medical profession and other healthcare practitioners, society has moved on and so too has medicine. In particular, it is possible to trace the influence of and response to feminist critiques of maternity services in the changed content and tenor of many medical interactions around these issues. This shift has been associated with the ascendance of ideas regarding ‘choice’ and ‘agency’, with a new emphasis on partnerships with service users and the importance of informed decision-making.

Medical sociology - and, indeed, medical sociology - does not, of course, exist in a vacuum, and has been shaped by broader cultural shifts, including what I’ve termed ‘the biographical turn’. Although biography has been an enduring feature of the literary scene, it is only relatively recently that we have witnessed the spread of the ‘celebrity biography’. Some ‘celebrities’ are serial auto-biographers, so, for example, Jordan – a.k.a. Katie Price – has already produced at least three that I’m aware of. Given her relatively young age it is likely that more will follow. What is striking about this is the apparently new-found need to package – and, indeed, re-package – one’s life; not at the culmination of someone’s career, but as an ongoing reflexive project. In 2000 Simon Williams published a paper in SHI in which he somewhat mischievously reversed one of the premises of Bury’s (1982) theory of ‘biographical disruption’. Whereas Bury has argued that chronic illness gives rise to biographical disruption Williams asked whether, in fact, causation operates the other way around. Williams argued that biographical disruption, itself – i.e. the loss of the capacity to anticipate and package one’s life according to a pre-existing template – can be experienced as a devastating rupture, which impacts negatively on an individual’s psychological health and well-being.

The advertising industry, as always, has been quick to plug into the biographical zeitgeist, perhaps most notably in a recent John Lewis advert, which depicted a woman progressing through the various stages in her life (as an enduringly loyal John Lewis consumer). This advert, with a soundtrack by the Guillemots of Billy Joel’s ‘Always a Woman’ was first aired during a break in Coronation Street on a Friday evening, and by the following week had had attracted over 120,000 hits on YouTube. Interestingly, this short sequence occasioned considerable controversy, with the chattering classes posting on the Guardian’s website, where many deplores the anti-feminist take on a woman’s role as reflected in an impoverished view of woman - as baby, toddler, child, teenager, bride, wife, mother and grandmother - whilst acknowledging that they had found the images and narrative surprisingly moving. Amidst this furore they seemed to have momentarily forgotten that this was, indeed, ‘only an advert’.

‘The Biographical Turn’ certainly permeates health promotion rhetoric and interventions. The language of health promotion is that of deferred gratification, whereby we are urged to forego particular behaviours (many of which may be enjoyable) in order to maximize future health and well-being. Nowhere is this more evident than in relation, once again, to pregnancy. Together with some colleagues I was recently funded to carry out a research project investigating the reasons for ‘low uptake’ of folic acid by pregnant women (Barbour et al., in press). As medical sociologists we can find ourselves in rather difficult situations, when we
work on commissioned studies which uncritically echo current – but always provisional – evidence; in this case the study – at least in its early stages - reflected the medical preoccupation with the elimination of risk through scrupulous planning, or biographical anticipation. Women are currently advised to take folic acid prior to conceiving and for the first 12 weeks of pregnancy. This is somewhat unrealistic, given the high percentage of unplanned pregnancies and also the length of time it can take some women to conceive. Further discomfort was to follow, as focus group discussions and interviews revealed that service users had a more nuanced take on biography than the simplistic health promotion version:

Mel: I actually felt quite guilty – probably about half way through … near the end of my (second) pregnancy - I actually started feeling quite guilty that I actually hadn’t taken anything, but then ….

Rose: Right – because you’d taken folic acid with the first?

Mel: Aye – I think I was quite worried about it. I don’t know if it’s just me, but maybe later on, intelligence in later years and things like that, and I started thinking, ‘Well, what if I’ve gave my first one a better start …

(Joint Interview 200808)

Introducing the idea of looking ahead and maximizing benefits for one foetus inevitably leads to comparisons with behaviour in past pregnancies and health promotion injunctions have considerable potential to invoke feelings of guilt, as the quote above illustrates.

An earlier interview study of couples attending a fertility clinic showed that they, too, looked backwards, as well as forwards. The following two poignant quotes involve women castigating their past selves:

You know, I think it’s just typical of me – to presume, you know, ‘Well, I want to do this and that’s when I’ll have babies’ and then you can’t. All those years spent taking precautions … (34 year old woman)

I keep kicking myself – no — thinking ‘Well, why did we leave it so long? Maybe if we’d started 2 or 3 years earlier we’d have a baby by now … (30 year old woman).

However, the picture was more complex, and, at times, the biographical focus simultaneously cast a forwards and backwards glance, as in the following quote where a woman anticipates her present self being castigated by a future self:

We would do IVF - we’ve talked about this long and hard. If we don’t, I think, down the line in 10 … 20 years’ time, we’d say “Well, what if we’d tried IVF?”

(33 year old Woman)

Attending to one’s biography, then, can be a demanding and unsettling business and is certainly not nearly as straightforward as current health promotion materials and approaches suggest.

In relation to maternity care and provision of fertility services, the new face of medicine now recognizes pregnancy and birth as social phenomena; embraces women’s (and, indeed, partners’ involvement in decision-making); focuses on the ‘couple’ as a unit; and emphasizes ‘choice’ – perhaps even to the point of reifying this last concept. However much ‘choice’ is championed it is, nevertheless, governed by often unexamined but powerful assumptions that serve to limit its exercise. ‘Choice’ is legitimated only within certain parameters – for example, at least in the popular media, individuals such as Victoria Beckham are disparaging labelled as ‘too posh to push’ – suggesting that ‘choice’ is fine, as long as women make the
'right choice'. Discussion about the impact of social class has been relatively muted, but some work, such as that of Nelson’s in the US in the early 1980s has shown that perceptions and experience are contingent on social class position and associated values and expectations. In her study of American working class women giving birth she found that their wishes were at variance with those of the middle class women more commonly studied by researchers and whose views were more likely to be taken into account in shaping – or re-shaping maternity services. The women interviewed by Nelson (1983) did not aspire to the natural births favoured by their more affluent sisters; indeed they wanted to minimize pain and were keen to control this and shorten the duration of their labours by whatever means was available to them.

Despite the ascendancy of the concept of ‘choice’ pregnancy and childbirth are frequently not experienced as being quite as straightforward as the rhetoric of ‘choice’ would suggest. Complications may arise to confound scrupulously delineated birth plans and there can be a considerable mismatch between women’s expectations and the unfolding event of labour and delivery. Rachel Thomson and colleagues (2011) explore these tensions in their new book on their recently completed study of first time mothers. Closely related to the notion of ‘choice’ is that of ‘control’. However in the event planning may turn out to be illusory. Conception, itself, is a relatively rare event and cannot be accurately predicted. Our study of young adults with cancer (Barbour et al., 2011), where we spoke to men and women at different stages in their reproductive careers highlighted the lack of conscious planning that often characterized childbearing. As one man told us:

(Our little girl was) “not planned as such but not…. You know we weren’t trying as such but we weren’t… (we were) not taking precautions … it was something that we had been thinking about for some time but erm weren’t actually putting an effort into having a planned…. but I mean it was something that we both wanted.”

(23m -49 year old man with leukaemia).

A previous study (Barbour, 1999) highlighted that, even in the context of ongoing fertility treatment, women could, and sometimes did, become pregnant in between IVF cycles. Although sociology has undoubtedly led to valuable improvements in maternity and fertility provision, the widespread adoption of ideas surrounding ‘choice’ ‘control’ and ‘agency’ may have led to an over-socialized – or, even, ‘over-sociolized’ - perception of reproduction.

A further aspect of the ‘sociolization’ of medicine is fertility clinics’ focus on the ‘couple’ as the treatment unit. At first glance this might appear an entirely benign approach, showing that clinical staff are cognizant of the huge social significance of fertility and the central role of biological offspring as the ultimate expression of a loving partnership. However, a closer and more critical examination of the way in which the notion of the ‘couple’ is invoked suggests that the picture is rather more complex. Fertility clinics are also delivering a product and it is striking to note the preponderance of photos of happy couples and healthy babies on clinic noticeboards, serving as a compelling – if somewhat misleading - advertisement. Nowhere are photos of happy childless couples to be seen, despite the uncomfortable reality that, even with the very best success rates achieved by clinics, failure to conceive remains the most common outcome of treatment. The pro-natalist stance of what could be termed the ‘fertility industry’ engenders muted discussion of other options open to couples. In particular, the insistence on focussing on the couple as a unit masks the other stark clinical observation that, frequently, only one partner has a fertility problem. In this context, constructing fertility problems as owned by the ‘couple’ raises the vexing question as to whether a ‘couple’ can, in any sense, be said to have a ‘biography’. Counselling is commonly offered to couples, but,
certainly in our own study, we were surprised to find that none of the 24 couples we interviewed had, in fact, taken advantage of this service, perhaps preferring not to explore the potential of fertility problems to impact on their relationship. Couples sought to portray their partnerships as stable and distanced themselves from the stereotype of ‘the neurotic infertile couple’ who were viewed as being defined by their failure to conceive; being obsessive about having a baby; and unable to call a halt to treatment. We were repeatedly told of the fear that readiness to take up counselling opportunities might be construed as indicating that all was not well within their relationship (which, in turn, they alleged, could lead to them being denied NHS-funded treatment). Our interviewees, thus, challenged what they saw as a dominant social construction. From a sociological perspective this ‘neurotic infertile couple’ can be viewed as a lay version of biographical disruption.

In a more recent study of young adults with cancer and concerns about future fertility (see Barbour et al., 2011) the tension between the clinical (in the shape of cancer and arguments regarding the urgency of treatment) and the social (in respect of relationship formation, consolidation and reproductive decision-making) was thrown into sharp focus. Young adults who might be in a relatively new relationship were suddenly faced with having conversations about their reproductive intentions and found themselves subject to ‘biographical acceleration’ as they were plunged into hypothetical and sometimes actual decision-making as a couple. Even for young men, for whom storing semen might appear a relatively straightforward matter, the picture was complicated as soon as a partner appeared on the scene, necessitating joint form-filling and speculation about future wishes in the light of a range of potential scenarios. Given that this potentially difficult process inevitably followed hard on the heels of a cancer diagnosis, this led us to question whether this is always strictly necessary. Whilst I would not deny the importance of difficult ethical issues, this may not be the best time to address these. Rather than medicine straying into considering complex ethical issues, a more acceptable solution might be to re-instigate an episodic approach, whereby samples are stored, pending in-depth discussion with ethics experts at a later point in the trajectory, when the question of use of stored semen is more likely to arise. Since most stored semen samples are never actually used, a staged process would appear more workable and, in the event, many such discussions may never need to arise.

Medicine’s involvement in ethical – even philosophical - issues is, of course, nothing new, as is evident from the history of the profession and its alignments. However, as ever more complex ethical issues are raised by the development of new technologies, rather than being something practised at the periphery of the medical gaze (i.e. in terms of abstract discussions with other professional groups), medicine’s ethical engagement has come to permeate everyday practices as part and parcel of the new requirements relating to patient involvement and informed decision-making.

However, there are some indications that, as it attempts to address these new demands, medicine is developing a new cultural repertoire. In this context, the relatively recent rise of the Medical Humanities is intriguing and is something that certainly merits further sociological attention. This new discipline - or sub-discipline - encompasses diverse strands, ranging from the study of established literary and artistic forms to cover more contemporary projects, such as graphic storytelling (with a Graphic Medicine Conference scheduled to take place in Leeds in November of this year). A key aspect of the Medical Humanities ‘movement’ is the embracing of patient narratives, following the recognition that subjective experience can be a legitimate source of knowledge. This marks a key shift in thinking, and challenges the conventional medical view of such pieces as anecdotal at best and, at worst, fundamentally flawed and unworthy of serious attention. However, rather than viewing accounts as talk that is both ideological and dilemmatic (as theorized by Radley & Billig, 1996), there has been a
tendency to privilege first-person stories and to take such accounts at face value, thereby risking ‘romanticizing’ (Atkinson, 1997) them. Such accounts veer from the ‘misery’ narrative to the ‘transformational’ (Rose, 1989) but, in the absence of the critical perspective advocated by Atkinson, remain essentially descriptive, are frequently condition-specific, and, thus, are ultimately analytically impoverished.

‘Recovery narratives’ form a distinct sub-genre and illustrate particularly vividly both the appeal and limitations of such accounts as presented and represented within the Medical Humanities and, one suspects, within the medical professional more generally. Recovery narratives set about embracing – even celebrating – misfortune with the often-repeated comment that the protagonist wouldn’t change what has happened, since this adverse event has since (i.e. retrospectively) been re-evaluated in terms of its capacity to illuminate the individual’s priorities and, thereby, to recast one’s biography with the illness episode assuming the pivotal position. Recovery narratives are both persuasive and all-pervasive. They are everywhere – from newspapers, magazines, TV documentaries, soaps, through auto-biography, self-help books, novels, films and the theatre. Whilst frequently encompassing and floridly describing suffering, the tone of ‘recovery narratives’ remains fundamentally upbeat and positive. The injunction to be positive is frequently echoed in cancer narratives – particularly in relation to breast cancer, where skills in the “emotional labour of self-transformation” (Seale, 2002) are emphasized. As Seale (2001) has observed, the language of struggle predominates and a positive attitude is often held to be instrumental in accomplishing survival. The journalist Barbara Ehrenreich (2010) – herself a cancer survivor - takes issue with what she describes as the ‘injunction to be positive’ and her account provides a rare challenge to a rapidly accumulating body of cancer narratives which reiterate the dominant view of triumph against adversity, reflecting what Seale (2002) has described as “the media-orchestrated fantasy about human powers”. There is otherwise little evidence of any dissenting voices and their appears to be scant potential for ‘organized resistance’ as theorized by Nikolas Rose (1989) – at least in relation to critiquing recovery and illness narratives.

As I highlighted earlier, perhaps the most significant challenge to medicalization, to date, was mounted via feminist critiques of maternity services. This development coincided with the ‘baby boomers’ reaching their childbearing years and reflected a whole raft of questioning with regard to personal relationships and political alignments. These self-same ‘baby boomers’ are now coming of age at a point where care of the rapidly expanding elderly population looks set to pose enormous financial and practical demands on an already struggling health and social care system. The French have a wonderful term for this phenomenon, referred to as ‘Le Papy-Boum’. The baby-boomers – or more accurately ‘papy-boumers’ – have frequently been constructed as having re-defined every lifecourse stage as they have passed through these. Admittedly such valorization is often carried out by ‘papy-boumers’, themselves, but there is no denying their sheer force of numbers and associated purchasing power. Already the effect of this ageing population of consumers is evident in the proliferation of marketing directed at this segment of the American market, with websites courting the ‘grey dollar’ in the form of advertising for products such as customized walking sticks, including a fetching cowboy model. As an investment opportunity this may, indeed, be where the smart money is.

Some commentators have viewed this now ageing population as possessing considerable power to re-define society and public spending priorities. Huber & Skidmore, for example, in a book gloriously entitled The New Old: Why Baby Boomers Won’t be Pensioned Off, argue: ‘The baby boomer generation has the potential to rewrite the political agenda: around the
distribution of traditional forms of public spending; around the new politics, focusing more directly on 'quality of life' for individuals and communities; or with a generational clash of priorities around cultural values, cosmopolitanism and social equality. Far-sighted politicians and civic entrepreneurs should be turning their minds towards the issues that could act as mobilising flash points, with the potential to define political consciousness for a new generation'. (Huber & Skidmore, 2003)

This is rousing stuff, and it is tempting to envisage the happy conjunction of supply and demand. One of my all-time favourite Biff cartoons depicts an elderly man in a wheelchair being propelled by a nurse who is saying, “Come on, Ben, it's time for your Van Morrison”. This conjures up a vision of personalized services with care homes pandering to the tastes and preoccupations of residents. I've long been trying to persuade the BSA to consider setting up a retirement home for medical sociologists. I envisage this as operating along the lines of a perpetual conference, where we might end up giving the same papers all the day, but this scenario, of course, is already not entirely unknown ...

Before we get too carried away with this enticing possibility, it is important to critically examine the claims made with regard to the revolutionary potential of the ‘papy-boumers’. Whereas the failings of the maternity services offered a convenient rallying cry for female baby-boomers, there is a lack of any identifiable concerns that characterize the experience of ageing and commonality of interests cannot be assumed. In theory, at least, care of the elderly and the shortcomings of the system might lead to such a challenge, but, in practice, there are likely to be important differences between what have been described as ‘early’ and ‘late’ boomers and social class differences are also likely to impact on experiences (Phillipson et al., 2008). Passage through the lifecourse may even have served to exacerbate such differences rather than acting as a unifying call to arms.

Notwithstanding the potential limitations to organized resistance on the part of an ageing cohort of baby-boomers, it is clear that the reach of health promotion is now extending beyond the early years. My Open University colleague, Carol Komaromy, recently remarked to me that, whilst previously women might have anticipated some respite from health promotion interventions upon reaching the menopause and leaving behind concerns about reproduction, we are now beset with advice about how to prevent Alzheimers. ‘Biographical Anticipation’ is very much part of the contemporary Zeitgeist. As we progress through one stage of life we are encouraged to maximize our health not just in the next anticipated stage, but beyond, with discussion about ‘Living Wills’ or Advance Directives', in the medical arena and, in the commercial arena, the appearance of persuasive publicity materials concerning funeral plans, where individuals can, if they so choose, seek to exert their preference beyond the grave. The ‘papy-boumers’ have certainly fuelled the demand for woodland burials, as perhaps the ultimate expression of green credentials and commitment. Taking this to its logical conclusion the reach of health promotion now – theoretically, at least - extends from pre-conception to the afterlife – from womb to wicker receptacle. Alongside such developments, medicine finds itself, increasingly involved in heated ethical debate around issues surrounding birth and death – particularly as new technologies and difficult ethical scenarios evolve apace.

There are other - perhaps less obvious, but nevertheless worrying - problems relating to medicine’s ‘Biographical Turn’. As shown by a few quotes I’ve presented we can see that this focus can, in fact, be detrimental for service users. The standardization, indeed reification of ‘biography’ can operate to mute dissenting voices and deny potentially liberating responses to adverse events and perceived health threats. The focus on the social – particularly when it privileges couples’ experiences of reproduction and fertility services raises difficult questions around individual, intersecting, or diverging biographies. Medicine’s ‘biographical turn’ is also
partial in that it emphasizes certain lifecourse trajectories at the expense of others – most notably via a markedly pro-natalist stance. The newly emergent patient accounts so readily embraced by the Medical Humanities and medical practitioners or various persuasions, are essentially over-simplistic and analytically impoverished. Undoubtedly we, as medical sociologists, have, at times, contributed to this skewed view of insights derived from research and are also at the mercy of funders who frequently encourage a condition-specific focus. I have been especially heartened at this conference to have heard several presentations which have taken a comparative focus to explore commonalities and differences across conditions. Both within the Medical Humanities and in health services research there is an over-attachment to ‘stage theories’ of progression through diagnosis, treatment and accommodation of illness, which fit well with a newly-adopted biographical focus, but which can lead to what Janice Morse (2000) has termed ‘theoretical congestion’. In the hands of service providers this can serve to over-ride a patient-centred focus with a view that emphasizes the universal. In effect, through focussing on those aspects which can be neatly summarized and presented, the resulting picture of the experience of illness may, like the much-criticized RCT, accurately describe the composite experience of a group whilst rendering inaccessible – and unaddressed – the experience of the individual. This version of biography over-simplifies and fails to treat biographies as unfolding and contingent.

I have, for the purposes of this argument, emphasized the novelty of medicine’s ‘biographical turn’. However, the medical profession has always claimed legitimacy with reference to guiding ethical principles, as outlined in the Hippocratic oath and the upholding of the confidentiality of the consultation in much the same way as does the clergy in relation to the confessional. Alongside the challenges thrown up by the emergence of ‘expert patients’ I would argue that we have witnessed the emergence – or perhaps re-emergence – of appeals to what I’ve called the ‘human doctor’. One of the most important functions of the Medical Humanities appears to be - at least according to the website of the Centre for Medical Humanities at the University of Durham (www.dur.ac.uk/cmh/medicalhumanities/) - “to offer a richly-textured way of understanding medicine” where the object of enquiry is “medicine as a human practice” and the Medical Humanities provide an arena where the ‘humanized’ face of medicine can be explored and even constructed.

To return to my starting point in this talk, which was my own PhD thesis on professional socialization for social work, I concluded that social work students had to negotiate what I termed ‘transsituational demands’ (Barbour, 1985) whereby they had to align their emergent professional ‘selves’ with public perceptions and expectations and their personal value systems. I viewed social work as one of several ‘people processing’ occupations, which, in contrast to the archetypal professional of medicine (with its established body of clinical knowledge and technical/procedural expertise), had to make its claims to legitimacy and authenticity on the alternative grounds of the value positions and personal qualities of its practitioners. As the cultural repertoire of medicine has evolved and as the profession has had to respond to new challenges, it would appear that medical practitioners are also, at times, invoking similar claims to those advanced by social work and other occupations concerned with the business of counselling, teaching and engaging in therapeutic interventions – i.e. ‘talking cures’. In the case of the medical profession, these bids for authenticity along lines formerly appealed to by ‘people processing’ occupations have not supplanted traditional claims based on professional attributes; rather they afford access to yet another avenue – alongside tried and tested competence claims.

I have earlier suggested that new technologies throw ethical issues into particularly sharp focus, but it may simply be that medical practitioners are nowadays more willing to acknowledge the dilemmas that they face in practice. A few years ago I acted as a consultant
on a study of user and professional views and experiences of termination of pregnancy. This piece of research (The TOPAZ Study) was carried out in the West of Scotland – an area well-known within the UK for its conflicting religious affiliations, which frequently culminate in acts of sectarianism and violence (often associated with but not exclusive to football rivalries). Not surprisingly, in this context, terminations of pregnancy are often carried out in a climate of secrecy and shame, due to a particular constellation of cultural and religious factors, which affect not only the women undergoing the procedure, but also the professionals tasked with providing the service. Two types of procedure were available – medical terminations (which involved merely inserting a prostaglandin pessary and waiting for abortion to occur) and surgical terminations (which involved the removal, under general anaesthetic, of the foetus). Some, but not all, of the hospitals involved offered second trimester terminations and gestational limits also varied. Interviews with staff members highlighted a variety of individual responses, including that of a Specialist Registrar who opted not to carry out surgical terminations but was prepared to perform medical terminations, and a nurse who limited her involvement to inserting a prostaglandin pessary, but who was not willing to assist in any procedures after this point (Kennedy, 2002). These professionals recounted how they had devised individualized accommodations which allowed them to navigate this ethically difficult field whilst retaining their personal values. Surprisingly medical sociology has not really concerned itself with studying those processes whereby professionals weigh up and balance their personal beliefs with their commitment to treat patients and exercise empathy towards individuals who find themselves in difficulty. With regard to studying the professional of medicine, medical sociology, so far, has tended to privilege structure (i.e. focussing on the macro and the processes through which medicine exerts and maintains professional dominance) at the expense of agency (of individual practitioners), whereas the converse is the case with respect to research into patient experience, which abounds with studies of agency and accommodations to illness. The discipline could benefit enormously from redressing this balance and such studies could, I would argue, go some way towards further explicating the relationship between structure and agency. This could perhaps address the important shortcoming of modernity identified by Margaret Archer (2003): that of dealing with the human person, and showing how the singularity of the individual is realized in practice, through such mechanisms as the internal conversations identified by Archer. Thus medical sociology could make a significant contribution to development of mainstream sociological theory.

To conclude then, there is much that is positive about the way in which the medical profession has embraced some sociological insights and its new-found willingness to listen to voices outside of its own ranks. However, this expanded and more permissive repertoire is not without its problems and, in some respects, it looks as if the pendulum may have swung too far, with medicine uncritically adopting some of the ‘half truths’ produced (or read into) accounts of medical sociologists whilst ignoring the all-important context and limitations placed around our findings. Medicine has started to embrace some of our concepts and insights, but does not have at its disposal the sophisticated analytical techniques associated with the scholarly activity of sociology and this leads to an impoverished and ultimately potential dangerous flirtation with compelling, but poorly understood arguments. We need, I think, to stop being automatically thrilled every time that someone invokes sociological ideas. Heartening though it is to see medicine embrace the ‘biographical turn’ this can be counter-productive and gives rise to a new set of problems. It is crucial that we – and, indeed, medical practitioners who partake of our research outputs – retain a critical perspective. As academics who often hold teaching appointments in medical schools we need to review our own role in encouraging and perpetuating some of the simplified understandings of complex
sociological ideas that we seek to convey to medical students. This, of course, presents considerable challenges, given the sort of timeframe involved and our frequently unspoken, but not unreasonable, conviction that some exposure to sociological thinking is better than none. The imperative to publish and the necessity of adhering to journal requirements (such as strict word limits) may also lead us to write in ways that, in turn, lend themselves to misinterpretation. When these accounts are perused by individuals unversed in the subtleties of sociological arguments, but who are, instead, seeking answers to a rather different practice-focussed set of questions, it is easy to see how the misleading but ‘sexy soundbite’ can prevail. We could also benefit from exploring the possibilities for engagement with the pubic – and, indeed, the professions – afforded by non-traditional media. Although I would stop short of advocating the approach followed by Alain Touraine (1981), whose ‘epistemology of reception’ approach involves harnessing the insights of members of the public in order to co-develop sociological theory and effect social change, I think we could do more in the way of encouraging our respondents (both patients and medical professionals) to ‘problematize’ alongside researchers, thereby, perhaps initiating the co-construction of new discourses. These would allow us to take a more critical look at developments such as medicine’s ‘biographical turn’ and might even lead to the sort of organized resistance invoked by Nikolas Rose (1989).

REFERENCES


