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Editorial

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Welcome to the first of two issues of MSo that will appear in 2014. As mentioned in my editorial for the previous issue, we are able to include an extended summary of the plenary paper delivered by Professor Catherine Pope to the 2013 annual BSA MedSoc conference held in York. Catherine's paper that begins this issue traces the impact of computing and web technologies on patients' medical encounters and on the lens through which medical sociology can be interrogated and theorised, in relation to both health experience and working in healthcare roles.

We have two peer reviewed articles that both draw on aspects of health practice in Nigeria. The first of these authored by Oluwatosin Alo discusses the culturally complex area of HIV prevention. The article by Ushie and Ugal considers the dilemmas faced by medical practitioners in relation to disclosing preventable medical errors that harm patients. The discussion is set in the context of litigation processes that involve patients in having to prove that errors are preventable and that health professionals are individually culpable for medical errors.

The commentary by Martyn Chamberlain of Loughborough University outlines changes to UK medical regulation arising from the 2008 Health and Social Care Act and the ways in which these have been responded to by medical elites. The specific focus is on changes to the organisation of the General Medical Council (GMC) and the measures it implements to ensure that medical practitioners are fit to practise.

The article we have selected from the MSN/MSo archive discusses viral computer threats and is authored by Simon Williams from the University of Warwick. This article that first appeared in MSN in April 1995 sets up a discussion about cyber security and surveillance and Simon has included comments about the ways in which issues highlighted in 1995 are now interwoven within the increased digitalisation of medicine, health and society.

For this issue we are delighted to include abstracts of two recently awarded PhDs. Our congratulations go to Sarah Brennenstuhl and Sandra P. Gonzalez-Santos. The final two sections include two book reviews followed by a digest from Maxine Birch of articles currently available through 'online first' access. The articles selected are drawn from the three journals Social Science and Medicine, Sociology of Health & Illness and Health. The articles focus on contemporary issues relating to diet, weight, eating and developing healthy lifestyles.

The next issue, to be published in June 2014, will be the last under the editorship of the Open University team and we have decided that its content will focus exclusively on material drawn from the MSN/MSo archive. It will provide an opportunity for reflection but also for looking forward as the BSA Medical Sociology Group develops a new portal for all things MedSoc!
Computers, Cyborgs, Webs and… medical sociology?

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Presented to the BSA Medical Sociology Group Annual Conference 2013

These are the notes that I wrote for the plenary. Unusually for me, as I often work from PowerPoint or bullet point notes, I wrote a script. So here it is, a version of my ideas for my talk. What I actually said on the day strayed from this text at points.

I want to begin by thanking the MedSoc committee for inviting me to give this plenary. It is an honour. Truly. It feels like coming home.

I confess that initially I wasn’t sure what to talk about. Empirical research? Methodology? Last year Kathy Charmaz talked about grounded theory and David Armstrong ‘did’ Durkheim and Darwin. And later at this conference Sarah Cunningham-Burley’s plenary is on biomedicine, bodies, identity and diseases.

I settled on this title “Computers, Cyborgs, Webs and… medical sociology?” because in my recent research I have been increasingly pre-occupied with these things. No-one else seems to have nabbed this topic so it seemed a safe place to start. And hey, you all came. So, thank you.

I am based in the Faculty of Health Sciences at Southampton and have the label ‘Professor of Medical Sociology’, but I have spent time over the past five years hanging out with computer scientists at Southampton. They have a cool building and, until Carl May arrived in Southampton, a better coffee machine. Thanks to them, a lot of my reading and thinking has been around ideas and debates that are on the periphery of medical sociology or sometimes not really connected to health and illness at all.

So this is what I plan to discuss. Computers, cyborgs and the Web. The ellipses and the question mark in the title are deliberate. I want to reflect on the possible connections between these things and things in between that might not be listed, and also to take a pause... so that we can try to understand the possible linkages. I want to (re)connect these technologies to medical sociology.

Here goes...

Within our lifetimes we have experienced the technological revolution centred on information and communication technologies.

Digital technologies include computer hardware and software, micro-electronics and global digital communication and data systems. In my working lifetime these technologies have been transformed (does anyone else want to admit that they were proud to have twin floppy drives?)


The words we attach to these things signal their reach and significance:

*Mobile.*
*Ubiquitous.*
*Pervasive.*

Digital technologies have transformed society in much the same way that the steam engine revolutionised the industrial era. Castells has characterised this process as a paradigm shift. In *The Rise of the Network Society* (2010) he argues that a new economy has emerged - which is informational, global and networked. Digital information and communication technologies have been at the heart of this transformation.

*New information technologies, by transforming the processes of information processing, act upon all domains of human activity, and make it possible to establish endless connections between different domains* (Castells 2010: 78 emphasis added).

In this important book, Castells elaborates this claim and explores the impact of this shift on work and organisation. I want to pick up on his theme of work and organisation here. But before I do that I want to remind us that medicine has not escaped this transformational process. (Notwithstanding that it is a field relatively unexplored by Castells himself). Digital information and communication technologies are embedded in the delivery and organisation of medical knowledge and health care. Sometimes we forget they are there.

In the UK, informational transformations mean that your GP records are most likely electronic (even if there is a Lloyd envelope somewhere in the archive), as are most of the records about your formal health care; data from x-rays and diagnostic results are routinely digitally transferred between service providers and professionals, booking systems for secondary care are computerised and online, telemedicine or ‘care at a distance’ and remote telemonitoring of symptoms and behaviours is becoming more commonplace, computer algorithms support clinical and sometimes patient decision making, and there are even a range of NHS ‘endorsed’ health behaviour apps.

Sociology and the parallel disciplinary field of Science and Technology Studies have examined many of these phenomena, including e-Health records (e.g. Haland 2011 Halford et al 2010) and a range of telemedicine and telehealthcare interventions (May et al 2001a MacFarlane et al 2006; Dyb and Halford 2009, Oudshoorn 2011; Roberts et al 2012; Mort et al 2009 Milligan et al 2011) May et al 2001b 2003; Timmons 2003; Heeks 2006; Nicolini 2006).

In one of the most important papers in medical sociology of the past decade Sarah Nettleton (2004) argued that informationalisaton had fundamentally altered medicine. She described how evidence based medicine was only really possible with digital archiving and retrieval and the rise of informational bodies and e-Health. Medical knowledge had she argued, escaped: the Dr-Patient relationship was becoming a meeting between experts because of shared access and co-production of information. Moreover, flows of information within networks meant that medicine was also ‘scaped’ - information was diffuse, distributed, and digitally mediated, unrestrained by time or space. This new cosmology of e-scaped medicine, engendered by changes in technologies - the changes Castells also describes - had fundamentally changed medical knowledge and practice.

I want to suggest that we - medical sociologists - must get to grips with the challenges and opportunities of informationalism. I will begin by briefly transporting you back to the 1980s (...I know some of you were there, I have the MedSoc disco photos).
My first empirical study looked at the problem of waiting lists for a district hospital (Pope 1991). Queues of people waiting months and sometimes years for planned surgery. One of the first things I learned was that the digital revolution had happened in the NHS because the waiting list was on a computer. Except that it was also on paper. The list was housed on cards in a wooden cabinet system not unlike the one pictured here.

Digital data processing was the solution to managing waiting. Except that it didn’t work. The medical secretaries and surgeons and others who used the list everyday needed a particular kind of store - one that was accessible, immediate, tactile, visually meaningful. The list was not a neat linear data queue but a living storehouse of goods serving myriad different needs. For me one of the most enduring memories was that the computer printout was stored by the bins - signalling for anyone who came into the office the worth of this digitised data.

This taught me an important lesson - technologies don’t automatically work. They have to be brought into use by people. Computer technology can fail to deliver the intentions of developers and innovators. It can trigger resistance (e.g. the secretaries and carpenters colluded in keeping the cabinet functioning). This means that if we are to understand technologies in healthcare we need to understand socio-technical relations (the relationships between computers and people who use them and the context in which this interaction occurs).

Since I carried out that study computers have become ubiquitous and more powerful. I began work at a time when our SPSS analyses were processed overnight on the mainframe at the Manchester processing centre. Computer technologies got smaller. Processing got faster. Today I have more computing power in this iPhone than they needed to send men to the moon. Computing has become pervasive and mobile.

Alongside these hardware developments a digitised network has evolved. The internet (the network of networks that uses a standard protocol – TCP/IP - to connect computers) began in 1960s. It was commercialised in 1990s, moving out of military, into academe and commerce and into the home, and now, here, to the palm of your hand.

The paradigm shift that Castells describes has computer technology is at its heart. This new informational paradigm is transforming work and the organisation of work - and this is profoundly shaping society. Castells talks about at least two types of worker that emerge from the engagement with information technology. Confusingly he has different ways of describing workers - as core and disposable - and as networkers and flex-timers (and those who are excluded - the jobless, the switched-off, the digitally excluded).

Networkers are the privileged few. They are what Andrew Ross (2003) refers to as ‘no collar’ workers: digitally savvy, highly connected and highly mobile, adaptable, possessing multiple and transferable skills. These are a largely metropolitan elite who live in ‘the space of flows’. Castells has a particularly biting description which may make aspirational types wince:

> There is an increasingly homogenous lifestyle among the information elite that transcends the cultural borders of all societies: the regular use of SPA installations (even when travelling), and the practice of jogging; the mandatory diet of grilled salmon and green salad, with udon and sashimi providing a Japanese functional equivalent; the pale ‘chamois’ wall colour intended to create the cozy atmosphere of inner space; the ubiquitous laptop computer, and Internet access; the combination business suits and sportswear; the unisex dressing style and so on. (Castells 2010:447)

Below the informational divide are flex-timers. They do flexible work unconstrained by traditional 40 hour week. Nor is it tied to a particular workspace - work can be undertaken on
the move and at home. Contractual rights are forfeited (social benefits, career pathways) and with them notions of employee loyalty to their employer. Work tasks are heavily surveilled and workers are disposable and casualised.

This new division of labour cannot be apprehended by debates about ‘the end of work’ or deskilling’. It is profound. “This transformation has shaken our institutions, inducing a crisis in the relationship between work and society” (Castells 2010:296)

Call centre work epitomises new ways of working in the informational economy. Castells himself spends some time explaining how finance has become an automated globalised industry built on digital information and communication technologies. But these new forms of work can also be found in healthcare. Computer decision support systems allow the incorporation of clinical expertise (research evidence) in computerised algorithms which can be used to organise and deliver health services from call centres.

Computer based algorithms were initially used to support doctors and nurses – for example the prescribing support tool previously called Prodigy now part of NICE Clinical Knowledge Summaries. Computer decision support systems or CDSS now underpin a new experiment – the use of non-clinical (clerical) workers to manage and prioritise patients seeking urgent an emergency care.

Working with a team of researchers at Southampton we have completed two ethnographic studies of telephone services for prioritising and managing calls (Pope et al 2003, Turnbull et al 2012). The services we studied use a computerised algorithm - CDSS - in 999 making decisions about whether you really need an emergency ambulance on a blue light or whether you should take a painkiller and wait and see your GP in the morning. And in out of hours and NHS 111, they identify emergency calls and reroute these and direct patients to services, booking out of hours appointments and providing information as required.

These healthcare call handling staff are a relatively cheap labour force. Many of the workers are part time. Many, but not all, are female. In this computerised healthcare work expertise (clinical evidence) is conceived as firmly located in the machine. Human beings are needed simply to press keys and click a mouse - and talk to the caller to get information to populate the algorithm.

Except that - just like the computer waiting list - this technology does not quite work as anticipated. Call handling work entails multitasking: talking through the headset, clicking a mouse, typing text, trying to establish rapport and control the pace of the call to ensure that the right information is obtained. It can be quite intense. We noticed that as the call handlers gained experience and became familiar with the system they were able to anticipate answers. They began to, as they described it, ‘drive the system’, directing probes and translating responses:

I observed [call-handler] trying to control the call pace. She was reading different options and clicking on them once the questions had been asked. Sometimes she did not read and was anticipating the answer. It was evident that she could not wait to finish she seemed quite impatient. Every time the call-handler was asking a question the patient talked about a new symptom. It was very difficult to triage. Study 1: Call handler observation, Urgent care Site 3
[the CDSS] also teaches you, because every time you use it, you learn. When you read the information, the next time you come to do that call again you know what to say. You [learn] to say things in different ways … like, the dreaded, ‘have you got a ripping or tearing pain question?’ Everyone says, ‘yes’, to that, so you learn how to say it in different ways. [the CDSS] helps you do that with the supporting information. Study 2: Call handler, Focus group, 111 Site 5

These workers exercise what STS scholars refer to as interpretive flexibility – they deploy discretion and experiential expertise to perform the task at hand in ways that adapt the technology. Over time this lends a clinical aspect to their work - they share team knowledge of symptoms and diseases, drawn on personal experience and learn from the algorithms to deliver the service.

Another striking feature of this work - which you have to remember is located in industrial call centre units, far removed from the patients and callers they work with, is the emotional labour it entails. Nicky James's insightful observation made in 1992 of the emotional component of nursing work applies here in these personal exchanges mediated by telephone, spatially separated. And echoing James's work this emotional labour is organisationally invisible and ambivalent: these staff appear to receive less support than their clinical colleagues yet on the face of it they are perhaps less equipped to deal with these situations.

Once I had the case of a 3 year old child who was unresponsive, lying in the arms of his mum. I had to leave the control room and went to cry into the toilet. It was so difficult. I could not deal with it. How could I help in such a difficult situation? … Nothing prepares you for this. Study 1: 999 call handler interview

We have been analysing these data and have begun to argue that call handling in health care is a new form of healthcare work. Call handling in health services is distinct from call handling in banking and insurance. It clearly has many features that resonate with labour process theory, and with Castells' ideas about flex-workers. This new workforce are low paid, part time and casualised, and their work is indeed subject to surveillance. It also has features which medical sociologists recognise - it is a patient-provider interaction albeit one in which the provider is not a clinician. It displays communication modes we understand from doctor and nurse-patient interactions. And it has this undercurrent of emotional labour. It also has some other interesting, perhaps more novel, features.

This work provides a place for older health workers to ‘end up’ while continuing to use skills acquired in clinical roles - we came across several staff who were former nurses and paramedics looking for fixed shift work, and a less demanding working environment. As well as this age variation, some of the sites we looked at also had an incredibly diverse workforce on other characteristics such as class, employment background, race, education and to an extent gender.

This is a growing workforce: in every site we studied there were plans for expansion. And with this there are tentative steps towards professionalization - we joked at the outset that we might be able to design a diploma course on the back of our ethnographic work and by the end of our study some stakeholders had begun to identify a need for NVQ level qualifications for these call handler staff.

Healthcare call handling clearly disrupts traditional divisions of labour and hierarchies, but it is not solely deskilling and substitution. Yes this work is creating new strata of workers but it also generating new roles for existing staff. In each of the sites, despite the initial techno-
optimism surrounding the computer system, a cadre clinical workers has been employed to augment and support call handling - to provide supervision, training and support for tricky, difficult cases.

These workers are flex-workers in Castells’ terms. They can be understood using his ideas and some concepts from labour process theory and sociology of work. But we also need a medical sociological perspective to fully understand the health aspects of this work.

Thinking about these data some more I have begun playing with the idea of cyborgs. Drawing on Actor Network Theory and Haraway (1991) I started to see the call handlers and the CDSS technology as human-machine configurations - to understand the necessary mutual shaping of the technology and the user. The CDSS and the call handlers appeared to be tightly bound together in a symbiotic relationship.

Jennifer Lapum and colleagues in Ontario have recently written (2012) about cyborgs in nursing, as a way of thinking about how to overcome the traditional opposition between technology and practice. They say: “it is time to take pleasure in the social reality of cyborgs and messy borders” and they call for nurses to acknowledge their cyborg ontology. In essence they seek to reconcile the human-machine.

While Lapum et al’s paper made an interesting point it clearly focused on clinical workers (nurses) not clerical staff. Moreover describing health care call handlers (or nurses) as cyborgs does not quite capture the performativity of this work.

Drawing on other thinking about work as practice (notably Bourdieu and Stephen Turner) I have begun to ask: Is this work in fact a cyborg practice? The machine (the computer decision support system) and the worker/call handler remain distinct and separate entities but in the moment of practice - in the minutes of each call - they combine and take on the cyborg. The call handler cannot function without the CDSS, but neither can the CDSS work without her. This is neither machines taking control or the humans. They are both necessary to the accomplishment of the task of call handling. But once this is done they separate and become discrete actors.

I offer this emergent concept to you to play with (as I will continue to do) and ask could we begin to explore the deployment of information technologies in healthcare using ‘cyborg practice’ to push our empirical and theoretical work further?

Having looked at computers and cyborgs I turn now to the Web.

Just 20 years old, the WWW is a system of interlinked hypertext documents that is enabled by a modest piece of computer code programmed by Tim Berners Lee and Robert Cailliau. HTTP (the Hypertext transfer protocol) - a vague but exciting idea - was initially developed to share data among physicists at CERN and now has an estimated 3.68 billion indexed pages, 600 million websites and some 2 billion users.

To understand the Web it is helpful to borrow from Actor Network Theory. The Web is a temporarily stabilised network (or network or networks). The Web we use today has altered over the past 20 years and is morphing as I speak.

The earliest http allowed us to link and explore a web of documents. These were static web pages. These were flat and fixed. The emergence of the so called Web 2.0 brought dynamic content allowing users to interrogate, adapt and interact with websites notably interactive social media platforms - Facebook, Twitter - that allow users to communicate and collaborate, to create and engage with Web content. The semantic web or Web 3.0 promises to convert this Web from a Web of interactive documents to a Web of Data.
To simplify hugely this requires identifying data entities using uniform resource identifiers (URIs) - these can be used to point to and ultimately connect entities. URIs comprise locators (URLs) and names (URNs) which together define what an item is and where you can find it. The URL for BSA medical Sociology Group can be specified as the path http://www.britsoc.co.uk/medical-sociology.aspx where resource called medical-sociology can be found in a network host whose domain name is britsoc.co.uk. URLs provide a unique string that identifies web resource in ways that potentially allow machine linking of data.

Why does this matter for medical sociology?

The Web is pivotal to e-scaped medicine. The linking of documents was essential to the release of medical knowledge from the confines of medical institutions and professions. Imagine the fate of EBM, or systematic reviewing and Cochrane without the searching, retrieval and archiving affordances of the Web. Moreover the features hardwired into the Web - openness and democracy - mean that the digitally literate and enabled patient can create and consume information about health, illness, and care. The loss of medical control so eloquently talked about by Sarah Nettleton, that has empowered expert patients (in positive and negative ways) was powered by the first and second iterations of the Web. The emergence of the interactive Web has enabled new opportunities for patients and carers to connect across place and time. A proliferation of online support groups allow patients link to each other - one to many, and many to many.

This is an area where there is some work in medical sociology but not enough. Clive Seale, Sue Ziebland and Jonathan Charteris-Black (2006) did a comparative keyword analysis of interview data and two support group sites and showed that online conversations play out established gendered linguistic patterns and made some interesting observations about subjective perceptions of the privacy of web forums. Earlier work by Ziebland (2004) used interviews collected for DIPEx (now healthtalkonline) to explore the consequences of easier access to health information and argued that this appeared to engender a “felt imperative to be (or present oneself as) an expert and critical patient, able to question advice and locate effective treatments for oneself.” Anne-Grete Sandaunet (2008) from Tromso suggested similarly that online support groups might not be as empowering and participatory as they appear - certainly not for all patients.

Questions remain that medical sociology could and should explore so that we understand how the Web is changing interactions and health behaviours (and how we in turn are changing the Web).

Take ‘The Body’ a topic that medical sociologists have been interested in (colonising) for some time. The Web provides a space for what Castells calls ‘networked individualism’ in essence platforms for individuals to rework the self and identify. Martyn Hammersley and colleagues have done some early interesting work studying ProAna forums on the Web where people with anorexia discuss strategies for reshaping their physical bodies. I have recently begun supervising a doctoral student - Becki Nash - who is looking at the making and remaking of material and virtual bodies on the Web. She is interested in the ways that Botox and dermal fillers are advertised and purchased online, their use enabled by DIY video guides posted on YouTube, and how these bodily practices are valorised and alternately vilified in Web imagery and atrocity stories of necrotic flesh and augmentation gone wrong. This is scratching the surface.

I am interested in some other properties of the Web. The first is big data: digital data sets so large they require non-standard processing facilities and software, which offer potential for real time analyses and if the semantic Web arrives, machine linked data. Mike Savage and
Roger Burrows (2007; 2009) have alerted us to the vast amount of data generated outside the academy by routine use of digital technologies - ranging from Tesco loyalty cards to utility and government records to scraping of activity data from the Web itself. These data might change what we know about health.

For example open data on prescriptions has been used to generate new analyses of prescription data - here is a recent example of the analysis of generic versus branded statin use. The open data people are excited about this. And I can see why they NHS policy makers might be - it might give them targets for intervention or cuts. But as a sociologist I am interested in what is behind these data - what does this mean and what makes patterns these patterns. Why would some of the poorest areas of the country have prescribing practices that cost more than some of the least deprived? What are the connections between patient help seeking behaviour, professional practices and the pharmaceutical industry and different models of healthcare organisation.

We have recently been doing some work about Twitter. This micro-blogging site which has an estimated 300 million users creating over 200 million Tweets a day is another lovely exemplar of Castells’ network society. Twitter is all about information flows across time and space between distributed and loosely connected individuals. And it’s another source of big data that we might want to harness for medical sociology. To date much research about Twitter can be characterised as ‘Twitterology’ - studies using naive content analysis and natural language programming which have delivered a hundred and one varieties of sentiment analysis. These studies typically collate large numbers of tweets and count keywords - like ‘happy’ - and this ‘analysis’ is used to compare the emotional states of nations and peoples across the globe.

Surely we are more methodologically adept than this?

In collaboration with Ramine Tinati and Les Carr (both of whom have backgrounds in computer science) and Susan Halford (a fellow sociologist) we have been exploring the potential of mixed methods for analysing Twitter data - and moving it from big to wide data (Tinati et al 2014). Ramine has developed software to dynamically model Tweets which can be used to explore the network properties of this part of the Web - looking at initiators and amplifiers , tweets and retweets and at flows of data over time. We are also looking at what happens if you combine this type of technical analysis with interview and documentary analysis. As a small demonstration Ramine ran the software looking at 677 tweets that used the hashtag #saveournhs (see http://www.cost-of-living.net/twitter-analytics-sociology-and-saveournhs/). This shows some interesting phenomena. Some key tweets propagate thought the network extremely rapidly. A few are part of long retweet chains. Several tweets specifically reference a hyperlink. Significant nodes do not necessarily have large numbers of followers. Some are positioned in the network in ways that suggest they offer what Putnam refers to as bridging capital or “a sociological WD-40” (Putnam 2000:22-3).

Maybe this kind of analysis can inspire some of you to engage with ‘the largest human information construct in history’ and to begin looking at how the Web shapes and is shaped by us and how we might explore the Web in the context of a sociology of health and illness.

When I wrote the abstract for this paper I said I wanted to talk about cybernetics. I think this is worth squeezing in if I can.

Castells is a post-Marxist scholar. Marx remains a key influence running through his work, much of which has latterly focussed on resistance. The other key theorist I mentioned was Haraway who is linked to another locus of resistance - Feminism. Into this mix, I want to add someone that you might not have heard of, Stafford Beer.
Stafford Beer died on August 23rd 2002. He was an operational researcher, regarded as the founder of management cybernetics. He was interested in complex social systems and had the notable distinction of working for 2 years Allende’s ill-fated Chilean government. Beer described cybernetics as an interdisciplinary subject focused (following Norman Weiner) on communication and control that explicitly recognises the connections between humans and machines. Cybernetics is concerned with having a goal and taking action to achieve it or as Beer put it “the science of effective organisation”. I wonder if we can borrow his ideas to inform the way medical sociology thinks about information and action?

Stafford Beer was clear that massive data are useless in themselves. He believed that technologies like computers could be harnessed to help people deliver change, but were not an end in themselves. He looked for models and ways of understanding complexity to intervene to make things better. A lot of his writing resonates with Castell’s more recent work which has focused on networked social movements - Occupy, uprisings in Egypt, Arab Spring as levers for social change.

I have talked about Computers, Cyborgs and the Web. I have suggested that we might want to draw in theorists like Castells and Haraway to help us get to grips with the challenges of informationalism. Castells might be a useful starting point for thinking about the technical transformation of health care work and Haraway - despite her opacity - might make us reconsider cyborgs in this context. I firmly believe that we have to notice the Web. We need to explore the co-construction of health and illness and web technologies and we must harness the potential of the Web for analysis - I demonstrated one possibility that might be used to explore social movements and networks of resistance centred on our own NHS.

But in closing I want to return to Stafford Beer. Presciently, in the context of what I have said about the information economy, network society, flex-workers, cyborgs and the Web he wrote that

> Science has been sold as the servant of man in the wrong way, and for the wrong reasons. Let us start with the source of wealth: production. Here science is put forward as the promoter of efficiency...But it is necessary to become conscientiously aware of the alienation that all this has induced in the industrial worker so that social scientists are now engaged in frantic attempts to restore some sense of humanity to the working situation in which so many find themselves. ...Something has gone wrong. (Stafford Beer 1974:23)

I feel that this is the most important connection in my talk - the connection between medical sociology and political activism. Perhaps the final challenge I can offer - to you, to medical sociology, is to connect the things I have spoken of so that we can act, and fight for the things that we know matter to patients and their families.

Thank you.
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Unveiling the Limitations of the Fear-Arousing Approach to HIV Prevention in Nigeria

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ABSTRACT
This article explores the implications of the alarmist approach to HIV prevention in Nigeria. The study focused on the impact of this approach among people living with HIV, in terms of their experiences of stigma, access to treatment and support, and status disclosure. Thirty women and men participated in two focus group discussions and 10 in-depth interviews. The results indicated that fear-inducing communications hold a risk for promoting stigma and blaming of victims, and tend to prevent, rather than encourage status disclosure. In addition, although exposure to accurate information can facilitate greater knowledge of HIV/AIDS, this is not enough to change people’s attitudes to stigma. However, positive portrayal of infected people can make a difference. This study thus suggested that, in designing and evaluating HIV communication campaigns, the focus should be on whether these are ethically sensitive to the problem of stigmatization.

Keywords: HIV/AIDS, stigma, fear-arousing communications, Nigeria

With a population of about 170 million (United Nations, 2012), and HIV/AIDS prevalence of 4.1 percent, Nigeria has the second largest number of HIV infected people globally (National Agency for the Control of AIDS, 2012; United Nations General Assembly Special Session, 2010). Besides their poor access to treatment and care, stigma is a tragic consequence that most affected people have to cope with in everyday life (Alubo, et al., 2002). In this article, I explore how the fear-arousing approach to HIV prevention shapes the lives of these people and the key question is whether this approach promotes stigmatization. Stigma has been recognized as a socially constructed phenomenon (Parker and Aggleton, 2002), whereby undesirable attributes (Goffman, 1963) can render people vulnerable to rejection, isolation, and extreme societal disapproval. In describing the process of stigmatization (as a convergence of interrelated components), Link and Phelan (2001) explained that society distinguishes and labels human differences, and then determines which characteristics are desirable and which undesirable. In the process of labelling, those who possess undesirable characteristics are placed in distinct categories to allow some degree of separation from the desirable population. When such separation leads to full execution of societal disapproval, a process of rejection, exclusion, and discrimination, stigmatization unfolds.

Although health problems such as leprosy and mental illness have long been recognized to attract a certain degree of stigma in Nigeria (Awofeso, 2011; Ronzoni, et al., 2010), the complexity and impact of HIV stigma seems unprecedented; moreover, it remains a serious impediment to public health (Adeneye, et al., 2006). To reduce HIV stigma in Nigeria, Babalola, Fatusi and Anyanti (2009) have argued that exposure to media communications, with explicit HIV/AIDS content, would increase people’s knowledge, which is a strong determinant of accepting attitudes. Chen, et al. (2007) corroborated this statement in their study of HIV stigma in China. They suggested that accurate knowledge of HIV/AIDS is the
answer to misleading ideas that foster fear and stigmatization. In contrast, Yang, et al. (2007) argued that strategies employing anti-stigma educational interventions to change public opinions have been ineffective. Instead of focusing on individual's attitudes to stigma, Link and Phelan (2001) have argued that prescriptions for interventions should be informed by the lived experiences of the stigmatized.

As fear arousal remains a legitimate approach in many African societies, Green and Witte (2006) have argued that this is an effective approach to take. With reference to the Ugandan context, they explained that acceptance and use of this approach contributed considerably to a reduction in HIV transmission. However, other observers have argued that the alarmist approach is counterproductive. For example, considering the context in Nigeria, fear-inducement has long been used as a strategy to promote risk-reducing behaviour but researchers have argued that such a strategy promotes stigmatization because it depicts HIV/AIDS and those living with it in a negative manner (Aborisade, Ikhariale and Afuye, 2005). The consequences, therefore, include widespread labelling of those infected as undesirable, sexually immoral, responsible for their condition, dangerous, and undeserving of societal sympathy (Adeokun, Okonkwo and Ladipo, 2006; Parker and Aggleton, 2002; Sacks, 1996). Other critics have also argued that fear-arousing messages might increase people’s perceptions of the risks in the short-term, but that, in the long-term, such messages tend to cloud the knowledge that individuals already possess about prevention and transmission (Earl and Albarracin, 2007; Bourne, 2010). Furthermore, Blumberg (2000) explained that fear-inducement is capable of generating defensive responses among the public. This article thus presents participants’ experiences of living with HIV/AIDS in Nigeria.

METHODS

This study was conducted among 30 Yoruba people (16 women and 14 men) who are living with HIV/AIDS in Osun state, Nigeria. Because the target population was hard to reach, I had to rely on local HIV/AIDS agencies in selecting the samples. The participants were recruited from a HIV treatment centre and a local HIV organization - which I describe as Location 1 and Location 2 respectively, to protect confidentiality - and were self-selected. Because of ethical issues (Economic and Social Research Council, 2012), I did not contact the participants until after they had expressed informed consent to participate. Officers in the two centres facilitated the consent process, ensuring that people were not coerced into participating. Because of the sensitive nature of this study, I did not invite anyone below the age of 18 to participate.

To obtain detailed narratives about their pre and post-diagnosis experiences and sexual practices, I took a qualitative approach (Rubin and Rubin, 2012; Power, 1998), which allowed data to be generated ethnographically. There were two focus group discussions (FGDs), one among the women, and another among the men. Ten in-depth interviews (IDIs) were conducted, (with six women and four men). The investigation process involved digital voice recording and note taking. On average, each FGD took one and half hours, while an IDI took one hour. The FGDs were conducted in enclosed spaces, which the participants considered safe and convenient. Because of the sensitive nature of this study, the need to protect confidentiality, and because of logistics, a mini bus was used as the mobile interviewing space for the IDIs. The analysis and presentation of data reflects direct quotes and descriptions of the women’s accounts, of which the majority have been translated from Yoruba to English. Possibly, the main limitation of this study was the reliance on data collected through self-reports, given that individuals might not give accurate accounts of their experiences on such sensitive issues (Mongkuo, Mush and Thomas, 2010). After examining
the transcripts and identifying themes, which had emerged from the data, NVivo 8 was used to code and categorize data under different themes (Welsh, 2002).

RESULTS

As stated earlier, the participants were selected from a HIV treatment centre and a local HIV organization, which I describe as Location 1 (L1) and Location 2 (L2) respectively. To protect confidentiality, their specific identities are not discussed in this article. However, they were low socioeconomic status individuals measured by their levels of education and income. The highest education achieved was secondary, while the majority were either unemployed or engaged in petty trading. Their ages ranged from 20 to 55 but the majority were below 40 year.

Pre-Diagnosis Experience

Consistent with a report, which revealed that most people in Nigeria, - 88 percent of women and 94 percent of men -, have heard about HIV/AIDS (National Population Commission and ICF Macro, 2009), the participants did indicate that they had good knowledge of this disease before their diagnosis. Most indicated that, pre-diagnosis, they not only considered HIV a serious problem, but also had a negative view of individuals with HIV/AIDS. For example, a woman (L1) said that,

*If I had met somebody with HIV in the past, I would have avoided standing next to him or her because I was so afraid of this disease.*

Likewise, a man (L2) stated that he previously thought that,

*The best way to prevent transmission is to force everybody to undertake screening. I used to say that the government should incarcerate those infected to prevent them from spreading the virus to us.*

Most of the participants acknowledged that they had developed a deep fear of HIV/AIDS prior to their own diagnosis, and that messages derived from media advertisements contributed significantly in shaping their negative attitudes towards infected people. Another man (L1) also told me that,

*I used to stay away from individuals whom I thought might be HIV infected.*

Many behaviour change theories reflect such assumptions and are sympathetic to heightening people’s perceptions of the severity of the disease (Blumberg, 2000; Rosenstock, Strecher and Becker, 1994). The participants’ comments indicated that although exposure to alarmist messages might increase people’s awareness, it involves a risk in terms of promoting stigmatization. In view of their current everyday life, all the participants agreed, as indicated in the literature (O'Leary, et al., 2007), that a more effective approach to reducing stigma would be to replace alarmist messages with constructive and accurate information that avoids depicting the extreme nature of HIV/AIDS.

Everyday Life with HIV/AIDS

Access to antiretroviral treatment means that many Nigerians are now able to live a relatively normal life with HIV, as with many other terminal conditions. However, according to the participants, widespread stigmatization remains a major reason why they still do not enjoy a good quality of life. It is the case that the social context in many societies rewards bodies that look desirable and healthy, but bodies that deviate from this (HIV infected, obese, or frail), are likely to be subjects of negative interpretations and stigmatization (Varas-Diaz and Toro-Alfonso, 2003). In relation to this, the participants described how current
communications on HIV prevention induce fear and encourage stigmatization. A woman (L2) stated that,

*Advertisements on AIDS would not encourage people to accept us as normal human beings. They use words like “aisan ti ko gbo ogun” (incurable disease) and “aisan ti n se iku pani” (a terminal disease). These are very alarming words and the more people are exposed to such words through the radio and television media, the more they would be afraid of us. They should stop confusing people by implying that individuals who are looking healthy do not have HIV, and that those of us who have it unavoidably will look awfully emaciated. Most of us became infected because we slept with someone without any symptoms. Nobody would have sex with someone who appears to have HIV or looking unhealthy.*

Portraying infected people as physically undesirable and horrifying ignores the fact that they can be asymptomatic and receiving antiretroviral treatment. For example, one man (L2) asked me, ‘Do I appear to you as someone with HIV?’ Of course, he did not appear to have any symptoms. In this regard, the participant said that,

*We would like people to understand that we are not dangerous to them or to portray us as such.*

In addition, a woman (L1) narrated her experience,

*People are frightened, nobody wants to come near us, and even my doctor whom I have observed treats me differently by wearing more than a pair of hand gloves when dealing with me.*

Literature supports that actions from health care professionals can often involve stigmatization of patients (Yang, et al., 2007; Roseval, 2007). More evidence from the participants suggests that health professionals in Nigeria might require more training in dealing with HIV cases, especially in terms of obtaining patients’ consent before screening, and in relation to pre and post-test counselling. A woman (L2) said:

*When my condition deteriorated, a doctor asked me to do blood test but I was neither told what I was screened for nor given the result. They gave me some drugs, which made me better, and then they asked me to bring a family member. They told my brother that I had HIV but I only became aware when discussing with other patients in our treatment centre.*

Such practices contrast with international standards, which stipulate that, in testing people for HIV, health providers should ensure that a person to be tested gives informed consent. In addition, testing services should be confidential, and the individuals tested should have access to appropriate pre and post-test counselling. In addition, the results should be made directly available, unless tested individuals declined (World Health Organization, 2012a).

Describing how fear-arousing communications contribute to why people blame them for their HIV condition, a woman (L1) said that,

*People say that we should not be pitied because they believe that we are all promiscuous and had refused to heed the warning that AIDS is a killer.*

The participants recognized that such perceptions do not take into account the diversity of their experiences. Many of them, women in particular, indicated that they were infected because of factors outside their control and therefore considered it undeserved to be blamed or stigmatized. A woman (L2) said that,
I know that my husband infected me but he did not tell me that he had HIV. I found out from the hospital where he was receiving treatment that he had died of AIDS.

Stating that 'I would have avoided unprotected sex with him’, this woman indicated further that, without any evidence that her marital partner was infected, it was impossible for her to have considered negotiating safe sex. While considering the complexity of their situations in relation to the issue of stigma, the most common desire expressed by the participants was that 'we hope that our HIV will be cured completely.' This desire was not just because of their experiences of stigma, they said that,

*Even though we have access to free treatment, it is inconvenient to be taking so many tablets daily, time after time, year after year.*

**Access to Support and Treatment**

Africa is a continent with established cultural values and members of the communities usually have shared understandings of their collective responsibility to support and care for members suffering from ill health. A good example is the *Ubuntu* culture (Tutu, 2000). However, as the participants indicated, such cultural values hardly apply to HIV/AIDS matters. The fear of this disease is often what generates the rationales for rejection and isolation, at both community and household level in Nigeria (Alubo, et al., 2002). While indicating that they were victims of such extreme societal rejection, the participants maintained that people are alarmed because of the messages derived from HIV advertisements. Therefore, to escape being stigmatized, the participants indicated that they avoid sharing or seeking support from people outside their groups. Thus, their source of support is confined to being a member of a HIV association. A man (L1) stated that:

*We meet once a month as a support group. This has helped us a lot in keeping our minds away from the HIV problems. Few weeks after my diagnosis, I became depressed and suicidal. Now, my association with others who have a similar problem has changed my views, I can now cope better. Besides supporting each other mentally and socially, those with occupational skills help to train the unskilled, so that we will all be less dependent. We also tell one another to avoid transmitting the disease and we share our experiences about the medical treatment we receive.*

Discussing their treatment further, I asked the participants whether they had adequate access, considering a report that 74 percent of the people at post-diagnosis stage who require HIV treatment in Nigeria are still lacking access (WHO, Joint United Nations Programme on HIV/AIDS and United Nations Children's Fund, 2011). In response, they acknowledged that they were privileged to be receiving free treatment. However, they added that the process involved is sometimes detrimental to their wellbeing. The participants in both L1 and L2 said they travel a great distance to access treatment. A woman (L1) stated:

*When we leave home in the morning, we do not come back until midnight. This is dangerous because of darkness, bad roads, and armed robbers. People usually missed treatment, especially when they are too ill to travel under such difficult situations.*

This means, importantly that many of them are at risk of drug resistance because of treatment interruption (Oyugi, et al., 2007). In addition, they expressed concerns about privacy and confidentiality. This is because treatment centres are usually located within hospitals, and thus a man (L2) explained that,

*We are always worried that our relatives and friends might see us attending HIV clinics.*
During the research, I observed this myself when I noticed that the rooms used for treatment and counselling were not strictly reserved for HIV service providers and users. The participants in this research considered this a serious violation of their rights to privacy and confidentiality. This is a basic requirement in providing HIV services (WHO, 2012a). Consistent with wider evidence, the participants indicated further that the threat of becoming exposed to the public is a reason why many do not adhere to treatment procedures (Rintamaki, et al., 2006).

**Disclosure of Status**

Research suggests that individuals diagnosed with HIV are worried not only about public reactions, but that the fear of stigma can also lead them to avoid disclosure to partners and families (Wolitski, et al., 2009). Having indicated earlier that they encourage each other in their support groups to avoid transmitting the virus to others, the participants were asked to describe how they balance between avoiding disclosure and protecting sexual partners from infection. At first, all of them acknowledged that it is dangerous to keep their HIV status secret to sexual partners, especially in regular relationships. However, most of them maintained that the fear of stigma is a major factor why they would not disclose to partners and family members.

Their responses on this issue varied and were classified into four categories. The first category, mostly men, indicated that they would only disclose status to partners who is also known as HIV positive:

- *I do not have a partner, but I would only consider someone with HIV. We would be able to understand each other.* Man (L1)

Participants in this category recognized that such relationships are not without risk, although researchers are still debating whether unprotected sexual intercourse between infected individuals can increase the risk of super-infection (Willberg, et al., 2008; Redd, et al., 2012). Super-infection means interactions between a new strain of HIV and the old that speed up disease progression and cause drug resistance.

Those in the second category, mostly women, said they wished they had concealed their status from their partners given their post-disclosure experiences. A woman (L2) stated that,

- *Now I am alone with my children, my ex-husband left me when he discovered that I am positive. This is why it is better to kept it a secret from families.*

Yet, these women acknowledged that not disclosing would increase the risk of transmission. Those in the third category would not disclose their status at all. A woman (L1) said that,

- *I still wish to get married one day but I will never tell the person I want to marry because he will run away from me. However, I will ask him to use condoms. If he refuses, I will leave him because they told us not to pass the virus to others.*

This group has the highest potential of transmitting HIV, as it might be impractical to continue to insist on condom use in a regular relationship while keeping their status secret (Skinner and Mfecane, 2004). In the last category were those who would not get into any forms of sexual relationships to avoid disclosure or transmission of HIV. They were mostly women:

- *I have been avoiding sexual relationships after my husband’s death. I do not want to infect others, as my husband infected me.* (L2)

In terms of disclosing to others outside the family, the participants expressed deeper concerns. Narrating his experience, a man (L2) said that,
I do not know how people got to know but in less than a month that I was diagnosed, my landlord demanded that I packed out because I have HIV.

This man told me that other tenants also threatened to leave if he remained in the shared house because they were terrified. Expressing a similar concern about wider disclosure, a woman (L2) stated that,

*If people knew about my condition, they would have isolated me, even from my children. My children are not infected and they unaware of my condition. I have not told them because I know that they are too young to cope mentally with such information.*

This reason represents why parents’ disclosure to children is low globally (Qiao, Li and Stanton, 2011). For most of the participants, avoiding public disclosure is also necessary to prevent losing their jobs, ‘if they know at work, they will sack me,’ a woman (L1) stated. As a civil servant, she indicated that societal disapproval of people with HIV/AIDS is also an institutional problem in the Nigerian job market. Supporting the earlier comment, a woman (L2) who used to own a small-scale business shared her experience:

*My hair dressing business closed down when customers stopped coming because they were frightened, thinking that I had HIV. I did not tell anyone but I think my appearance before I started treatment caused the rumour. I am now unemployed and unable to provide for myself.*

As the participants indicated that they were unwilling to disclose their status in the public, it is clear from their comments that the fear of stigma is a key factor. Although they suggested that they would not deliberately spread the virus, the unwillingness to disclose because of stigma makes this situation more complex, especially in marital contexts that condom is rarely used. Disclosure is not only important to prevent transmission to sexual partners and children; it can also encourage individuals at risk to undertake voluntary screening. In summing up, the participants indicated that they need more support to be able to maintain risk-free behaviour, and that the fear of stigma remains a major constraint.

**DISCUSSION**

One of the major issues in the field of health promotion that requires more rigorous research is the ethical and unintended negative implications of fear-inducement (Guttman and Salmon, 2004; Donovan and Henley, 2000). From this study, strong indications have emerged which link fear-inducement and stigmatization. Yet, it is difficult to say that this approach is effective in promoting risk-reducing behaviour, as a report showed that Nigeria had the second largest population of the newly infected in 2010 (Joint United Nations Programme on HIV/AIDS, 2011). By creating fear and fostering intolerance against people living with HIV, this approach is ethnically weak and counterproductive in practice. Consistent with findings from this study, wider evidence suggests that, when people are living in fear of stigma, they are less likely to undertake preventive behaviour, undertake voluntary screening, disclose status, access care, or adhere to treatment (International Center for Research on Women and London School of Hygiene & Tropical Medicine, 2010).

Undoubtedly, more needs to be done to help Nigerians have accurate knowledge of HIV transmission and prevention. However, contrary to common prescriptions (Babalola, Fatusi and Anyanti, 2009), it emerged that accurate knowledge is not enough to change people attitudes about stigmatization when fear remains a major influencing factor. This study showed that people with deep fears, regardless of their levels of knowledge, are more inclined to isolate infected people. This is understandable, because everybody has an
instinctive tendency for self-preservation behaviour if frightened or when feeling endangered by a situation. This was starkly illustrated for me when I shook the hand of an HIV positive participant and I was immediately advised by one of the medical officers providing treatment at L2 to avoid further physical contact because ‘these people carry a lot of infections.’ This issue was a complex ethical challenge for me. However, not only did I ensure that my actions did not constitute stigmatization, I had already been inoculated against Tuberculosis, which remains the most common opportunistic infection among HIV infected people globally (WHO, 2012b). Overall, more research is needed to understand how to achieve effective communications on HIV prevention, which are capable of fostering social environments that are favourable to people living with HIV/AIDS, and are supportive of status disclosure and voluntary screening.

CONCLUSION
As Bourne (2010) noted, the graphic nature of fear-arousing communications makes them effective to drawing people’s attention to HIV/AIDS. However, the question is whether they are effective as a motivating force for behaviour change. The answer to this question will vary across different societies. As such, to know whether fear-inducement is delivering positive outcomes among a target population, the focus should be on the specifics and contexts. Therefore, it is crucial to research further the everyday lives of people living with HIV stigma. As suggested by Hastings, Stead and Webb (2004), a better alternative to fear-inducement is positive reinforcement appeals and humour. However, this should not mean trivializing the huge impact of HIV/AIDS on public health. Stakeholders in Nigeria need to explore the potentials of this alternative strategy to know whether it is capable of dispelling current myths about HIV/AIDS that are fostering stigmatization. While it might be unrealistic to think that HIV stigma can be completely eradicated through this alternative strategy, it nevertheless, points the way to a more ethical practice.
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Right to Health Through Litigation: Ethical Dilemma in Medical Error

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ABSTRACT
Health caregivers often face dilemmas in the choice of whether to disclose or cover-up their own preventable medical mistakes, which are harmful to patients’ health. Patients have to choose between suing a caregiver who reports medical errors to them and forgiving them. The decision about whether to report errors and whether to litigate can cause serious moral and ethical dilemmas. We examined voluntary reportage of error and its effects on medical negligence or malpractice litigation. We also examined the difficulty patients or their relatives face in proving that indeed the errors the patients alleged were ‘preventable’, as well as the burden of litigating a health caregiver who has voluntarily reported their own error. There is need to create an environment whereby disclosure becomes standard practice and medical errors are minimised, to reduce the potential for conflict between caregivers and patients and generally improve care.

Keywords: Preventable medical error, Dilemma, Voluntary reportage, Medical Negligence, Litigation, Patients, Caregivers

INTRODUCTION
Globally, health reforms are focusing on the principle that all individuals have a right to good health and if that right is denied, they can seek redress through litigation. The litigant can sue the government, group or individual they perceive to be impeding their right to good health. Putting this principle of right to health through litigation into practice can be a daunting task; this can come in the form of medical errors. Preventable errors in health care pose an enormous threat to patient safety, especially in low income countries where the level and quality of medical services are poor. In Nigeria, for example, available data show that there are only about three doctors to every 10,000 people in the population. Knowledge of the incidence of medical errors in the health system (especially by the public) is lacking. What people know is based on conjecture as little scholarly research has been done.

One of the most difficult aspects of the caregiver-patient relationship in health care is the difficulty of reporting one’s own error to the patient and litigating one’s caregiver. Whereas the principles of ethics demand that any error in patients’ care be communicated to them, actually doing so can be difficult. Physicians, for example, do not embrace the ethic of voluntary reportage of error (Woolf et al., 2004); reportage means that they open themselves to criticisms, litigations and other patients’ reactions. The patients are most likely to take action against the health care personnel who make a mistake in their care. On the basis of this, are the caregivers to risk being prosecuted by telling the patients that they made a mistake while caring for them? Is it right then for the health personnel to cover up their errors since without their say-so the patients may never be aware of the errors? How would the patient or their relatives receive the information that the illness they were trying to relieve has
been aggravated or that their relative may have died due to human errors? Should the patients or their relatives sue the government for not providing adequate health care service which can guaranty their safety? These are weighty questions that raise ethical considerations and place both the health experts and patients in a dilemma. This paper grapples with these questions. The rest of the paper is divided into three sections. In the sections that follow, we highlight the issue of how health care providers (are expected to) handle medical error situations and how patients and their relatives react to error disclosure while a concluding section summarizes the paper.

**How should health care providers handle medical error situations?**

According to the Doctors’ Guide (1997), physicians and indeed, all medical personnel have an ethical obligation to tell patients about serious medical errors when such disclosure will benefit the health of the patients and to show respect for the patient’s autonomy. Failure to do this will bring caregivers into direct opposition to principles of justice. One of the principles of biomedical ethics, according to the Helsinki Declaration, is respect to human subjects. In spite of the implied risk that care providers would be sued when an error has come to the knowledge of patients or their relatives, it is ethically correct to report any adverse medical event to the subjects involved. The risk involved in doing so is that patients may then proceed to sue them or report them to their professional associations. This risk could be removed if the caregiver chooses not to report the error, but which violates ethical principles guiding care provider - patient relationship.

According to Liam Donaldson, Chief Medical Officer of the United Kingdom and Chairman of the World Alliance for Patient Safety, ‘to err is human, to cover up is unforgivable. To fail to learn is inexcusable’ (in PAHO, 2007). If research and interest in medical error is to improve the quality of health care delivery, then Donaldson could not be more apt. When mistakes are made, it is necessary to report them so that adequate safeguard can be built against future occurrences, and the caregivers, acting on the knowledge gained from the mistakes, can then provide better services in the present and be better equipped for the future. Of course, there is the weighty question of whether reporting medical error to patients or their relatives would heal the wound created by such errors and whether legal action against the individual health officer would eliminate the fact of the problem.

Nevertheless, one of the main findings of Woolf et al.’s (2004) study is that physicians do not like to reveal or disclose their errors and that when they choose to report, such reports are hardly complete, accurate, free of bias, or representative of all errors in health care. Primarily, Woolf et al noted that physicians attempt to cover up their errors for fear that their regulatory bodies may sanction them and because of litigation from the patients or their relations. Reporting medical errors may be viewed by health personnel as a way of calling their competence into question. The fear that their peers or professional bodies may devalue them if it became public knowledge that they were sued for medical error may be a strong factor in the decision not to report. The problem with non-reportage of errors in health care is that patients are left in the dark regarding actions which affect them directly and oftentimes affect their health adversely, especially given the general low level of medical knowledge (Jegede, 2002), and poor awareness and knowledge of medical error in particular.

Whereas people seek medical help to maintain a favourable state of health, preventable errors undermine this, and given that patients are mainly unaware of the occurrence of errors and how they may harm them (Oyebode, 2006), their basic right to good health is put in jeopardy. Errors may cause patients to stay longer in the hospitals, pay more (especially in a fee-for-service context), and generally be unable to pursue other basic life activities. Apart from this, it is difficult to prove that an error occurred in one’s care or indeed to prove
that the mistake was ‘preventable’. This burden of proof, lack of adequate information, high level of illiteracy and poverty, work both independently and jointly to foreclose litigation against medical negligence or malpractice in countries with high levels of illiteracy. So in the light of this, would it not serve the caregivers better if they covered up medical errors? The truth is, cover up may be better for them, but they would be violating the biomedical ethics of openness and lack of harm and betraying their fiduciary duties to the patients.

The emphasis on disclosure is a clear pointer to the fact that the patients themselves may not know anything about medical errors. This may be more striking in many developing countries where patients do not access to their own medical records, and even when they do access their records, they may not be able to decipher the ‘medical handwriting’ and ‘jargons’ of health professionals. In fact, many times, patients are not even told what exactly their health problems are. Thus, Cleopas et al. (2006) contend that appropriate response to medical errors must take account of patients’ expectations. For example, patients expect that errors should be openly disclosed (Vincent, et al., 1994; Hingorani, et al., 1999; Wu, 1999; Cantor, 2002; Gallagher, et al., 2003; Mazor, et al., 2004).

However, open disclosure of errors by caregivers is not a complete safeguard against malpractice litigation. This places the caregiver in a moral and ethical dilemma: should they just carry on as if nothing harmful happened to the patient (since there is the likelihood that the patient would not know about it if not informed by experts)? Or should they do the right thing by reporting the error in spite of the risk of their medical license being seized by their professional associations?

The Institute of Medicine’s (2000) report on patient safety issued a central statement that medical errors should be viewed primarily as failures of institutional systems rather than failures of individuals. However, Landrigan et al. (2004) found that the public do not embrace such a view; rather, they feel that persons responsible for medical errors should be sued, fired, and subjected to suspension of their professional licenses. Yet, Blendon et al. (2002) report that a significant percentage of respondents in a study thought that patients were very often or somewhat often, at least partially, responsible for errors made in their care (see also Donchin, et al., 1995). It is within the purview of such confusion on whom or where to place the blame that it may appear necessary to seek solutions rather than blame. Thus, it is necessary for caregivers to report errors not only to patients but also to management so that measures can be sought to forestall future occurrence.

Generally, patients place their health in the care of health professionals on the trust of their competence to restore them to a healthy equilibrium, any adverse event in the process of doing so needs to be reported so that the trust is not betrayed. Such a report would go a long way to helping the patient in the recovery process.

How would patients and their relatives react to error disclosure?

One of the expected benefits of medical error disclosure is that it reduces the level of animosity resulting from knowing that one’s health had been compromised as a result of error. There is considerable recommendation right now for the disclosure of errors to patients as standard practice (Liang, 2002; Gallagher, et al., 2005), but there is limited evidence about the impact of such policy on malpractice litigation and relationships between caregivers and patients (Cleopas, et al., 2006). Nevertheless, Kraman and Hamm (1999) have suggested from their study that a policy of open disclosure does not increase malpractice claims, while Vincent et al. (1994) claim that lack of openness itself is a motivation for lawsuits. This can only be so if the patient or the relatives are knowledgeable about the error or if they base their claim on conjecture, in which case, they would be faced with the burden of proving that the error did occur and was indeed, preventable.
A survey of hospital management in the United States revealed that disclosure of errors to patients is increasing but also that the fear of malpractice litigations remains the main barrier to disclosure (Lamb, et al., 2003). Whereas this can be said to be a positive development, the same cannot be said of many less developed countries. Although research is scarce, it is obvious from the lack of national databases on malpractice litigation and medical error disclosure that caregivers in many hospitals may not be ready to report ever committing an error (Ushie, et al 2013) and patients are largely ignorant of medical errors. Therefore, without disclosure, patients and indeed the public, go on oblivious of the problem while it flourishes in the health care system.

Patients and the public generally react negatively to medical errors. Several studies have explored people’s opinions through experientially manipulated hypothetical scenarios that describe a medical mishap to them and then ask their opinions about the mishap. These studies have established that perceptions of the public are more negative when an error has severe health consequences (Blendon, et al., 2002; Schwappach & koeck, 2004), and when the error is not disclosed to the patient (Witman, et al., 1986; Mazor, et al., 2004). Both adverse health outcomes and non-disclosure of the error concern the patient directly, so that the importance of these variables for people’s perceptions is not surprising.

However, it is doubtful whether patients are sensitive to the responsiveness of health care staff once an error has occurred, in particular the prompt recognition and management of the error (Cleopas, et al., 2006). In a study conducted through the use of simulations and hypothetical patient and errors, Cleopas et al. found that 71.4% of real patients were of the opinions that the care received by the hypothetical patient was bad or very bad, 60.2% considered that the patient was treated in unsafe conditions, and 25.5% would not recommend the hospital based on the scenario. But the assessment of the care varied considerably according to the version of the scenario. Only 34.0% of respondents assigned to the best-case scenario considered that the hypothetical patient received bad or very bad care compared with 89.5% of those assigned to the worst-case scenario. The apportionment of blame to both the care-giver and the condition or environment where the care is given as reported by Cleopas et al. underscores the importance of approaching medical error research from both the individual and system perspectives, that is, error can both be caused by institutional and individual factors. Perception has a pivotal part to play in how patients would react to error disclosure or non-disclosure.

CONCLUSION

The picture of the modern health care system as a tensed, conflict ridden environment where both the caregivers and the patients are perpetually on the lookout for each other makes it unsafe for medical attention. The need to have a comfortable and understanding caregiver-patient relationship is thus precipitated on the fact that it provides a good working environment. Unless a two-way understanding – the humility to disclose error and the humanness to see error as a mistake – is reached, the dilemmas of error reportage and litigation may not be overcome. First of all, in an error incidence, the health care system should be able to decide whether a caregiver, pressed with the burden of attending to many patients in need, with a bounded time-frame, should take the time to talk to a patient who has suffered a medical error. Or whether it is much better to attend to other patients in the belief that it is more politically correct to save other lives when the problem of the injured patient may not be remedied.

It is at a time like that that the service of social workers and sociologists is so much needed. The duty of speaking to the patients (including disclosure of error) is delegated to the social
worker while the caregiver goes on with other patients. Now, the caregivers who made a
mistake in the patient’s care may be so internally distraught that he may not be able to
handle the patient directly themselves. This is where the social departments of hospitals
become very useful. The disclosure of the error is handled not specifically as a particular
caregiver’s problem but as a problem to be borne by the system. The job of the social worker
in an error situation would be both that of gently breaking the news of the error to the
patients and educating them on the possibility of the error being like other errors that
humans make (tact and finesse are highly needed since other human error may not result to
permanent disabilities, death, etc.). Only in this way can a good health and social order
environment be guaranteed and the dilemmas of whether to disclose or cover up and
whether to litigate or not may be resolved.

In such a situation, it becomes necessary for caregivers to report errors not to the patients
themselves but to management or some other body. Thus, the disclosure of medical error
becomes institutionalised and functions through this body or management to convey
information to the patients. The disclosure by health caregivers may also be in form of daily,
weekly or monthly report of work. This work reports are then reviewed for consistency with
standard practice.

Another good way may be the periodic review of safety practices or case histories by a body
commissioned to do so. This, apart from resolving the burden of having to disclose error to
patients, can also help the health care system to have a view of its own safety standards
since the rate of mortality in a hospital is partly a reflection of its safety standards and quality
of service (Dubois, 1999).
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Reforming Medical Regulation in the United Kingdom: From Restratification to Governmentality and Beyond

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ABSTRACT

This paper is concerned with contemporary reforms to the institutional body responsible for overseeing the regulation of the medical profession in the United Kingdom: the General Medical Council (GMC). Recently the state has introduced legislation which has changed the organisation of the GMC and how it ensures medical practitioners are fit to practice. It is argued that these changes provide supportive evidence for the restratification thesis. This holds that rank and file practitioners are becoming subject to greater peer appraisal and review as a result of external pressure to reform medical governance and increase professional accountability mechanisms. But it is also noted that reforms in medical regulation are bound up with a broader shift in how good governance is conceptualised and operationalized under neo-liberal mentalities of rule as the state seeks to promote at a distance a certain type of citizen-subject congruent with the enterprise form within the risk saturated conditions associated with high modernity. The paper concludes that it is important to investigate contemporary reforms in the regulation of doctors while also bearing in mind the broader socio-political context so social scientists can better contribute to current debate concerning how best to regulate professional forms of expertise.

Keywords: General Medical Council, Governmentality, Medical Profession, Medical Regulation, Restratification

INTRODUCTION

The medical profession in the United Kingdom (UK) is regulated by the General Medical Council (GMC). The GMC came into being as a result of the 1858 Medical Act. This made it compulsory for all individuals who practice medicine in the UK to obtain state-recognised registration if they wish to work as a licensed medical practitioner. The GMC maintains the register, defining the nature of the qualifications necessary to obtain registration as well as the conditions under which a doctor can be removed from the register. Traditionally membership of the GMC has been dominated by medical elites such as the royal colleges and medical schools. This essentially granted the medical profession a collectively held monopoly over the regulation of doctors (Stacey 2000). Yet the last two decades have seen the introduction of a series of reforms to the GMC. Including the gradual growth in non-medical members. The paper outlines changes made to the GMC as a result of the 2008 Health and Social Care Act and how medical elites have responded to them. It also discusses how social scientists have conceptualised contemporary reforms in medical regulation. In doing so it notes the importance of paying close attention to how rhetorical arguments concerning the tacit and specialist nature of medical expertise are often successfully deployed by medical elites as they seek to maintain some semblance of...
collective professional autonomy and regulatory privileges in the face of greater state-endorsed third party surveillance of their activities (Chamberlain, 2012). The paper concludes by noting the need for social scientists to also pay close attention to how changes in medical regulation take place against a broader background of how good governance is conceptualised and practiced under neo-liberal mentalities of rule.

Harold Shipman and the 2008 Health and Social Care Act

The 2008 Health and Social Care Act can be said to represent a watershed in the regulation of the medical profession in the UK. Certainly on the surface it seems to have effectively ended one hundred and fifty years of exclusive medical control over the GMC (Chamberlain 2010). But it would be incorrect to say that medical control of the GMC went completely unchallenged for a century and a half. As the twentieth century progressed, a series of high profile medical malpractice cases reinforced the need to introduce a more stringent system of checks and balances to entrenched medical power and autonomy (Gladstone 2000). For instance, in the 1990s the Royal Bristol Infirmary case saw several children die due to botched procedures which the surgeons involved tried to cover up (and were by and large successful in doing so until a medical colleague finally came forward to report what had happened). Bristol led to significant changes to National Health Service (NHS) governance and performance monitoring systems, including the adoption of clinical governance frameworks to guide health care delivery, alongside the introduction of annual NHS performance appraisal for consultants and general practitioners (Chamberlain 2009). Bristol also reinforced to medical elites such as the royal colleges that they needed to adopt more open and transparent governing regimes which included all the stakeholders involved i.e. patients and other health care professions (Davies 2004). Consequently they set about establishing clearer practice standards that could be operationalized into performance outcomes against which the fitness to practice of members of the profession could be regularly checked (Black 2002). As the then chairman of the GMC, Donald Irvine, noted (2001: 1808), ‘the essence of the new professionalism is clear professional standards’.

Yet the fact of the matter is that the internal reforms initiated by medical elites during this period were felt to be inadequate by the victims of medical malpractice. A tipping point was reached with the case of Harold Shipman, a general practitioner from Hyde in Greater Manchester. During a criminal career spanning three decades Shipman was able to use his position of trust to murder two hundred and fifteen of his patients (Stacey 2000). The watching public, already horrified as Shipman’s story began to unfold, were at a loss to understand why it was not until well after his conviction that the GMC finally struck him off the medical register. It appeared the GMC was acting to protect the rights of Shipman instead of to respect the memory of his victims. This sense of bewilderment rapidly turned to anger when it became clear that Shipman had come before a GMC fitness to practice panel previously for prescription abuse (Gladstone 2000). The GMC had had its chance to stop Shipman from practising medicine, but had decided to let him continue. Whatever the reasons behind the GMC’s decision, the families of Shipman’s victims, patient rights advocacy groups, the media and even government ministers, all began to call for far reaching reforms to medical regulation (Smith 2005).

Undoubtedly the Shipman case played a pivotal role in reinforcing the need to address medical control of the GMC (Chamberlain 2010). Smith (2005: 1174), at the end her subsequent governmental review of the Shipman case, was ‘driven to the conclusion that, for the majority of GMC members, the old culture of protecting the interests of doctors lingers on’. She also said that “it seems….that one of the fundamental problems facing the GMC is the perception, shared by many doctors, that it is supposed to be ‘representing’ them. It is
not, it is regulating them….In fact the medical profession has a very effective representative body in the BMA, it does not need – and should not have – two” (Smith 2005: 1176). In 2007 the Health and Social Care White Paper was announced as a result of Smith’s report. This subsequently passed through parliament as the 2008 Health and Social Care Act. The Act introduced several key reforms in medical regulation. Non-medical lay members now have to make up half of the GMC membership. Furthermore an independent system overseen by the Public Appointments Commission was introduced to elect GMC members. While the grounds on which fitness to practice cases are judged was also changed. Such cases have traditionally been judged on the criminal standard: beyond all reasonable doubt. A situation that frequently led commentators to argue the GMC’s disciplinary procedures first and foremost protected doctors (Allsop 2006). But the Act required that such cases now be judged on the civil standard of proof - on the balance of probability. It is argued that this will enable underperforming doctors to be more easily stopped from practicing medicine. While to enhance impartiality and the independence of the hearing process, the Act also required cases be heard by an independent adjudicator, not by members of the GMC (Department of Health 2009).

The Act also introduced what was called a ‘GMC affiliate’ (later known as a ‘Responsible Officer’). This person operates at a local NHS level to coordinate the investigation of patient complaints. They also work with NHS management, the GMC and the royal colleges to implement, at a local level, new arrangements for ensuring every doctor is fit to practice in their chosen specialty. This process is called revalidation (Donaldson 2006). Since the Bristol case doctors had undergone an annual developmental check of their performance as part of the conditions of their NHS employment contract (Black 2002, Chamberlain 2009). But Smith (2005: 1048) felt that this process would not have flagged up Shipman as a risk to patients and did ‘not offer the public protection from underperforming doctors’. Smith argued for the need for a more stringent and rigorous performance appraisal system. As a result, the Act made it compulsory for doctors to pass revalidation to stay on the medical register. The revalidation process involves a mixture of clinical audit, direct observation, simulated tests, knowledge tests, patient feedback and continuing professional development activates (Donaldson 2008). Although originally planned for introduction in 2010, the development and piloting process took somewhat longer than expected, with revalidation finally being introduced nationally on a “roll out” basis in late 2012. It now being expected that this process will be completed by the end of 2016 at the latest.

**A Decline in Medical Autonomy?**

The changes to the GMC introduced by the 2008 Health and Social Care Act undoubtedly present a significant challenge to medical autonomy in the form of collective medical control of the GMC. Some academic commentators, much like doctors themselves, have proclaimed that the reforms introduced by the Act effectively brought an end to the idea that medicine as an autonomous independent profession (Chamberlain 2012). But the viewpoint that there has been a decline in medical autonomy is a long standing one which has existed in various forms ever since the emergence of health care managerialism in the NHS in the late 1970s (White 2001). The rise of hospital management, consumerist ideology and patient rights movements have been held by some commentators to indicate that medicine is being proletarianized or deprofessionalized (Elston 1991). But not all academics have agreed that medical autonomy is in decline. Eliot Friedson in particular has repeatedly noted that the need for doctors to exercise discretion in their work is an issue which is unlikely to disappear due to the complex and highly specialist nature of modern medical expertise (Freidson 1994 2001). Although originally an ardent critic of entrenched medical power Freidson now argues that medical practitioners themselves, not patients and NHS managers, must
ultimately control their work activities (Freidson 2001). Not least of all because the nature of their specialist expertise demands society recognise that in order to do their job effectively professionals have to possess ‘independence of judgement and freedom of action’ (Freidson 2001: 122).

Friedson claims that professional monopolies are ‘more than modes of exploitation or domination they are also social devices for supporting growth and refinement of disciplines and the quality of their practice’ (Freidson 2001: 203). Here he is echoing the view long held by medical practitioners themselves that it is not the principle of professional self-regulation that in itself is unjustifiable, only particular instances where it has been abused. Doctors must now work with the public to make sure such abuses do not happen again (Irvine 2003 2006). It is important to acknowledge that recent moves to reform the GMC by the state have reinforced that they need the cooperation and proactive involvement of medicines elite institutions to achieve their goal. This is because contemporary challenges to professional autonomy have brought to the foreground the fact that the principle of medical self-regulation was first institutionalised in the form of the GMC as it provided a workable solution to the complex problem of ‘how to [both] nurture and control occupations with complex, esoteric knowledge and skill...which provide us with critical personal services’ (Freidson 2001: 220).

It is the dynamic nature of this need to both nurture and control professional expertise which has led Friedson, amongst others, to challenge the viewpoint sometimes found in the social sciences that contemporary reforms in medical regulation provide further evidence for the argument that medical autonomy is in decline (Chamberlain 2012). It was argued that instead of undergoing a period of decline, medicine is in fact undergoing a process of restratification, which is sustaining medical privilege and power. Albeit in a more risk-aware, open and transparent, standards-driven, form (Chamberlain 2009). The process of restratification involves the medical profession becoming increasingly reorganised into more pronounced elite and rank and file strata. Certainly the specialist nature of professional expertise, alongside the concurrent need for professionals to exercise a degree of discretion in their work, does arguably create what can be called a ‘buffer zone’ which protects doctors 

Undoubtedly medicine’s relationship with the general public is changing. However medicine is not necessarily losing control of its monopoly over its expertise. The development of new techniques to monitor the efficiency of performance and the allocation of resources does not in itself reduce medical autonomy. What matters is whose criteria for evaluation are used and who controls any ensuing action. This is an important point. For to function ideologically as a method of occupational control professionalism requires that occupational members control the technical evaluation of work activities (Stacey 2000). This leads to a situation where while the individual autonomy of doctors is affected by contemporary events the collective institutionalised autonomy of the profession as a whole remains by and large intact, albeit in a transformed form (Freidson 1994). For whatever changes are made to medical regulation process, medical control over entry onto (via medical school and junior doctor training) and exit from (via appraisal of their continue competence) the legally underwritten state approved register of practitioners, will continue for the foreseeable future. For example, take the much vaulted medical competence test known as revalidation. As the paper has already noted this purports to be a thorough assessment of a doctor’s fitness to practice in their chosen medical specialty, which they must pass to stay on the medical register (Donaldson 2008). It is also expected that the process will involve collecting
feedback from patients and management on a doctor’s work performance to enhance transparency and accountability (Catto 2006). However, at a day to day level and beyond, the development of revalidation and its piloting and implementation has been overseen and quality assured by the royal colleges. Not least of all because it is expected that a mixture of clinical audit, direct observation, simulated tests, knowledge tests and continuing professional development activates, will together ensure a doctor is regarded as competent (Chamberlain 2012). Furthermore, it was announced in late 2010 that after undertaking a period of extensive consultation the government does not now see any advantage in removing GMC control over adjudication in medical malpractice fitness to practice cases (Department of Health 2010). The governmental focus for now has moved to ensuring that reforms to the GMC continue to enforce a shift toward a rigorous and fair complaint and fitness to practice adjudication process. Possible options voiced for consultation include a greater focus on the use of rehabilitative measures within the complaints system when concerns about a doctor’s clinical performance exist, alongside the development of a more streamlined GMC tribunal system (Department of Health 2010). Only time will tell what the real affects of such changes will be.

In the final analysis, the state has had to water down its proposals and accept that given the specialised nature of medical expertise peer review remains an essential method by which an individual doctor’s clinical competence can be legitimately assessed and underperformance addressed (Irvine 2003, Catto 2006 2007). Furthermore, it needs to be acknowledged that there is another reason why the state does not want the GMC abolished: it is a self-funding body paid for by doctors themselves. It is unlikely that the state would agree in the current economic climate to fund an independent body to take over the role of the GMC. The Health and Social Care Act of 2008 did nevertheless put into place checks and balances to medical control over doctors activities. Doctors may still possess more freedom to control their own affairs than other occupations typically do but they are arguably more publicly accountable than they ever have been (Chamberlain 2012). Consequently, and in line with the restratification thesis, the current situation is perhaps best summed up by Moran (1999: 129-30) who says that: ‘…states are more important than ever before, either in the direct surveillance of the profession or in supervising the institutions of surveillance…[this] has not necessarily diminished the power of doctors; but it has profoundly changed the institutional landscape upon which they have to operate’.

The Governmentality of Performance Appraisal

Yet the current regulatory landscape also brings to the foreground an important point that has been overlooked by some academics and social commentators who concern themselves with the complex problem of how best to regulate professional forms of expertise. The fact is that contemporary reforms in medical governance are not singularly grounded in the need to transform the nature of medicine’s relationship with the general public through making it more open and publicly accountable. Rather, changes in medical governance are arguably also bound up with shifts in governance more generally, and indeed, are aimed at subject-citizens as much as they are the medical profession (Johnson 1994). That is, they can be said to be bound up with a shift in the conditions under which good governance can be practiced given current economic and socio-political realities. It certainly can be argued that the introduction of performance appraisal tools such as revalidation is just one more example of the internationally recognised trend that, like other occupations and indeed many areas of contemporary social life more generally, doctors are becoming subject to a seemingly ever increasing number of formal calculative regimes which seek to survey and performance manage their practices in order to better economise and risk manage them (Coburn and Willis 2000, Checkland et al 2007, McDonald et al 2008).
Over the last two decades there has been substantial growth in the use of audit and performance appraisal to survey, monitor and manage the activities of experts as well as sections of the general population often regarded by governing elites as particularly economically troublesome and risk heavy (i.e. criminals, the unemployed and so on) (Power 2009). This growing concern with standardisation and transparent accountability is bound up with the re-emergence of liberalism as an economic and political philosophy (Townley 1999). Against this background it has been argued that performance appraisal is a distinctive form of neo-liberal Governmentality: a system of control which utilises surveillance and rationality to turn the object of its gaze into a calculable and administrable subject open to control and risk management (Townley 1993a 1993b, Newton and Findley 1996, Rose 2000). Here appraisal is said to act as an information panopticon, operating through the use of two key panoptic disciplinary mechanisms: normalisation and hierarchy (Zuboff 1988). Normalisation, or normalising judgments, involves comparing, differentiating and homogenizing in relation to assumed norms or standards of what is proper, reasonable, desirable and efficient (Foucault 1991). Appraisal possesses normalising judgments due to its focus upon establishing behavioural norms in the form of ‘on the job’ task standards from which to judge individual performance. Hierarchy involves a process of judging, ranking and rating an individual without in turn being judged (Gordon and Miller, 1991). A point which brings to the foreground the fact that no matter how personally developmental and socially beneficial it is argued to be, it remains an exercise in one group exerting power and control over another.

Although this Foucauldian perspective notes appraisals usefulness as a disciplinary tool for identifying and correcting performance, it nevertheless does not hold that it is a straightforward punitive disciplinary tool, solely concerned with identifying and correcting poor performance ‘from the outside’ (Townley 1997). Indeed, it is argued that appraisal may well seek to promote and reward certain behaviours and rectify others, but it nevertheless does so using as far as possible a more subtle and invasive form of soft power (Rose 2000). Certainly, within medicine, appraisal seeks to work on the subjectivity of appraisees at a distance through requiring they engage in self-surveillance of their clinical performance as if it were a normal and everyday practice as a result of the availability of best-evidenced clinical guidelines and protocols (Sheaff et al 2003). For example, revalidation requires medical practitioners keep a record of their work activities which contains personalised information relating to prescribing patterns, the outcomes of case note analysis, the results of clinical audit, as well as patient complaint case outcomes and surgical operation success rates (Chamberlain 2012). They must use this information to identify and publicly record areas of personal developmental need in relation to best-practice performance frameworks, guidelines and protocols (Bruce 2007). Furthermore they must subsequently record activities and achievements that demonstrate they are proactively meeting their self-identified learning goals. With this record being subject to subsequent peer review, in order to prove they are willing as a matter of good professionalism to admit to areas of poor performance and learn from them (Irvine 2006). This is why performance appraisal tools such as revalidation are often promoted within medicine on the grounds that they formalise what already should be a normal and natural part of a doctor’s day to day self-monitoring of their clinical performance (for example, see Snadden and Thomas 1998, Davis et al 2001, Wilkinson et al 2002, Donaldson 2008).

This invasive soft power style of governance is arguably a generic feature of contemporary neo-liberal forms of rule. It has been argued that there has been a profound shift in ‘the nature of the present’ (Rose 1992: 161) and the way ‘we come to recognise ourselves and act upon ourselves as certain kinds of subject’ (Rose 1992: 16). Due in no small part to the re-emergence of liberalism and the growing ascendancy of the concept of the enterprise self
throughout all spheres of modern social life (Chamberlain 2012). Burchell (1996) argues that neo-liberalisms dual advocacy of the self-regulating free individual and the free market has led to ‘the generalisation of an “enterprise form” to all forms of conduct’ (Burchell 1996: 28). Enterprise - with its focus upon energy, drive, initiative, self-reliance and personal responsibility - has assumed a near-hegemonic position in the construction of individual identities and the government of organisational and everyday life. Enterprise has assumed ‘an ontological priority’ (du Guy, 1996a: 181). Consequently, as Burchell (1993: 275) notes: ‘one might want to say that the generalization of an “enterprise form” to all forms of conduct – to the conduct of organisations hitherto seen as being non-economic, to the conduct of government, and to the conduct of individuals themselves – constitutes the essential characteristic of this style of government: the promotion of an enterprise culture.’

Against this background it can be argued that given the utility of professional forms of expertise in legitimizing normative governing regimes, changes in how such expertise operates are as much directed towards the object of good governance - the population in general and the individual subject-citizen in particular – as much as they are experts themselves (Rose 2000). That is, contemporary shifts in medical regulation can be seen to be the result of re-alignments undertaken to bring traditionally closed systems of professional governance into sync with shifting conceptions of what constitutes good governance so the state can achieve its broader objective of promoting the enterprise form. For in terms of Berlin’s (1969) famous dichotomy of ‘positive’ and ‘negative’ liberty, although liberal mentalities of rule may appear at first to promote ‘negative liberty’ (i.e. the personal freedom of the individual-subject to decide who they are and discover what they want to be), in reality they promote ‘positive liberty’ (i.e. that is a view of who and what a citizen-subject is and should be). It certainly can be argued that a key facet of advanced liberal society is its central concern with disciplining the population without recourse to direct or oppressive intervention. Yet liberal mentalities of rule seek to promote good citizenship by discursively constructing and promoting subjective positions for subject-citizens to occupy in relation to the form of the enterprise self. Typically this is associated with a bundle of characteristics such as energy, resilience, initiative, ambition, calculation, self-sufficiency and personal responsibility (Chamberlain 2012). For the world of enterprise valorises the autonomous, productive, self-regulating individual, who is following their own path to self-realisation, and so it requires all society’s citizens ‘come to identify themselves and conceive of their interests in terms of these…words and images’ (du Guy 1996a: 53).

CONCLUSION: RESEARCHING ‘GOOD GOVERNANCE’

This paper has outlined current developments in the regulation of the medical profession in the UK. In doing so it has highlighted how these provide evidence to support the restratification thesis: rank and file doctors are becoming increasingly subject to greater surveillance and performance appraisal by medical elites as a result of external pressure to reform medical regulation and curtail professional autonomy. But perhaps more importantly the paper has also argued for the need for social scientists to contribute to current debates relating to how best to regulate professional forms of expertise while also bearing in mind that such discussions take place against the background of a broader shift in how good governance is conceptualised and operationalized under neo-liberal mentalities of rule as the state seeks to promote at a distance a certain type of citizen-subject congruent with the enterprise form (Rose 1999, Chamberlain 2012). The recent introduction of reforms to the GMC, alongside the introduction of performance management tools such as revalidation, provides an ideal opportunity for the establishment of such a research program. It is undoubtedly important for social scientists to use their expertise to help medical elites strike
a balance between protecting medical autonomy and ensuring medical work remains open to a necessary element of surveillance and control in order to protect the general public from poorly performing doctors. But it is equally important that they do so while also considering the type of citizen-subject and forms of subjectivity promoted and sustained by contemporary governing regimes (Chamberlain, 2011). Not least of all because it is arguable that under the guise of advocating minimal forms of government as the natural way of things, liberal mentalities of rule run the risk of promoting a highly limiting view of what it is to be a human being, let alone a good citizen, within today’s increasingly complex social world. This is a state of affairs that we must all guard against.
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Anthropomorphism and the Computer “Virus”: The Latest Chapter in the Illness as Metaphor Story? – A Postscript

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Returning now almost two decades later to this MSN piece, my abiding impression is that what at the time felt like something genuinely new, intriguing and hence worth writing about is now such a banal or commonplace feature of life and living today in the information age that is barely merits mention and is certainly no 'news' at all!

The following points nevertheless are worth stressing as an 'update' of sorts on my thinking here in the intervening years.

First and foremost, to these 'viral' computer threats I was first writing about in 1995, we must now of course add, as part and parcel of contemporary risk culture and society (cf. Beck 1992: Giddens 1991), not simply constant updates to our 'anti-viral' software, but a number of other new digital risks and threats, given rapid developments in information and communication technologies since this time, including the advent of Web 2.0 and the proliferation of social media. Digital risks and threats, that is to say, such as online 'flaming', 'trolling' and 'phishing', and countless other issues to do with so-called 'cybersecurity' and surveillance in the twenty-first century. Consider, for example, the RCUK 'Global Uncertainties: Security for all in a Changing World' programme, led by the ESRC, where cybersecurity features as one of six core areas. 'Our increased reliance on electronic systems', we are told:

...means that successful cyber attacks are likely to have significant damaging consequences. The combination of enhanced threats, increased vulnerabilities and more serious consequences increases the cyber risk to which we are all exposed.

Hence the need, RCUK continues, for 'interdisciplinary research' in order to 'achieve more effective cyber security and to help develop new mitigations.' (http://www.globaluncertainties.org.uk/research/cybersecurity, accessed 10/2/2014).

As for the mega amounts of data all this digital activity generates, what to make of it, and what is done with it, well that of course now goes by the name of 'Big Data': something I shall not elaborate on any further here in this postscript, but see Uprichard (2013) for a recent excellent discussion in the equally excellent new 'Discover Society' online magazine, which I recommend all MSN readers to read regularly if not already doing so. (http://www.discoversociety.org/focus-big-data-little-questions)

A second closely related point returns us to the long standing debate about the relationship between medical sociology and mainstream sociological theory, this time albeit in the guise of the so-called 'information age'. Despite numerous bridges now forged between medical sociology and mainstream sociological theory, one theorist, as I have recently argued elsewhere (Williams 2012), is notable by his absence, namely, the sociologist par excellence of the 'information age', Manuel Castells. This indeed becomes all the more curious given the growth of interest in medical sociology in recent years in the digitalisation and informationalisation of medicine, health and society (Webster 2007, Miah and Rich 2007, Nettleton 2004, Seale 2003). Castells indeed has much to offer us here, in my view, from his
early formulations of these matters in volumes I, II and III of the information age (Castells 2000, 2010a,b), to his more recent work on 'communication power' and the 'real virtuality' of the digital world today (Castells 2009).

A third, quite literally 'vital' matter, concerns the fact the despite the computerisation and digitalisation of almost everything today, we now live not simply in an 'information age' but a 'biological age'. A biological age, that is to say, given significant advances in bioscience, biomedicine and biotechnology in recent decades; advances indeed which are fundamentally reconfiguring prevailing notions of normality and abnormality, health and illness, therapy and enhancement. A biological age, moreover, where computer models and metaphors of digital minds and the brain as an isolated 'information processor' are now increasingly problematised in favour not simply of embodied but extend minds, social brains, neuroplasticity and so forth. And a biological age where, as Rose (2007: 20) tellingly remarks, the 'artificially enhanced body is no longer a cyborg.' No longer a cyborg, in the sense that many forms of enhancement today do not so much seek to 'hybridise' the body in human-machine like ways that Haraway's (1990) cyborg manifesto suggests, but in ways that render us not 'less' but 'all the more' biological, including organic 'transformations' of the vital 'nomativities' of life itself (Rose 2007: 21). To Turner's (1992) notion of the 'somatic society' therefore, perhaps we might profitably update this still further in terms not simply of moves in the direction of new more complex, open, post-genomic, pro-social forms of biology now, but of the increasingly 'biosocial' ways in which we are coming to 'know' and 'govern' ourselves today. Somatic societies in this sense then, we might say, are 'biosocieties' through and through (see for example, Rose 2007; Rabinow 2008, 1996/1992; Gibbon and Novas 2008).

A final point concerns future agendas in these digital domains. Clearly there is much still to do here, in medical sociology and beyond, including further empirical work on what Nettleton (2004) appositely terms 'e-scaped medicine' in the information age. Perhaps one of the most exciting if not cutting edge digital developments here however, in my view, concerns the advent of so-called 'm-health' as part of parcel of these wider e-health developments on the one hand, and the so-called quantified self (QS) movement on the other hand. The 'm' in question here, of course, stands for 'mobile', as in the multiple ways we can now monitor and manage our bodies and ourselves on the move, so to speak, courtesy of digital apps, health related or otherwise, for our smart phones, tablets, laptops and so on - see Lupton (2013, 2012), for example, for a recent sociological discussion of these developments within and beyond the health domain. Take sleep for instance, another key sociological and political matter in my view, as I have argued extensively elsewhere (Williams 2011, 2005). A variety of apps are now available to monitor and manage if not improve or optimise our sleep, including some approved sleep apps in the new NHS health apps library: a case of the 'm-apping' of sleep in the digital age, in effect. To date, however, there has been precious little sociological research on these issues, in medical sociology or elsewhere. Hence many sociological questions and issues remain to be addressed here in the coming decades, from further studies tracing the design and development of such apps to their multiple meanings and uses in every day/night life, and the wider issues of power, privacy and surveillance they raise.

Perhaps then it might be instructive to revisit this postscript in another few decades or so, assuming I am still alive by then, to see what further progress has been made along these sorts of lines in the interim, and hence how up-to-date or out-of-date these further musings of mine are by then. Time will tell...
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Anthropomorphism and the Computer “Virus”: the Latest Chapter in the Illness as Metaphor Story?

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In this world of uncertain times one thing remains clear: namely, that when you are in a hurry things invariably go wrong! So it was one busy Wednesday in January when, sandwiched between my morning and afternoon teaching sessions, I tried to transfer some files from one Computer to another. All of a sudden, and much to my embarrassment, an ominous alarm signal started to emanate from the PC I was using and broadcasting to all and sundry that something terrible had gone wrong. A message flashed up on the screen notifying me that a computer ‘virus’ had been detected and that I should close down the PC and seek help. Somewhat bewildered and perplexed, I consulted a colleague who told me that the best thing to do was to go straight over to the computer centre where somebody would be able to help me.

It was from this point on that suddenly, in the midst of a plethora of high-tech computer terminology and acronyms such as RAM, ROM, VDU, I found myself plunged into the ready-to-hand vocabulary of illness which was being used to describe my plight: one in which the guiding scheme of imagery was of ‘contamination’ and of sexually transmitted disease. Indeed, to my surprise I subsequently found out that some of these viruses do actually have names related to HIV, AIDS and other STDs.

From here, it was only a small step to being ineluctably drawn into a whole new set of issues, and it is these I wish to recount in this short article. First, crucial existential questions such as ‘Why me?’ and ‘Where did it come from?’ suddenly come to the fore. Here the search for reasons resonates with the search for meaning in the context of (chronic) illness. Moreover, this also involved me having to try and ‘trace contacts’ in a similar manner to the practices of genito-urinary clinics, and was further reinforced by the necessity of having to fill out a form reporting the incident to the computer crimes department of New Scotland Yard!

Secondly, the upshot of this is that your PC, to which you may have become quite attached - after all, it is your personal computer - has suddenly become ‘infected’. In other words it is ‘sick’, and this may spill over, however irrationally, into more generalised feelings of physical and moral ‘contamination’. As a consequence, feelings of guilt and shame tend to be invoked: you don’t really want to broadcast the fact that you’ve caught a ‘virus’ especially when you find out it is from your ‘partner’!

From this flows the third issue: namely that you, are now at risk of giving the ‘virus’ to others, particularly if you engage in ‘high risk’ practices such as ‘irresponsible’ or ‘reckless’ ‘disk-swapping’! Similarly other people, such as the editors of Medical Sociology News, who have ‘multiple contacts’ with a variety of sources, are at particular risk of ‘contracting’ the ‘virus’ ergo please remember to check your disks are ‘virus free’ before sending them to us in future!
Finally, having ‘contracted’ the ‘virus’, there is, of course, the whole ritual process of ‘decontamination’ or ‘disinfection’ terms which are actually used in the anti-virus packages – which one has to go through and which involve reporting to a professional ‘expert’ who then ‘diagnoses’ which particular ‘strain’ of the virus you have and how to go about treating it. Inevitably, if somewhat ironically, in the light of the imagery which this conjures up, these rituals of ‘decontamination’ do actually result in a feeling of ‘purification’ and ‘cleanliness’ once they have been performed. Moreover, a similar feeling of ‘moral purity’ and ‘virtue’ may also emerge when a quick ‘diagnostic test’ indicates that your PC is ‘virus free’.

What then, are the morals of this story? Able to reflect on this experience now with somewhat more equanimity than at the time, I think the following points and issues emerge.

First, as symbolic and structuralist anthropologists have demonstrated, humans find the body ‘good to think with’ (Schepper-Hughes and Lock 1987). Thus Mary Douglas (1973), for example, has ably documented how the body is a natural symbol and treasure trove from which spring some of our richest metaphors and cultural constructions of society and social relations. In this respect, if we take O’Neill’s (1985) point seriously that human beings cannot do without the practice of anthropomorphizing aspects of their world, then the attribution of a ‘virus’ to what is in effect an inanimate, impersonal object, namely our PCs, represents the latest twist to this tale. Indeed, as media coverage has recently highlighted, those who download pornographic material on their PCs are now at risk of catching a particularly nasty new strain of computer virus, designed by some moralizing ‘hacker’.

The situation becomes even more complicated when we realise that, as we approach the twenty-first century, not only have we come to conceptualise computers in bodily terms, but also the body in computerised terms. In this respect a dialectical interplay of metaphorical projections and schemes of imagery is set in motion with potentially disturbing consequences. Not only do computers ‘catch’ viruses, they also possess ‘memories’ (Lupton 1994). Moreover, they ‘think’ and ‘process’ vast quantities of information much faster than we ourselves can. Indeed, humans are liable to error, computers aren’t - the only errors which computers make are programmed in by humans. Despite this fact, humans have increasingly been depicted as ‘organic computers’ and the mind has been ‘bureaucratized’ (Berman 1989). Within this scheme of imagery, bodies become cyborgs, whilst diseases are viewed as the result of malfunctions in information processing or ‘communications pathology’ (Haraway 1991). This is particularly so with respect to work on the human brain. Thus Lupton for example, cites an article by Young and Concar (1992) in New Scientist in which the human brain is referred to according to its ‘information storing capacities’, its ‘memory’s hardware’, its ‘internal filing system’, ‘the machinery that enables us to retain a sequence of digits, letters or words’, ‘electrical impulses’, ‘fine tuning connections between neurons’ and ‘memory networks’ (Lupton 1994: 60).

These processes have been extended even further with the discovery of DNA and the current project of ‘mapping’ the structure and sequence of genetic material in the human genome. This results in an image of the body and mind as ‘machine-like "systems" that can be visualized on a computer screen and understood simply by deciphering a code’ (Nelkin and Tancredi 1989: 15, quoted in Lupton 1994: 60). As a consequence, individuals are in danger of being reduced to their DNA codes (Lippman 1992) and the machine-metaphor of the human body is further reinforced albeit in a manner which Descartes himself way back in the seventeenth century could not have envisaged!

Indeed, as Frank has recently remarked, the Baudrillardian nightmare has arrived in the modern hospital. In this respect, if the modern hospital was to have an emblem it would have to be the video screen rather than the patient’s body (Frank 1992). In other words, this is a
situation in which the Foucauldian clinical gaze has given way to the ‘hyperreality of images without grounding’ (Frank, 1992: 84). Instead of the patient’s body being at the centre of medical practice and discourse, we find instead ‘multiple images and codings’ through the use of a wide range of sophisticated medical technology (e.g. the ultrasound screens, CAT scans, ECG monitors etc…) whereby the body is ‘doubled and redoubled’; a scenario in which the reality is that there is no reality, rather the real simply disappears in an endless chain of self-referential images or simulacra.

At a more general level, the changes sweeping through society as a consequence of information technology have profound implications for the nature of our embodiment and the shape of our future lives. In particular, they suggest a trend towards the ‘dis-embodiment’ or ‘de-corporealisation’ of contemporary culture. Thus, the absurdity of the statement: ‘I’m here but I’ve left my body behind’ becomes a chilling reality with the advent of cyberspace and virtual reality. Within this no-(wo)man’s-land not only do bodies and communities assume a virtual status, but the nature of working life and leisure opportunities becomes profoundly and irrevocably transformed. In short, contrary to the current emphasis upon the body and self identity in modern western societies (i.e. what Turner (1992) terms the ‘somatic society’), it is possible to envisage an alternative hypothesis or a counter-trend for the future involving what might be termed, for want of a better phrase, the ‘decorporealisation’ or ‘dis-embodiment’ of contemporary culture. Perhaps the fullest expression of this disdain for the body comes from Foster (1993), who quotes approvingly the character Plughead in Steven Lovy’s 1989 film Circuitry Man, who states ‘Why jack off when you can jack in?’ (1993: 11). In other words, why remain dependent on an organic body when access to the extended nervous system of a computer network is available?

Secondly, this tale again highlights the ways in which the language of illness is imbued with moral and metaphorical qualities which serve to transform, often in a negative manner, the meaning of personal affliction. In this respect Sontag’s (1989) recent book serves to extend her critique of the metaphorical nature of TB and cancer to the metaphors and dread surrounding the AIDS virus. In particular, the following passage echoes the points I have sought to develop here:

And the strictures about contact now have their place in the computer world as well. Computer users are advised to regard each new piece of software as a “potential carrier” of a Virus. “Never put a disk in your computer without verifying its source”. The so-called vaccine programs being marketed are said to offer some protection; but the only sure way to curb the threat of computer viruses, experts agree, is not to share programs and data (Sontag 1991: 165).

Doubtless medical sociologists are acutely aware of the dangers of moralising about disease and of the need to strip away the mythology and negative connotations which surrounds certain illness conditions. Yet one has to fight very hard in order to avoid becoming sucked into such discourses. This, in turn, poses the obvious next question: namely, would the use of a different vocabulary to describe the problems I confronted on my PC have altered my experience and interpretation of these events or happenings: I think the answer is, undoubtedly, yes. And yet it is also clear that the argument about stripping illness of its metaphorical garb is also a hollow one. As Johnson (1987) has cogently argued, the use of metaphorical projections and schemes of imagery which are intimately tied to our embodiment, is a fundamental aspect of human language, meaning and rationality. And whilst we’re on the topic of metaphor, have you noticed the ‘number’ of bodies which currently litter the pages of academic journals and texts; the list grows longer every day! Thus we have ‘anatomical’ bodies, ‘biochemical’ bodies, ‘psychosomatic’ bodies, ‘genetic’ bodies, ‘sick’ bodies, ‘disabled’ bodies, ‘holistic’ bodies, ‘docile’ bodies, ‘reflexive bodies’,
'risky' bodies, 'panic' bodies, ‘uncertain’ bodies, ‘sexual’ bodies, ‘virtual’ bodies, ‘cyber’ bodies, ‘social’ bodies, the body ‘politic’, ‘celestial’ bodies, and any other body you care to mention. In truth of course, these are simply aspects of our embodiment, rather than ‘bodies’ in their own right, and this endless doubling and redoubling of the body is nothing other than a playful ‘language game’ to borrow Wittgenstein’s famous phrase.

Thirdly, whilst the cyborg may, according to Haraway (1989), offer the possibility of a post-gender world and exposes a series of ‘leaky distinctions’ between nature, biology and culture (Haraway 1991), it is nonetheless the case that, computers, just like humans, can also become (metaphorically) ‘sick’. Moreover, machines may not totally escape gender categorisation and stereotyping, as the ‘gendering’ of certain computer parts testifies. Thus, plugs with ‘prongs’, for example, are termed ‘male’, whilst sockets are referred to as ‘female’. Indeed, as writers such as Foster (1993) and Cherniavsky (1993) suggest, cyborgs and the cyberpunk genre actually uphold the gendered embodiment and subjectivity it seems to unravel, and technology is in fact patterned upon a ‘fethisisation’ of the maternal body (Doane 1990). Within this context a dualism is resurrected in which a disdain for the (female) body as a ‘meat puppet’ is matched by a quest for the ‘disembodied’ (male) mind lodged in the ‘ecstasy’ of Cyberspace.

Fourthly, on a more pragmatic note, the sheer inconvenience this episode caused in terms of the time and effort it took to sort out should also be emphasised. Although apparently I had a relatively benign ‘stoned boot sector virus’ others are far more malicious, bringing your system to its knees and corrupting your data files! No wonder, in high technology, information based society, these viruses are taken so seriously as organisations now face the risk of their data banks being ‘wiped clean’ over night. The costs are obvious, and New Scotland Yard clearly see this as a new strain of crime of an increasingly troublesome sort.

Finally, perhaps on a slightly more flippant note, this tale adds a totally new, more sinister, meaning to the acronym PC: for now PC not only stands for your personal computer (police constable, politically correct etc…) but also for ‘Possibly Contaminated’. Therefore, perhaps the most appropriate, if somewhat troubling, note to finish on is to pose the following series of questions which are likely to get you all rushing to your computer to find the answer and ‘protect’ yourselves: is your PC ‘PC’ or is it ‘OK’?; are you a ‘high risk disk swapper’?; and are you taking the necessary precautions against contracting the ‘virus’?
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The Welfare State and Socioeconomic Inequalities in Women's Health Dynamics: A Comparative Study of Four OECD Countries

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ABSTRACT

While it is known that social policies influence the organization of employment and family life, this knowledge is rarely used to understand women's health. The current study uses feminist welfare state theory to examine socioeconomic inequalities in women's health dynamics in countries differing by the extent to which their social policies encourage male breadwinning and female caring/homemaking. The pathways underlying these inequalities are also investigated. Socioeconomic inequalities in health are hypothesized to be largest in strong male-breadwinner states (Britain/Germany), smallest in weak male-breadwinner welfare states (Denmark), and intermediate in modified male-breadwinner states (France). Further, family and income will explain more of health inequalities in strong and modified versus weak male-breadwinner regimes.

The analysis uses longitudinal data from the European Community Household Panel (1994-2001) for working-aged women from Britain (n=2,193), Germany (n=2,421), France (n=2,400) and Denmark (n=1,412). The effects of socioeconomic position (measured by education) on self-rated health trajectories are examined using Latent Growth Curve Models; model estimates are compared cross-nationally using z-scores. Pathways linking education to health are identified by determining how much employment status, family roles and household income attenuate health inequalities in each country. The analyses are repeated for a sub-sample of mothers of young children—a group for whom policies surrounding the integration of employment and family are critical.

Low education predicts worse initial health in all countries, but not faster health decline. Against expectations, education-based inequalities in health are largest in weak male-breadwinner states, but income explains virtually none of that inequality. By contrast, income has a larger explanatory role in regimes where women's unpaid caregiving is encouraged. Employment status is a relatively important mediator of the education-health relationship in all policy contexts, while family roles are not. Restricting the analysis to mothers reveals a much smaller education gradient in health in Denmark, providing evidence that weak male-breadwinner states are most effective at reducing health inequalities among mothers, relative to all women. Feminist welfare state theory better predicts cross-national differences in pathways underlying socioeconomic inequalities in health than the magnitude of inequalities, and may be most useful for understanding the health of mothers with young children.

Keywords: socioeconomic position; gender; welfare regimes; education level; self-rate health;
The sociocultural aspects of assisted reproduction in Mexico

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ABSTRACT
Assisted reproduction (AR) became available in Mexico during the mid eighties. Since then, the AR industry has developed and flourished within a context of little regulation, considerable media coverage and an increasing number of consumers. As part of this process, terms such as 'assisted reproduction', 'infertility', 'eligible AR users' and 'qualified AR service provider' have required definitions. Through four years of multi-sited ethnographic work at clinics, conferences and online forums, and by analysing media coverage and legal debates around infertility I have charted the introduction and development of AR, and I have tried to understand the process of its assimilation and (re)construction within the Mexican setting. The organisation of this thesis reflects the dynamic complexity with which the different actors have constructed the Mexican AR arena. The thesis begins with a description of the theoretical framework and the methodological rationale, followed by a genealogical analysis of Mexican AR focusing on the elements that made its adoption possible, the transformation of gynaecologists into AR specialists, the establishment of AR clinics and services, and the emergence of two new types of AR specialist: the andrologist and the AR biologist. I then analyse the way AR is framed as a paranatural procedure that imitates nature while simultaneously going beyond it and examine the elements that make up what the community of AR specialists suggest are the major causes for infertility: 'the age factor' and 'the male factor'. Finally, I describe the pilgrimage AR users embark on in search of parenthood and their quest for information and support. Understanding the process by which AR has been assimilated and transformed in the Mexican context sheds light on the way techno-science is (re)constructed when it arrives in new settings. In addition, this knowledge has the potential to inform local medical and social practices, and regulatory frameworks in the field.

Keywords: Medical Sociology, Science and Technology Studies, Human Assisted Reproduction, Ethnography, México
Book Review

Cregan, Kate

Key concepts in body and society
ISBN: 978-1847-87544-0
224pp

Reviewer: Merryn Ekberg
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While the academic discipline of sociology has a long history, the sub-discipline of the sociology of the body is a relatively new entry into sociology and sociological theory. However, although new, it is a welcome addition to our understanding of the social world and especially, to our understanding of the complexities of our late modern, or post-modern societies. In what has been described as a visual society, mediated society, technological society or consumer society, the human body is now a central feature in all social actions and interactions.

Cregan's book, Key Concepts in Body and Society, provides an excellent introduction and overview of this emerging field and is ideal for students exploring the origins and scope of the relationship between the body and society. It has been written (and should be read) as an extended dictionary, which provides a clear definition of the key terms, followed by an exploration of the core concepts, a review of the seminal text and a concise review of the leading theorists.

One of the strengths of this book is the interdisciplinary approach to each topic. Whilst the emphasis is on the sociological approach, the discussion in each chapter successfully incorporates ideas from other disciplines such as history, philosophy, psychology, cultural studies, anthropology and science and technology studies. In turn this highlights that the field of 'the body and society' is dynamic rather than static and opens up many new opportunities for further collaborative and cross-disciplinary work.

This reference book will primarily be used by undergraduate and postgraduate students new to the field and it would be an ideal book for exam revision as it is easy to read and covers a vast amount of material in a very condensed format. Its scope and readership however will not be confined to students, it will also be a valuable resource for academics who work within sociology as well as those working on the margins. For example, scholars working in acting and performance studies, media studies, fashion and advertising, politics, cultural studies, health studies, sport studies, and science and technology studies will all find this a useful reference book.
When so many theories, theorists and ideas are covered in one small book, there is obviously a loss of depth. However, the aim is not to provide a depth analysis of existing theory, or to suggest a new theory, but rather, the aim of this work is to provide an integrated review alongside some contextual and comparative analysis. There is great value on bringing all the key concepts together in one volume where the author can offer a new interpretation, make new connections and emphasis the core themes. Individual, in-depth, theoretical works are important, but so too are these works of integration, synthesis and comparison. The topics are obviously covered very briefly, but the further reading and reference list at the end of each chapter enables the interested reader to pursue the concept in more depth.

Although many key concepts have been covered, there is some selective bias and inevitably some topics are missing. For example, the idea of the aesthetic, expressive, creative and artistic body has not been included, and this would seem an important topic for understanding modern society. But perhaps these gaps provide new opportunities for further empirical and theoretical studies in this ongoing project. Perhaps this is what the book does best, it makes the reader more familiar with the field, it makes the reader excited by the rich body of work already contained within this field and it inspires the reader to make additional theoretical or empirical contributions to the field.
Book Review

Bradby, Hannah

**Medicine, Health and Society**


189pp

Reviewer: Paul Dawson

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Bradby's Medicine, Health and Society offers a critical overview and insight into the sub-discipline of medical sociology. Chapters covered include social theory and medical sociology; health inequalities; bodies, pain and suffering; and the personal, local and global. Throughout the work she weaves a narrative that critically appraises individual contributions to medical sociology and wider theories and themes, while simultaneously examining the state of medical sociology.

The text begins by staking a claim on the current state of medical sociology as "a reflexive endeavour which has devoted a large number of words to considering its own origins, legitimacy, progress and potential" (3). Bradby explores this theme adroitly and in the final chapter of the book leaves the reader not only with an exploration of the key theories, research and areas of medical sociology, but also with a striking image of what medical sociology should be.

Each chapter explores individual pieces of scholarship and research and embeds them within thematic trends that are at the forefront of medical sociology. Alongside each chapter's specific focus Bradby continually overlaps themes from other chapters: for example, showing how inequalities relate to painful bodies, or the links between the professional introversion of medical sociology and it's dismissal of health services research ("an area that medical sociology can comfort itself by characterising as descriptive and atheoretical" 119). In doing so Bradby builds and develops themes from earlier chapters and maintains the predominant theme of questioning a critical self-reflexive medical sociology. At the end of the book a direct (and perhaps irreverent) answer is provided that the reader feels Bradby has been building up to throughout the entire text:

"Aiming a critical sociological gaze at globalized, and not just nationally bounded, settings while bearing in mind the vision of suffering humanity that is at stake in the social relations of health and medicine, perhaps sums up the contradictions of our work as compassionate rock-chuckers" (172)

This is a refreshing take on medical sociology, which - as Bradby states - is often lost in introversion and reflexivity.

The pace of her examination is in contradiction to those approaches to medical sociology which are overly reflexive. The insights, not only into the state of the sub-discipline but also
with regard to the scholarship she explores, circumvent the often-heard gripe of students (particularly medical students) that sociology leads nowhere. The reader is left not only with an understanding of the value of medical sociology beyond sociology but also with a desire to ask and seek out further questions that have a direct bearing on human suffering.

Although the critical reflexive theme of considering its own origins is a hallmark of the text, Bradby seems desperate to push medical sociology away from the introversion of sociology-for-sociology's-sake and into that of a discipline which seeks to challenge those areas of medicine that, through vested interests or the violence of normative presumptions, lead to human suffering. This is of paramount importance to the text: if the key theme of the book is to offer an interpretation of the current state of medical sociology, then the value of being sociologically aware of human suffering is a subtext which surfaces brilliantly in the final chapter.

There are areas, though, that some puritanical readers with advanced sociological knowledge may consider weak. One such example is in a section that deals with social constructionism, wherein post-modernism is seen as the originating condition of social constructionism. Although I sympathise with Bradby's assertion, there is much more to social constructionism than its post-structuralist or post modernist forms. Bradby does recognise that feminist theory has links with social constructionism, but social constructionism - which is of such importance to medical sociology, and indeed sociology - is not given diligent enough attention within a work that is otherwise thoroughly researched and expertly observed.

Putting this aside, however, there are fresh insights and interpretations with respect to the emerging concerns of medical sociology, such as biotechnology and bioethics, or medical migration. These provide the work with a contemporary feel and, coupled with the direct assertions of the value of medical sociology to human suffering, heighten the significance of the text. Although I hold limited reservations of this book's place on medical degree courses, due, at times, to its presumptions of sociological understanding, it would suit courses looking to introduce non-sociology students to medical sociology. Indeed, if the tutor is keen to propose sociology as a key facet of the medical professional's education, then students should be pushed to read this as a text that supplements introductory texts. Alongside this, it should definitely be key introductory reading for medical sociology courses at undergraduate and postgraduate levels.
Current Online First Articles: A Digest

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Following previous digests published here the articles are drawn from ‘Articles in Press’ on the Social Science and Medicine (SSM) website; ‘Early View’ on the Sociology of Health and Illness (SHI) website and ‘Online First ’ on the Health website. Similar to the previous digest (Cavaye 2013) the scene for my selection emerged from the re-occurrence of articles relating to contemporary problems of eating, diet, weight and managing healthy lifestyles.

From Health, Kristensen and Koster (2014) present an interesting investigation into ‘Contextualising eating problems in individual diet counselling’. This article starts from the assumption that individualistic, bio-psycho interventions such as health coaching, diet counselling, and motivational interviewing, do not fully respond to the complex, contextual qualities of eating problems. This position is not unexpected as one of the authors is a narrative therapist and the other an anthropologist working in the sociology of food. Both authors examine narrative practice (White and Epston 1990, White 2007) as a means to contextualise eating problems: "In our work with eating problems, we engage in collaborative mapping of how the client’s problem is continually constituted through social interaction and historical context” p:. A storytelling strategy, ‘externalisation’ is used to identify the problems experienced as an external entity, existing outside, independent of the person. This external ‘problem’ is then articulated, reflected on and analysed. This reflective analytical stage is called ‘co-researching’ the problem in the person’s ‘life world’. The authors argue this narrative practice allows the client and the therapist to explore social obligations, relationships, structures and discourses that shape the eating practices and each individual's response. This permits the complex and contextual qualities of an eating disorder to be observed and addressed. The authors do not claim that narrative practice enables the client to challenge the social structures and discourses that shape them. This narrative practice works to change the way the story is told and consequently is seen to offer new opportunities to respond differently to the problem. The authors present their argument systematically, initially discussing the philosophical and psychotherapeutic underpinnings of narrative practice, and then followed by a series of analytical case studies from the clinical setting. This analysis identifies three key contextual themes that frequently frame the person’s story. The first theme, ‘logistic eating problems’, shows how the problem is located within schedules, organisations and social practices of preparing food, and eating food. The second theme ‘social eating problems’ emphasise social relationships where issues of intimacy and trust are contextualised through the mediums of eating and types of food. The last theme focuses on ‘discursive eating problems’ when people locate their self-identities within ideal discourses of gender, body, health and diets. Research evidence from this psychotherapeutic setting depends upon the coherent and robust analysis of case studies. Here the authors present a persuasive and interesting point of view on the success of this phenomenological therapeutic practice, one that fits well with those who seek to prioritise the social within the complexities of health and illness.

The next article from SHI ‘The pursuit of preventative care for chronic illness: turning healthy people into chronic patients close’ (Kreiner and Hunt 2013), explores doctor/patient interaction and the micro processes involved in the medicalization thesis. The
authors present qualitative data from more than 100 clinical observations plus in-depth interviews with 58 primary-care physicians and 70 patients in the US to show how risk indicators transform preventative health to illness management. This builds on previous research that has highlighted new categories of "borderline disease" or "pre-disease" where risk factors become a symptom to be treated. In this study blood pressure and blood glucose results identify specific risks, both determined by evidence and clinical guidance. Evidence from population comparative norms determine acceptable/unacceptable threshold measurements combined with clinical guidance from improved knowledge of causation and long term implications influence interpretations of risk. The data from consultations and doctors’ descriptions demonstrate how high blood pressure or glucose levels test results become targets to be reduced. In turn, this minimises healthy lifestyle discussions and prioritises interventions such as drug treatment to bring measurements within acceptable thresholds. The patient interviews also show how this shift towards treatment rather than prevention is internalised as 'being a diabetic' or 'having an illness'. The authors conclude how aggressive interventions to reduce risk can unintentionally result in illness. The authors end with a compelling warning that if preventative care increasingly shifts towards illness management the well-being of the individual is compromised for the overall maintenance of a healthy population. This powerful warning is sustained and clearly documented by the research data here. It will be interesting to see how this warning influences future research in the UK NHS, where risk factors and population norms are increasingly more prominent in the clinical setting.

The next article also from SHI, ‘Sustained multiplicity in every day cholesterol reduction: repertoires and practices in talk about ‘healthy living’’, (Will and Weiner 2014) picks up some of the issues expressed in the previous paper. Will and Weiner (2014) compare two datasets from different research projects but both consisting of interview accounts on health activities undertaken to lower cholesterol levels. This leads the authors to analyse the discourses in relation to interpretative repertoires. They focus on the specific terms and narrative constructions used to describe healthy living behaviours such as diet, exercise and weight loss. This analysis reveals the ease in which the participants use three repertoires of health, pleasure and practicalities. They show how the repertoires of health and pleasure coincide. Here contradictions of healthy or pleasurable (but unhealthy) activities coexist. This mixing of repertoires begins to portray notions of being ‘ordinary’, neither being a health fanatic or an unhealthy risk taker but a ‘balanced’ person. Most importantly, the authors continue to propose how such repertoires function differently. The health and pleasure repertoires interact in order to justify, moderate and balance the actions undertaken. The pragmatic repertoire remains relatively inert, where discourses portray "what is", determined by the social context with little room to manoeuvre. The repertoires are also analysed in relation to temporal and spatial determinants to confirm the consistent shifting patterns across different timelines and social contexts. The authors conclude that from this group of active health seekers (to reduce cholesterol levels) there is little evidence of a coherent or dominant healthy discourse. Instead a ‘sustained multiplicity’ take place ‘as people tried out different foods, routines, incorporated products into everyday life and made messy compromises in the spaces of household and beyond’: p.11. Most health promotion and prevention researchers and practitioners recognise the complexity of grasping when healthy choices transform into healthy actions. This paper establishes the importance of discourse analysis to approach this complexity in everyday life. As the authors indicate it will be interesting to see further analyses on how interpretative repertoires function to support or challenge the adoption of healthy lifestyles. I would however, like to hear more on the point made at the beginning of the paper regarding “metaphors of balance-the balance of the high
wire" that the authors attribute to the work of Mol (2008). I felt disappointed as this was lost during the discussion of repertoires but perhaps this is for another paper.

I am fortunate that the next paper selected from SSM 'Maternal Work and Children's Diet, Activity, and Obesity', (Dater, Nicosia, and Shier 2014) balances my previous bias towards qualitative methods. Childhood obesity is a major concern in the US. Research has established a link between obesity rates for children and the hours mothers spend in employment. This study aims to examine the mechanisms that link mothers' working hours to childhood obesity. In order to address the multiple mechanisms that could link mothers’ time at work with childhood obesity the researchers develop particular statistical models to examine specific variables and co-variables. The researchers use a US national dataset on young children in kindergarten. From the datasets information on children in 2004 and 2007 is used to explore links between the children's BMI measurements, diet, physical activity, sedentary behaviour and time for supervised and unsupervised play/activity. The mother's health and ability, income, the hours worked, and the time spent parenting are incorporated into the statistical modelling. Information on parents’ education and income is calculated into two categories of high and low socio economic status (SES). The researchers support the focus on mothers noting how other research continues to indicate mothers as the primary care giver irrespective of the hours spent in paid employment. Correspondingly, there is scant evidence to suggest changes in the working patterns or parental responsibilities of fathers.

From the statistical modelling the researchers conclude that increased number of paid work hours for mothers links directly with an increase in their children's unhealthy diets and incidences of obesity. The statistical modelling demonstrates how multiple mechanisms are involved here and the causality of time constraints is not as clear-cut as previously thought. Time constraints when managing children's diets can limit time for food preparation, involve increased use of ready meals, fewer family meals, more unsupervised snacking or increased sedentary activities. While these mechanisms were found in both higher and lower socio economic families a higher income could result in more paid for organised sport activities. A potential benefit diluted at times by increased time spent in sedentary activities. The research concludes that the complexity of the mechanisms that link childhood obesity with mothers paid work requires flexible policies that redress work-family balance across all socio economic groups.

Finally, I find myself unable to leave this space without highlighting SSM’s 'Introduction to the special issue on structural stigma and health' (Hatzenbuehler & Link 2014). My selection of these 'early' online articles reminds me of the medical sociology legacy I have benefitted from. The renewed academic attention to the concept of structural stigma in this special issue reinforces the importance and relevance of key sociological concepts in contemporary health. Structural stigma is defined as "societal level conditions, cultural norms, and institutional policies that constrain the opportunities, resources and well-being of the stigmatised" (Hatzenbuehler & Link 2014:p2). The introduction to this special issue discusses how the collection of papers applies this working definition across varying methodological approaches, contexts and health issues. I am captured by the authors' excitement to see how structural stigma will influence our explanations and interventions of health inequalities for the future.
REFERENCES

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