

Volume 2

Issue 1

June 2007

MSo

Medical  
Sociology  
online

**Liverpool University Editorial Team:** Helen Bromley, Sara Edwards, Paul Harrison, Julia Hiscock, Suzanne Hodge, Paula Hodgson, Mona Killey, Jude Robinson, Clare Thetford

***Medical Sociology online***  
University of Liverpool

[MSo@liv.ac.uk](mailto:MSo@liv.ac.uk)

<http://www.medicalsociologyonline.org/>



A free access publication of the British Sociological Association

## Editorial Board

Helen Bromley, *University of Liverpool, UK*  
Sara Edwards, *University of Liverpool, UK*  
Paul Harrison, *Web Editor*  
Julia Hiscock, *University of Manchester, UK*  
Suzanne Hodge, *University of Liverpool, UK*  
Paula Hodgson, *University of Liverpool, UK*  
Mona Killey, *University of Liverpool, UK*  
Jude Robinson, *University of Liverpool, UK*  
Clare Thetford, *University of Liverpool, UK*

## Aims and scope

The objective of *Medical Sociology online* is to publish high quality articles in the broad area of medical sociology based on original research using qualitative and quantitative methods. As a publication of the BSA Medical Sociology Group, MSo has a special interest in promoting the work of all sections of the academic community, including postgraduates and first time authors as well as people who have achieved eminence in their field. MSo encourages and welcomes the submission of articles or commentary pieces on research methodology, ethical issues in research, and the teaching and learning of medical sociology.'

*Medical Sociology online* is supported by the British Sociological Association (BSA), and the BSA Medical Sociology Group (MSG),

### *The British Sociological Association (BSA)*

The British Sociological association is the professional organisation representing sociologists in Britain. Our aim is to represent the intellectual and sociological interests of our members. Our members are drawn from a wide range of backgrounds – research, teaching, students and practitioners in a variety of fields. The BSA provide a network of communication to all who are concerned with the promotion and use of sociology and sociological research.

For more information, or to become a member of the BSA, please visit [www.britsoc.co.uk](http://www.britsoc.co.uk)

The British Sociological Association was founded in 1951 and is a registered charitable company (charity no: 1080235).

### *The BSA Medical Sociology Group*

The BSA Medical Sociology Group exists to promote scholarship and communication in the field of the sociology of health and illness in the United Kingdom. The group is one of the largest and most active study groups of the British Sociological Association. Membership of the BSA brings benefits in terms of reduced conference fees and journal subscriptions, but most Medical Sociology group activities are open to non-members.

The convenors of the Medical Sociology Group are Gillian Bendelow and Nina Hallowell.  
E-mail: [medsoc.convenor@britsoc.org.uk](mailto:medsoc.convenor@britsoc.org.uk)

For more information about BSA Medical Sociology Group, please visit [www.britsoc.co.uk/specialisms/52.htm](http://www.britsoc.co.uk/specialisms/52.htm)

# Contents

<b>Editorial Forward</b>	<b>1</b>
Introducing the <i>MSo</i> Editorial Team	
<b>Articles</b>	
<b>Narratives of Pregnancy Loss: the role of self-help groups in supporting parents</b>	<b>3</b>
Bernadette Susan McCreight	
<b>Commentary</b>	
<b>Carework: Brief Notes on Enduring and Emerging Issues for Medical Sociology/Sociology of Health and Illness</b>	<b>17</b>
Virginia Olesen	
<b>Opinion Piece</b>	
<b>Getting Acquainted with Acquaintanceship</b>	<b>21</b>
<i>David Morgan</i>	
<b>Acquaintances, friends and strangers – do they matter to medical sociology?</b>	<b>23</b>
A response to David Morgan Julia Hiscock	
<b>Book Reviews</b>	
Oshinsky, David M. <b>Polio: an American story.</b>	<b>26</b>
Reviewed by Ruth Bridgens	
John Heritage and Douglas W. Maynard (Editors) <b>Communication in Medical Care: Interaction between primary care physicians and patients</b>	<b>28</b>
<i>Reviewed by Sara Edwards</i>	
Beth Alder, Michael Porter, Charles Abraham, and Edwin van Teijlingen (Editors) <b>Psychology and Sociology applied to Medicine (Second edition)</b>	<b>30</b>
<i>Reviewed by Stephen Brindle</i>	
Gill Hek and Pam Moule <b>Making Sense of Research: An Introduction for Health and Social Care Practitioners</b>	<b>31</b>
Reviewed by Charlotte Pearson	
Alexander Rodlach <b>Witches, Westerners, and HIV (AIDS &amp; Cultures of Blame in Africa)</b>	<b>33</b>
Reviewed by Anne-Marie Martindale	

Samantha King <b><i>Pink Ribbons, Inc.: Breast Cancer and the Politics of Philanthropy.</i></b> Reviewed by Karen Kaiser	<b>35</b>
<b>Submitting Books for Review</b>	<b>36</b>
<b>Books available for review</b>	<b>36</b>
<b>The Sociology of Health and Illness Book of the Year Prize 2007</b>	<b>38</b>
<b>Living with the Genome</b>	<b>39</b>
 <b>Current research, postgraduate abstracts and recently awarded grants</b>	
<b>Research project title:</b> ICT, The Digital Divide and Habitus in the Self-Management-Management of Heart Conditions	<b>40</b>
<b>Research project title:</b> A Mixed-Method Test of the Validity and Transportability of Information-Motivation-Behavioural Skills (IMB) Model Constructs to Understand and Predict HIV/AIDS-Related Sexual Behaviour among Youth in a South African Township	<b>42</b>
<b>Research project title:</b> Growing up with Congenital Heart Disease: A qualitative study of the experience of young people aged 13-19.	<b>43</b>
<b>Research project title:</b> 'Neuroscience, clinical practice, and the (re)construction of personality disorder.	<b>45</b>
<b>Research project title:</b> The changing needs of people with sight loss	<b>47</b>
 <b>Congratulations!</b>	
<b>Ruth Bridgens, Cardiff University</b>	<b>49</b>
<b>Lindsey Dawson, University of Liverpool</b>	<b>51</b>
<b>Lydia Lewis, University of Aberdeen</b>	<b>52</b>
<b>Marisa G Lincoln, City University, London</b>	<b>54</b>
<b>Sachlav Stoler-Liss, Ben Gurion University of the Negev, Israel</b>	<b>56</b>
<b>Anne Townsend, University of Glasgow</b>	<b>58</b>

**Conference Reports and Reviews**

**Review of ESRC Seminar - The Narrative Turn: Revisioning Theory.** 60

Mona Killey and Clare Thetford

**Seminar Series on Mental Health: Halfway Report** 62

John Aggergaard Larsen

**A Day in the Life of...**

**Penny Sargent – PhD Student** 64

**Obituaries**

**David Kelleher** 65

**Perer Marris** 66

**Call for Papers** 68

**MSo Call for Papers** 70

## **Editorial Foreword**

### **University of Liverpool Editorial Team**

We would like to welcome all readers to this second edition of *Medical Sociology online*. Thank you to all of the people who have contacted us to wish us well with the new online format, and to say that they have found the articles stimulating and enjoyable. We hope that we have managed to carry former readers of *Medical Sociology News (MSN)* with us, as well as attract a new readership through this open-access electronic format. We are still developing our website and the 'look' as well as the content of *MSo*, and welcome your comments on what we have managed to achieve so far, as well as those which highlight areas where there is room for improvement.

We have extended the deadline for the autumn issue of *MSo* to enable us to accommodate any late submissions after presentations at the British Sociology Association Medical Sociology Group annual conference in September. The deadlines for submission of articles intended for peer-review are:

**Autumn 2007: 28<sup>th</sup> September 2007 (Published November 2007)**

**Spring 2008: 28<sup>th</sup> March 2008 (Published June 2008)**

Details of how to submit your paper can be found at:

<http://www.medicalsociologyonline.org/submissions.html>

As one of the stated aims of *MSo* is to publish the work of both emerging and established authors, we are pleased to present an article by an emerging author, Bernadette McCreight, entitled 'Narratives of Pregnancy Loss: the role of self-help groups in supporting parents'. This paper highlights the importance of shared experience and mutual support in helping both women and men affected by pregnancy loss come to terms with an experience that can otherwise leave them feeling socially isolated and unable to come to terms with what has happened to them.

We also have a commentary piece from the eminent medical sociologist and feminist scholar Virginia Olesen, discussing how we conceptualise and research the role of carers, entitled 'Carework: Brief Notes On Enduring and Emerging Issues for Medical Sociology/Sociology of Health and Illness'. The unveiling of the hidden work involved in caregiving emerged from the predominantly feminist literature in the UK and the USA, and explored the formal/paid and informal/unpaid dichotomy. The commentary raises important theoretical questions for the disciplines of medical sociology, sociology of health and illness, and indeed anthropology, including issues around conceptualisations about health, illness, and care work itself. In addition, the emergence of globalisation has, and will continue to have an impact upon the demographics of who is cared for and who performs the care giving, which is commented upon.

In the last edition we introduced the 'Opinion Piece', where we invite a leading academic to write a thought provoking piece on an issue relevant to the sociological study of health and illness. For this edition, David Morgan shares his reflections on the nature of the relationships with people we hardly know, but who may enter our thoughts and lives in particular ways, in a piece entitled 'Getting Acquainted with Acquaintanceship'. In her response to this piece, 'Acquaintances, friends and strangers – do they matter to medical sociology?', Julia Hiscock relates David's work to the arena of medical sociology. Julia

argues for a broadening of the boundaries of medical sociology to include the influence our social worlds can have on our health. It proposes a range of ways in which our interactions with others impact on our health.

The Book Review section continues to flourish and this edition of MSo contains reviews of six very different titles, reviewed by readers in the UK and North America. This section also contains an updated list of books available for readers to review, including the keenly awaited and recently published title 'Fracture: adventures of a broken body' by Ann Oakley. MSo readers are encouraged to get in touch if they are interested in obtaining one of the books listed for review.

The Book Review section also contains a feature on the books selected for the shortlist of the Sociology of Health and Illness (SHI) Annual Book Prize. The winner of this award will be announced at this year's BSA Medical Sociology Group Conference, to be held Thursday 6th – 8<sup>th</sup> September, 2007, in Liverpool, UK, and details will follow in the winter edition of MSo.

The Postgraduate Study and Awards section and the Congratulations! section have been reformed as 'Postgraduate Congratulations', where postgraduates can share their good news and achievements. We also plan to introduce a Current Research section in future issues where researchers can share details of current research being undertaken. We welcome submissions for this section from all members of the medical sociology community.

We also have reflections from attendees at two recent seminars - one on the use of narrative in research and the other on mental health. We welcome brief, insightful commentaries on conferences and seminars, and if anyone who is attending the Medical Sociology Group conference in Liverpool this year would like to write a review, please do get in touch. The final feature is 'A day in the life of...', and is something we have revived from former issues of MSN. This time a postgraduate student at University College London, Penny Sargent, shares a typical day with us.

Thank you for taking the time to read this latest edition of MSo, and we hope that MSo will continue to provide a platform for debate and discussion amongst the medical sociology community world wide. In addition, we look forward to welcoming many of you to Liverpool in September for the 39<sup>th</sup> annual BSA Medical Sociology Group Conference.

# Narratives of Pregnancy Loss: the role of self-help groups in supporting parents

**Bernadette Susan McCreight**

*University of Ulster*

Email: [bs.mccreight@ulster.ac.uk](mailto:bs.mccreight@ulster.ac.uk)

## **ABSTRACT**

This paper presents findings from research carried out in Northern Ireland on the experiences of parents who have lost a baby through stillbirth or miscarriage. The research was based on interviews and group observations with men and women who were members of pregnancy loss self-help groups. The paper will draw on an interpretative perspective based on Habermas's (1987) theory of communicative action to explore the ways in which membership of self-help groups enabled parents to cope with the pain of personal grief after a pregnancy loss. It was found that self-help groups provided a supportive communicative forum in which grieving parents could share their own stories and find support within a community of peers. These findings have clear implications for those working with and through self-help groups, and who are concerned to ensure the efficacy of the limited resources available for this kind of support.

## **KEYWORDS**

Narrative / Pregnancy loss / Self-help Groups / Life-worlds

## **Introduction**

This paper explores how engagement with shared narratives among self-help group members can support parents coping with the experience of a pregnancy loss<sup>1</sup>. Parents who lose a baby through pregnancy loss often feel socially isolated. Riches and Dawson (2000) acknowledge that in modern societies there has been a decline in traditional family and community support networks. Parents, therefore, increasingly have to find their own resources for coming to terms with their loss. This paper examines ways in which self-help groups can facilitate

---

<sup>1</sup> An earlier version of this paper was presented to the First Candles/SIDS International Stillbirth Conference, Washington DC, 2005.

opportunities for parents to articulate their experiences of loss in the presence of other supportive and empathetic parents. Consideration is also given to the role of narrative within the research context generally. The accounts of grieving parents who took part in this study were explored within an analytical framework derived from Habermas's (1987) theory of communicative action, in which communicative action occurs when 'interaction is mediated through talk and is oriented to agreement' (Greenhalgh et al., 2006). For Habermas, in communicative action individuals share experience of events that 'make sense' primarily in the context of their own life-world. These sharing practices not only enhance mutual understanding among parent members trying to carry out routine tasks, but also contribute positively to the self-understanding process.

Self-help groups related to medicine have been increasing in number in England, continental Europe and the USA (Kelleher, 1994). These groups generally share a belief that experiential knowledge assists individuals exposed to expert knowledge implicit in medical expertise to achieve a sense of well-being and personal empowerment. There are considerable variations among roles and ideologies adopted in self-help groups. Some groups can be categorised as instances of 'new social movements'<sup>2</sup>, organised around health-related issues and providing individuals with coping skills and new knowledge that helps them recover well-being. Habermas (1987) attributed the rise of these social movements to the dominance of expert systems in advanced capitalist societies, whereby, for example, medical knowledge and practices become hegemonic and threaten the symbolic and subjective dimensions of social life. New social movements which have made significant contributions related to health are examined in Scambler's (1987) study of women's experience of childbirth, where he argues that medicine, based in science and technology, has come to overpower the lay knowledge of women. Rogers and Pilgrim's (2001) study of mental health user groups shows how they grew out of members' need to represent their individual voice and experience of living with a mental illness. A common feature of these movements is the opportunity afforded to individuals to pursue their aspiration to identify with others and share similar experiences and understandings.

Brown et al., (2004) studied social movements organised around access to health care services. They cite the work of the 'Environmental Breast Cancer Movement' to illustrate how such groups challenge existing medical/scientific knowledge and practice. These movements frequently involve activists collaborating with scientists and health professionals to obtain treatment, prevention, research and funding. Novas (2006) refers to this type of group as 'patients' organisations', 'key sites where practices of identity formation and socio-political activism intersect' (289). He shows how such a social group, made up of patients, their families, and carers, as well as the association that represents them, works to realise the potential of new genetics to enhance human health. Novas concludes that 'hopes for cures or treatments that are expressed and acted upon by participants in patients' organisations have distinctly biopolitical dimensions in the sense that, through working alongside scientists, health professionals and political authorities, they attempt to shape the future health and well

---

<sup>2</sup> A broader picture of the growth of new social movements in health is given in a special issue of *Sociology of Health and Illness* (2004) Vol. 26. No. 6.

being of specific populations' (ibid: 302). Although the ideologies of these groups differ in terms of their goals and organisation, group members have common goals, namely to seek recognition of the validity of lay knowledge and experience, to engage actively in the production of scientific knowledge of their condition for the benefit of individual group members and to help one another.

In her study of pregnancy loss support groups in the United States, Layne (2006) suggests that although infant loss support groups share a number of characteristics with other new social movements, they are unique in a number of ways. While some social movements engage in transforming personal experiences of illness through working alongside the scientific community, health professionals and public authorities, members of pregnancy loss self-help groups engage more particularly with making sense of what has happened to them in order to construct a richer understanding of events and gain support from their community of peers.

The parents in this study were concerned above all to explicate the origins of their grief and give voice to their concern that the full impact of pregnancy loss should be recognised. A contested issue for parents was not rejection of rationality as such, but rather a wish to challenge the pervasive, normative conception of rationality underpinning scientific knowledge, and allow expression of plural accounts grounded in heterodox rationalities drawn from groups that have shared particular experiences and understandings. This paper aims to demonstrate that pregnancy loss self-help groups allow grieving parents to construct modes of communicating suited to their needs, and provide an opportunity to engage with a community in which narrative accounts are shared and so become a resource for comparison, re-interpretation and mutual understanding.

## Method

The research was a qualitative study exploring experiences of miscarriage and stillbirth among parents who attended pregnancy loss self-help groups. Six self-help groups convening monthly throughout Northern Ireland were observed over a period of three years. Permission to attend meetings was granted by group members and facilitators. The groups included the Stillbirth and Neonatal Death Society (SANDS) (four groups), Remember Our Child (ROC) (one group), and Miscarriage Support Group (MSG) (one group). Data gathered from observations of group meetings in the form of field notes provided a framework for highlighting important issues during subsequent interviews. Semi-structured tape-recorded interviews were carried out with men and women who attended the self-help groups and who volunteered to take part in the study. Pseudonyms were used to protect the identities of the parents. The tapes were transcribed verbatim. Ethical approval for the study was obtained from the Research Ethics Committee, University of Ulster, Northern Ireland.

## Research participants

Twenty-three women and fourteen men took part in the study. Eight women had experienced a stillbirth; seven had experienced a miscarriage; six had experienced both stillbirth and miscarriage; one woman in the study had experienced twin stillbirths, and one woman had experienced a miscarriage, as well as twin stillbirths. Two women had no living children. Three men had experienced loss from a miscarriage, six from a stillbirth, and five had experienced loss from both miscarriage and stillbirth. The age of the participants ranged from nineteen to sixty. At the initial interviews the period elapsed since the pregnancy loss ranged

from two months to thirty-four years. The members of the self-help groups are not taken to be representative of the majority of persons who have experienced pregnancy loss, but represent those who have decided to seek a new form of interpersonal communication sufficiently robust to tolerate difference, and sufficiently open to permit non-judgmental sharing of experience.

### Data analysis

Interviews were transcribed and analysed with the assistance of the QSR NUD\*IST Vivo computer software package, predicated on themes drawn from observations carried out during self-help group meetings and individual interviews. The analysis was structured around common features of experience and grief recurring within several accounts. The initial question was designed to elicit a description of their experience; in practice responses extended to lengthy narratives. An area of concern articulated by parents was feelings of powerlessness due to inadequate communication between parents and medical personnel during clinical encounters. The importance of finding support through a self-help group was expressed by parents as paramount in helping them to come to terms with their experience and more clearly understand their profound loss of identity. Themes such as 'power and communication', 'the role of self-help groups in supporting bereaved parents' and 'self-identity' were then considered and interpreted with reference to Habermas's theory of communicative action.

### Narrative within a research context

Narrative is a means of establishing what has been experienced, as feeling, event, pleasure or pain, in a stable and communicable form, enabling it to be communicated to others with shared interests with whom a relationship of some kind is sought or enjoyed. Some narrative functions are particularly relevant to social research. Polkinghorne's (1995) review essay categorises the subject matter of narrative, or stories, as human action, existing in time and accorded meaning by the thoughts and intentions of the human agent. His discussion of narrative analysis demonstrates how key paradigmatic and heuristic features of the use of narrative analysis for research purposes can be explicitly and systematically applied by a researcher. Yet his distinction between 'fictional' narratives, and 'ideal', or biographically recounted life events, is misleading in at least two respects. Such a polarisation between fictional and biographical representation implies that the work of imagination and memory occupy and refer to distinctly separate spheres, or domains, of experience. Secondly, an ontological gulf is posited between the 'idealised' domain of narrative, and the 'real' domain of historical or biographical events, which could undermine a methodological basis for interpretive claims constructed on the evidence of personal accounts. Ricoeur (1984) avoids such a polarisation by locating the unity of experience and account in the person and persona, or role, of the actor/narrator. Such a unity is made possible by narrative's structural foundation in plot. As Bruner (1990) points out, 'people do not deal with the world event by event, or with text written sentence by sentence, they frame events and sentences in larger structures'.

Ricoeur's (1984) treatment of narrative unifies the domains of event and language act by employing the concept of discourse. Discourse is to be understood as arising from its dialectical relation to the social world. In other words, its existence is posited by, or dependent upon, its antithesis, the larger structure. As Ricoeur formulates the relation: 'In

order to introduce the dialectic of event and meaning, I propose to say that, if all discourse is realised as event, all discourse is understood as imbued with meaning. What we wish to understand is not the fleeting event, but rather the meaning which endures' (ibid: 134). This meaning is embodied in narrative as a figuration, or giving of a formal shape to personal experience.

A narrative approach to the interviews was adopted in this study enabling parents to become authors of their own stories. It was crucial to acknowledge these narratives not as mere chronologies, but as a form of storytelling where the format provided the structure for interpretation and offered opportunities for constructing meanings unconstrained by familial or professional strictures. Preliminary observation sessions involving members of the self-help groups made it apparent that the purpose of the storytelling was to conduct an analysis of events which highlighted the grief of parents and the ways in which this grief was, or was not, dealt with.

### **Power and communication**

Narrative has been characterised as an alternative mode of knowing used here to capture parents' personal experiences of loss. By contrast, medical expertise derives its power and legitimacy from roots in universal systems of formal knowledge (Scambler, 1987). Habermas (1987), distinguishing between expert systems and the individual life-world, argues that the development of expert systems such as medical knowledge and practices has given them a dominance that now threatens the symbolic and subjective dimensions of social life. Medicine, like other expert systems in the contemporary world, is steered by the mediation of power and money (Kelleher, 1994) and concentrates resources on the growth of scientific knowledge and its application through advanced technology.

It has been argued (Scambler, 1987) that medicine's attempts at system rationalisation have led to the colonisation of the individual life-world. The colonising relationship is marked by the tendency of more powerful professional groups to support the coercive imposition of meanings on clients or patients. Habermas's (1981) insistence on the rationality of what may be termed community life-worlds among the less powerful, such as participants in self-help groups, offers a means of recognising the legitimacy of knowledge and practices developed through group activities. In so doing, Habermas offers a justification for the growth of centres of resistance to enable relatively disempowered groups to find common ground on which to negotiate their own meanings and interpretations of their experiences. This perspective is endorsed by Giddens (1984) who problematises the dominance of inherited social structures in his treatment of agency, implying that groups need not deterministically accept privileged ideologies that protect and enhance the authority of elite knowledge.

From the mid 1990s there has been a growing body of literature on the place of illness narratives within medical sociology (see Frank, 2000; Radley, 1999). Most of the studies have centred on patients' coping strategies during physical and terminal illnesses. Narrative studies are not only confined to illness and disease, but have come to be used in a variety of different contexts. Examples may be found in Miller's (2000) study of women's narratives of childbirth experiences, and Rappaport's (2000) study of narratives among individuals with a history of mental illness. In their study of narrative accounts of limited English speakers during primary care consultations, Greenhalgh et al. (2006) found that unequal power relations and the institutional context constitute the major barriers to communicative action within the clinician/patient encounter. The authors note that the fundamental precondition for

communication is the positive interpersonal relationships between the different parties (1183). Toombs (1993) posits the view that patients and medical practitioners live in different 'life-worlds'. Though their structures of meaning and knowledge are different, each needs to hear the 'other's' stories in order to make sense of the patient's medical experiences. The language of consultants cannot easily be separated from the social practices within which their words are embedded. For communication to be possible between disempowered patients and powerful members of the medical profession, language needs to be adapted to create a framework of mutual and, for parents, supportive understanding between the two groups. Self-help groups facilitate this process of navigation and translation from a medical language framework to one capable of expressing real experiences within the griever's life-world.

### **The role of self-help groups in supporting bereaved parents**

This study found that parents within the self-help groups characteristically constructed experiences of birth, death, and bereavement through narratives. Parents shared knowledge, established identities, and suggested strategies of action by telling stories to each other. Within the self-help groups, parents created communities of peers linked by their collective experiences of loss and a wish to provide a safe context for expression of their grief. A number of studies (Brier, 2004; Trulsson & Rådestad, 2004; Säflund, et al., 2004) have shown that parents who experience a pregnancy loss need support at this difficult time. In their study of a pregnancy loss support group in the United States, Wilson and Soule (1981) found that group members regarded each other's support and caring as a lifeline. Aspects of group structure and relationships, as experienced within the self-help groups by parents in the present study, are explored in the next section.

#### **Roles, relationships and accessibility**

Each self-help group was an informal association among bereaved parents, dependent on voluntary association, and not subject to mandatory requirements of attendance or participation. Members of the self-help groups raised funds from voluntary donations, used to meet expenses such as pregnancy loss support packs for parents which they distributed to hospitals throughout Northern Ireland. In addition, the groups raised money to provide hospitals with small coffins, baby clothes, and photographic equipment so that parents may have a photograph of their baby. The group facilitators considered themselves 'befrienders' and not trained counsellors. Such a role characterisation reveals one of the operating principles adopted by the groups: to promote and sustain mutuality and equality within the groups.

Brown (1992) argues that when establishing a support group for pregnancy loss it is critical to have a dedicated and skilled organiser and facilitator, preferably a professional with experience of working with groups. In contrast, this study found that although some volunteer facilitators expressed feelings of 'burnout' as a result of pressures of full-time employment, family commitments and the intensity of fund-raising activity needed financially to sustain the group's activities, most parents willingly became involved with facilitation and fund-raising over an extended period. Moffitt (2005) outlines the advantages of what she terms a 'closed group' format of support, where the same group of bereaved parents meet once per week for six consecutive weeks, and engage in a structured programme of events for helping them through their grief. The present study, however, found that most parents remained in the groups long after their experience of pregnancy loss. A group such as the

closed format which Moffitt describes would, therefore, be inadequate for parents who find the impetus to join a group at different and later stages of grief. Parents who were members of the group for considerable periods of time related how telling their own stories in the presence of other newly bereaved parents alleviated their own sense of helplessness. In turn, newly bereaved parents related how they were given 'hope for the future' by listening to parents who had gone through similar experiences and had 'survived'.

In parallel with the findings of the present study, Wilson and Soule (1981) suggest that when parents turn to traditional sources of comfort, they are often distraught at the lack of understanding shown by others. Furthermore, the authors point out that 'as the group is composed of people who have had varying amounts of time since their actual experience of pregnancy loss, hope can be given by those who have travelled beyond the days of disorientation and now feel their lives are reorganised and reoriented' (ibid: 184). It is equally important that group meetings are transacted between equals who can develop mutual understanding of emotional and psychic needs, and ensure that a diversity of social perspectives (Vincent, 1992) on parents' experiences are established.

### Kinship sanctions

Parents told how family and friends often had difficulty understanding the prolonged duration of their grief. Misunderstood by close family and friends over an extended period, feelings of guilt among bereaved parents become intensified. Doka (1989) suggests that there is a prevalent view that grief should only be recognised within a context of kinship, and that it is appropriate to empathise within, but not without, a kinship group. Habermas (1987: 157) locates such instances in the life-worlds of traditional societies, where 'the system of kinship relations forms something like a total institution...the calculus of kinship relations also defines the boundary of the social unit'. Kinship relations are supported by the principle of 'amity', among members obligated towards mutually supportive communication within a kin system. The finding from this study, however, was that kinship relations did not sanction expression of grief and that traditional norms tended to proscribe discussion of loss. A component of the grief felt by parents was the lack of a socially approved mechanism for the expression and sharing of the grief within families and close kin. One parent, Patrick, who lost his baby through stillbirth, related how when he spoke to his mother about the loss of his baby, she told him that it was time to stop crying as he had cried long enough. Another parent, Connor, influenced by urgings from his extended family that he had to be strong for his partner, was unable to express his grief in crying after losing his first baby through stillbirth. The following narrative from Connor illustrates how he unexpectedly found support through a self-help group:

*I could have kicked everything around him (group facilitator), I could have wrecked the furniture, but he sat and listened. He didn't say 'you have to be strong', he just sat and listened. He listened to how angry I was, he watched me cry, and he didn't say I couldn't do that. It was unbelievable to feel that you can move on, and not blame yourself. (Connor; stillbirth).*

In forming self-help groups among themselves, parents were taking steps to establish a space for grieving outside the restrictions experienced as a result of kin-based prohibitions, and attempting to construct a life-world where empathy could be expressed among 'strangers', and grief recognised as a valid form of expression. The formation of these non-kin fora for shared narratives opened the way for formulating new ways of looking at situations that had given rise to grief, and a critique of the social circumstances in which grief had occurred. In the

course of time, this process led members to challenge some professional definitions and interpretations of their experiences.

### Guilt and depression

Brier (2004) notes that high levels of guilt following miscarriage often lead to depression which tends to be unresolved without professional help. But the role of psychiatrists was frequently criticised, especially by several women in this study who were prescribed anti-depressants following their loss. The women expressed concerns that their grief had been redefined as a mental illness, until they found help through a self-help group and realised that other women were experiencing the same emotions. The following narratives demonstrate how they experienced intensification of their grief owing to perceived shortcomings in psychiatric medical care:

*I had psychiatric help and was put on anti-depressants. But nothing helped. I didn't believe there was any way out of my depression until I discovered a Miscarriage Support Group and met women who had undergone similar experiences. (Elizabeth; 3 miscarriages).*

*He (psychiatrist) asked me all kinds of stupid questions like did I make cups of tea for people who were not actually there. I said, look, my baby died, and I am naturally upset, and he said 'I'll increase your Prozac'. I thought, hold on a minute. He thinks I'm mad. (Katherine; 1 stillbirth, 2 miscarriages).*

The women were regarded by consultants as psychiatric referrals, and their accounts reflect a wider tendency to label women in distress as suffering from depression and needing medication as a normal remedy. In these instances, women demonstrated resistance to the prescriptions of scientifically sanctioned medicine and refused to accept that their grief should be categorised as a mental disability. They were asking for their grief to be validated instead of objectified.

Several women were told by a hospital consultant that they had experienced a 'spontaneous abortion', or 'missed abortion', or that the remains of the baby were 'nothing but a product of conception'. One woman, Rachael, who suffered a miscarriage, described how she woke from an anaesthetic to be told she had experienced a spontaneous abortion. She stated: "I felt the doctor was implying that I had had an abortion and that I was to blame." Rachael added that this remark had intensified her feelings of depression. In these instances, application of formal knowledge, and its linguistic expression in medical language exemplify the exercise of power and inscribe doctors' domination on those who are presented as patients (Friedson, 1986). The discourse of medicine, embodied in the formal technical language used by medical consultants, has excluded parents from understanding their loss and aggravated their feelings of guilt and self-blame.

Some parents related how the self-help groups helped them come to terms with and obtain release from guilt. Natalie, who had experienced a stillbirth, stated:

*I had all these feelings inside me, and I was afraid to let them out because I didn't know what was going to happen. I felt like picking up the TV and throwing it through the window, just out of frustration. And the first meeting of SANDS somebody else said the same thing, and I thought thank goodness I am normal, I am not going mad. (Natalie; stillbirth).*

One man, Brian, who lost a baby through miscarriage, expressed his frustration at the lack of information provided by the hospital on pregnancy loss self-help groups:

*I was an emotional wreck basically, but I could have been a lot worse if I had not found the SANDS group. But the hospital didn't tell me about SANDS. I can't understand why they didn't tell me about it, especially when I asked them" (Brian; miscarriage).*

Many parents initially blamed themselves for their pregnancy loss. One woman, Deidre, who lost one baby through stillbirth, and another through miscarriage, continued to reflect self-incriminatingly on the possible causes of her losses:

*I would be asking myself, was it that glass of red wine I had, or was I going over that hump-back bridge too quickly? Stupid things really, but you have to analyse everything (Deidre; stillbirth and miscarriage).*

Another woman, Natalie, who lost her baby through stillbirth stated:

*I think a lot of my anger was due to guilt. I felt very guilty, I felt I should have known there was something wrong (Natalie; stillbirth).*

Previous research also confirms that pregnancy loss leads to high levels of guilt (Hutchon, 1998) and self blame (Stirtzinger et al., 1999). Within the self-help groups parents were able to express these feelings of guilt, and through a mutually constructed social process involving shared understanding of experience come to comprehend and come to terms with guilt arising from pregnancy loss. By recreating the reality of pregnancy loss, parents are able to validate each other's experiences and emotions and thereby mitigate the damaging effects of grief and self-blame.

### The ambiguities of self-identity

A parent's self-identity is often challenged when their baby dies. In articulating his own experience of miscarriage, Dubose (1997: 368) states how 'the experience is one in which something or someone has been suddenly ripped from one's life-world'. He notes that the immediate reaction often involves disintegration of the self-in-the-world that had been inhabited before the loss. This concurs with the findings of this study in which parents related how they experienced a profound loss of identity. One woman, confident, before the loss of her stillborn twins, of a clearly mapped out future with her partner, felt that bereavement had changed the meaning of their lives together:

*We were never again the carefree young couple looking forward to the rest of our lives, our lives all mapped out. A huge hole had been planted and life would never have the same meaning again. (Monica, twin stillbirths).*

Loss of identity and resignation is also expressed vividly by Marian, who lost her baby through miscarriage:

*I don't think I will ever be the same person again. I think you learn to live with it, you don't accept it, but you live with it. (Marian, miscarriage).*

Men in the study reported how they were unable to express and acknowledge their grief, or seek support within the extended family and wider community. Stinson et al., (1992) suggest that as a result of gender socialisation, men may see asking for help or admitting their need as inappropriate. The authors note how societal norms, expectations that men should be strong and in control, make it difficult for them to get support from others. One father, William,

who attended a SANDS group meeting initially to support his partner, also found help and support for himself within the group. He notes:

*The group facilitator asked me 'how have you been coping?' and the standard answer came 'I'm fine, I'm here for my wife, and she put her arm on mine and said 'how do you feel?' So I proceeded to tell the whole story and I broke down and cried and if someone had told me I could go into a room full of strangers and bare my soul and cry and not feel uncomfortable with it, I would have laughed at them, but I just told my story and I cried. (William; stillbirth).*

The men who attended the groups reported how the action of narrating their experience of pregnancy loss allowed them to express their emotions in a form in which their experience was understood and publicly valued, and where their male identity was not compromised. Seidler (1994) notes that it is when emotions are read as a sign of weakness that they compromise male identity. He suggests that although men have emotions and feelings of their own, they discount and devalue them as sources of knowledge and avoid expressing them. The self-help groups were a crucial resource for men, providing tacit support derived from shared 'intuitive standards' in a community setting. The groups offered a forum in which men could come to terms with problems experienced concerning their identities as fathers, and around the nature of their feelings, for which they had no explanations by which to understand their experiences of enduring grief. Some men, for example, questioned their identity as fathers, and felt uncertain as to their right to the status of 'father'. Men would only utilise this forum if they felt that there was adequate space and familiarity for them to express their grief in ways they considered appropriate. For men, the concept of a self-help group was not familiar, nor were they in tune with the discourses of pregnancy adopted by women in what is still considered a female domain. The views expressed by men revealed their inability to articulate grief within discursive rules established within familial communities and their reasons for seeking an alternative discursive setting. Designing cultures of communication that are habitable and usable should, therefore, be a priority in the development of self-help groups.

Layder (1996: 193) suggests that 'the life-world represents the patchwork which, through communicative action, draws together the different strands of social life, such as the assertion and maintenance of self-identity, the regulative effects of social norms and the stock of knowledge that informs shared understanding'. Pregnancy loss self-help groups can afford parents the opportunity to express concerns within a discourse and shared life-world through which they are able to assign meaning to loss and make sense of their experience. Knowledge gained in the context of a self-help group is assimilated and evaluated through narrative stories, instead of being reified and detached from those personal understandings by which self-identity is secured (Vincent, 1992). The groups allowed parents to collaborate in the construction of each other's interpretative frameworks, which took account of their need to interpret their experiences for themselves, rather than submit to the imposition of pre-conceived hospital categories.

## Discussion

One of the most important forms of social support for many parents who lose their babies is being allowed to grieve in an emotionally supportive environment (Rajan, 1994). The emergence of pregnancy loss self-help groups reflects growing resistance to professionally led definitions and constructions of parental experiences. In general, the groups are poorly resourced in terms of finance and support materials. Nevertheless, the groups appear to have

reached a stable stage of development where the commitment of members at least compensates for material and financial shortages. The groups, despite their poor resources and relative lack of expertise in areas such as publicity and organisation, have gained significant improvements in terms of changing policies and legal definitions of lived personhood<sup>3</sup>. These successes demonstrate that it is possible for groups of parents to offer resistance to established procedures for validating their loss. Indeed the term 'resistance' carries important resonances within the tasks set by the groups themselves.

Such resistance can be viewed both as revolt against the colonisation of parents' life-worlds by the medical profession and as an attempt by parents to provide a new vision for communities where loss has previously been accommodated by being marginalised. The dynamic element of the process by which parents have come to create understandings resides in the action taken by parents themselves to foster and participate in experiential learning with other individuals with whom they could freely articulate their experiences. Aggregations of individual experiences facilitated cross referencing and cross validation, so that parents could see their own experiences and associated feelings mirrored in the lives of others. They learned the difficulty of the task they had undertaken, as they formed relationships with strangers and worked collaboratively to construct sets of meanings that enabled them to make their grief visible and intelligible within new relational experiences. This new relationality supported parents in the face of the coercive rationalities imposed within the institutional regime, and provided an escape from the limitations upon personal disclosure enforced within close-knit community affiliations. Discursive experiences within the groups validated and reactivated the construction and articulation of new life-worlds formed around and in support of the needs of the parental community.

Parents also showed that they contested the categorisation of their grief as pathological, and the associated intensification of their grief through loss of autonomy. Their struggle is relevant to other areas of human sorrow, since, as the parents worked to gain control over their grief through creating their own meanings, they realised that they were constructing a possible alternative to subjection to psychiatric discourse in which they had been categorised as victims of unconscious feelings outside their control, or of biologically determined factors.

The success of the self-help groups raises questions concerning the rights of parents in grief, and the way in which support for such parents should be organised. If grief is perceived as an 'illness', the parent becomes a 'patient', and the articulation of experience is perceived as manifestation of a 'condition' rather than a marker of emerging recovery of autonomy. There is a case for suggesting that parents in grief should be approached as persons needing a forum for communication rather than a course of treatment. In order to achieve this understanding it is necessary first to recognise the status which parents wish to attach to the unborn baby, and to accept that socially derived perspectives and definitions of lived personhood are valid for

---

<sup>3</sup> From 1861 until 1992, a stillbirth was defined by law as a baby born after twenty eight weeks gestation; a baby born earlier than this was not given a formal burial. From the late 1980s SANDS lobbied Parliament to reduce this qualifying period, and in 1992 the Stillbirth (Definition) Act set the age of legal viability for a foetus at twenty four weeks. Parents were then able to register and bury their babies at this earlier stage (Green, J., and Green, M. 2006: 78-79).

those who express them.

## Conclusion

Pregnancy loss self-help groups in Northern Ireland support parents to acknowledge and work through their grief. Sharing of emotional and social support, providing adequate advice and information following loss, enable parents to engage together to enhance personal growth and self-identity. Observation within the groups revealed how parents coped with their experience of pregnancy loss by utilising stories they tell about it. Kelleher (1994) points out that self-help groups are a challenge to modern medicine because medicine has lost much of its emancipatory orientation and defines human suffering in a technical-instrumental language. The pregnancy loss self-help groups presented a challenge to such medical practices, resulting in improved local services for parents who have experienced pregnancy loss. Group members' use of narrative discourse revealed the benefits of being allowed to construct new forms and fora of communication. By reconstructing their experiences in their own words, before an audience of their own choosing, they were able to have their experiences validated. In addition, they portrayed their feelings as informative, valid sources of information rather than symptoms of a pathology requiring medication. It is clear that the groups have, in their local context at least, significantly influenced social and institutional practices. The study demonstrated that grieving persons benefit more from an environment of self-help and mutual support, than from medicalised care. Institutional definitions and procedures of care, especially in situations as fundamental as a baby's death, must build upon and be formed around the experiential knowledge of those who grieve such loss.

## Acknowledgements

I wish to express sincere and deep gratitude to the parents in the study for sharing their experiences with me.

## References

- Brier, N. (2004) Anxiety after Miscarriage: a review of the empirical literature and implications for practice. *Birth*, 31(2): 138-42.
- Brown, P., and Zavestoski, S. (2004) Social Movements in Health: an introduction. *Sociology of Health and Illness*, 26(6): 679-94.
- Brown, Y. (1992) The Crisis of Pregnancy Loss: a team approach to support. *Birth: issues in perinatal care and education*, 19(2): 82-9.
- Bruner, J.S. (1990) *Acts of Meaning*. Cambridge, MA: Harvard University Press.
- Doka, K.J. (1989) *Disenfranchised Grief: recognizing hidden sorrow*. Massachusetts: Lexington Books.
- Dubose, J.T. (1997) The Phenomenology of Bereavement, Grief, and Mourning. *Journal of Religion and Health*, 36(4): 367-74.
- Frank, A.W. (2000) The Standpoint of Storyteller. *Qualitative Health Research*, 10(3): 354-65.
- Friedson, E. (1986) *Professional Powers: a study of the institutionalization of formal knowledge*. Chicago: University of Chicago Press.

- Giddens, A. (1984) *The Constitution of Society: outline of the theory of structuration*. Cambridge: Polity Press.
- Green, J., and Green, M. (2006) *Dealing with Death: a handbook of practices, procedures and law*. (Second edition) London: Jessica Kingsley.
- Greenhalgh, T., Robb, N., and Scambler, G. (2006) Communicative and Strategic Action in Interpreted Consultations in Primary Health Care: a Habermasian perspective. *Social Science and Medicine*, 63(5):117-87
- Habermas, J. (1981) New Social Movements. *Telos*, 57: 194-205.
- Habermas, J. (1987) *The Theory of Communicative Action: the critique of functionalist reason*. Cambridge: Polity Press.
- Hutchon, D.J.R. (1998) Understanding Miscarriage or Insensitive Abortion: time for more defined terminology? *American Journal of Obstetrics and Gynaecology*, 179(2): 397-8.
- Kelleher, D. (1994) Self-help Groups and their Relationship to Medicine. In Gabe, J., Kelleher, D., and Williams, G. (eds) *Challenging Medicine*. London: Routledge.
- Layder, D. (1996) *Understanding Social Theory*. London: Sage Publications.
- Layne, L.L. (2006) Pregnancy and Infant Loss Support: a new, feminist, American, patient movement? *Social Science and Medicine*, 62(3): 602-13.
- Miller, T. (2000) Losing the plot: narrative construction and longitudinal childbirth research. *Qualitative Health Research*, 10(3): 309-23.
- Moffitt, Perry-Lynn. (2005) Pregnancy Loss Support Programme Employs Effective Group Format. First Candles/SIDS International Stillbirth Conference. Washington DC. (conference abstract) <http://www.firstcandle.org>.
- Novas, C. (2006) The Political Economy of Hope: patients' organisations, science and biovalue. *BioSocieties*, 1: 289-305.
- Polkinghorne, D.E. (1995) Narrative Configuration in Qualitative Analysis. In Hatch, J.A., and Wisniewski, R. (eds) *Life History and Narrative*. London: The Falmer Press.
- Radley, A. (1999) The Aesthetics of Illness: narrative, horror and the sublime. *Sociology of Health and Illness*, 21(6):778-96.
- Rajan, L. (1994) Social Isolation and Support in Pregnancy Loss. *Health Visitor*, 67(3): 97-101.
- Rappaport, J. (2000) Community Narratives: tales of terror and joy. *American Journal of Community Psychology*, 28(1): 1-16.
- Riches, G., and Dawson, P. (2000) *An Intimate Loneliness: supporting bereaved parents and siblings*. Buckingham: Open University Press.
- Ricoeur, P. (1984) *Time and Narrative*. Vol.1. Chicago: Chicago University Press.
- Rogers, A., and Pilgrim, D. (2001) *Mental Health Policy in Britain*. Basingstoke: Palgrave.
- Säflund, K., Sjögren, B., Wredling, R. (2004) The Role of Caregivers after a Stillbirth: views and experiences of parents. *Birth*, 31(2): 132-7.
- Scambler, G. (1987) Habermas and the Power of Medical Expertise. In Scambler, G. (ed) *Sociological Theory and Medical Sociology*. London: Tavistock.
- Seidler, V.J. (1994) *Unreasonable Men: masculinity and social theory*. London: Routledge.
- Stinson, K.M., Lasker, J.N., and Toedter, L.J. (1992) Parents' Grief Following Pregnancy Loss: a comparison of mothers and fathers. *Family Relations*, 41(2): 218-23.
- Stirtzinger, R.M., Robinson, G.E., Stewart, D.E., and Ralevski, E. (1999) Parameters of Grieving in Spontaneous Abortion. *International Journal of Psychiatry in Medicine*, 29(2): 235-9.
- Toombs, K.S. (1993) *The Meaning of Illness: a phenomenological account of the different perspectives of physician and patient*. Dordrecht, the Netherlands: Kluwer Academic.

- Trulsson, O., & Rådestad, I. (2004) The Silent Child: mothers' experiences before, during, and after stillbirth. *Birth*, 31(3):189-95.
- Vincent, J. (1992) Self-help Groups and Health Care in Contemporary Britain. In Saks, M. (ed) *Alternative Medicine in Britain*. Oxford: Clarendon Press.
- Wilson, A.L., and Soule, D.J. (1981) The Role of a Self-help Group in Working with Parents of a Stillborn Baby. *Death Education*, 5(2): 175-86.

Bernadette McCreight is a lecturer in the School of Sociology and Applied Social Studies at the University of Ulster

Address: Room 12L15, School of Sociology and Applied Social Studies, University of Ulster, Shore Road, Newtownabbey, County Antrim BT15 4DP, Northern Ireland  
Email: [bs.mccreight@ulster.ac.uk](mailto:bs.mccreight@ulster.ac.uk)  
Phone: 02890 366201

## Carework: Brief Notes on Enduring and Emerging Issues for Medical Sociology/Sociology of Health and Illness

**Virginia Olesen**

*University of California, San Francisco*

Email: [Virginia.olesen@ucsf.edu](mailto:Virginia.olesen@ucsf.edu)



### Preamble

By way of a personal introduction to this commentary piece I would like to thank the team at Medical Sociology online for inviting me to write for MSo, my first contribution to an online publication. I have participated over many years in BSA Med Soc meetings with many fond memories of beloved colleagues and founders who are no longer with us and the refreshing presence of stimulating contemporary colleagues. I have been an enthusiastic, envious MSN reader since Paul Atkinson's editorship, on through the Agony Aunt Marjorie columns and into the new cyber moment, enthusiastic because I have always found stimulating ideas and a treasure trove of information, envious because Yankee medical sociology/sociology of health and illness (hereafter MS/SHI) has had no such publication.

### Introduction

Of the numerous concepts which underpin, propel and challenge MS/SHI, care and caregiving cut across a wide range of critical issues. They move from intimate levels of interaction to state policy and programmatic agendas. They implicate crucial concerns about the intersectionality of race, class, gender, age, sexual orientation, disability. They invoke fundamental questions about moral issues in our fields. Whilst recognising currently critical questions in formal caregiving, this commentary focuses on informal or hidden caregiving, though recent scholarship usefully modifies the formal/informal categories, noting "women's multiple positions as care labourers within and across public and private domains" (Litt and Zimmerman, 2003: 159; Lan, 2003; Zimmerman, Litt and Bose, 2006a). My emphasis on informal caregiving here allows me to focus on what these issues mean for MS/SHI and for my own long standing concerns about the implications for stratification in health care systems (Olesen 1989).

Numerous social, health based and economic trends influence informal caregiving - aging populations, the burdens of chronic illnesses, shifts of care from institutions to the home, diminishing numbers of potential caregivers as women seek other work (Olesen, 1997: 404-406). These trends have been widely discussed in the caregiving literature, so will not be scrutinised here. Rather, I will briefly note processes of globalisation and informal caregiving

and try to suggest implications for MS/SHI.

## Brief History

Much of the history of MS/SHI can be read as a history of care/caregiving starting with the earliest work on doctor-patient relationships, health visitors, the “formal” caregivers. Absent from the early explorations, and for some decades, were informal or unaffiliated providers who, unrecognised in these analyses, were nevertheless, providing significant amounts of care, to the ill and the healthy. That care was both undervalued and devalued. Later scholars using large datasets estimated the 1997 value of informal caregiving in the US as \$196 billion, far larger than the value of formal home health care or nursing home care (Arnot, Levine and Memmott, 1999). Full credit for calling attention to these hidden providers in the early 1980s is due British feminist sociologists, Helen Evers, Hilary Graham, Meg Stacey, Claire Ungerson, Janet Finch and Dulcie Groves. Simultaneously, U.S. scholars, Emily Abel, Margaret Nelson, Berenice Fisher, Joan Tronto, Eva Kitay, were exploring similar questions. Since then, there has been an outpouring of feminist work on care from Francesca Cancian, Stacey Olker, Shirley Hill, Madonna Harrington Meyer, Jacquelyn Litt and Mary Zimmerman.

These were essentially US-UK focused, as were most later explorations, though that has changed significantly with recent work noted below in the section on Globalisation and Informal Care Work. Analyses of care in non-Anglophone societies, such as there were, were not easily accessible, perhaps because the dominant English language publications translated few articles and many Anglophone scholars do not read literature in other languages (Social Science and Medicine’s international and cross disciplinary orientation usefully countered and continues to counter this). Moreover, the anthropological literature, potentially quite valuable, was not seriously explored, a regrettable indication that scholars in medical sociology and medical anthropology were, and are, too often unaware of relevant work in one another’s field. For fuller details on this history, see Olesen, 1989: 5-6; Olesen, 1997: 398-406; Olesen, 2005: 219.

The growth of scholarly interest in care, caregiving and care work has been substantial. News of regional conferences in Britain as well as American feminist sociologists’ Carework Network conferences on care work<sup>1</sup>, suggest growing numbers of interested scholars. Since 1997 there have been 15,582 entries on care, etc. in *Sociological Abstracts*. Between January and March, 2007, there were 155. It is not easy to know precisely how many articles appeared on what type of caregiving. An informal guess, based on quick survey of most recent years suggests that work on informal caregiving has become increasingly prominent. Important explorations continue in the realm of formal caregiving, as an excellent bibliography compiled by Tamara Smith of Albany University shows (tsmith@albany.edu).

Though care and caregiving remain widely used terms, increasingly, perhaps since the mid 1990’s, scholars foreground the concept of “carework” to include both formal/paid and

---

<sup>1</sup> the 5<sup>th</sup> forthcoming at ASA in New York, August 2007, <http://www.carework-network.org>

informal/hidden/unpaid care. Particularly with regard to informal or hidden caregiving, this conceptualisation takes care as a topic in the analysis of work, hence realising opportunities to understand the complexities and opening new spaces for inquiry. It sidesteps the problem of essentialism found in some care literature (Olesen, 1997: 398), and makes possible social, economic, emotional and cultural analyses of informal care (Zimmerman, Litt and Bose, 2006b: 4).

### **Globalisation and Informal/Hidden Carework: Implications for MS/SHI**

One of the human faces of globalisation is that of the careworker drawn from impoverished settings to international contexts where a better life seems possible for her/him and those at home who receive their remittances. These remittances constitute a crucial resource for their home state as, for instance, the significant migration of Filipina nurses and domestics (Parrenas, 2000; Gueverra, 2003). Zimmerman, Litt and Bose conceptualise some of the consequences of this movement as “crises of care” (2006c: 10). This refers to multiple issues, among which are: what happens to the elderly, chronically ill, or children for whom the carers had cared, and who are left behind in the “care” of others? What care work, formal or informal, does or does not come into play?

It also speaks to the too frequent vexing and painful situations the migrating caregivers themselves experience, such as sexual, economic and social abuse, and poses the question of who cares for these care workers?

It raises questions about how informal care workers are helped to deal with the biotechnical complexities of contemporary western medical practices when these are transferred from medical settings to the home (Kaye and Riessman, 1991).

It should refer, but does not, to the fact that informal care work, as so insightfully conceptualised by Hilary Graham (1985) is also productive work in that it produces conceptualisations of health, illness and how to be ill etc. The migrating careworker doing informal care work helps create those conceptualisations.

It asks for renewed attention to the gender, racial and ethnic characteristics of informal careworkers whose labour frequently sustains the more privileged classes.

These issues, all of interest to MS/SHI, also invoke questions about the organisation and stratification of health care systems in all societies on which globalisation impacts. In aging western societies informal health care work may become ever more dependent on globalisation’s migratory processes. This has major implications for structures of care, regulation, and at the most basic level, humane care for the suffering. In “donor” societies from which careworkers migrate, informal health care work may alter in ways which also shape the structures and possibilities of humane care for the suffering. As Zimmerman, Litt and Bose so forcefully and elegantly argue (2006), issues of informal care work are not tied only to one society, but reflect multiple dimensions in numerous societies linked by globalisation’s vectors.

This challenges MS/SHI to explore new ways to understand the complexities posed by informal care work with the same vigour applied to inquiries about formal care-giving. Recruitment of informal workers, their status and performance, their impact on definitions of health and illness, their well being, their place in and contribution to health care systems are familiar questions with new meanings and implications for a greater understanding of the care of the well and the suffering.

## References

- Arnot, P. S., Levine, C. and Memmott, M. M. (1999). The economic value of informal caregiving. *Health Affairs (Millwood)*, 18(2):182-8.
- Graham, H. (1985). Providers, negotiators and mediators: women as the hidden carers. In Lewin, E. and Olesen, V., *Women, Health and Healing: Toward a New Perspective*. London: Tavistock-Methuen.
- Gueverra, A. (2003) *Manufacturing Bodies for Sale; The Biopolitics of Labor Export in the Philippines*. Unpublished doctoral dissertation, Department of Social and Behavioral Sciences, University of California at San Francisco.
- Kaye, L. W. and Riessman, S. I. (1991). Life prolongation technologies in home care for the frail elderly: issues in training, policy and research. *Journal of Gerontological Social Work*. 16(1): 79-91.
- Lan, P-C. (2003). Maid or Madam? Filipina migrant workers and the continuity of domestic labor. *Gender and Society*, 17(2): 187-208.
- Litt, J.S. and Zimmerman, M. K. (2003). Guest editors' introduction: Global Perspectives on gender and casework: an introduction. *Gender and Society*, 17(2): 156-165.
- Olesen, V. L. (1989). Caregiving, Ethical and Informal: Emerging Challenges in the Sociology of Health and Illness. *Journal of Health and Social Behavior*, 30(1): 1-10.
- Olesen, V. L. (1997). Who cares? Women as informal and formal caregivers. In Ruzek, S. B., Olesen, V. L. and Clarke, A.E.(Eds.), *Women's Health, Complexities and Differences*. Columbus, OH: Ohio State University Press.
- Olesen, V. L. (2005). Early millennial qualitative feminist research: challenges and contours. In Denzin, N. K. and Lincoln, Y.S.(Eds.) *The Sage Handbook of Qualitative Research, 3<sup>rd</sup> Edition*. Thousand Oaks, CA: Sage.
- Parrenas, R. (2000) Migrant Filipina domestic workers and the international division of reproductive labor. *Gender and Society*, 14: 560-581.
- Zimmerman, M. K., Litt, J.S. and Bose. C.E. (Eds.) (2006a). *Global Dimensions Of Gender and Carework*. Stanford, Ca: Stanford University Press.
- Zimmerman, M. K., Litt, J.S. and Bose, C. E. (2006b). Introduction. In Zimmerman, M. K., Litt, J.S. and Bose, C. E. (Eds.), *Global Dimensions of Gender and Carework*. Stanford, Ca: Stanford University Press.
- Zimmerman, M. K., Litt, J.S. and Bose, C. E. (2006c). Globalization and multiple crises of care. In Zimmerman, M.K., Litt, J.S. and Bose, C. E. (Eds.) *Global Dimensions of Gender and Carework*. Stanford, Ca: Stanford University Press.

Virginia Olesen is Professor of Sociology (Emerita) at the University of California, San Francisco.

Email: [Virginia.olesen@ucsf.edu](mailto:Virginia.olesen@ucsf.edu)

## Getting Acquainted with Acquaintanceship

David Morgan

Keele University

Email: [d.h.j.morgan@ext.keele.ac.uk](mailto:d.h.j.morgan@ext.keele.ac.uk)



He was bald, smartly if conservatively dressed and aged around sixty. He always seemed to be reading *The Daily Telegraph* and, although this may be a false memory, he seemed to be concentrating on the racing pages. He occupied the same seat in the station buffet, almost every morning. He paid no interest to the arrival or the departure of trains. He occasionally exchanged a few words with one or two other people. And then, one day, he was no longer there. Or possibly it was me who no longer made this regular journey, stopping briefly in the buffet when I arrived too early or if the train were late.

It was incidents like this that stimulated my developing interest in acquaintanceship, which I am currently developing as a book to be published by the Open University Press. The man in the buffet was clearly not an intimate such as a friend. But, over the weeks or months, he was also more than a stranger. I developed some (real or imagined) knowledge about him, at least enough to make up stories about him and why he was in the buffet at this time in the morning. He could be seen as a passing acquaintance. Other acquaintances, such as taxi drivers or shop assistants, are more fleeting. Yet others, such as neighbours or workmates, emerge as more fully rounded individuals yet these too are rarely intimates. We might even speak of celebrities or fictional characters as acquaintances.

What has this to do with the Sociology of Health and Illness? First, in common with many areas of modern social life, everyday contact with health agencies and professionals involves waiting. (The theme of “waiting” itself deserves more detailed sociological attention). In the waiting rooms – as in my station buffet – we encounter others who become more than strangers but who are rarely intimates. Further, the professionals we deal with frequently have detailed, intimate and embodied knowledge of us although they, themselves, are not intimates. The others that we encounter through our regular or irregular passages through the health service form part of that complex, loose set of acquaintances.

I feel that acquaintanceship has been a neglected area of social enquiry, overshadowed by both the apparent stress on intimacy in late modernity and the allure and threat of strangers in our urbanised environments. At the very least, acquaintances may provide us with fleeting insights into worlds other than our own. But, more profoundly, they may also be seen as part

of the wider patterns of connectedness that makes social life possible.

David Morgan is Emeritus Professor in Sociology at the University of Manchester and Visiting Professor at Keele University.

Correspondence to: [d.h.j.morgan@ext.keele.ac.uk](mailto:d.h.j.morgan@ext.keele.ac.uk)

## Acquaintances, friends and strangers – do they matter to medical sociology? A response to David Morgan

Julia Hiscock

*University of Manchester*

Email: [Julia.Hiscock@manchester.ac.uk](mailto:Julia.Hiscock@manchester.ac.uk)



David Morgan has thrown at us a concept rarely, if ever, considered within medical sociology - that of acquaintanceship. He is concerned that with late modernity's emphasis on intimacy (and I would add, on individualism) forms of connectedness such as acquaintanceship have been ignored.

Can Morgan's piece broaden for us the boundaries of what medical sociology could, or should, consider? In an already broad and possibly disparate sub-discipline, some may believe that acquaintanceship falls outside of our concerns. I, however, would argue the opposite, that other people in our social worlds can have a profound influence on our health. Because of this I would maintain that within medical sociology we should be engaging with the dynamics of interpersonal connections and their effect on our health. This could include friends, neighbours or colleagues. It could also at times include strangers. And it could include acquaintances such as David Morgan's *Telegraph* reader (why did he stop catching the train – a change of job, a weariness with that early start, or an illness? Did Morgan notice, as I do at my morning station, when the regulars have a bad cold, look stressed, pale or hung-over, or when they turn up with a new girlfriend?).

I am of the belief that our fleeting interactions with others, including acquaintances, can impact on our health in a number of ways. Firstly, through some kind of Foucauldian self-surveillance, we can reflect on our own lifestyle and health options, by observing those of others. What do we think about ourselves and our own health, when we observe joggers, gym bag carriers and apple eaters or, on the flip side, the smokers outside the office or the fast food diners? And do we control our own health behaviour as a result of those reflections?

Secondly, strangers (slightly different from acquaintances, as Morgan reminds us) enter our personal space and our health in uninvited and unexpected ways. This might be through the cold caught from a fellow traveller on the bus, or, after a car crash, through our dependence on the intervention of a total stranger in what could be the most urgent medical crisis of our life. In doing so that stranger momentarily becomes an intimate.

Thirdly, within the context of reflexive late modernity, we are supposedly free to create and recreate our self. Sometimes this is by choice. At other times, such as at the onset of illness, it is by necessity. Illness identity and the biographical disruption (Bury, 1982) it can

create has been a longstanding theme in the sociology of health and illness. Friends, and possibly acquaintances, invariably play a role in identity formation and reformulation, and may also be involved in illness identity and the process of coping with or responding to biographical disruption and reconstruction.

Acquaintances could be conceptualised as 'weak ties'. Granovetter (1973) proposes that weak ties, people in more distant parts of our social networks, can be more useful to us than strong, closer ties. We could apply this notion to health support, health information or health advice. It may be for example that one of our 'weak ties', our acquaintances, has the same condition we have, or had the same health related decision to make. This puts them in an ideal position to play an important role in helping us to manage our health.

Strangers and acquaintances also play a role in arenas more familiar to medical sociologists. Morgan refers to the people with whom we share our waiting rooms (and I am very enthusiastic about his suggestion of unpicking sociologically what goes on in the process of waiting). I could add to the people in the waiting room, those with whom we develop an important connection for a fleeting period of time in a shared hospital ward. How do these people, these interactions, influence our health? Do they help us to better understand the human condition, or at least the condition that brought us there? Do we learn some tips? Or some motivation? Or receive or give some support? At the very least these kinds of interactions with people we meet fleetingly in medical contexts may offer us new reflections on illness. Here I am reminded of the debate on suffering in the Opinion Piece of the first issue of this journal ([www.medicalsociologyonline.org/](http://www.medicalsociologyonline.org/)). Gareth Williams, Arthur Frank and Iain Wilkinson (2006) discussed how it is that we, as medical sociologists, can actually engage with, or really appreciate the reality of suffering. Possibly one moment when we do begin to feel the meaning of others' suffering is when they touch our lives through some kind of interaction, however distant or fleeting.

These subjects have not been totally ignored by medical sociologists. The literature on lay beliefs and lay epidemiology provides us with an, albeit oblique, reference point for these ideas. It helps us in thinking about how other people with whom we brush our way through life may offer us different, usually less medicalised, models to explain our health. Elliot Friedson's (1970) concept of the lay consultant is possibly the closest medical sociology has yet come to the ideas in David Morgan's piece. Our friends, and possibly occasionally our acquaintances, become the people we consult about our health. This can happen in place of, or before, a visit to a medical professional is 'sanctioned' (Zola, 1973). I am reminded here of conversations I am sure we have all overheard on trains, buses and over the kettle at work.

The medical professionals we encounter are an interesting type of acquaintance. As Morgan notes, they 'have a detailed, intimate and embodied knowledge of us although they, themselves, are not intimates'. As medical sociologists we are concerned about a dehumanised and disembodied treatment from (some) medical professionals where we feel disconnected not only from the entirety of the parts of our body, but also from the human being who is focusing on one part of us. Some models of health try to overcome this. Complementary and alternative medicine, community pharmacists, peer health buddies, some specialist nurses and so on try to integrate a holistic or relational approach to managing health. And despite the end of GPs' personal lists, we apparently still treasure our special relationship with our GP, as one of the few health professionals with whom (in some cases at least) we have a relationship which is a tad more than a stranger, possibly more than an acquaintance.

Morgan's piece introduces his interest in acquaintanceship. Yet the applicability of these ideas for medical sociology could be taken further to look at the health role of social relationships more broadly. The predictive and protective role of social networks for health

has been well documented. Self-help groups and internet communications between people who share a condition have also been studied by medical sociologists (see Bernadette McCreight's paper in this edition) and underscore the importance of Morgan's overall theme of the central role of connectedness in social life, and I would add in health. David Morgan ends his piece with a call for us, as sociologists, to recognise the importance of this connectedness. I would endorse this, and I would add a call for us as *medical* sociologists to recognise the importance of connectedness for health.

## References

- Bury, M. R. (1982) Chronic illness as biographical disruption. *Sociology of Health and Illness*, 4: 167-82
- Frank, A. W. (2006) Suffering: The elephant in medical sociology's closet. A complementary response to Gareth Williams. *Medical Sociology Online (MSO)*. 1: 42-44
- Friedson, E. (1970) *Profession of medicine: A study of the sociology of applied knowledge*. New York: Harper and Row
- Granovetter, M. S. (1973) The strength of weak ties. *The American Journal of Sociology*, 78, (6): 1360-1380.
- Wilkinson, I. (2006) The problem of suffering as a problem for sociology. *Medical Sociology Online (MSO)* 1: 45-47
- Williams, G. (2006a) Suffering Sociologists and the sociology of suffering. *Medical Sociology Online (MSO)*. 1: 39-41.
- Williams, G. (2006b) Shoulder to Shoulder: a rejoinder to Arthur Frank and Iain Wilkinson. *Medical Sociology Online (MSO)*. 1: 48-50
- Zola, I. K. (1973) Pathways to the doctor: from person to patient. *Social Science and Medicine*, 7: 677-89

Julia Hiscock is a Research Training Fellow in the University of Manchester, undertaking a study on social networks and self care, based in NPCRDC (National Primary Care Research and Development Centre) and conducted jointly with the Department of Sociology. This research is funded by a NCC RCD Personal Fellowship Award, leading to a PhD.

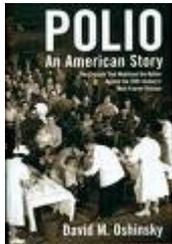
Julia is also an editor of Medical Sociology Online (MSO).

Address: National Primary Care Research and Development Centre, The University of Manchester, Williamson Building, Oxford Road, Manchester, M13 9PL

E-mail: [Julia.Hiscock@manchester.ac.uk](mailto:Julia.Hiscock@manchester.ac.uk)

Phone: 0161-275-7662

## Book Reviews



Oshinsky, David M.

**Polio: an American story.**

Oxford University Press 2005 £18.99 (hbk)

(ISBN0195152948) 342pp.

**Reviewed by Ruth Bridgens, Cardiff University**

David Oshinsky's Pulitzer prize-winning *Polio: an American story* (2005) is a social history of the dramatic race to create a polio vaccine and was published in the 50th anniversary year of the Salk vaccine. Oshinsky begins his book by noting the irony that the successful vaccine ended research on polio as a disease and led to millions of patients being forgotten. This is mirrored by the prize being awarded to this book over two others, written in the same year, which concentrated on the patients' experiences. These were; *Polio and its aftermath* by Marc Shell, and *Living with polio: the epidemic and its survivors* by Daniel Wilson.

Although polio has mostly been forgotten in the medical and public's mind, the story of research into the disease and the development of the vaccine are important to the history of medicine as much of the origin of current practice could be traced to that time. Polio is thought to have existed since ancient Egyptian times as an endemic childhood disease which only rarely caused weakness or paralysis. Improved hygiene in the early 1900s may have led to decreased childhood resistance and the beginnings of more serious epidemics in children and adults. *Polio: an American story* begins with a history of early polio epidemiological research in the late 1800s and early 1900s and the foundation of private medical research institutes, such as the Rockefeller Institute, designed to bring together groups of scientists for full-time research.

The second chapter tells the story of Franklin Roosevelt, who had polio in 1921 when he was 39, and his role in the development of the concept of large-scale private health charities, and fundraising with The National Foundation for Infantile Paralysis and the March of Dimes in the 1930s. Innovations such as aggressive advertising and 'poster children' made what was quite a rare, although terrifying, disease more visible. The rest of the book traces the polio research of the late 1930s and 1940s, the debate over a live or killed vaccine, and the vaccine race in the early 1950s between Albert Sabin, Jonas Salk and Hilary Koprowski, which resulted first in the successful Salk inactivated vaccine in 1955 and, in 1961, the Sabin live vaccine. The story of polio research is one of brilliant inspiration, dreadful mistakes, power struggles, media hype, government indecision, questionable ethical practices, and the beginnings of public distrust in vaccines.

This story has been told before, although perhaps it is important enough to repeat again and again. However, one aspect of the 'American story' that comes through particularly clearly in this version was the deep ethnic and class tensions between the East Coast middle-class scientists (Harvard, Yale and Johns Hopkins), and the immigrant scientists who could not get jobs at the major universities and research institutions. Only they were willing to muddy their hands with vaccine research, which was seen by the top universities as commercial applied science. Sabin, Salk and Koprowski were Eastern European Jews and anti-Semitism was quite overt at that time. Prestigious universities like Harvard and Yale had strict Jewish, other immigrant and black quotas.

Another interesting twist to the story concerns the animosity between Sabin and Salk, which went beyond their disagreements about vaccines and personal ambitions to the minor differences between them as immigrants. Sabin, who emigrated from Poland to the US as a teenager, had slowly and meticulously gained respect in the world of polio research and felt assimilated into mainstream science research. Salk, the son of Russian immigrants, was younger, had appeared on the scene after much of the groundwork had been done, and was treated by other polio researchers, including Sabin, as opportunistic. However, Salk was admired for attempting to merge pure science and humanitarian aims, and visited his hospital's children's wards to keep in mind the devastating effects polio could have. This humanistic attitude made it particularly ironic that Salk, like Koprowski before him and later Sabin, first tested his vaccine on mentally handicapped children, only a short time after the Nuremberg Code was developed in response to Nazi medical experiments.

Neither Salk nor Sabin received the Nobel Prize for developing the killed and live polio vaccines, which are both still used around the world, because it was not seen as original work. The Nobel Prize went to Harvard virologists Enders, Robbins and Weller in 1954 for growing poliovirus in a test-tube using non-nervous tissue, an essential first step for developing the vaccine. Unlike Salk, Enders was seen as a true scientist, a modest man who insisted that his young assistants share the prize with him. After conducting a field trial using nearly two million children, Salk became a hero with the public, but not with scientists, as he rarely credited his co-workers or other polio researchers. The government, considering it had no role other than to license the vaccine, came under heavy criticism when there was no organised nationwide distribution after the trial. The 'Cutter incident', in which distribution of one of the first commercial batches containing live virus led to over 200 serious cases of polio, initiated deep questioning about the role of government and private enterprise in public health.

Oshinsky ends his story of the triumphant conquest of polio by briefly returning to the forgotten patients, and their struggle for recovery. Some had fought hard for disability rights and others had shunned a disability identity, leading highly active 'normal' lives. In middle age, many began to experience new symptoms, such as weakness, loss of stamina, pain and fatigue, which were named postpolio syndrome (PPS). Oshinsky suggests that this new problem created "powerful bonding" in patients, who were then able to mobilise the medical profession. To an extent this is true, but generally doctors have remained sceptical of PPS, and some patients, who, like Sabin, felt assimilated into society, have unwittingly colluded with the medical profession by being reluctant to accept their symptoms. On the other hand, others are angry that the medical profession remains uninterested in the long-term consequences of a serious childhood illness. Using one of medicine's greatest successes, Oshinsky has intricately interwoven several stories about early 20th century medical research and philanthropy, but the book may have benefited from more analysis of the role of marginal groups, whether immigrants or disabled people, in creatively helping to change societies.



John Heritage and Douglas W. Maynard (Editors)  
**Communication in Medical Care: Interaction between  
 primary care physicians and patients**  
 Cambridge University Press. 2006 £23.99(pbk).  
 (ISBN 0-521-62899-7) 488pp.

**Reviewed by Sara Edwards, University of Liverpool.**

In this useful volume, the editors, John Heritage and Douglas W. Maynard, leading conversation analysts in the field of communication and interaction in health care, deconstruct the primary care consultation, using a selection of the most current conversation analysis studies of doctor-patient interaction to provide a phase by phase account of the medical interview. Each chapter is written by leading contributors from the fields of linguistics, sociology, and medicine, many of whom make excellent use of transcription extracts to illustrate their points.

In constructing this volume the editors sought to replicate Byrne and Long's classic study *Doctors talking to patients* (1976), by examining the constituent phases of the primary care visit, whilst departing from the approach adopted in this study and much of the previous research in this field in one important way. Whilst previous approaches have concentrated primarily either on the conduct of the doctors, *or* on that of the patients, Heritage and Maynard advocate a "co-constructive" approach, emphasising the conduct of *both* parties, recognising that it is by acting together that doctor and patient assemble each particular visit with its interactional textures, perceived features, and outcomes (p.19).

In the introduction the editors locate the field of study by giving an overview of research in doctor-patient interaction, beginning with Byrne and Long's study, and moving on to an evaluation of the two main approaches which have shaped the field of doctor-patient interaction: process analysis, and the microanalysis of discourse. The editors then give a concise introduction to conversation analysis (CA), including a useful review of three possible applications of CA for analysing the medical encounter: overall structural organisation, sequence organisation, and turn design.

Jeffrey D. Robinson draws on physician-patient consultation data to examine how physicians typically solicit patients' presenting concerns. This provides a fascinating insight into how the design of the doctor's initial question or greeting is formulated according to perception of reason for presentation. It also highlights how these subtle differences in wording can impact on the development of the consultation, including patients' perceptions of doctors' competency. Robinson, along with John Heritage, then looks at how patients account for their visit to the doctor and the task that patients face, at the beginning of the medical visit, of presenting their medical concern as "doctorable". This involves justifying and legitimising their decisions to seek medical attention. Following on with this theme Timothy Halkowski explores patients' narratives of problem discovery, which chart the process of how the patients decided that their problems were "doctorable". In producing these narratives patients attempt to provide an account which shows that they have balanced good-faith efforts to deal with the problem themselves first, whilst not being neglectful of their health.

Virginia Teas Gill and Douglas W. Maynard provide a fascinating discussion on patient presentations of their own explanations for their illnesses, and the complexities for the physician of responding to and including these accounts in their explanation of illness.

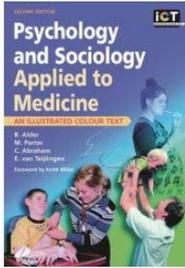
Elizabeth Boyd and John Heritage then look at doctor question design during the foundational “taking the history” element of the consultation.

Making use of consultation video-recordings, Christian Heath provides a thoughtful chapter on the physical examination and the role of both the patient and the physician in objectifying the body. Some interesting observations are made here about the transcription of relevant interaction from video recordings in order to aid analysis. Also making use of video-recorded data Anssi Peräkylä explores issues relating to diagnosis, in particular the dilemma between the expectations concerning the doctor’s authority and the patient’s “knowledgeability” in medical consultations. Remaining with the diagnostic phase of the encounter, Maynard and Frankel discuss uncertainty in diagnosis, delivery of bad news and management of emotion, and the fascinating paradox of how ‘good news’ can sometimes pose equally challenging issues for emotional management when concerning unexplained symptoms and ‘symptom residue’.

Tanya Stivers provides an interesting analysis of treatment recommendations and examines turn-taking in the consultation, demonstrating how this is utilised, for example, in terms of patients and parents withholding acceptance of diagnosis. Stivers also reveals patients’ tendency to respond to treatment recommendations far more than to diagnosis, and explores how physicians manage pressure from patients to prescribe when it is not appropriate to do so. David Greatbatch further examines the treatment component of the consultation, evaluating coordination of delivering verbal information concerning prescribed medicines with the writing of prescriptions via a computer.

Maria-Leena Sorjonen and colleagues use Finnish data to examine how issues of lifestyle are discussed, making some interesting observations about how discussions relating to lifestyle differ between the United States and the Nordic (Scandinavian) countries. Candace West then examines the little-studied phase of primary care visit closure, exploring the diversity of mechanisms for closing the consultation and making interesting observations about the relationship between health care delivery systems and patterns of closure in the United States. In the final chapter Paul Drew considers the “misalignment” between doctors’ and patients’ perceptions of “emergencies” in the context of “after hours” calls to a British GP’s practice.

A thorough guide to CA transcription symbols is provided at the front of the book, including explanations of some symbols which the reader might come across if using older transcripts. The chapters all follow on from each other beautifully and combined they provide an excellent insight of the primary care visit from start to finish. The writing style of each chapter is clear and accessible, thus they can also be utilised individually to aid study of particular aspects of doctor-patient interaction. However, this feature might have been further improved if the references had been included at the end of each chapter, rather than as one long reference at the end. A glossary of terms might also have been useful. Other than these very minor suggestions I do not see how this volume could have been any better constructed. The “co-constructive” approach adopted is reflective of current developments in the field of doctor-patient communication and this volume makes a substantial contribution to this fascinating area of study. I have personally enjoyed reading this text immensely and I have referred to it on countless occasions already for my PhD studies. I would whole-heartedly recommend this book to anyone who is interested in doctor-patient interaction, any aspect of the primary care consultation, sociology of medicine, conversation analysis or sociolinguistics.



Beth Alder, Michael Porter, Charles Abraham, and Edwin van Teijlingen (Editors)

**Psychology and Sociology applied to Medicine (Second edition)**

Churchill and Livingstone: Edinburgh. 2004. £24.99 (hbk) (ISBN 0443-07295-7) 192pp.

**Reviewed by Stephen Brindle, University of Aberdeen**

This is the second edition of the very popular ICT text produced as a response to changes in the UK medical curriculum that required student-centred learning, early patient contact and a problem-based approach. After four reprints the text has now been updated to include several new chapters and attempts to take into account the GMC's recent recommendations that behavioural sciences be integrated throughout the entire curriculum. The second edition is thus well worth obtaining for those who are already happy with the earlier book. For those new to the text, it is important to be clear about the writers' aims. This book is not a specialist text but, by providing a series of topics introduced in two page spreads, each with a case study, bullet point summary and 'Stop and Think' section, along with lots of entertaining cartoons and useful graphic data, it acts as a springboard for the students to explore topics of interest further.

There are 34 contributors coming from a broad church, and one can have fun guessing the various writers' specialisms as one works through the chapters. This is in many ways one of the charms of the book, but it also draws attention to the limitations of attempting to introduce both sociology and psychology in such a limited space with regards so many topics. As a result the text is occasionally a little superficial. I felt this was particularly the case in parts of the largely sociologically based section entitled 'Life Cycle'. The chapter on 'Adolescence', was all a bit obvious and the 'Stop and Think' section was a little patronising in asking the students to consider how far they consider themselves to still be adolescents. Similarly, I think it is nigh on impossible to cover menstruation, pregnancy, childbirth, (and menopause!), all in a two-page spread. If medical students are to be convinced of the value of sociology to their profession, then it is dangerous to give any kind of impression that it is a subject that states the obvious. Fortunately, this was the exception rather than norm and most chapters were pitched at a suitable level and most importantly, for students, had that absolutely compulsory element, namely relevance. The case studies were an excellent contribution to this and the whole drive of the book is to encourage medical students to see their patients as human beings, which is after all the whole point. This is where the value of a well-illustrated text comes into play, providing opportunities to visually illustrate, for example, the elderly being stereotyped as frail or depressed, and also the inclusion of the odd amusing cartoon such as the nurse barking at a recently arrived hospital patient: 'Are you the leg?'

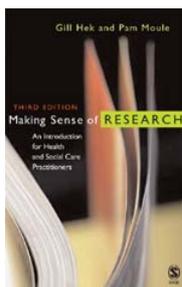
The relevance of this text is reflected not only by way of specific practical working situations, but also by the whole structure of the book's sections, which engage with every aspect of the working role of the medical student. The sections work through the individual's life cycle, and on to personal development and the individual in society. It covers, illness prevention and health promotion, and then goes on to look at the all important doctor-patient relationship. It then discusses the main forms of illness and disability and the patients' ability to cope. Finally there are two very important sections: the first dealing with the vexed issue of funding and assessing needs, and the second, a section of particular relevance to student doctors, which deals with being a medical student and a junior doctor, and concludes with a

chapter on the nature of the profession of medicine in general.

One section that should be compulsory reading for any would-be medical practitioner is the section entitled 'The Doctor patient relationship'. Here it is really spelled out how doctors can increase their effectiveness if they move from a disease-centred to a patient-centred approach. We are taken through the whole process from deciding to consult, anxieties during consultation, ways that doctors can affect patient adherence to advice (particularly important when, according to the text, 45% of patients are non-adherent), along with the most sensitive situations such as breaking bad news and preparing patients for major surgery. The two-page spread on 'Communication Skills' is excellent, emphasising the importance of physical setting, body language etc. for effective clinical communication. The 'Stop and Think' question is particularly apposite at this point sitting as it does like 'a spanner in the works' in the face of all the sound advice: 'some doctors argue their job is just to treat disease not deal with how people cope with it'.

The two sections on 'Illness and Disability', one would assume, would be appealing to medical practitioners because of the way they home in on specific illnesses that are likely to be encountered at the 'chalk face'. This aspect makes it more likely that practitioners will engage with the way sociological and psychological factors impact on these illnesses. The case studies in these sections are excellent, focusing largely on the psychological impact on patients, and reinforcing the clear relevance this has for medical students. The case study for the Cancer spread is particularly interesting in drawing attention to the need for the appropriate language: 'Doctor. The tests on your breast lump are negative. Miss Browne. So there's nothing you can do.' This brings back memories of my own mother's distress returning from the doctor who had read out her medical details: 'This patient has been complaining of the following...'. My mother's response: 'These doctors, who do they think they are?... I didn't complain!' Thus the more student doctors can be made aware of the need for them to be 'singing from the same song-sheet' as their patient with regards to language used the better.

In conclusion this is a text that should clearly be a must on all university courses related to the medical profession.



Gill Hek and Pam Moule  
**Making Sense of Research: An Introduction for Health and Social Care Practitioners**  
 Sage Publications: London. 2006. £17.99 (pbk)  
 (ISBN 9781412923620) 155 pp.

**Reviewed by Charlotte Pearson, Denbighshire Social Services**

This book is written by two colleagues from the University of the West of England, Bristol. The book is in its third edition now and the developments from the previous edition have included new and updated material on data protection, literature searching techniques, meta-analysis and critical appraisal tools.

The book is based on the premise that research skills are a crucial part of what is required by professionals within health and social care settings, and therefore these professionals need to be able to read and analyse research to enable them to apply it to their work. The book is

thus designed to assist professionals and students to understand research.

Making Sense of Research is a straightforward guide to the basic concepts of research within this field. The layout has been well developed to include boxes which highlight learning outcomes, key terms and key points. These simple tools will all help professionals to draw out important issues in need of consideration. The book also includes a glossary of research terms and a critical appraisal framework.

One drawback, as with many texts, is that the reality of working within health and social care means that the majority of professionals will not be able to find time to read, digest and ultimately apply the practices of this book. However, this is not a criticism of the text itself, rather of the system and the on-going pressures of the working day. One way around this might be for strategic planners and researchers within the health and social care setting to digest the text and disseminate key concepts and methods as appropriate. A further way forward would be for this text to be a core text of students who intend to work within such settings, in order that the concepts and importance of research begin to be embedded in the next generation of health and social care professionals.

Topics covered within this book include: the role of research in health and social care; the nature of knowledge; the research process; searching and reviewing literature; approaches to and design of research; research problems, aims, questions and hypotheses; sampling; understanding data collection techniques; making sense of analysis; ethical issues; how to develop critical skills, and implementing research findings.

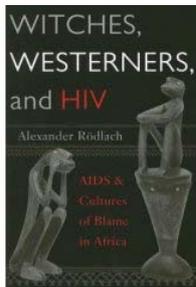
The first chapter in this book – the role of health research in the health and social care professions – is essential reading in order for professionals within a range of settings to acquire an understanding of what research is and why it is important. The authors do not convey that they believe the act of research, (in terms of a research project) should be the role of all professionals – rather they comment that what all health and social care professionals need are the skills and knowledge to enable them to comprehend research findings, and the ability to use evidence in order to offer service users the most effective provision. It is also considered crucial for practitioners to have an appreciation of ethical issues within the research arena. The authors identify a clear need for any professional training courses and qualifications to address the issues of research and research ethics, to ensure the development of a professional knowledge base which is built on evidence of what works.

Chapter three is very useful in terms of providing an overview of the research process. This will be helpful for professionals who want to widen their understanding, without becoming burdened with the detail of the process. This is a short and efficient chapter, which draws the reader's attention to the major components of the route research can take.

Chapter seven is also particularly well written and well pitched. This chapter concentrates on sampling and sets out, in a clear manner the key issues to consider in sampling. I think this could be a particularly helpful chapter to health and social care professionals, and encourage them to appreciate the factors that can affect selection. In a similar way, chapter eight should also be particularly beneficial to practitioners. More and more now, health and social care professionals are being asked to monitor their performance and collect data for reporting and analysing purposes. This chapter may help to facilitate an understanding of the need for accurate data and the ways in which this can be collected. This will be helpful background reading for professionals who require robust data collection techniques in order to monitor progress towards outcomes in their field.

Overall this book is an easy read text with key messages regarding research within the health and social sector. It will be a valuable tool for health and social care students and professionals, although time constraints of day-to-day working may inhibit progress for individuals within organisations. It will therefore be crucial for those involved in planning,

commissioning, monitoring and evaluating services to take this agenda forward and be responsible for digesting and rolling out research models and practice.



Alexander Rodlach

**Witches, Westerners, and HIV (AIDS & Cultures of Blame in Africa)**

Left Coast Press. 2006. £17.99 (pbk).

(ISBN978-1-59874-034-9) 272pp.

**Reviewed by Anne-Marie Martindale, University of Liverpool**

The cover immediately draws the readers' attention and does much to convey the serious and mysterious themes within. On the surface *Witches, Westerners, and HIV* looks much like many anthropological accounts. However, somewhat unusually, it has been written by a Catholic Priest and based on his PhD fieldwork. The field in this case is Southern Zimbabwe, which Father Rodlach inhabited as a parish priest from 1991-1998 and then again from 2001-2003.

The book takes the suffering and death of thousands of Zimbabweans as its starting point. In the introduction we read about a visit to the family of a man dying of AIDS and the two questions underpinning the text are asked: "*Why do I have to suffer so much; and Who is responsible for this?*" (Page 3). Rodlach states that such questions were frequently asked over the course of his ministry, and that he became interested in peoples search for answers. He argues that these questions cannot be answered without an understanding of two key belief systems: sorcery; and conspiracy theories, and that these, in turn, must inform anti HIV/AIDS programmes. The first three parts of the book deconstruct these processes and explore them with related themes such as infidelity and the role of Westerners. The final part, *The Implications of Culture* compares theories of blame and concludes with a summary of practical AIDS management applications.

Part 1 sets out Rodlach's reasons for being in the field and finishes with an account of his methodology. Coming so early in the account the reader is quickly assimilated into the author's world. Whilst acknowledging the potential for conflict between his dual role as Priest and anthropologist the author states that it was far from a problem. "*My priestly role had a limited positive impact on a related issue*" (page 21). He argues that it helped to establish trust between himself and his informants, and that it gave him a reason to remain in Zimbabwe, when foreigners and those of European descent were treated with suspicion and mistrust. As this account is not a traditional ethnography it is difficult to assess the validity of these claims, however, the text is peppered with sections of interviews with his informants.

In the second chapter of Part 1 Rodlach sets out the five problems that influenced his choice of methods: the ambiguous nature of healers; the difficulties of a westerner asking (illegal) sorcery questions; the challenge of disclosing private information and the dynamic nature of sorcery and conspiracy theories. Whilst illuminating, the chapter does not end with a breakdown of how the chosen methods address these problems. The methods, long-term participant observation, single and group interviews, archival and mass media resources are stated at the start of the chapter. This does the book a disservice, as the reader has to go back and try to tease out the connections, which disrupts the flow and makes any critical assessment of the methodology and findings more difficult. Nevertheless, in terms of content,

a rich variety of material has evidently been used. Political cartoons, local art images and public health posters are put to effective, illustrative use throughout.

Part 2 explains the relationship between AIDS and sorcery. Three types of sorcery are identified and their role in the explanation of misfortune is made clear. Rodlach puts forward a set of convincing arguments, weaving in the work of anthropologists as well as informants. The depth of his local knowledge is evident throughout this section. For example, his accounts of a sorcerer's servant being, and the role of infidelity in the spread of AIDS are peppered with indigenous terms. These are defined and used to explain the complex and overlapping local systems of blame. At the end of Part 2 the reader is left in no doubt that a western medical view of HIV/AIDS is simply inadequate to understand the incidence and management of this epidemic in Zimbabwe.

Part 3 explains the relationship between AIDS and conspiracy theories, paying particular attention to the role of the local and national media. Nationally, Whites, Westerners, and health care professionals are blamed for the spread of HIV/AIDS, whilst locally, witches and sorcerers are thought to be responsible, either knowingly or unknowingly. As in earlier chapters Rodlach's local knowledge shines through. I was hoping that Part 3 would start to tie the micro and more macro threads together in time for the implications of culture in Part 4, however it didn't and I was left slightly disappointed. In Rodlach's defence he does state that researching something which people don't necessarily see occurring first hand is problematic. However I'm not completely convinced by this explanation. There is an established tradition of witchcraft research within anthropology.

Part 4 explores the implications of culture for the spread and management of HIV/AIDS in Zimbabwe. Rodlach concludes that sorcery (the explanation of individual misfortune) and conspiracy theories, (which explain social problems), are part of two interwoven narratives, used interchangeably. Various meanings are attributed to a story about how HIV/AIDS might have been initially transmitted. The account takes up most of the chapter and finishes with a short analytical section, putting the supposed causes of HIV/AIDS into context. This is one of the few occasions in the book where the author pulls the threads of his arguments together, which is slightly frustrating as it leaves the reader wanting more. The final chapter examines the applications for the AIDS crisis. It is full of useful and practical ideas about how to apply knowledge on cultures of blame to the management of AIDS.

Overall this book is definitely worth a read. It is packed with field notes and stories. Rodlach's understanding of the field is definitely impressive. However, I felt the book didn't quite fulfil its early potential. In my opinion the continuous focus on narrative accounts has left little room for the larger, related discussion about the relationship between theories of blame and the political and socio-economic context in which they operate.



Samantha King  
***Pink Ribbons, Inc.: Breast Cancer and the Politics of Philanthropy.***  
 University of Minnesota Press. 2006. £12.63(hbk)  
 (ISBN 0816648980) 157pp

**Reviewed by Karen Kaiser, University of Illinois at Chicago.**

While there are a number of excellent books on the changing cultural and medical responses to breast cancer, King's "Pink Ribbons Inc.: Breast Cancer and the Politics of Philanthropy" (2006) augments the literature on breast cancer by focusing on the "philanthropic arm" of the breast cancer movement. As such, I found King's book to be a remarkably clear analysis of the seemingly complex and ubiquitous web of breast cancer fundraising endeavours present in contemporary American culture.

King's central argument is that breast cancer is an excellent example of neoliberalism and definitions of good citizenship which encourage purchasing as a way of doing good. King supports this argument by providing a convincing and clear overview of the development of corporate "strategic philanthropy" and "cause related marketing" (Chapter 1). Under strategic philanthropy, corporate philanthropic efforts came to be viewed as part of overall corporate (money-making) strategies and worthy causes were linked to products as a way to differentiate brands and build consumer loyalty. As these strategies developed, corporations readily adopted breast cancer as an ideal cause because supporting breast cancer was invariably seen as a good thing. In turn, consumers are encouraged to view consumption activities, such as purchasing breast cancer postage stamps (Chapter 3) or paying a fee to participate in a breast cancer walk (Chapter 2), as ways to be good citizens.

For medical sociologists, the many examples of breast cancer philanthropy in Pink Ribbons illustrate how disease meanings are constructed and, as King argues, are often limited in scope and therefore limiting to those who experience disease. In particular, she highlights the limited range of cultural messages about breast cancer survivorship (Chapter 5) and contrasts these contemporary images of "cheerful" survivors with the more nuanced and critical ideas of an earlier breast cancer narrative from Audrey Lorde. I found King's discussion of the Avon corporation's international breast cancer marketing efforts to be fascinating (Chapter 4). Here again, the image of breast cancer is strategically constructed and attached to consumer products, such as pink ribbon pins sold for ten rand each in South Africa (page 89). However, in this case the images are disseminated in countries where breast cancer may not be the most pressing health concern for women. Thus, King argues Avon and other corporations are not only shaping the images of breast cancer, they are shaping the status of breast cancer as a global health concern. Throughout the book, and in her discussion of the races and walks organised to raise money for breast cancer, King also notes that the marketing of breast cancer products is geared towards curing the disease, rather than towards preventing the disease. Notably, however, King says little about how prevention could be part of the breast cancer message, perhaps because the issue of how to best prevent breast cancer is controversial and has its own set of debates and roadblocks.

In short, King's book is both an insightful review of the breast cancer movement and an important statement about American culture, giving, and neoliberalism. *Pink Ribbons* is most

successful when King focuses on 1) corporate strategies to use breast cancer to market products and enhance corporate image, and 2) consumption as a way of doing “good”. The one criticism I can make of the book is that perhaps King could have further developed the arguments sprinkled throughout the book on race and the traditional roles of women. Unlike her somewhat superficial treatment of race and gender roles, King’s discussion of the development of corporate charity around breast cancer and the development of the breast cancer postage stamp is thorough and enlightening. King is clearly critical of the dominant breast cancer players, such as the Komen foundation and Avon. Critics may feel that she fails to acknowledge the good done by these organisations and the progress that has resulted from their efforts. Therefore, I was glad to see that in her conclusion King does address these potential criticisms. In doing so she strengthens her argument that the marketing of breast cancer has worked to suppress alternative ways of experiencing the disease and has shaped our nation’s research priorities.

### Submitting a book review

MSo welcomes the submission of book reviews within the discipline of medical sociology. A list of books available for review will be published in each edition (see below), and books may be obtained from the editorial team. However, the editorial team will also be happy to consider reviews of books not listed, provided they are of relevance to the medical sociology community. There is no prescribed format for reviews, although reviewers should provide the full reference of the book, including the price, number of pages and the ISBN. Book reviews should be no longer than 1000 words. Completed reviews should be submitted as a Microsoft Word document via email to [MSO@liverpool.ac.uk](mailto:MSO@liverpool.ac.uk). Book reviews will not be subject to peer review, and the decision to publish will be made by the editorial team. The editorial team also reserve the right to edit articles prior to publication.

The editorial team would also strongly encourage readers of MSo to specify particular areas of medical sociology that they would like to see book reviews in, or key medical sociology texts they would be interested to read a review on.

### Books available for review

Eilidh Garrett, Chris Galley, Nicole Shelton and Robert Woods (Eds) (2006) *Infant Mortality: A Continuing Social Problem*. Aldershot: Ashgate

Dennis Waskul and Philip Vannini (Eds) (2006) *Body/Embodiment: symbolic interaction and the sociology of the body*. Aldershot: Ashgate.

John A. Vincent, Chris R. Phillipson and Murna Downs (Eds) (2006) *The Futures of Old Age*. London: Sage.

Angus Clarke and Flo Ticehurst (Eds) (2006) *Living with the Genome: Ethical and Social Aspects of Human Genetics*. Basingstoke: Palgrave Macmillan.

Matt Wray (2007) *Not Quite White: White Trash and the Boundaries of Whiteness*. Duke University Press.

Johan Fritzell and Olle Lundberg (Eds) (2007). *Health Inequalities and Welfare Resources. Continuity and Change in Sweden*. Bristol: The Policy Press.

Anne Oakley (2007) *Fracture: Adventures of a Broken Body*. Bristol: The Policy Press.

If you wish to review one of books listed above please contact the editorial team, [mso@liverpool.ac.uk](mailto:mso@liverpool.ac.uk).

## **Sociology of Health and Illness Book of the Year 2007**

The Sociology of Health and Illness Book Prize of £1,000 is awarded annually each September to the author(s) or editor(s) of the book making the most significant contribution to the sub-discipline of medical sociology / sociology of health and illness and having been published over the three years preceding 1<sup>st</sup> January 2007.

### **This year the following books have been short-listed:**

Timmermans, Stefan.

**Post-mortem: How Medical Examiners Explain Suspicious Deaths**

*University of Chicago Press 2006*

nominated by Jonathan Gabe.

Dopson, S., Fitzgerald, L.

**Knowledge to Action? Evidence-Based Health Care in Context**

*Oxford University Press 2005*

nominated by Jane Sandall.

Weinberg, D.

**Of Others Inside: Insanity, Addiction and Belonging in America**

*Temple University Press 2005*

nominated by Dana Rosenfeld.

Lehoux, P.

**The Problem of Health Technology: Policy Implications for Modern Health Care Systems**

*Routledge 2006*

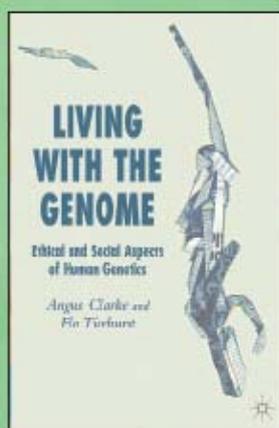
nominated by Carl May.

The winner will be announced at the British Sociological Association Medical Sociology Group Annual Conference, which will be held at the Britannia Adelphi Hotel, Liverpool between 6th - 8th September 2007. Further information about the SHI Book Prize and the Medical Sociology Group Annual Conference can be found at the following website.

<http://www.britsoc.co.uk/specialisms/Medical+SSG.htm>

palgrave  
macmillan

New from Palgrave Macmillan



### Living with the Genome

Ethical and Social Aspects of Human Genetics

Edited by Angus Clarke and Flo Ticehurst

A whole new world of genetics research is underway with its exciting potential for a better understanding of heredity and genetically inherited disease. But the current explosion of human genetic information has the potential for abuse also - for damage to rights, privacy and fair treatment for individuals and vulnerable groups.

Featuring contributions from the prestigious and authoritative *Encyclopedia of the Human Genome*, this book brings us up to date on the urgent social, legal and ethical aspects of the Human Genome enterprise, accessibly written and introduced for the undergraduate, postgraduate and general reader.

September 2006    Paperback    £19.99    1-4039-3621-8



Available from all good bookshops or direct from [www.palgrave.com](http://www.palgrave.com)

+44 (0)1256 302866

[www.palgrave.com](http://www.palgrave.com)

## Current research, postgraduate abstracts and recently awarded grants

This section allows researchers and postgraduates to share details of new and current research projects and recently awarded research grants of specific interest to medical sociologists. If you would like to include details of your own current research or recent award in the next edition of MSO please go to: <http://www.medicalsociologyonline.org>

### Research project title: ICT, The Digital Divide and Habitus in the Self-Management-Management of Heart Conditions

#### Researchers

- Professor Paul Bellaby, Institute for Social, Cultural & Policy Research, University of Salford
- Professor Rose Baker, Centre for Operational Research and Applied Statistics, University of Salford
- Ms Frances Bell, Information Systems Institute, University of Salford
- Professor Stephen Kay, Salford Health Informatics Research Environment, University of Salford
- Dr Sally Lindsay, Institute for Social, Cultural & Policy Research, University of Salford
- Dr Simon Smith, Institute for Social, Cultural & Policy Research, University of Salford

#### Lead contact details

Professor Paul Bellaby  
Institute for Social, Cultural and Policy Research  
4<sup>th</sup> floor Humphrey Booth House  
University of Salford  
The Crescent  
Salford  
M5 4QA

Tel: 0161 295 2828

Email: [p.bellaby@salford.ac.uk](mailto:p.bellaby@salford.ac.uk)

#### Funding body

Economic and Social Research Council (within the E-Society Programme) and HEFCE Science Research Infrastructure Fund.

## Project timeline

2005-2007

## Abstract

The internet offers potential for interactivity by providing a dynamic medium for influencing learning and behaviour change, especially in enabling intersubjective peer communication. By randomised controlled trial we test whether a virtual community of multiply deprived older heart patients (n=108) aged 50-74, enables its members to better manage their heart conditions. We have given free home computers, one-year broadband subscription and training (to the experimental group). We draw on repeat questionnaires, focus groups and qualitative data from the website to examine whether a health portal influences health behaviour change.

## Publications relating to this research:

Lindsay, S., Smith, S., Bell, F. & Bellaby, P. (2007) Tackling the digital divide: exploring the impact of ICT on managing heart conditions. *Journal of Information, Communication & Society*, 10(1): 1-20.

## Conference presentations

Lindsay, S., Smith, S. & Bellaby, P. 'Can informal e-learning and peer support help bridge the digital divide?' *British Sociological Association*, London, UK, April 12-14, 2007.

Bellaby, P., Lindsay, S. & Smith, S. 'What can be learned about the prospects for and the drivers of rapid innovation by comparing what has happened with the Internet and what must happen with sustainable energy?' *British Sociological Association*, London, UK, April 12-14, 2007.

Bellaby, P., Smith, S. Lindsay, S. & Bell, F. 'The ethical aspects of online research'. *E-Society Online Research Methods Colloquium*, London, UK, March 28-29, 2007.

Lindsay, S., Bellaby, P. et al. 'Using the Internet to help manage heart conditions'. *ESRC Symposium: The Impact of Self Care Initiatives on Patients*, Salford, UK, January 26, 2007.

Bell, F., Smith, S., Lindsay, S. & Bellaby, P. 'Approaches to learning in the 'Hearts of Salford' project'. *Understanding and Responding to Digital and Social Exclusion Workshop*. London School of Economics, London, UK, December 12, 2006.

Smith, S., Lindsay, S. & Bellaby, P. 'Community computing interventions in multiply deprived urban areas: an effective vehicle for health promotion?' *International Conference on Urban Health*, Amsterdam, October 25-28, 2006.

Bellaby, P., Lindsay, S. & Smith, S. 'Can ICT empower the multiply deprived?' *Association of Internet Researchers*, Brisbane, Australia, September 27-30, 2006.

Lindsay, S., Smith, S. & Bellaby, P. 'Tackling the digital divide: Exploring the impact of ICT on managing heart conditions'. *International Symposium on Information, Communication and*

*Society*, York, UK, September 20-22, 2006.

Lindsay, S., Smith, S., Bellaby, P. & Kay, S. 'Non-use of ICT among a deprived elderly sample'. *E-Society Program Meeting*, York, UK, September 18-19, 2006.

Bellaby, P., Lindsay, S. & Smith, S. 'Enabling healthy choices: Is ICT the highway to health improvement?' *British Medical Sociology Group Conference*, University of York, UK, September 15-17, 2005.

**Research project title: A Mixed-Method Test of the Validity and Transportability of Information-Motivation-Behavioural Skills (IMB) Model Constructs to Understand and Predict HIV/AIDS-Related Sexual Behaviour among Youth in a South African Township**

**PhD candidate: Mr. William DeJanes, MSc, University of Oxford**

Contact details

Mr William DeJanes  
Sexual Health and HIV/AIDS Group  
Department of Social Policy and Social Work  
University of Oxford  
Barnett House  
32 Wellington Square  
Oxford OX1 2ER

Email: [william.dejanes@exeter.oxford.ac.uk](mailto:william.dejanes@exeter.oxford.ac.uk)

Funding body

Clarendon Fund, University of Oxford (October 2004-present); John Fell Fund, University of Oxford (April 2006-present).

Abstract

This study will measure the validity of IMB constructs as discrete and interactional predictors of risky sexual behaviour in the novel context of a South African township. First, using cross-sectional data from students enrolled in randomly selected secondary schools, we will identify which constructs are statistically associated with HIV-related risk behaviours. Second, we will use significant statistical relationships as focal points for semi-structured in-depth interviews among a randomly selected sub-sample of participants. These findings will help contextualise risky sexual behaviour within this high-risk group, and address the feasibility of transporting a well-validated Western-oriented model of HIV prevention to South African townships.

This project builds upon prior research conducted, including a quantitative study involving an HIV/AIDS-related knowledge, attitudes, and behaviours (KAB) cross-sectional survey of 127 adolescents aged between 13 and 19 years from 6 randomly selected schools in Khayelitsha – the largest township in South Africa's Western Cape. Statistical analysis

included HIV/AIDS-related knowledge, sexual behaviours, STI prevalence, peer pressure, extent of drug and alcohol consumption, and a number of secondary cognitive variables. This was completed for an MSc dissertation in Evidence-Based Social Intervention at the University of Oxford.

**Research project title: Growing up with Congenital Heart Disease: A qualitative study of the experience of young people aged 13-19.**

**PhD candidate: Ms Mona Killey, University of Liverpool**

Contact details



Ms Mona Killey  
Health & Community Care Research Unit  
(HaCCRU)  
Thompson Yates Building  
Quadrangle  
Brownlow Hill  
The University of Liverpool  
L69 3GB

Tel: 0151 794 5589

Email: [mona.killey@liv.ac.uk](mailto:mona.killey@liv.ac.uk)

Web: <http://www.liv.ac.uk/haccru/>

Mona is currently working as a research assistant within the Health and Community Care Research Unit, at the University of Liverpool where she is working on a British Heart Foundation funded evaluation of Paediatric Cardiac Liaison Nursing. From December 2006 she began part time study towards a PhD on young people's experiences of growing up with congenital heart disease.

Supervisors

- Dr Jude Robinson, HaCCRU, University of Liverpool.
- Dr Paula Hodgson, Division of Primary Care, University of Liverpool.

Aims and objectives

Congenital heart disease (CHD) is a heart condition resulting from an abnormality in heart structure, or function, which is present at birth. Treatment for CHD has evolved substantially over the last four decades. Advances in paediatric cardiology and cardiothoracic surgery have resulted in children with CHD now surviving well into adulthood (British Heart Foundation, 2003). Thus, individuals are faced with the task of potentially living with ill health over a longer period of time. This can have a significant impact on many of the normative rites of childhood associated with growing up such as education, the emergence of sexuality, and participation in peer group activities. Moreover, coping with CHD in such a transitional

period as adolescence may pose a threat to an individual's sense of identity and may transform values, expectations, and life priorities. It also raises questions of how the young person manages their condition during this stage of their life. Despite this, research into the childhood and adolescent experiences of living with chronic illness has long omitted this group. Therefore the rationale for this PhD study is based on the dearth of research seeking to understand the experience of living with a complex congenital heart condition from a young person's perspective. The study aims to explore the subjective experience of growing up with complex CHD through the individual biographies of young people diagnosed at birth or soon after.

The main aims of the study are:

- to understand the ways in which young people experience and live with complex congenital heart disease;
- to understand how these young people construct their identities as a result of living with this condition;
- to understand how their illness experiences are shaped and influenced by the social environment, including relationships and social networks, and the system of care.

## Methods

In attempting to understand this experience, this PhD study will employ the biographical-narrative interpretive method (BNIM) for the purposes of interviewing a sample of young people living with a complex cardiac condition. This method of in-depth interviewing has been used for over 15 years, both directly and in a modified version, which would be employed in this study. A single question is asked initially to elicit the participant's experience, and may lead to an account of varying length. A second sub-session then ensues, within which the interviewer asks narrative pointed questions about the topics raised in order to produce even more narrative rich data. The method works on the principle of conceptual openness (Wengraff, 2004), and may be useful where there are no prior hypotheses to be tested, which is akin to the research design employed in this study.

In addition to biographical interviews This PhD project will aim to utilise visual data, in the form of photographs, where possible, in order to enhance and bring visual meaning to the aspects of the illness experience. Moreover, it will attempt to engage with visual data not only as a way of illustrating textual data, but as a medium through which new knowledge may be created. Participants in the research will be asked to bring to the interview various photographs which they feel serve to illustrate some of their life experiences. They will be asked where possible to select photographs that have particular meanings to them as an individual. This method, known as photo elicitation, not only serves as an icebreaker and encourages rapport between researcher and respondent, but it also elicits rich data from the respondent which might not have been achieved through the interview method alone (Prosser, 1998).

## References

British Heart Foundation, (2003) *Congenital heart disease statistics*. London: British Heart Foundation.

Prosser, J. (ed) (1998) *Image based Research: A source book for qualitative researchers*.

London: Falmer Press

Wengraff, T. (2004). The Biographic-Narrative Interpretive Method (BNIM) Shortguide November 2004 (version 22).

### Stage of research process

This study began in December 2006 and has now received ethical and research governance from each of the NHS Trusts involved and recruitment of participants will be underway by the summer of 2007. It is anticipated that this study can be completed within 4-5 years of the start date.

### **Research project title: 'Neuroscience, clinical practice, and the (re)construction of personality disorder.'**

### **PhD candidate: Martyn Pickersgill, University of Nottingham**

#### Contact details

Mr Martyn Pickersgill  
Institute for Science and Society (ISS)  
West Wing  
Law and Social Sciences Building  
University Park  
University of Nottingham  
Nottingham  
NG7 2RD

Email: [LQXMDPI@Nottingham.ac.uk](mailto:LQXMDPI@Nottingham.ac.uk)  
[http://www.nottingham.ac.uk/iss/people/staff\\_role.php?id=MjA1&page\\_var=personal](http://www.nottingham.ac.uk/iss/people/staff_role.php?id=MjA1&page_var=personal)

Martyn Pickersgill is currently undertaking an ESRC '+3' Studentship at the Institute for Science and Society (ISS), University of Nottingham. He began full-time study in 2005 and expects to complete in 2008. His thesis is currently titled, 'Neuroscience, clinical practice, and the (re)construction of personality disorder.'

#### Supervisors

Dr Paul Martin (ISS, Nottingham)  
Dr Alison Kraft (ISS, Nottingham)  
Professor Kevin Howells (Psychiatry, Nottingham)

#### Aims and objectives

- Describe the historical development of the diagnostic category Antisocial Personality Disorder and the causal models used to explain it from the 1950s to the present day.
- Explore how neuroscientific research into Antisocial Personality Disorder is being conceptualised by those researching it.

- Examine how psychiatrists and clinical psychologists use diagnostic criteria for Antisocial Personality Disorder, and investigate the ways in which findings from neuroscience are being integrated into their frameworks for understanding both the category and the patients diagnosed with it.

## Methods

Critical discourse analysis of:

- Documents at the National Library of Medicine, Bethesda, Maryland, and the Melvin Sabshin Library and Archives of the American Psychiatric Association, Arlington, Virginia.
- Transcripts of semi-structured qualitative interviews with neuroscientists, psychiatrists, and clinical psychologists.

## Stage of research process

Currently, writing-up documentary research and analysing transcripts from interviews with neuroscientists. I expect to be interviewing my clinical participants in late spring.

## Invited papers

'Whither Psychopathy? Anti-sociality and American Psychiatry', *The Oxford Forum for Medical Humanities*, University of Oxford, March 1, 2007.

'Antisocial Diagnostics: Changing Accounts of Bad Behaviour in the American Journal of Psychiatry, 1950-2005', *Developments in Mental Health since 1945: International and Local Perspectives*, Centre for the History of Science, Technology and Medicine, University of Manchester, February 23, 2007

'The Ghost of the Psychopath: Antisocial Behaviour in the American Psychiatric Association, 1950-2005', Nottingham Healthcare NHS Trust Managed Innovation Network for History, Duncan Macmillan House, January 31, 2007.

'Seeing is Believing: An STS Response to the Subjects and Objects of Medical Imaging', North American Society for the Sociology of Sport Conference, *Re-Imagining Community/Re(En)Visioning Sport*, November 3, 2006.

'Psychopathy, Delinquency and Antisocial Personality Disorder: Changing Accounts of Bad Behaviour in The American Journal of Psychiatry, 1950-2005', The National Institutes of Health Biomedical History Special Interest Group, the National Institutes of Health, Bethesda, Maryland, September 26, 2006.

## Conference papers

'Neurologic Technoscience and the Sociology of Disordinance', British Sociological Association Annual Conference *Social Connections: Identities, Technologies, Relationships*, University of East London, April 14, 2007.

'Subjects to Objects: The Politics of Imaging Technologies in Clinical Practice', Society for

the Social Studies of Science (4S) Conference, 'Silence, Suffering and Survival', Vancouver, Canada, November 2, 2006.

'Disordering Personality: The Construction and Governance of Somatic Subjectivity', *Vital Politics II*, London School of Economics, September 9, 2006.

'The Disordered Body: the Neuroscientific Reconstruction of Personality Disorder', European Association for the Study of Science and Technology (EASST) Conference, *Reviewing Humanness: Bodies, Technologies and Spaces*, Lausanne, Switzerland, August 25, 2006.

'Imaging/Imagining Antisocial Personality Disorder: Clinicians' Perceptions of Neuroscience in Practice', Postgraduate Forum for Genetics and Society (PFGS) Regional Meeting, *Researching Expectations*, University of York, December 9, 2005.

### **Research project title: The changing needs of people with sight loss**

#### Researchers

Dr Clare Thetford, HaCCRU, University of Liverpool  
Dr Jude Robinson, HaCCRU, University of Liverpool  
Dr Paul Knox, Orthoptics Division, University of Liverpool  
Mrs Jignasa Mehta, Orthoptics Division, University of Liverpool  
Prof. David Wong, St Paul's Eye Unit, Royal Liverpool Hospital

#### Lead contact details



Clare Thetford  
Health & Community Care Research Unit  
(HaCCRU)  
Thompson Yates Building  
Quadrangle, Brownlow Hill  
University of Liverpool  
L69 3GB

Tel: 0151 794 5330

Email: [Clare.thetford@liv.ac.uk](mailto:Clare.thetford@liv.ac.uk)

Website: <http://www.liv.ac.uk/haccru>

#### Funding body

The Pocklington Trust, London

#### Project timeline

Started January 2007 – due to complete by December 2007.

## Aims & objectives

Recent studies have indicated that service providers are not always aware of, or able to respond to the changing needs of people with sight loss. People experiencing sight loss may themselves not be aware of the degree to which their sight has deteriorated, nor have easy access to information about their condition, treatments and supports. This study will identify and explore the changing needs of people with sight loss, using a social model of disability.

## Methods

The study is comprised of: (i) Interviews with 34 people with sight loss, including a biographical narrative interview covering both recent and more distant life stories in relation to sight loss, and completion of a visual function questionnaire; and (ii) Semi-structured interviews with 15 professionals providing health, rehabilitative and social services for people with sight loss.

## Stage of research process

Received full ethical approval and honorary contracts for two NHS Trusts. Currently completing interviews with key stakeholders, service providers and people with sight loss.

## Forthcoming presentations etc.

A workshop will be held in Liverpool upon completion of the project (estimated December 2007). The aim of this session is to share the findings of the research with both professionals and lay people to whom it is most relevant. It will serve as an opportunity to discuss the implications of the research findings for policy and practice. Persons best placed to effect changes in light of the findings of the research will be encouraged to attend. Please contact Clare Thetford for details if you would like to attend. Clare looks forward to hearing from other researchers working in similar or related areas.

## Postgraduate Congratulations!

Medical Sociology Online would like to celebrate the award of Masters Degrees and PhDs in subjects in and relating to medical sociology. This is important not only in celebrating individual's achievements, but also incorporating their work into the body of knowledge of medical sociology.

If you would like to include details of your own recent award in the next edition of MSO please go to: <http://www.britsoc.co.uk/publications/MSOnline.htm>

### Ruth Bridgens

Congratulations to Ruth Bridgens who was awarded her PhD in July 2006 for her thesis entitled, 'Silenced voices: narratives of polio and postpolio syndrome.' Her PhD was funded through an ESRC award at Cardiff University.

#### Abstract

The polio epidemics of the 1940s and 1950s are largely forgotten now, but thousands of people in the UK and millions worldwide who had polio are now reporting new deterioration. This is referred to as postpolio syndrome (PPS), about which the medical profession is often sceptical or ignorant. The thesis explores the experiences of long-term disability after childhood illness and recent contested symptoms in people who had polio as children or young adults. The study consisted of an initial survey of 170 people who had polio, concerning their polio history and recent PPS symptoms, followed by in-depth biographical interviews of 31 people who had varied severity of polio at different ages. Most of the people interviewed had recovered well after a lengthy rehabilitation and sometimes later surgery.

The principal themes of the narratives encompass independence, forgetting polio, working hard, resisting discrimination, and achieving as much or more than other people. Within this dominant narrative are smaller stories of vulnerability and not being listened to as children; a key theme being the general lack of understanding, and especially the lack of acknowledgement by the medical profession in relation to subjective symptoms such as fatigue and pain. Using analytical frameworks from medical sociology, medical anthropology, and disability studies, the thesis demonstrates the complex and paradoxical nature of narratives about long-term disability. These are narratives in which people live in a liminal world, both physically and socially, and attempt to find a balance between normality and difference.

#### Related publications

Bridgens R. (2007) Autoethnography and untold stories. *Qualitative Researcher*, 4: 4-6.

Bridgens R. (2006) The broken doll: looking for memories and making sense of memories. In Milnes K., Horrocks C., Kelly N., Roberts B. and Robinson D. (eds) *Narrative, memory and knowledge: representations, anaesthetics and contexts*. Huddersfield: University of Huddersfield

Bridgens R. (2005) Walking and work: narratives of polio and postpolio syndrome. In Kelly

N., Horrocks C., Milnes K., Roberts B. and Robinson D. (eds) *Narrative, memory and everyday life*. Huddersfield: University of Huddersfield

Bridgens R. (2005) Commentary: Postpolio syndrome -- "We aren't dead yet." *BMJ*, 330 (4 June): 1318-9

Bridgens R. (2005) Postpolio syndrome: what's it all about? *British Polio Fellowship Bulletin*, July: 18-20

#### Written work in progress

Bridgens R. Triumph or tragedy: narratives of disability and liminality, submitted to *Sociology of Health and Illness*

Silence and untold stories: narratives of childhood disability  
(a more close-up view of childhood disability focusing on family relationships and the silence about illness and disability)

Autobiography, polio and paralysis: men's stories?  
(an exploration of gender and disability through polio autobiographies and research interviews)

The patient's disease: illness, disease and the doctor-patient relationship  
(this article will examine conflicts between the doctor and patient's disease stories when the disease does not fit easily into medical paradigms, and the collusion of medical and social scientists in psychologising disease with language such as 'biopsychosocial' or the 'mindful body')

Also in progress is an autoethnographic book loosely derived from the PhD.

#### Related conference presentations

2006 (4-6 September) 3rd mid-term conference of the ESA Research Network 'Qualitative Methods'. *Autoethnography and narrative: survival and 'being lucky'*

2006 (29 June-1 July) Communication, medicine and ethics conference, University of Cardiff. *Autoethnography and the doctor-patient relationship: bladder pain and 'bladder' pain*

2005 (27-29 June) SPA Annual Conference -- Well-being and social justice, University of Bath. *"No triumph, no tragedy": childhood illness, stigma and blame*

2005 (5 April) Narrative, memory and knowledge, University of Huddersfield  
The broken doll: looking for memories and making sense of memories

2004 (16-18 September) BSA medical sociology group conference, York  
Sanguinity or bitterness? Narratives of polio and postpolio syndrome

2004 (3-5 June) Communication, medicine and ethics conference, University of Linköping, Sweden. *Doctors and the invisible: "This leg looks perfectly powerful."*

2004 (3 April) Narrative, memory and everyday life, University of Huddersfield  
Walking and work: narratives of polio and postpolio syndrome

2003 (26-28 June) Communication, medicine and ethics conference, University of Cardiff.  
*Silenced voices: understanding postpolio syndrome through illness narratives*

## Lindsey Dawson

Email: [lindsey-jane.dawson@liv.ac.uk](mailto:lindsey-jane.dawson@liv.ac.uk)

Congratulations to Lindsey Dawson who recently received her PhD from the University of Liverpool for her thesis entitled, 'A study of the factors which affect decisions to undergo palliative chemotherapy in patients with advanced Non small Cell Lung Cancer.'

Her PhD on patients with advanced cancer and palliative care / treatment decision making was funded by a North West NHS Research and Development Training Fellowship Grant and was awarded in 2006.

The following papers (working titles) are being prepared for publication drawing from the findings and discussion of the thesis.

- 1) "We all need hope but what hopes do we need"
- 2) "The perception of choice and the management of uncertainties"
- 3) "When one size does not fit all"
- 4) "The naming of cancer and selling of chemotherapy"

## Current and future work

Lindsey will be working as a post-doctoral researcher with Dr E Marshall (Clatterbridge Centre for Oncology) and Professor E Perkins (Health and Community Care Research Unit, University of Liverpool) as a post-doctoral researcher. She will be exploring the impact of palliative treatment regimes upon the family / carers; and patient and professional experiences of early hospital discharge versus inpatient care for the management of low risk febrile neutropenia in cancer patients.

## Lydia Lewis

Email: [lydia.lewis@warwick.ac.uk](mailto:lydia.lewis@warwick.ac.uk)

Tel: 02476 523120

Congratulations to Lydia Lewis who was recently awarded her PhD from the University of Aberdeen for her thesis, 'User Involvement in Mental Health Services: A Feminist Critical Discursive Analysis'.

The study aimed to explore the outcomes of user involvement in mental health services for the participation of women and men service users and for service development, and determine implications for policy and practice.

The research was carried out in the north-east of Scotland and conducted from a feminist and critical discourse analytic perspective. Its focus was on how (gendered) power relations operate in and through language within the field of user involvement in mental health services. A multi-method research design was employed that included analysis of national and local government mental health policy documents, participant observation at meetings of three mental health service user/community groups, and in-depth interviews with service users, providers and practitioners who took part in local user involvement activities.

A number of effects of policy discourses surrounding user involvement were found. The discourses served to homogenise and pathologise users of mental health services, whilst eclipsing socio-political factors associated with distress and experiences of service usage, including those of gender and social class. They also served to create *disorders of discourse* – misunderstandings and conflict – between users and service providers/practitioners in the study field. A variety of ways in which user involvement operated as a case of power *over* discourse, for example through the regulation of the nature of the debate within policy forums, were identified. Power was also found to operate *in* and through discourses and discursive practices in the field setting. This included through the dominant discourse of 'mental illness' and the ways in which this worked to undermine users' authority and credibility. In the face of these processes, users engaged in discursive struggle to (re)claim power and authority in their interactions with mental health services. Gender was found to be a silent, yet omnipresent, dimension of power in the field setting.

The thesis concludes that the discourse order of mental health services in the region had been reconfigured as a result of user involvement, but without significant changes to the social organisation and power relations of these. Consequently whilst there was evidence of the transformatory *potential* of user involvement, this was presently discursively and structurally constrained. The main social effect of user involvement was therefore to reinscribe and reproduce existing hegemonies within mental health services, albeit whilst destabilising these to some degree by opening space for a 'user presence' and for contention of existing ideologies and service arrangements by users.

Recommendations for mental health policy and practice include the need to shift services further towards a social model of mental distress, and to revalue lay and experiential knowledge. A rearticulation of user involvement policies to give greater recognition and support to autonomous organisations and to enhance engagement with issues of power and social inequality is also recommended. Implications for political practice and organising in the mental health field include the need: for autonomous organisations; to build symbolic and

social capital; to engage in consciousness-raising; and to buy into the current social and political climate.

Lydia now holds an ESRC/MRC Post-Doctoral Fellowship in which she is further exploring aspects of her PhD topic until September 2008.

## Related publications

### Articles

Lewis, L. (2007). Interpretive Authority and the Gender Lens. *Sociological Review*, 55 (2): 273-292.

Lewis, L. (2005). User Involvement within Scottish Mental Health Policy: Locating Power and Inequality. *Scottish Affairs*, 51 (Spring): 79-107.

### Reports

Lewis, L. (2004). *User Involvement in Mental Health Services in Grampian*. Briefing paper published at the University of Aberdeen, November 2004. Available at: [www.aberdeenccn.info/Web/Site/MiscPages/publications.asp?menuID=9&MenuItemID=17&MenuType=MENU](http://www.aberdeenccn.info/Web/Site/MiscPages/publications.asp?menuID=9&MenuItemID=17&MenuType=MENU)

## Related conference presentations

‘User involvement in mental health services: the place of personal experience and emotions’. *British Sociological Association Medical Sociology Group Annual Conference*, Heriot Watt University, Edinburgh, Sept. 2006.

‘User Involvement within Scottish Mental Health Policy: Locating Power and Inequality’. *International Joint Congress, European Perspectives on Changing Health Systems*, hosted by the European Society for Health and Medical Sociology and la Societa Italiana di Sociologia della Salute. Bologna, Italy, September 2004.

‘Researching User Involvement in Mental Health Services: ‘Uncovering’ Gender’. *Sociological Challenges: Conflict, Anxiety and Discontent*, British Sociological Association Annual Conference. University of York, March 2004.

‘User Involvement Discourses in Mental Health Policy: A Critical Feminist Analysis’. *Social Futures: Desire, Excess and Waste*, British Sociological Association Annual Conference. University of York, April 2003.

‘Gender and Shared Decision-Making in Psychiatry’. Invited contribution to the *North East Medical Sociology Conference*. University of Aberdeen, March 2002.

## Forthcoming conference presentation

‘The Women’s Movement, The User/Survivor Movement and the Politics of Mental Health (Services)’ . Oral presentation to be delivered to The *Second International Conference on Interdisciplinary Social Sciences*, University of Granada, Spain, 10-13<sup>th</sup> July 2007.

## Marisa G Lincoln

Email: [Mgl66@open.ac.uk](mailto:Mgl66@open.ac.uk)



Congratulations to Marisa Lincoln who was recently awarded a PhD from City University, London for her thesis titled, 'The impact of economic rationalism and new public management on health and welfare provision: accounting for the gap between social health care policy and practice in two Scottish maternity care units.' Marisa currently works for City University on the BSc in Health Science programme.

### Abstract

The administration of welfare in Britain and beyond, in the last thirty years, has seen a series of changes culminating in the new public management (NPM) approach in the delivery of public services. Current literature suggests that traditional collectivist values underlying state welfarism are at risk under the precepts of NPM and economic rationalism (Hood 1991; Clarke and Newman 1997; Hunter 2002). Since rigid economic calculation is not always possible or rational on a social, psychological, or medical scale, social policy prescriptions have to bend to its calculative pulse.

The study took place in Scotland where two highly contrasting maternity units were investigated. In-depth interviews were carried out with a sample of 43 health practitioners and key financial management personnel.

The comparison of the two sites highlights how organisational size, structure and the midwifery system in place can impinge on the viability and implementation of social health policies such as those recommended in the Cumberledge Report (1993).<sup>1</sup> Whilst constrained budgetary procedures have hampered the full expression of service user choice and continuity of care, largely due to inadequate staffing or practitioner skills, the dictates of new public management have had a more turbulent impact on the larger than on the smaller unit.

Service user choice is not only inhibited by economic rationalism but also by internal institutional agendas. The obstetricalisation of childbirth, for example, conditions demand and, therefore, affects choice for the service user. The gap between social health policy and

---

<sup>1</sup> Cumberledge Report (1993) *Changing Childbirth* London HMSO

practice is widening as mergers take precedence over the retention of smaller, relatively low-tech maternity care units.

The thesis concludes that a comprehensive approach towards health and health care, where service user choice and continuity of care are recognised, and which considers the social context in which economic action takes place would lead to improved health and welfare outcomes overall.

#### Related publications

Lincoln, M.G. (2006) The social health care policy implementation gap: moving beyond the impacts of the 'new' public management *Public Policy and Administration* 21(4) Winter 2006

Lincoln, M.G. (2004) 'Changing Childbirth' and Maternity Services in Scotland *Aims Journal* 16(1): 18-20

#### Written work in progress

Lincoln, M.G. (2006) Economic rationalism and the centralisation experiment: the closure of small and medium-sized maternity units

Lincoln M.G. (2006) Priorities in the provision of health care: social health care and the professions

Lincoln M.G. (2006) The impact of managerial reform on two health care organisations: finding solutions beyond NPM

## Sachlav Stoler-Liss

Email: [sachlavs@hotmail.com](mailto:sachlavs@hotmail.com)



Congratulations to Sachlav Stoler-Liss who was awarded her PhD in May 2006 from Ben Gurion University of the Negev, Israel. Her thesis titled, 'Health promotion and health education in multi-cultural societies: The case of Israeli mass immigration (1949-1956) (Hebrew), was funded by The Israel National Institute for Health Policy and Health Services Research.

### Related publication

Stoler-Liss, S. and Shvarts, S. (2004). "Fighting ignorance and undeveloped habits": Doctor's and nurses' conceptions regarding immigrants during mass immigration to Israel, 1949-1956. *Israel* 6 (31-62) (Hebrew).

### Related conference presentations

Stoler-Liss, S., Shvarts, S. and Bursztein, V. "Fighting ignorance and undeveloped habits": Doctor's and nurses' conceptions regarding immigrants during mass immigration to Israel, 1949-1956. September 2002 – 38<sup>th</sup> International Congress on the History of Medicine, Istanbul. (English)

Stoler-Liss, S. "One foot on the steering wheel – the other on the window" – Israeli nurses and road delivery in the 1950s. October 2002, Birthing and Bureaucracy: The history of childbirth and midwifery, Sheffield. (English)

Stoler-Liss, S. and Shvarts, S. "Easier than extracting a tooth": Doctors, abortions and the Israeli nation-building process. Health between the private and the public-shifting approaches, 6<sup>th</sup> annual conference of EAHMH (European Association for the History of Medicine, Oslo, September 2003. (English)

Stoler-Liss, S. and Shvarts, S. "The medical reasons, as you all know, are highly subjective" – Abortions, doctors, and the Israeli nation building process. 5<sup>th</sup> European Social Science History Conference, Berlin, March 2004. (English)

Stoler-Liss, S. and Shvarts, S. "I do respect": Public health nurses, cultural differences and the mass immigration to Israel during the 1950s. 11<sup>th</sup> Qualitative health research conference, Utrecht, May 2005. (English)

Stoler-Liss, S. and Shvarts, S. "Does mother work for Tnuva dairy?": Breastfeeding, national

ideology, public health nurses and the mass immigration to Israel during the 1950s. 6<sup>th</sup> European Social Science History Conference, Amsterdam, March 2006. (English)

#### Forthcoming conference presentations

“Ignorance is the Immigrants’ worst enemy”: Social interpretation of the medical absorption of immigrants to Israel during the 1950s. Submitted to the American Sociological Association, New York for presentation in August 2007.

#### Future research directions

Sociology of health; health and immigration; gender and health; sociology of the body; health and communication.

## Anne Townsend

Email: [atownsen@interchange.ubc.ca](mailto:atownsen@interchange.ubc.ca)



Congratulations to Anne Townsend who was awarded a PhD for her thesis, 'Multiple morbidity and moral identity in mid-life: accounts of chronic illness and the place of the GP consultation in overall management strategies.' Funded by the MRC, Anne's PhD was completed at the University of Glasgow and awarded in December 2005. Anne is currently a Post-Doctoral Fellow in the Centre for Applied Ethics at the University of British Columbia, Vancouver where she is building on her PhD findings, and interviewing people with a recent diagnosis of rheumatoid arthritis (RA). She is interested in the moral dimension of living with RA, and its ethical implications. This is a collaborative study with members of the Canadian Arthritis Network and Anne is keen to make international comparisons. Anne is also involved in a Knowledge Translation Study in Canada.

### Related publications

Townsend, A., Hunt, K. & Wyke, S. 2003, 'Managing multiple morbidity in mid-life: contradictions and tensions around medication use. A qualitative study', *British Medical Journal*, vol. 327, pp 837- 840.

Townsend, A., Wyke, S. & Hunt, K. 2006, 'Self-managing and managing self: practical and moral dilemmas in accounts of living with chronic illness', *Chronic Illness*, vol. 2, pp 185-194.

### Written work in progress

'Exploring consulting behaviours'  
'Accounts of the GP consultation'

### Related conference presentations

Townsend, A., Hunt, K. & Wyke, S. 2003, 'Managing Multiple Morbidity in mid-life: contradictions and tensions around medication use', *The Annual Medical Sociology Conference*, The University of York, UK

Townsend, A. 2004, 'I never let my health get me down I'm better than that: Managing multiple chronic illness and maintaining moral character', *The Couch-Stone Winter Symposium of the Society for the Study of Symbolic Interaction*, Vancouver, BC, Canada.

Townsend, A., Wyke, S. & Hunt, K. 2005, “‘I know I’m being daft when I say I’m just going to carry on’”: Managing chronic illness in daily life’. *New Perspectives, International Conference on Patient Self-management*, The University of Victoria, Vancouver Island, BC, Canada.

Hunt, K., Wyke, S., Ziebland, S. & Townsend, A. 2005, ‘A Necessary Evil? People’s Negotiations of Medication Use Within Self-Management’, *New Perspectives, International Conference on Patient Self-Management*, The University of Victoria, Vancouver Island, BC, Canada

#### Forthcoming conference presentations

‘Exploring consulting behaviours’ Paper in progress for the *Annual Society for Social Medicine conference, 2007*

‘Accounts of the GP consultation’

Paper in progress for the Annual Medical Sociology conference 2007

## Review of ESRC Seminar - The Narrative Turn: Revisioning Theory

Part of a Seminar Series entitled 'Narrative Studies in Interdisciplinary Perspective: Theories, Methodologies and Revisions.'

Centre for Narrative and Auto/Biographical Studies

University of Edinburgh

23<sup>rd</sup> March 2007

**Mona Killey and Clare Thetford**

*University of Liverpool*

A bright and sunny spring morning found us at the charming city campus of the University of Edinburgh. We had made the journey north, along with 70 other academics, from PhD students to professors, to attend the first in a series of narrative focused seminars organised by the centre for Narrative and Auto/Biographical Studies at the university and funded by the ESRC.

The inaugural seminar entitled 'The Narrative Turn: Revisioning Theory' promised an exciting programme of speakers. These scholars hailed from a range of disciplinary fields and presented papers which were not directly related and yet seemed to feed into each other as the seminar progressed. The format of the day was paper giver followed by discussant, with the latter commenting on the arguments and premises put forward by the former. The whole afternoon had been put aside for questions and discussion of the presented papers, and this was facilitated by the submission of questions to the Chair (Professor Liz Stanley) prior to the afternoon session. The written questions were intended to relieve some of the pressure associated with raising your hand to ask a question, particularly for less experienced researchers surrounded by some much esteemed academics. As junior researchers ourselves we thought this was a great move and welcome further use of such an approach. However, subsequent discussion on email lists have highlighted that some participants found this to be restrictive in facilitating debate.

After feeling a little disengaged from and overwhelmed by the amount of presentation during the morning session, the day suddenly came to life in the afternoon. Professor Stanley made a formidable chair not only in keeping the presenters in check but in challenging them with some tough questions. In addition, her evident knowledge of the particular area brought together so coherently the strands of discussion. The content of the papers presented was interesting and thought provoking, and highlighted not only the range of theoretical ideas and approaches to narrative, but also the areas in which these different and often conflicting ideas intersect. The day generated three overarching themes. The issues of: interdisciplinarity, and whether it is a desirable feature of narrative theory; reflexivity and the presentation of self; and finally the issue of small stories or individual narratives, and what they contribute (or not) to the field of narrative research.

A great deal of stimulating and vibrant discussion was had, as each set of presenters responded to some well formed and testing questions. The issues presented in the morning sessions were lifted beyond the abstract and considered in light of the reality of applying such theory to research projects. For us, this was where the success of the day was found. We also welcomed the opportunity to hear and learn from scholars who were well established in their different disciplinary fields, although some of their presentation styles did not do their evident

expertise any justice. We left with our heads buzzing having taken away a great deal to consider in our own work, not least the various streams of theory underpinning narrative research, and the apparent divergences in this approach as a form of social inquiry across different disciplinary fields. We look forward with anticipation to our next visit to Edinburgh for the 3<sup>rd</sup> seminar in September.

**Acknowledgements:** We would like to thank our hosts the Centre for Narrative and Auto/biographical Studies at the University of Edinburgh, in particular Andrea Salter, Liz Stanley, Liz Bondi, Louise Jackson, Susan Manning and Steve Tilley for their organisation of the event. We would also like to thank the ESRC not only for funding the seminar series, but also travel to and from the seminar allowing many PhD students and junior researchers to attend at little cost to themselves or their institution.

This ESRC Seminar Series is ongoing during 2007 and 2008. It is anticipated that each of the seminars will have a different format, so forthcoming seminars will have further space for discussion and different arrangements of papers relative to questions and comments. Attendees at the inaugural event are invited to at least one other seminar in the first three of the series, to be held this year. Therefore it is hoped that the series will allow ongoing discussion of the issues that arise throughout. For more information about the Seminar Series please see: [www.sps.ed.ac.uk/NABS/](http://www.sps.ed.ac.uk/NABS/)

## Seminar Series on Mental Health: Halfway Report

**John Aggergaard Larsen**

*University of Surrey, co-organiser of the ESRC seminar series*

The study of mental health is in a vital period sparked by methodological and theoretical developments in the social sciences, but also driven by a wave of critical and self-reflexive thinking by leading figures in the clinical practitioner disciplines. While the 1960s saw a boost in theoretical developments energised by Goffman's observations of the institutionalising effects of the mental health asylums and the anti-psychiatric movement, a 'new wave' of critical examination of mental illness, mental health policy, psychiatric treatment, talking therapy and social care is emerging. This is happening against the background of active service user involvement in policy development and research, supported by a current policy agenda with emphasis on person-centred care and giving the service user a say in decisions on their treatment and care.

A series of four seminars is currently underway in the UK to bring together academics, clinicians and service users to discuss the direction and possible future implications of this 'new wave' in the critical social science of mental health and psychiatry. The current political and research climate is ripe for this opportunity for social sciences to engage with partners working and living with concerns of mental health and illness. The time has passed for social sciences to just be taking a critical side stand. At the same time, the popularity of applying social science approaches needs careful scrutiny to ensure that they retain and further develop their critical and theoretical powers to raise questions to the powers of the day.

The series of four seminars was developed in interdisciplinary collaboration between social scientists from institutions across the UK, and it is supported by funding from the ESRC. The first seminar was held at the Royal College of Psychiatrists in London in November 2006, and it provided an overview and examination of innovative methods for researching mental health issues. In the keynote presentation the anthropologist Professor Sue Estroff (author of 'Making it crazy') shared her experience of working in the USA as a social scientist in collaboration with mental health practitioners and service users, stressing the need for research and 'evidence' to remain committed to lived experiences. Other presentations discussed how an anthropologist contributes to the clinical knowledge production in a London mental health team, the usage of historical and archival research on psychiatric treatment and the need for advancing epistemological reflection on user-lead research. The afternoon included presentations on combining quantitative and qualitative approaches, collaborative film-making and the perspective of embodiment in research on voice-hearing. The seminar concluded with an open discussion with the audience led by Professor Estroff.

The second seminar on 'Mental health, social exclusion and inequality' was held at the University of Manchester in March 2007. The first session included presentations outlining our current understanding of the relations between mental illness and socioeconomic and ethnic status, arguing the need for a better empirical and theoretical integration with clinical knowledge. The second session examined the concept of social capital in relation to social exclusion. In the third session it was asked how policy may influence mental health, and how social scientists and service users can act to influence policy developments. Presentations from the first two seminars are available to download as slides and audio from the seminar series website (see below).

The third seminar is on 'The life world and emotional wellbeing' and will take place in

Nottingham on the 28<sup>th</sup> of September 2007. The seminar series will be concluded with a discussion of the role of mental health social movements at the University of Essex in March 2008. Please visit the seminar website for registrations and further details: <http://www.mhseminars.info>.

## A Day in the Life...

**Penny Sargent – PhD Student**

*University College London*

Email: [p.sargent@ucl.ac.uk](mailto:p.sargent@ucl.ac.uk)

22 March 2006: After a cycle, train journey and tube across London I arrive at uni, grateful that I managed to avoid any delays on the way. I check my emails over coffee and a muffin then head to the lab building for our weekly Department of Gynaecological Oncology translational research meeting. Today's presentation, by the head of the translational research laboratory, was on CGH micro-array analysis to classify epithelial ovarian cancers. It was very interesting to learn about the complexities of ovarian tumour analysis and classification. I can now appreciate how time consuming, expensive and technically difficult the process is. The discussion ran a little over time so afterwards I had to rush to main campus to attend the statistics course I'm enrolled on.

After a morning of learning about survival analysis I head back to the Department of Gynaecological Oncology to attend a lunchtime journal club. Today's paper is on the healthy volunteer effect and is presented by one of the Research Fellows in the department. The paper was quite complex but highly relevant to the main research being conducted in the department, which is the United Kingdom Collaborative Trial of Ovarian Cancer Screening, a randomised controlled trial involving 200,000 post-menopausal women. My PhD research is a symptoms sub-study attached to this trial.

After journal club I have a quick update meeting with my supervisor to discuss how my PhD research is progressing. I was happy to inform her that I received full ethical approval a few days beforehand. We discuss my plans to visit Belfast, Gateshead, Llandudno, Nottingham and Portsmouth to conduct interviews for my project. I'm thoroughly looking forward to starting data collection!

In the afternoon I go to statistics for a practical session then I head back to my desk to check emails, read journal articles and work on my methodology chapter. At five o'clock myself and other PhD students in the department attend a presentation on 'how to write a conference poster', followed by wine and nibbles. When this finishes I head home to do some training for the Himalayan mountain climb I've got booked for April.



*Penny at the foot of Mt Mera in Nepal, following her successful climb to the summit.*

## Obituary: David Kelleher

David Kelleher, who has died suddenly from a stroke aged 71, was a well known figure in British medical sociology. His background, like many sociologists from his generation, was not initially in the sociology discipline. After his National Service in the early 1950s, David read for a degree in English at Goldsmiths College in London as a mature student. A period of teaching in South East London was followed by lecturing posts, initially in teacher education and then at Guildhall, now London Metropolitan University. In the early 1980s David undertook a Master's course in medical sociology at (the then) Bedford college in London. During this period David became increasingly interested in social aspects of health and illness, and went on to undertake research on the experience of living with diabetes. His book on the subject was published by Routledge in 1988. In subsequent years David focussed on the role that self help groups can play in the lives of those living with chronic conditions; his work in diabetes and self-help remains influential on research in the field. For example in a paper by Rona Campbell and colleagues on 'meta-ethnography' (Campbell et al. 2003) David's discussion of coping and normalisation in the experience of diabetes was used to synthesise research from other sources.

From his base at London Metropolitan, where he was now teaching sociology and research methods, David developed a range of contacts and projects with local groups in the East End of London. These focussed particularly on the health experiences of ethnic minorities, first among the Bangladeshi population, and then in the Irish community. Working with his colleagues Sheila Hillier and Gerry Leavey, David explored the wider role of identity (ethnicity being only one dimension) and health status – a topic about which David had strong and complex views. Two edited collections on ethnicity and identity were published as the result of these collaborations: *Researching Cultural Differences in Health* (with Sheila Hillier) in 1996 and *Identity and Health* (with Gerry Leavey) in 2004. David's other main interest was in the writings of the influential German sociologist Jürgen Habermas and this led to further collaborations and publications. David's most recent book (published shortly before he died, and co-edited with long-term colleagues Jonathan Gabe and Gareth Williams) was a second and revised edition of *Challenging Medicine* – documenting the far reaching changes in health care and the medical profession at the turn of the 21<sup>st</sup> century. David's work has been influential on a generation of young sociologists interested in health; as an active member of the British medical sociology 'study group' he will be remembered by many for his generosity of spirit and his supportive and encouraging approach in developing their own work. Formal recognition came in the shape of a Readership, conferred on David by London Metropolitan University in 1991.

### Reference

Campbell, R., Pound, P., Pope, C., Britten, N., Pill, R., Morgan, M. and Jenny Donovan (2003) Evaluating meta-ethnography: a synthesis of qualitative research on lay experiences of diabetes and diabetes care. *Social Science & Medicine* 56(4): 671-684

Professor Mike Bury  
Royal Holloway University of London

## Peter Marris: an appreciation

Peter Marris died on 25<sup>th</sup> June 2007 at the age of 79. He first came to prominence as one of the group of sociologists, headed by the late Michael Young (later Lord Young of Dartington) who formed the now legendary Institute of Community Studies in the East End of London. This group produced sociological classics such as Peter Wilmott and Michael Young's *Family and Kinship in East London* (1957), and Peter Townsend's *The Family Life of Old People* (1957), with their deceptively simple coalescence of social arithmetic and qualitative accounts. Marris's own contribution to the work of that period, *Widows and their Families* (1958), was also an important study, but probably less well known. The Institute, now The Young Foundation, continues its work on 'social action and research', recently publishing *The New East End*, a portrait of the dramatically changed streets and homes of Tower Hamlets.

I first came across Peter Marris when I was studying for my MSc in medical sociology in 1979 at what was then the Bedford College annexe in Harley Street. He may have been on the reading lists for my undergraduate studies, but if he was I have no memory of him. However, I most emphatically remember reading Marris's *Loss and Change* (1974) on the recommendation of George Brown, who was teaching research methods on the Master's degree. *The Social Origins of Depression* (1978) by George Brown and Tirril Harris had just been published, and George was talking a lot to his students about the social processes that lead to loss and change, and how we can develop sociological explanations for their impact on people's everyday lives and feelings. Peter Marris wrote about these things in a powerful way.

I love *Loss and Change* in the same way that I might say I love a particular novel or poem. One of Marris's former students, reflecting on his death, admitted: 'I cried the first time I read Peter's *Loss and Change*',<sup>1</sup> and I know exactly how she feels. Although I never met him, or even saw him across a crowded seminar room, or heard him speak, I feel a deep affection for Peter Marris because of the effect that book had on me. It would be very difficult to summarise what it said and why it had such an effect, but it seemed to me to be a book which put the sociological imagination to work. The question which preoccupied Marris was: 'What happens when familiar forms of life are disrupted'? In introducing the collection of chapters that deals with, *inter alia*, bereavement amongst women in the East End of London, slum clearance in Nigeria and the USA, and students' experiences of higher education, he tells us how he came to see that each of these studies had something to say about the experience of transition: 'In each, as I saw it, the anxieties of change centred upon the struggle to defend or recover a meaningful pattern of relationships... It seemed to me that the concept of grieving could be applied to many situations of change which we would not ordinarily think of as bereavement...'.<sup>2</sup>

---

<sup>1</sup> Ann Forsyth (2007) 'Truly great teachers: remembering Peter Marris', *Planetizen: the Planning and Development Network*. <http://www.planetizen.com/node/25428>

<sup>2</sup> Peter Marris (1974) *Loss and Change*, London: Routledge and Kegan Paul, p1

While lots of social scientists write about the connections between personal troubles and public issues, Marris demonstrated them in the very texture of his prose. Strangely enough, I never really considered Peter Marris to be a sociologist. I had always thought of him as someone who wrote beautifully about urban policy and planning, partly because of his work on slum clearance (originally in *Family and Change in an African City*, 1961), and partly because of his work with Martin Rein on community action projects in American cities during the period of President Lyndon Johnson's 'War on Poverty' in the 1960s (*Dilemmas of Social Reform*, 1967) – which contains important substantive and methodological lessons for what we refer to these days as 'regeneration'. In the mid-1970s Marris moved to the United States, eventually becoming an American citizen. Marris returned to the themes of his early work in *The Politics of Uncertainty* (1996), writing with the analytical skill and literary flair that characterised all his writing. But it is no surprise to read in Michael Wilmott's obituary in *The Independent* that it was *Loss and Change* of which Marris himself said: 'It is the work I care about most, and hope it will not be forgotten'.

As Hazel Blears settles into her new role as Secretary of State for Communities and Local Government, I like to think of Peter Marris as an angel, hovering at her shoulder, whispering. If that is too fanciful for the readers of Medical Sociology Online, then perhaps I should just say that I would feel comforted by the thought of a copy of *Loss and Change* on the Secretary of State's bedside table.

**Gareth Williams**  
**School of Social Sciences**  
**Cardiff University**



Monograph Series Editor:

Dr Hannah Bradby  
Department of Sociology  
University of Warwick  
Coventry CV4 7AL  
[h.bradby@warwick.ac.uk](mailto:h.bradby@warwick.ac.uk)

## **Call for papers**

### **Communication in Healthcare Settings: Policy, Participation and New Technologies**

Edited by: Alison Pilnick (University of Nottingham), Jon Hindmarsh (King's College London) and Virginia Teas Gill (Illinois State University).

Proposals for papers are invited for contributions to the fifteenth monograph in the series to be published by *Sociology of Health and Illness* in conjunction with Blackwell Publishers. The monograph aims not only to build on the existing foundations of interactional research in medical sociology but also to broaden the scope of this field by featuring studies involving a varied range of healthcare professionals and a wide range of healthcare delivery sites. The volume will focus on the following themes:

- The use of new technologies in healthcare interaction.
- Participants' orientations to new healthcare policies and procedures and the way in which policies are (or are not) talked into being.
- Professional/client interaction in professions allied to medicine.
- Interaction between clients with communication disorders and healthcare workers.
- Interaction in healthcare education and training.

The monograph will appear both as a regular issue of the journal and in book form. We anticipate that most papers will report original empirical research, although we also welcome innovative theoretical and conceptual work. We are keen to receive contributions from an international range of researchers and from young scholars in the field who are currently establishing their research reputations. Those working in social science disciplines cognate to medical sociology are also encouraged to participate.

Potential contributors should send an abstract of up to 800 words by **October 30<sup>th</sup> 2007** to Alison Pilnick ([Alison.Pilnick@nottingham.ac.uk](mailto:Alison.Pilnick@nottingham.ac.uk)). Informal email enquiries prior to submission are welcomed by all editors ([jon.hindmarsh@kcl.ac.uk](mailto:jon.hindmarsh@kcl.ac.uk); [vtgill@ilstu.edu](mailto:vtgill@ilstu.edu)). The abstract should provide a realistic indication of the content of the proposed article and, if reporting an empirical study, include (1) major issue or research question (2) methods (3) data source(s) (4) findings and (5) implications for healthcare practice or delivery. Name and institutional affiliation of author(s) should also be supplied, including full contact details of the main author.

Proposals will be reviewed by the editors and the outcome will be notified by January 14<sup>th</sup> 2008. Authors whose outlines are short-listed will be invited to submit an article of 6000 to 7000 words by **July 1<sup>st</sup> 2008**. All such submissions will be refereed in the usual way for *Sociology of Health and Illness* submissions and should follow the journal's style guidelines (<http://www.blackwellpublishing.com/submit.asp?ref=0141-9889>). The planned publication date is September 20

A free access publication

of the British Sociological Association

# MSo



## Medical Sociology Online

**Formerly Medical Sociology News (MSN)**

*Medical Sociology online (MSo)* will publish high quality articles in the broad area of medical sociology based on original research using qualitative and quantitative methods. As a publication of the BSA MedSoc Group, *MSo* has a special interest in promoting the work of all sections of the academic community, including postgraduates and first time authors as well as people established in their field. *MSo* encourages and welcomes the submission of articles or commentary pieces on research methodology, ethical issues in research, and the teaching and learning of medical sociology.

## Medical Sociology online is now seeking articles

Deadlines are

Autumn 2007: 28<sup>th</sup> September 2007 (Published November 2007)

Spring 2008: 28<sup>th</sup> March 2008 (Published June 2008)

Please access the website

<http://www.britsoc.co.uk/publications/MOnline.htm>

for full submission details, or email the editors on [MSo@liv.ac.uk](mailto:MSo@liv.ac.uk).