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EDITORIAL FOREWORD

University of Liverpool Editorial Team

It is in anticipation of the packed programme for the British Sociological Association's Medical Sociology Group Conference in Durham, September 1st to 3rd, 2010, (<http://www.britsoc.co.uk/events/medsoc.htm>), that we prepare this issue. As usual, the conference promises stimulating papers, debate and (hopefully) inspirational thinking as to how medical sociologists will engage with the challenges in Higher Education, health and society in general over the next decade. It is appropriate, therefore, that in this issue we have papers on methodological innovations; on lay health knowledge in Bolivia; and also Rose Barbour's thought provoking piece that draws our attention to the opportunities for medical sociologists to engage in key health debates and contribute to knowledge, whilst at the same time highlighting some of the very real challenges we encounter when trying to do so. In these articles, the authors show how the unique voice of medical sociology can speak to wider audiences on issues of major significance, emphasising the need for medical sociology to actively to promote the relevance of its work both nationally and internationally, and to ensure that the present contribution of medical sociologists to key contemporary health and social issues is fully recognised.

Despite the high quality of submissions we continue to attract to Medical Sociology online, it is with regret that we announce that this is the last issue that will come from the Liverpool team. While our enthusiasm for MSo has not waned, the opportunity for us to dedicate serious time to the production of each issue has reduced over the last few years. We feel that it is time for another team to come forward to take on MSo and to dedicate the time and energy to its production and development that it deserves. We believe that our particular contribution has been to convert MSo to a free-access, online edition and to introduce a system of peer-review for articles. While a new team may wish to use the current format, they may well wish to bring their own ideas and vision to MSo (as we did) to enable this BSA Medical Sociology Group publication to go on from strength to strength.

If you are interested in considering forming the new editorial team, please contact Jude Robinson (j.e.robinson@liverpool.ac.uk) for an informal discussion, or to express a formal interest to the BSA MedSoc Committee, please contact Jenny Cairns (jenny.cairns@britsoc.org.uk).

If you would like to submit an article for peer-review to Medical Sociology online, please use the link: <http://www.medicalsociologyonline.org/submissions.html>, but please be aware that there may be a delay in the publication of your article until a new team is in place.

The University of Liverpool Editorial Team

Helen Bromley, Paul Harrison (Web Editor), Julia Hiscock, Suzanne Hodge (Edition Co-ordinator), Paula Byrne, Mona Killey, Jude Robinson (Editor) and Sara Wheeler.

Peer-reviewed papers

‘A novel coronavirus was isolated from patients’: recovering the intricacies of microbiological practice from textual accounts of the 2003 SARS outbreak

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ABSTRACT

The idea of the underdetermination of scientific facts is, in part, the legacy of the very first science and technology studies researchers who stepped into laboratories in the 1980s in order to study practical day-to-day scientific work. Working with ethnographic and ethnomethodological methods they found human hands teasing and coaxing recalcitrant ‘natural’ objects into doing what they were supposed to do ‘naturally’. But are direct, first hand perceptions of biomedical practice the *only* means towards the sociological end of recovering the details of laboratory practice? The assumption that ‘yes, they are’ is often to be found in ethnographic scholarship on and around the medical sciences. But *does* the textual rendering of practice – as articles, reports, transcripts, and so on – *necessarily* reduce the possibilities of comprehending practice? This paper suggests not. Working through a case-study of the laboratory-led hunt for the aetiological agent behind the 2003 severe acute respiratory syndrome (SARS) outbreak, it suggests that the kind of *indirect*, ‘second-hand’ perception offered up by texts *can* indeed allow for a partial recovery of the past.

KEYWORDS

Practical medical microbiological work, severe acute respiratory syndrome (SARS), aetiology, textual analysis, styles of practice.

Introduction

‘Experiments’, Ian Hacking once declared, ‘don’t work’ (1983: 229). Apparatuses do not perform, materials do not behave, and manipulations fail. Even when they *do* work, human hands and human ingenuity are ever present, teasing and coaxing recalcitrant ‘natural’ objects into doing what they are supposed to do ‘naturally’. This, the idea of the underdetermination of facts, is in part the legacy of the very first science and technology studies researchers who stepped into laboratories in the 1980s in order to study practical day-to-day scientific work (Collins, 1985; Knorr-Cetina, 1981; Lynch, 1985). But are direct, first hand perceptions of biomedical practice the *only* means towards the sociological end of recovering the details, the hesitations and intricacies, of that practice? Recent studies of, for example, cervical screening (Singleton, 1998), surgical work (Hirschauer, 1991; Moreira, 2006), flow cytometry (Keating and Cambrosio, 1999), immunology (Cambrosio and Keating, 1995), and angiography (Moreira, 2000), might seem to suggest that ‘yes, they are’. There, the overriding preoccupation is with the detailed and observable practices making up the incarnate production of cervical screening, surgical work, and so on and so forth. And, as a result, ethnographic, and in some cases ethnomethodological research methods are deployed in order to understand those practices. But what can be said with some certainty is that in each case the choice of research method(s) would have been dictated not by *epistemological*, but *pragmatic*

considerations: the practices and interventions of interest were, quite simply, directly available, in the here-and-now, for sociological analysis. It is important to maintain this distinction. For it seems that all too often the pragmatic explanation – ‘an ethnographic/ethnomethodological approach was chosen *because direct access to biomedical practices and interventions was available*’ – is allowed to merge with, and in some ways become, an epistemological explanation – ‘an ethnographic/ethnomethodological approach was chosen *because it represented the only way to recover biomedical practice in all its glorious intricacy*’. Rather than standing as ‘one’ means towards the sociological end of recovering practice, direct, hands-on ethnographic methods come to seem as if the ‘only’ means. As Landecker (2007: 21-22) has noted, for instance, ‘the assumption often found in ethnographic and historical scholarship’ on and around the medical sciences is that ‘interviews’ and ‘access to the experience of the person’ are ‘somehow closer to reality than published papers’ (2007, 21-22). And this, of course, has profound implications for the investigation of *past* practices and *past* interventions; the kind of events one can only know *indirectly*. The fact that attention to the past renders ethnographic and/or ethnomethodological methods redundant all too easily leads to the assumption that the name of the research game has to change; that once such methods are ruled out one has to give up the search for a praxiography of the biomedical.

But *does* the textual rendering of practice – as articles, reports, transcripts, textbook accounts, codified data, and so on – *necessarily* reduce the possibilities for comprehending such practice? *Does* it necessarily lead to the deletion of all hesitations and ‘tinkering’ (Knorr Cetina, 1981); in short, to the loss of everything that would be of interest to the sociologist of biomedical practice? These are timely questions. The sheer scale of contemporary biomedical research, often with just one project involving scientists working out of hundreds of laboratories across the world has meant that, even for sociologists who manage to break through the initial ‘access barriers’, the only viable research methods are usually expensive, time-consuming ‘multi-site’ ethnographies. But of course, if texts could somehow be rendered as useful as laboratories to those sociologists, then an important methodological advance would have been made. And that is why this paper seeks to address precisely such questions. In doing so, its aims are twofold. Firstly, it seeks to make the case that the kind of *indirect*, ‘second-hand’ perception offered up by textual analysis *can* allow for a partial recovery of the past. But then, and secondly, in the very manner in which the case is constructed – with, for example, a densely woven narrative style, and deep, painstaking analyses of seemingly unimportant microbiological details – the paper deliberately seeks to provide a glimpse of how such a textual analysis of practice might perform itself into being. Working through a case-study of the laboratory-led hunt for the aetiological agent behind the 2003 SARS outbreak, it advocates the use of textual sources as *primary* informants. In what follows, section 2 tells of a particular diagnostic event that took place during the hunt, and points towards the methodological problems that accumulate once attempts are made to ask ‘how’ the event was achieved, in and as practice. In section 3, a critical examination of the arguments against a textual solution to those problems serves as the prelude to the development of an ethnomethodologically inspired reading strategy. Armed with this textual approach, section 4 returns to the case-study, examining the many textual accounts that surround this particular diagnostic event. Finally, a brief concluding section looks to foreground the substantial analytical gains that accrue once this textual solution to the problem of studying past biomedical practice is allowed to play itself out, ‘in the field’ as it were.

‘SARS is caused by a Coronavirus’

In a ‘global alert’ issued by the World Health Organization (WHO) on 15 March, 2003, a new and emerging infectious disease was born. Whilst describing ‘a series of outbreaks of pneumonia in Viet Nam, Hong Kong Special Administrative Region, and China’, the phrase ‘severe acute respiratory syndrome’ was used for the first time (WHO, 2003a). From a biomedical standpoint, however, the most striking thing about the alert is not so much its performative-work, but the fact that references

to aetiology, and the need to provide this new entity with an aetiological agent, abound. As the co-ordinator of the WHO's outbreak response team, Dr. Klaus Stöhr, was to note some weeks later, the WHO's initial response to SARS was built around the principle that 'the unidentified causal agent could lead to an exceptionally dangerous outbreak'. In the view of 'WHO epidemiologists and virologists, as long as the causal agent remained unknown, and no specific interventions against the agent were available,' the chances of SARS 'establish[ing] endemicity' would increase exponentially. That was why, as Stöhr continued, the 'identification of the causal agent' had been given 'paramount importance in the overall containment strategy' (Stöhr, 2003: 1730). Indeed, just two days after the initial SARS alert, the WHO 'set up a network of scientists from 11 leading laboratories around the world to expedite identification of the causative agent of SARS'. Virological data soon began to accumulate. During a WHO organised press conference on 25 March, for example, Stöhr was able to report on how:

These 11 laboratories in these nine countries have found already two very strong contenders, two viruses which are consistently isolated from many patients from very many different countries. (WHO 2003b)

The two viruses to which he referred were, respectively, a human metapneumovirus from the family Paramyxovirus, and a coronavirus of the family Coronaviridae. But for Stöhr, and indeed for the members of the network whom he sought to represent during that press conference, these were not aetiological significant findings. The fact that more than one virus had been identified was not, in their opinion, evidence that a complex, multi-factorial disease outbreak was in the process of developing. Already, his metaphoric reference to 'two very strong contenders' in the extract above might hint at his belief in some kind of singularity-to-come. But there is no need for any deep rhetorical analysis here. For as he went on to confess during that same conference, 'we are all a bit puzzled by these results'. And the 'puzzlement' of Stöhr's collective 'we' stemmed from the fact that 'it is not normal that one disease is caused by two viruses'. As a result, 'research was ongoing' and 'laboratories would have to strengthen their research activities' (WHO, 2003b).

The first indications that SARS was a 'normal' rather than an 'abnormal' disease were not long in coming. On 10 April, a WHO-SARS laboratory network team led by Thomas Ksiazek at the Centre for Disease Control and Prevention, Atlanta, USA, published the results of their aetiological studies in the *New England Journal of Medicine* (Ksiazek *et al.*, 2003). 'A novel coronavirus associated with SARS' (henceforth NCA) was one of the very first papers to single out the coronavirus, and the coronavirus alone, for aetiological attention:

A novel coronavirus was isolated from patients...and the evidence indicates that this virus has an etiologic role in SARS. (Ksiazek *et al.*, 2003: 1953)

Despite references to various diagnostic techniques – cell cultures, electron microscopes, enzyme-linked immunosorbent assays, reverse transcriptase and real-time polymerase chain reactions systems, and indirect fluorescent antibody tests – the paper also makes clear that 'cell-culture' was the crucial technique during initial 'isolation' attempts:

The identification of this novel coronavirus *relied* on classic tissue-culture isolation to amplify the pathogen and then on electron-microscopical studies to identify the type of virus, a member of the family Coronaviridae, and molecular studies to confirm the identity of the virus, characterise its unique nature, and help link it to the disease. (Ksiazek *et al.*, 2003: 1961 *my emphasis*)

The denouement to this tale of aetiological discovery came soon afterwards, at another WHO-led press conference on 16 April. In an opening statement to the journalists gathered at the WHO's

headquarters in Geneva, Dr. Stöhr made clear that ‘all the data have been put on the table, have been reviewed, and the colleagues have come to a consensus agreement’. The consensus agreement, he went on to note, had been directly informed by the work of Ksiazek and his research team, and meant that ‘we can now, with all confidence, say that the causative agent of SARS is the coronavirus’ (WHO, 2003c).

SARS and the loss of direct medical microbiological practice?

Theoretically, one disease ‘normally’ has one cause; and *empirically*, one disease – SARS – was found to have one cause – a coronavirus. But how was this ‘perfect fit’ actually achieved at the level of medical microbiological practice? Methodologically, a focus on practice – not just what scientists think or write but also what they do and the materials they work with – is now well established in the sociology of science. Since at least the late 1970s, post-positivist and post-Kuhnian scholars have been making various sorties and excursions onto a terrain once considered the sole preserve of epistemologists: the technical *content* of science (see Zammito, 2004: 128-136). In particular, a number of attempts have been made to investigate the technical content of laboratory work via the use of ethnographic, and, in some cases, ethnomethodological methods (Collins, 1985; Knorr-Cetina, 1981; Lynch, 1985). And, as the practical and day-to-day work of laboratories has been opened up to sociological analysis, so too has the *material basis* of that research: ‘experimental systems’ (Rheinberger, 2000) research ‘platforms’ (Keating and Cambrosio, 2003), and research ‘infrastructures’ (Bowker and Starr, 2000); in short, all of those closed-off sections of the material world that scientists employ in order to carry out their day-to-day work.

In my own post-graduate research into the ‘isolation’ of the SARS coronavirus, attention had to be given to the practices and interventions through which a cell-culture was made to yield up a novel coronavirus (Attenborough, 2010). To recover that practice, the material basis of the cell-culture work had to be foregrounded and studied with an almost obsessive attention to detail. And yet, unlike those afore-mentioned post-positivist studies of practice, this was an attention to detail that involved *textual* rather than ethnographic or ethnomethodological methods. Although many archives were consulted, many practicing microbiologists interviewed, and a microbiological laboratory visited on a number of occasions during the research, the path I followed through the field of diagnostic cell-culture technique derived, for the most part, from the published record; that is, from hundreds of little known publications with titles like ‘Proliferative growth of SARS coronavirus in Vero E6 cells’ (Ng, Tan, See *et al.*, 2004); from contemporary laboratory manuals, textbooks and journals; from now out of date manuals, textbooks and journals, some dating back to the 1940s and 1950s; from conference proceedings; from WHO documents, recommendations, reports, updates, press conferences; and so on and so forth.

In a sense, to suggest that textual rather than ethnographic or ethnomethodological methods were deployed is to suggest the obvious. There is, after all, nothing left for the sociologist with an interest in the practical isolation of the SARS coronavirus to investigate: the WHO declared the SARS outbreak over a number of years ago, the laboratory network has long since been disbanded, and the coronavirus has not re-entered the social body since. Yet in another sense it is a suggestion requiring of a little more explanation. For it seems to me that a generally held assumption in the sociology of science is that whenever direct access to the day-to-day doing of laboratory work is lost, then so too is any possibility of recovering laboratory practices and interventions in all their corporeal glory, as they hesitate and as they stutter. On this assumption, of course, my own research strategy would be rendered useless. And, in a sense, one can see why this assumption holds such epistemological credibility. In this particular instance, for example, the only actually existing reference to the direct practical activity of cell-line culturing undertaken by Ksiazek’s research team seven years ago appears in their 10 April, 2003 research article. It is just two sentences in length. With the aetiological question resolved, the hesitations of aetiological *practice* have long since been smoothed

over. Seven years on, and as Latour (1987: 100) might note:

Nature talks straight, facts are facts. Full stop. There is nothing to add and nothing to subtract.

Towards a textual method of studying practice

But then, does this assumption necessarily hold? Does it follow that when direct practice is lost to history, the name of the research game suddenly has to change? I want to suggest that it does not; that just because one is left with textual data, and textual data alone, all possibilities for recovering the intricacies, hesitations and tinkering of practice are not necessarily lost. But how to do so? In a world in which, as I have suggested, direct access to laboratory work is normally equated with the study of such practice, how is it possible to make this suggestion appear at all convincing? In this section, the strategy I pursue is perhaps best described as a 'trial of strength', assessing whether or not the suggestion can stand up to the force of one of the most excoriating critiques of textual methods in the study of scientific practice: Lynch's (1993) *Scientific Practice and Ordinary Action*. Therein, Lynch develops an ethnomethodologically inflected critique of the use of reports, archives, transcripts, codified data, and other such documents by social scientists as representations of practice. It is built around the idea that a 'gap' exists between the work of composing a text and the retrospectively analysable properties of the resultant document. As one traverses this gap; as one moves from the former work of composing to the resultant document, Lynch suggests any active, direct sense of that work is *necessarily* lost. To make this point, Lynch recounts a simple exercise carried out by one of Harold Garfinkel's students, Stacy Burns:

Burns produced a videotape that framed a typist's hands at an electronic typewriter keyboard. The tape documents the typist's hands working at the keyboard while her voice gives a running commentary of 'what she is doing' as she composes the text. The typed document is shown unfolding on a sheet of paper positioned in the carriage while the typist strikes a sequence of keys, crosses out and restarts a passage, and pauses between letters while considering aloud what to do next. The videotape thus frames a distinctive 'pair' of intelligible documents: (1) a 'real-time' video sequence of typing, complete with hesitations and commentary, and (2) a typed page that can be read, copied, and analysed independently of the real-time sequence. On the videotape, the typed page can be seen as the product of a course of work, but when the page is read as a disengaged text, its coherent semiotic features implicate a different order of 'authorship'. The completed sentences stand as documents of a coherent set of 'ideas', 'intentions', 'grammatical competencies', and so forth, *which no longer display the local history of production documented by the videotape. The written text's analytic features do not document the singular 'hesitations', 'interruptions', and 'second thoughts' made evident by the tape.* (1993: 289-290 my emphasis)

As Lynch goes on to note, from an ethnomethodological perspective:

The two documents stand in a relation of 'asymmetric alternation': one document (the videotaped sequence) enables the recovery of the other (the text on the page), but not vice versa; the written text's analysable field *no longer retains a trace of the surplus details* of typing. (1993: 290 my emphasis)

For Lynch, this example:

Clearly demonstrates the kind of *reduction* that is accomplished whenever social scientists use reports, archives, transcripts, codified data, and other such documents as representations of a practice. (1993: 290, my emphasis)

A lack of ‘hesitation’; ‘no trace of a surplus’; a form of ‘reduction’: at the very heart of Lynch’s ethnomethodological enterprise is the denial of any kind of *formal* equivalence between literary representations and life-world activities. Without an investigation of direct practical activity, he suggests, one is able to say very little about that activity. If this is so, then it follows that my ability to recover an understanding of how the cell-culture technique was put to work, is virtually non-existent. As with the typist’s document, bereft of any hint of a ‘running commentary’, so too the various microbiological documents relating to SARS-CoV. Bereft of all ‘hesitations’, ‘interruptions’, ‘surpluses’ and ‘second thoughts’, they would therefore lack any hint of the practical activities that, unlike the textual reports they enabled.

Considering this critique from a literary perspective, however, Lynch seems unnecessarily pessimistic about the use of texts in the study of practical scientific work. His critique, built as it is around a seriously retro understanding of a text’s ‘implied reader’ (see Wales, 2001), presents the social scientific reader as something of a ‘textual dope’; as someone who only ever seems capable of following, very directly, in the footsteps of a text’s author. What that author, as an author, manages to lose, is subsequently lost forever to the reader. Lynch’s social scientific reader is never able to see beyond the ‘reductions’, or the ‘losses’ perpetrated by the text. But as the narratologist Toolan makes clear (2001: 68 my emphasis), this understanding of a text’s ‘implied reader’ would be frowned upon by most contemporary literary theorists:

We assume that the author had a particular kind of reader in mind. But then again perhaps they did not, *or perhaps – as reader – I don’t care even if they did, and refuse to comply with that oblique effort to include or exclude me.* As Walter Ong pointed out [in *Orality and Literacy* 1982], the writer’s audience is always a fiction, a convenient provisional target. *Real readers, real audiences, can apprehend stories in quite unpredicted ways, seeing a different point to them.*

Of course, whilst it *is* true that microbiological documents relating to the cell-culturing of the SARS coronavirus did, when considered as isolated entities, present formal, purified and simplistic accounts of that work, this was by no means an insurmountable problem. For it *was* possible to apprehend those documents ‘in quite unpredictable ways’, ‘seeing a different point to them’, and drawing out the details of the practical activities that were implicated within the stories they told. And in two ways. *Firstly*, by focusing upon the seemingly innocuous and mundane technical details included within those documents: here the phrase ‘cytopathic effect’; there the phrase ‘master seed’; here the term ‘inoculation’; there, the make-up of the cell-cultures. And then, *secondly*, by dragging those phrases away from their ‘host’ text and into the (inter)textual mass of medical microbiological, and SARS related research literature. Indeed, that mass of literature, the *intertextual* in literary terms, is something else that Lynch’s critique of textual methods fails to take into account. For such is the *sheer scale* of contemporary scientific publishing that there is always a way to become a (non)implied reader; or, put another way, there is always a way to take a mere ‘detail’, extracted from its ‘host’ text, *somewhere else*: here, a different opinion regarding its importance; there, a microbiologist who tropes that detail in an entirely different way; here, an out of date microbiology textbook that reveals something about that detail which is now passed over in silence by contemporary textbooks; there, the work of a different research group that has begun to problematise that detail. And so on and so forth. If Lynch’s implied reader can be said to be a little too good-mannered, then today, there are plenty of ways that one can find to abuse the isolated scientific document.

An ethnomethodology of the text

Defensive *theoretical* arguments to one side, however, there is also a purely *pragmatic* argument to be made for the use of textual methods in the recovery of medical microbiological practice. For

certainly in the case of the cell-culturing episode, the menial task of reading literally hundreds of documents quickly came to seem *the only adequate way* to enter into the doing of that diagnostic work; the only adequate way, in other words, to get at what Landecker has referred to as ‘the texture and the density of a whole field of activity’ (2007, 22). The sheer scale of SARS research, the involvement of medical microbiologists working out of hundreds of laboratories across the world, would have meant that any direct, ethnographic or ethnomethodological methods would have limited one’s ability to roam freely across the ‘research front’. And unhindered, almost anarchic movement, was precisely what was required in order to recover a practical achievement that had slipped into so many temporally and geographically diverse spaces: here, a nasopharyngeal sample collected in a Hong Kong hospital; there, a continuous cell line in Atlanta, U.S., from which a ‘master-seed’ had been taken; here, a cynomolgus macaque in a Rotterdam Laboratory, infected with the coronavirus and waiting to die; there, a genetically modified N protein developed from a strain of the coronavirus and put to work in a research laboratory. Indeed, rather than describing this strategy, somewhat dismissively, as the ‘menial task of reading’, it should perhaps be interpellated as a bona fide approach to sociological research seeking to grapple with the contemporary medical sciences; an approach that takes scientific literature as *a primary informant or source*. And although it was suggested earlier that this research refuses all ethnomethodological methods, perhaps it would be better to suggest that it involves none of the by now well established ethnomethodological methods for studying *material practice*. For what I would suggest is that the obsessively detailed reading method deployed in the following case-study is better described as a form of *textual ethnomethodology*, searching for the incarnate production of microbiological ‘practice’ via the second-hand inscription.

The SARS Coronavirus, considered as a textual event

So, having considered the arguments for and against an ethnomethodology of the text, and having come down on the side of the former, the question I want to ask in this section is how might this method play itself out ‘in the field’? Consider the following extract from Ksiazek’s research paper, NCA. It appears in the ‘Methods’ section (2003: 1954-1956), under the sub-heading ‘Isolation of Virus’:

To identify viruses associated with SARS, we inoculated a variety of clinical specimens (blood, serum, material from oropharyngeal swabs or washings, material from nasopharyngeal swabs, and tissues of major organs collected at autopsy) onto a number of continuous cell lines, including Vero E6, NCI-H292, MDCK, LLC-MK2, and B95-8 cells. All cultures were observed daily for cytopathic effect. Maintenance medium was replenished at day 7, and cultures were terminated 14 days after inoculation. (2003: 1954)

Compared to the kind of methodological discussions taking place under the sub-heading ‘Molecular Analyses’ this extract is both simple and brief. The specific conditions of production for molecular tests are displayed at great length and in painstaking detail, with the presence of human hands and human ingenuity indexing something of the ‘new-ness’ of molecular methods. And yet everything changes when the text turns to cell-culturing technique. Those hands, and that ingenuity, suddenly disappear. The extract above represents the only attention given to such technique in the entire article. Over their many years of use within the medical sciences, they have become *entrenched* methods. And that is why, in comparison to molecular methods, they are taken for granted. Ksiazek and his research team did not feel the need to lead their readers through so many steps here: a few basic references are given, but that is all. Perhaps the only glimpse of human hands and human ingenuity comes with the use of the transitive verb ‘to inoculate’. And yet, even there, nothing is written about the specificities of the process. An entire context of discovery slips away into the

shadows created by this verb. Faced with such ‘slippage’, the fact is that *even* with a close reading of this article; *even* with a reading that could get so close to it, so close to the discipline of medical microbiology, that it would become possible to go native and forget one’s identity as a sociologist, there would still be little if any chance of recovering practice. Granted, one would have learnt a great deal about the unquestionable end-result, but one would know next to nothing about how the unquestionable came to pass. As with the example of the typist in Lynch’s ethnomethodological critique, the way in which the unquestionable ‘hesitated’, was ‘interrupted’ and had to deal with ‘second thoughts’ would have been lost. So instead, it is necessary to begin by focusing all attention upon that one word, ‘inoculated’, in which the faintest of hints of human ingenuity can be detected, before then (briefly) dragging it outwards, and into the realm of the intertextual.

Collection, transportation and preparation of clinical samples

As good a starting point as any at this juncture is a laboratory manual, *Jawetz, Melnick & Adelberg’s Medical Microbiology* (Brooks *et al.*, 2007). Therein, a section entitled ‘Purification and Identification of Viruses’ (2007: 380-381) notes that the ‘starting material’ for studies of viruses ‘is usually large volumes of tissue culture medium, body fluids, or infected cells’ (2007: 380). But, as it goes on to make clear, those starting materials have to go through a process of ‘purification’ (2007: 380) prior to their actual inoculation onto a cell-culture:

Pure virus must be available in order for meaningful studies on the properties and molecular biology of the agent to be carried out. (2007: 381)

‘Purification’: the virologists’ Holy Grail. Naturally, *in vivo* as it were, microbes live in communities, existing as a disordered and unruly assemblage. Thus, when seeking one virus from a SARS case sample *in vitro*, the primary task is to separate non-aetiological from aetiological microbes. Another text, this time a laboratory manual, makes clear the diagnostic importance of these attempts at ‘purification’:

Specimen from sites with a *normal flora* (e.g. upper respiratory tract, faeces, genital specimens) – are cultured on selective media *designed to suppress normal endogenous flora but which also allow likely pathogens to grow*...Sputum and urine specimens are sometimes described as ‘*clean contaminated*’, because normally both should be sterile, *although they may become contaminated during sampling*: sputum by upper respiratory tract flora or urine by perineal flora. Some ‘*contaminating organisms*’ may also cause contamination (e.g. pneumococci from the pharynx may contaminate sputum). Quantitative culture is performed to help distinguish *contamination (low numbers of bacteria/several different bacterial species)* from *infection (high numbers of single bacterial species)*. (Elliot *et al.*, 2007: 127 my emphasis)

So let us now relate this procedural information back to Ksiazek’s work of ‘inoculation’. For what Ksiazek and his research team made clear during that article’s introductory section is that they ‘*received clinical specimens* from [SARS] patients in several countries’ (2003: 1953). One of their first research tasks, then, would have involved some kind of ‘purification’ of the ‘received clinical samples’.

So what might that purification have entailed? An answer to this question can be found in the most recent edition of *Fields Virology* (Knipe and Howley (eds.) 2007). Included within chapter 17, ‘Diagnostic Virology’ (Storch, 2007: 565-594), is a small sub-section entitled ‘specimens for viral diagnosis’ (2007: 566). Therein, we find that ‘the likelihood of making a specific viral diagnosis depends largely on the quality of the specimen that is received in the laboratory’. Important variables are listed as ‘the type of specimen, the quality and amount of specimen material obtained, and the

time and conditions of transport to the laboratory' (2007: 566). NCA itself does in fact provide a little information on the *first* variable, the type of specimens received by Ksiazek's research team:

To identify viruses associated with SARS, we inoculated a variety of clinical specimens (blood, serum, material from oropharyngeal swabs or washings, material from nasopharyngeal swabs, and tissues of major organs collected at autopsy) onto a number of continuous cell lines. (Ksiazek *et al.*, 2003: 1954)

And, despite the fact that it omits any reference to the quality of the specimens (variable 2), or the ways in which they were prepared for transport to, and inoculation within, the laboratory (variable 3), such information is not hard to come by. For as has already been mentioned, Ksiazek's research team were working as part of the WHO-SARS laboratory network. As a result, they were using samples prepared and transported along lines set out in the WHO's own laboratory recommendations. The information below, for instance, is taken from a WHO sampling protocol, 'Sampling for SARS diagnostic tests' (WHO, 2003d):

Type of specimen	Method	Medium/ container/ shipment
Nasopharyngeal or oropharyngeal	Swab: use only sterile Dacron or rayon swab with plastic shaft	Sterile vials with viral transport media Ship on ice (+4°C)

Given that NCA refers to its use of nasopharyngeal specimens, and given too that these sampling recommendations suggest such specimens as 'the specimens of choice for the detection of respiratory viruses' (2003d), I want to devote some attention to the WHO's recommended methods for collecting nasopharyngeal samples:

Have the patient sit with head tilted slightly backward. Instil 1 – 1.5 ml of *nonbacteriostatic saline* into one nostril. Flush a plastic catheter or tubing with 2-3 ml of *saline*. Insert the tubing into the nostril parallel to the palate. Aspirate nasopharyngeal secretions. Repeat this procedure for the other nostril. (2003d my emphasis)

Already at the very first stage of specimen collection it would seem that a process of 'purification' has begun. 'Nonbacteriostatic saline', 'saline': removal of unwanted bacteria seems to have been of paramount importance here. Indeed as one laboratory manual concludes, such 'a preliminary purification [at the level of the clinic] will remove most non-viral matter' (Butel, 2007: 380). But what now of variable 3, preparation of those samples for transport? The medium for storage advocated by the WHO was 'sterile vials with viral transport media [VTM]' (WHO 2003d). Why? Because, as one review article puts it, clinical samples collected from the nose will be 'contaminated with microbial flora' (Leland and Ginocchio, 2007: 50). The metaphor of contamination perhaps already suggests what is going to happen to the flora. But another laboratory manual makes its fate even clearer:

Normal endogenous flora must be suppressed...contaminating organisms must be removed during sampling. (Elliot *et al.*, 2007: 127)

This also explains why the WHO recommended that the clinical samples be collected with a Dacron or polyester swab and subsequently placed in a sterile vial with a VTM:

VTMs ‘*contain antibiotics*’ along with ‘a buffered salt solution, and a proteinaceous substance (such as albumin, gelatin, or serum), and a pH indicator’ (Leland and Ginocchio, 2007: 50 my emphasis).

These antibiotics and ‘nonbacteriostatic saline’ solutions, then, marked the start of a decontamination process that would have continued when the specimens arrived at Ksiazek’s laboratory. But even at this stage, there is only one passage from NCA in which any kind of hint is given as to what the laboratory processes of purification might have entailed:

Given the serious nature of SARS and the suggestion of person-to-person transmission, it was decided to handle all clinical specimens in a biosafety level 3 environment. All division into aliquots, pipetting, and culture attempts were performed in laminar-flow safety cabinets in a biosafety level 3 laboratory. (Ksiazek *et al.*, 2003: 1954)

It seems to have been deemed more important to alert readers as to *where* ‘handling’ and ‘culture attempts’ took place, rather than *how* they took place. And so, once again, it is necessary to look beyond NCA in order to understand the activities involved in the practice of ‘inoculation’. Turning once again to *Jawetz, Melnick & Adelberg’s Medical Microbiology* (Brooks *et al.* (eds.), 2007), the following information can be found under the heading ‘Virus culture: preparation of inocula’:

Bacteria-free fluid materials such as cerebrospinal fluid, whole blood, plasma, or white blood cell buffy coat layer may be inoculated into cell cultures directly or after dilution with buffered phosphate solution (pH 7.6). (Carroll, 2007: 725)

However, it is also noted that materials containing:

Bacteria (throat washings, stools, urine, infected tissue, or insects) must be inactivated or removed before inoculation. (Carroll, 2007, 725)

The nasopharyngeal swabs received by Ksiazek’s research team were obviously materials of the latter type. They would have been ‘contaminated’. Processes of ‘inactivation’ or ‘removal’ thus had to be completed in the laboratory rather than the clinic. But how would this have been achieved? Although ‘specimen processing guidelines differ from laboratory to laboratory’ it is nevertheless true that ‘most laboratories clarify certain sample types (e.g., respiratory samples) as follows prior to inoculation into cell cultures’ (Leland and Ginocchio, 2007: 50):

The transport medium tube is vortexed, the swab is discarded, the liquid medium is centrifuged...material may [then] be liquefied in antibiotic – containing medium and filtered through a 0.45- μ m filter. The end product is a supernatant fluid that can be used to inoculate cell cultures. (2007: 50)

A key passage. In virological terms, ‘to *vortex*’ something is to release the contents of the swab into a fluid solution. But it is the use of a *differential centrifuge* in order to ‘centrifuge’ the material that is perhaps of most interest here. In a differential centrifuge:

A suspension is centrifuged at low speed (not >2000 rpm) for 10 minutes to sediment insoluble cellular debris...It is a convenient method for removing many bacteria from heavily contaminated preparations of small viruses. Bacteria are sedimented at low speeds that do not sediment the virus, and high-speed centrifugation (<2000 rpm) then sediments the virus. The virus-containing sediment is then re-suspended in a small volume. (Carroll, 2007: 727-728)

In this way not only *bacteria*, but also *fungi*, *cells*, *blood mucus*, *fibres*, *etc.*, are pelleted into the

bottom of the spun tube, while the viruses in the ‘suspension’, which will not be spun down by the g-force generated by the centrifuge, can be collected. A fascinating form of separation. Much effort in science studies over the years has been devoted to grappling with the question of how scientific controversies close (see Latour, 1987). In the case of this differential centrifuge, we can see this deep, epistemological question being managed as a shallow, and practical task. The technology ends up distributing two (potentially) warring camps – impurity and aetiological uncertainty, and purity and aetiological certainty – into different but co-present sites. Understood in this way, the difference between controversy and controversy *resolution* stands as nothing more, and nothing less, than a few centimetres of murky liquid.

It is also worth pointing out here that the ‘liquid medium’ referred to in the extract above would have been treated with ‘bactericidal agents’, either *antibiotics* or even *ether* if it had been considered non-harmful to the virus in question. These agents would have been added to the supernatant in concentrations of 10-15%. In addition, it is possible that ‘extensively contaminated material’ from the nasopharyngeal aspirates would have been ‘liquefied in antibiotic-containing medium and filtered through a *filter*’ (Smith, 2000: 13). The extract presented above suggests the use of a 0.45- μm (micro-metre) size filter, but in fact the size of the filter would have been up to Ksiazek and his colleagues (the standard sizes are 0.45- μm 0.65- μm and 0.90- μm). Irrespective of the final choice, however, the function of the filter is clear: to separate smaller viral particles from the larger bacterial ‘*debris*’ (Forman and Valsamakis 2003, 1228 my emphasis): bacterial life forms, measuring between 1 and 5 micro-metres in diameter, would not have been able to pass through any of these filters.

Conclusions

In a sense, this paper has been about the *promise* and the *performance* of a textual ethnomethodology of practice. Firstly, the performance. For in methodological terms, instead of ‘telling’ the aim here has been that of ‘showing’, deliberately seeking to provide a glimpse of what a textual ethnomethodology could, or might, look like, through the very construction of the paper. The narrative style at work; the deep reading strategies that get so close to the texts, so close to the discipline of medical microbiology, that it almost becomes possible to go native and forget one’s identity as a sociologist; the unhindered, almost anarchic movement between and across the pages of many, many texts: certainly, these are the characteristics, perhaps even the sacrifices, that my own ethnomethodological method has had to accept in order to reclaim the hints, the traces, the brief flashes of practice, from the spaces of microbiological texts.

Have they been worthwhile sacrifices? This is where talk of the method’s promise is relevant. For although this paper has sought to make the case for an ethnomethodology of the text at a theoretical level, it has also sought to make clear the analytical gains that accrue once this theoretical possibility is put into practice and used to cut into the empirical reality of the text. Considered as an isolated text, for instance, Ksiazek’s 2003 SARS research paper reveals little about the practice of cell-culturing. The precariousness of an aetiological discovery which now, seven years later, seems so certain and so ‘natural’, is allowed to slip away. In this paper, however, I have sought to retrieve something of that precariousness. Focusing on just one word from that paper – ‘inoculated’ – before then dragging it out into the realm of the intertextual, it has been possible to make something happen that would not have happened had those past practices and interventions been left for dead. For what this ethnomethodological reading has yielded is a sense that the practical doing of aetiology, as a medical microbiological event, was the product of a particular ‘style of practice’. This is a term borrowed from the work of Ian Hacking (1992). There, it is used to provide an ‘explanation’ for the fact that ‘despite our recent enthusiasm for refutation and revolution’, an ‘extraordinary amount of rather permanent knowledge’ has accumulated within the laboratory sciences (1992: 29). Hacking’s claim is that:

As a laboratory science matures, it develops a body of types of theory and types of apparatus and types of analysis that are mutually adjusted to each other. (1992: 30)

Styles of practice, then, are self-vindicating entities in the sense that:

Any test of theory is against apparatus that has evolved in conjunction with it – and in conjunction with modes of data analysis. (1992: 30).

This, their self-vindicating structure, is what produces their stability.

So, was the seemingly ‘perfect fit’ between Dr. Stöhr’s normality – one disease has one cause – and the empirical findings accumulated by the cell-culture – one disease (SARS) has one cause (a coronavirus) – a natural, serendipitous occurrence? Or was a self-vindicating style of practice at work here? Certainly, it is plausible to suggest the existence of a particular style of *aetiological* practice at this juncture. Indeed, one only has to reconsider the case-study data to foreground the plausibility of such a suggestion. From the initial gathering of patient samples to the final observation of the cultured cell-line in Ksiazek’s laboratory, a number of technical virological practices were being deployed in order to enact a singular pathogen, isolated and alone: saline solutions, antibiotics, differential centrifuges, filters and so on. Dr. Stöhr’s theory of normality, it seems, was inscribed within the very practices of cell-line diagnosis. Seen in this light, the singular coronavirus was not found, but achieved, and achieved through the kind of practices and interventions that are still, just about, recoverable from our (seemingly) dead, (seemingly) lifeless, textual records of the 2003 SARS outbreak.

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Exploring the challenges of implementing socio-culturally appropriate Primary Health - looking at community health worker training in Bolivia

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ABSTRACT

The need to increase access to health care, particularly in poor marginalised communities, means that training people to provide socio-culturally appropriate care at the local level remains a challenge, thirty years on since the 1978 Alma Ata declaration. This paper explores why training community health workers remains problematic, by revisiting ethnographic data of CODIGO, a community health organisation working in Bolivia. CODIGO clearly frames its health worker training in what it calls 'integrated health'. Implicit in this notion is the need for health care to be socio-culturally relevant. A diverse body of literature is used to reveal the hidden macro-level power dynamics at play in current primary health care practice and also the interrelating factors at the micro-level that affect community health worker training in low and middle income countries (Bastien 1990; Fals Borda 1985; Freire 1996). While the data explored in this paper was gathered in 2003 it remains pertinent and adds a new perspective to the existing literature. May's (1994) work looking at ethnic minority education is drawn on to apply the notion of mutual cultural competency to CODIGO's training programme. Given May's work is influenced by Bourdieu, the notions of habitus, misrecognition and symbolic violence are then employed for the analytic frame (Bourdieu, and Passeron 1990). The paper concludes that the complex and dynamic circumstances of community health care training, especially in socio-culturally diverse and resource poor settings, requires planners to be mindful of the macro- to micro-related factors and then make pragmatic decisions of what can and cannot be done.

KEY WORDS

Cultural competency, primary health care, community health worker training, politico-economic inequalities

Introduction

In 1978 the World Health Organisation (WHO) and United Nations (UNICEF) held a conference in Alma Ata (in the then USSR), which resulted in the Alma Ata declaration of 'Health for All by the Year 2000' principally through the provision of primary health care (PHC) that:

... reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities. (WHO 1978: 2)

Alma Ata was part of a broader movement which led to the 1980 Brandt report (Green 2007). It encompassed activists of differing political persuasions and aimed to inspire 'bottom up'

development strategies encouraging local communities and groups to participate in, and (hopefully) ‘own’, the work being done (Chambers 1983; Fals Borda 1985; Freire 1996; Warren, Slikkerveer, and Brokensha 1995). This included training people as community health workers (CHW) to provide basic health care services within their own communities and address the severe lack of trained medical personnel, especially in rural areas. The idea of CHWs was based on the bare foot doctors in China and similar programmes elsewhere such as Guatemala (Bastien 1990; Saunders, and Carver 1986; Zhang, and Unschuld 2008).

Even following the down turn in the global economy in the 1980s (Bergesen, and Lunde 1999; Cammack 2002) and the change to ‘selective’ primary health care (Cueto 2004; WHO 2000) the need to provide socio-cultural appropriate health care and train community workers to counter lack of other trained health personnel has remained (See - Davis-Floyd 2000; Goodman et al. 2006; Janovsky, and Peter 2006; Lewin et al. 2009; Replogle 2007; Sheikh et al. 2006; UNAIDS 2006; Warsame et al. 2007). However such initiatives tend to be framed by pro-market notions of social contracts, decentralisation and the transfer of technology and expertise from the ‘haves’ to the ‘have nots’ (Navarro 1984; Tarimo, and Webster 1997; Thérien 2002). Navarro (1984) critiques the suggestion that global development in this form is achievable, as it hides the ideological underpinnings of capitalism that maintain entrenched power relations. Similarly, Kelly and Charlton (1995) see the Alma Ata inspired ‘Health for All’ strategy in polemic terms. The subjective and holistic notions of health seem to eschew the biomedical model while being constrained by a technocratic and scientific rationale that in fact supports biomedicine. The inherent contradiction inevitably works against the idea that socio-culturally appropriate health care is possible.

How health workers are trained is central to the implementation of a health care service. Along with the many voices calling for changes at the heart of Alma Ata and community development in the 1970s were adult educationalists. Some like Friere (1996) and Fals Borda (1985) fuse a socio-political concern for community development and the need to increase adult literacy and education generally. Others have influenced health worker training as one field related to adult learning in particular David Kolb’s experiential learning based on Kurt Lewin’s work of the 1940s (Kolb 1984; Rogers 1986). At the heart of all adult learning theory, irrespective of whether it is the more socio-politically inspired forms of Friere and Fals Borda or that of Kolb and Lewin, is the belief that adult learning is based on their previous learning and experience and therefore needs to be socio-culturally contextualised in the learner’s own world. Joseph Bastien a medical anthropologist who has looked at the socio-cultural complexity of introducing Western medicine into the Andean regions of Bolivia, draws together the threads of this discussion. In particular he studied a community health worker programme in Oruro, Bolivia, during the 1980s (Bastien 1990). He concluded that community health workers ideally need to come from the community they will serve, and have the same socio-cultural background. They need to be supported and trained to continue embracing their community’s local health knowledge and beliefs, while using the relevant aspects of Western medicine innovatively. The incorporation with equal respect given to these different constructs of health knowledge and practice reflects May’s (1994) use of the term ‘cultural competency’. May argues for the need for learners to be culturally competent in both their own culture and in that of the prevailing dominant form. The road to achieving this level of mutual cultural competency and therefore socio-culturally appropriate health care is highly complex. It necessitates changes across a range of inter-connected factors, such as a shift in power relations away from biomedicine and neo-liberalised healthcare provision. This would enable not only an acceptance of different health constructs, but practical infrastructural changes that decrease socio-economic inequity, by improving a nation’s infrastructure in terms of roads, water and energy supplies and importantly social welfare and education services (Bristow 2007). Until then, community health worker programmes are more than likely to continue to fail, especially when attempting to scale them up

from the local to the national level (Janovsky, and Peter 2006).

This paper seeks to understand why mutual cultural competency is easier said than done, by exploring the work of CODIGO¹, a community health Non-Governmental Organisation (NGO), training health promoters in the department of Cochabamba, Bolivia. In this paper ethnographical data is revisited to explore how CODIGO's health promoters were trained and the ways this might affect their ability to be mindful of the socio-cultural context of the population they care for.

Bolivia

Bolivia is a politically unstable and tense country (López Levy 2001). In 2006, however, it elected its first indigenous president Evo Morales since independence from Spanish rule in 1825. The political tension remains and is indicative of the high socio-economic inequity in Bolivia with the indigenous populations being substantially poorer and marginalised than the rest of the population (Thorp, Caumartin, and Gray-Molina 2006). In terms of health related statistics Bolivia has an under-five mortality rate (U5MR) of 57/1000 live births and is ranked as having the 61st highest rate globally (UNICEF 2009).

The Bolivian Health Service was decentralised under the *Ley de Participación Popular* (Popular Participation Law) in 1994. While, the management for all public services is now at municipal level, a large proportion of health service delivery is managed by national and international NGOs such as CODIGO or Catholic and other religious bodies. The majority of these agencies are funded by bilateral and multilateral organisations including both international governmental organisations (GOs) and NGOs (Bristow 2005).

Culturally, Bolivia, like other Latin American countries, is at least two 'nations' in one, consisting of Andean Indian and Creole Hispanic populations, with distinct cultures² and very different health beliefs and practices. Andean Bolivia is an integrated social, physical and metaphysical whole that grows out of its history and pre-Incan past (Allen 1988). Creole Bolivia, generally, conforms to the norms of a neo-liberal Western scientific stance. However, there are some who fall between the two, the Mestizos, some of whom through marriage, education or wealth, have been able to move into the Creole Bolivia, while a few have returned to their Andean roots. The Cholos/as, the semi-urbanised poor men and women, live on the edge of both cultures with restricted opportunities to make their views known or to effect change (Arnold, and Yapita 1996).

Researching the CODIGO project

The opportunity to do the original ethnography, which was conducted in 2003, developed out of a prior working relationship between the author and CODIGO director, Mgr. Roxana Valesquez. The ethnography explored how the hegemony of the dominant development paradigm informs and affects the transmission, integration and use of health 'knowledges' (diarrhoeal diseases being the focus) by local community based health promoters.

Ethnography was selected as the research methodology of choice as it allows the researcher to explore social groups and their ways of behaving in their everyday settings, in this case community health workers and their trainers (Lambert, and McKevitt 2002; Savage 2000; Walsh 2004) A reflexive research approach was taken building on the researcher's previous experience as a health practitioner in resource poor settings in Latin America and Africa. Accordingly the research was framed by an expectation that the social phenomenon observed and experienced would be interrelated and complex (Lambert, and McKevitt 2002; Savage 2000). The research was carried out in three phases. The first and third phases, based in Bolivia, lasted just over five months each. The second phase of one month was based in the UK. The research extended from

CODIGO and its trainee health promoters at the micro-level and wove in and out of both the meso- and macro- levels of Bolivian and international socio-cultural contexts and health systems. Ethical approval for the research was granted via the Faculty of Education at the University of Manchester but formal ethical approval was not needed by the Bolivian authorities. Nevertheless, the researcher worked closely with the CODIGO directors to ensure all participants understood the nature of the research and that they were happy to take part. Verbal consent was also obtained prior to each interview.

Theoretical framing

As an ethnography this study lies within a critical sociological frame (Burawoy 2005) with the research enquiry centring on the issues and problems affecting society, especially in the ways these issues are formed by the politico-economic relationships between social groups.

In keeping with the grounded approach inherent in ethnography, no a-priori theoretical assumptions were made other than the desire to maintain a critical focus. However an ethnographic approach assumes that the researcher is a key actor in the research process seeking to interpret the social phenomena they have witnessed through the lens of their knowledge and experience (Lambert, and McKeivitt 2002; Savage 2000). Thus while an open mind was kept, it became apparent that the use of May's (1994) notion of 'cultural competency' as 'mutual cultural competency' was increasingly useful as an explanatory term. It enabled exploration of the different factors affecting CODIGO's ability to train the health workers in the ways it had intended. May's work is in part drawn from the work of Pierre Bourdieu, in particular the role education plays in developing a 'secondary habitus' (Bourdieu, and Passeron 1990). While Bourdieu can be criticised for being overly deterministic (Williams 2003; Williams 1995), he does enable a way to think about how agency and structure are involved in complex social contexts, such as training health workers in culturally diverse and socially inequitable contexts. Habitus, the location of agency, relates to the way the norms, actions and representations associated with a particular social group are embodied, produced and reproduced within individuals. Past experiences inform actions in the present, and, in turn, present actions anticipate without conscious effort their future outcome. In this way the character of the group is maintained and structures are reproduced. It is an: 'embodied history, internalised as second nature and so forgotten' (Bourdieu 1999: 111). It guides and directs individual behaviour while still giving choice, although limited to those decisions that might be consistent with the habitus of the social group. People of all social groups within a society are likely to assume the view of the dominant group is 'correct'. According to Bourdieu, this can be to the extent that they 'misrecognise' their own 'cultural capital' (values, knowledge and practices etc) and thus devalue them. Bourdieu calls this process 'symbolic violence' in that the dominant group is able to suppress other cultural perspectives.

To explain how social groups, particularly dominant groups, reproduce themselves and maintain their influence, Bourdieu talks of primary and secondary habitus and of pedagogic action and authority. Primary habitus is the type into which a child is born, and learns through pedagogic action that has been authorised (pedagogic authority) by their family and class (or ethnic group) (May 2001). Secondary habitus is developed, by pedagogic action of sufficient length for it to become an 'enduring' habitus, most notably, within schools but also through training in specialised areas such as health care. The formation of an individual's habitus is structured by what Bourdieu calls a 'field'. The most obvious field is social class but so are politics, education, art, ethnicity and medicine whether this is biomedicine, Ayurvedic or Andean. Fields intersect and overlay each other; they are moulded by the taste and disposition of the dominant class or social group and through this relatively more powerful social group's influence over others.

Thus from a Bourdieuan perspective the field of biomedicine can be viewed as being relatively more powerful in many contexts than other forms of medical practice. At the heart of May's cultural competency is not simply a concern for those whose habitus is formed by a relatively powerful field, e.g. a biomedical doctor or nurse educator, but a desire to understand those whose primary habitus is relatively less powerful, e.g. a trainee health promoter, in order for both groups to gain a mutual understanding and respect. At the heart is the desire for the less powerful trainee health promoters to competently affirm their own primary habitus while simultaneously benefiting from all that the biomedical field may have to offer. Thus this form of cultural competency is one of mutuality.

Research methods

A detailed research diary and participant observation were used throughout all the research phases (Ellen 1984; Walsh 2004). 300hrs of health promoter training were observed directly, with a further 32 hrs with other healthcare training institutes, to act as a comparison (CARE 1994; Foster 1996). Participants for interview were recruited purposively using a modified 'snowballing' or 'networking' approach (Bloch 2004). The aim being to reflect where possible CODIGO's social networks and relationships with governmental and non-governmental agencies within Bolivia. This process was supplemented by indentifying other potential participants via an internet search. The final number of participants was determined by theoretical saturation (Ritchie, Lewis, and Elam 2003). At the meso departmental level 12 in-depth semi structured interviews were held with staff from the ministry of health (MOH), multilateral governmental organisations (GOS) and NGOs. At the macro national level 11 in-depth semi structured interviews were conducted with staff from the MOH, Multi-lateral and bi-lateral GOs and NGOs (Byrne 2004). The final phase also included a questionnaire developed from the funnelled data of the earlier phases. The questionnaire added breadth of data to the study and complemented the richness of information arising out of the other methods. It was completed by 119 respondents: 61 of CODIGO's health promoters and 58 state-trained nursing auxiliaries (Bristow 2005; Silverman 2001; Walsh 2004). The qualitative analysis was an ongoing, iterative process of refining themes arising from the data (Seale 2004). SPSS was used to provide a descriptive analysis of the data obtained from the questionnaires (De Vaus 2002). Informed consent was obtained verbally in Quechua or Spanish as appropriate, either via an interpreter, or directly with the researcher. Given the trilingual nature of the research, the quality of the data collected was ensured via back translation, participant checking and triangulation of different research methods and participant groups (Kuper, Lingard, and Levinson 2008).

Research Setting

The ethnography specifically aimed to explore how the health promoters trained by the NGO use their new health related knowledge when they return to their home communities in the rural and semi-urban areas of Cochabamba.

CODIGO Bolivia

CODIGO Bolivia, is a country programme of CODIGO International, a church-based NGO from the United States, based in a semi-urban community on the outskirts of Cochabamba, Bolivia. CODIGO³ was started in the late 1980s by a Colombian couple, Dr Juan Carlos De Pedro and Mgr Roxana Velasquez. They rejected the adoption of the biomedical model that had evolved since Alma Ata as inappropriate in the specific Bolivian context of ethnic diversity, inequity and poverty. Instead they were inspired by, Freire's theories of 'conscientisation' and 'praxis' (Freire 1996)⁴.

CODIGO's stated aims are to transform people from passive objects of somebody else's world into active subjects contributing to their own individual and collective livelihoods (CODÍGO 1992). In conjunction with their Frierean ethos they also developed an approach to health care called 'integrated health'. This approach is based on the social model of health (Whitehead 1995), where health is regarded as part of the wider socio-cultural, politico-economic context at all levels of society - local, national and international. CODIGO describes its approach as a 'systemic ecological healthgenic' model, intended to emphasise healthy people rather than disease, and be participatory, democratic and sustainable. Within this, they attempt to address a range of interrelated issues: basic health care and ill-health prevention; the use of traditional and local medicines as well as western biomedicine; income generation; organic agriculture; protection of the environment; human rights and community law (De Pedro, and Velasquez 1992). Implicit in this concept is the need for the health promoters to develop mutual cultural competency in both their own local health knowledge and practice and biomedicine. Through this approach CODIGO has distanced itself from Bolivia's state service, including the SEDES (local health services), characterising them as 'community-based pathogenic biological' models that, while they address the social setting of health, are still biomedical and disease-focussed (De Pedro, and Velasquez, 1992).

CODIGO draws on an eclectic mix of learning theories for its health promoter training programme - Vygotsky's activity theory, Montessori's self-directed and contextualised learning, Freire's popular education and 'Problem-Based Learning' based on US medical training. It is also mindful of the Andean forms of learning and knowledge that emphasise practice, incremental learning and reflective discussion or 'nurturing dialogue' (De Pedro, and Velasquez 1999, 2001; Stobart, and Howard 2002). These approaches together:

open possibilities of varied mental processes (gender based, cultural, multigenerational artistic, religious) encouraging the development of minds open to the search for the truth, using more natural, critical language, validating the values and visions of ordinary people. (De Pedro, and Velasquez [translation] 1999: 61)

The training programme consists of three phases, each divided into two parts. First is an Introductory Course lasting five weeks, followed three to six months later by a four-week Complementary Course. In total there are three Introductory Courses and three Complementary Courses. The aim of the Complementary Course is to consolidate learning from the Introductory Course in the light of the promoters' experiences in the field. The introductory courses present the themes relevant to its phase, using a variety of training methods: talks, group work, role plays, codes, games, discussions and practical demonstrations. The complementary courses, on the other hand, are largely self-directed in that they concentrate on problem based learning approaches using the themes covered in the introduction.

Key Informants

The types of people CODIGO trains are selected to reflect its ethos – the 'Cholos/as' the rural and semi-urban poor of mixed or Andean origin such as, Felipe and Carolena. Felipe and Carolena became key informants with the author making frequent visits to their home as well as spending time with them while they were on training courses at CODIGO.

Felipe

Felipe was sponsored by OSL (Organizaciones del Salud Latina) to do his training with CODIGO. At the time of the research he was eighteen and lived with his mother, grand-mother and younger brother in Kuturipa, a rural community located a good 90 minute steep walk from the road and then a forty-minute bus journey to either Cochabamba or the sub district capital

Santivañez. Family members describe themselves as subsistence farmers and pastoralists. Though they have electricity, they have no running water; and their land is very arid. The nearest potable water is an arduous forty-minute, walk away.

Felipe left school after six years of primary education but CODIGO inspired him to return and he subsequently started at a *SEMA* (secondary school for adults), which he attended once a week. As this took him half a day to walk there, he would generally stay overnight.

Carolena

Carolena was sponsored by RIPE (Research Institute for Popular Education)⁵ to be trained by CODIGO. At the time of the research she was 20, unmarried and a goat herder on her parents' small holding in Tapacari, the high valleys of Cochabamba.

Her home was a two-hour, hilly walk to the nearest small town (the district sub-section of Waca Playa). If a member of her family wanted to get to Cochabamba he or she had to wait for a Saturday or Monday to make the three hour lorry or bus journey. During the dry season they could go by a different route through another small town, from which lorries leave every day. However, during the rainy seasons the paths to this town are treacherous.

Carolena is the eldest of nine children, with three sisters and five brothers. She and her sister Maria left school before completing the primary level, as will the two younger girls. The boys, on the other hand, are expected to complete and graduate from high school.

Carolena and Felipe exemplify the people trained by CODIGO to be health promoters – young, Quechua (Andean language) speakers, with minimal or at least interrupted education, belonging to poor rural subsistence communities that are to varying degrees isolated from urban Cochabamba. In the following sections I will draw on examples from theirs and their fellow trainee's experiences of health promoter training and practice.

Research Findings – Exploring mutual cultural competency in CODIGO's Integrated Health Training Programme

Over the years CODIGO has justifiably gained respect for its work. However it is also possible to say that the rhetoric of its goals is not matched by its success in their implementation. Despite CODIGO's achievements it has not been able to put its theory of integrated health fully into practice and therefore enable mutual cultural competency and socio-culturally appropriate health care.

Separated knowledge

The lack of evidence of integrated health knowledge can be seen in how CODIGO's health promoters keep their local Andean and biomedical health knowledge separate, rather than drawing on both forms together. Group work conducted early on in the field research proved to be significant. This was carried out with some of CODIGO's promoters taking their second level course. The discussion involved the promoters answering the following question:

Where or from whom have you heard information or learned about ARIs (Acute Respiratory Infections) or ADDs (Acute Diarrhoeal Diseases) before coming to CODIGO?⁶ [Translation]

The words used to frame the group work were deliberately taken from CODIGO's training manuals and therefore familiar to the promoters. Their reply, noted down in the research diary, was that they had never heard of ARIs or ADDs before coming to CODIGO. After some discussion and clarifications in Quechua (Andean language), the promoters did start to talk about the traditional illnesses such as '*Sipi Chupasqa*'⁷. Their response was a surprise to the author,

rather it had been expected that they would talk with ease and respect about their local knowledge. Instead they seemed to compartmentalise what they knew. This was confirmed later by observing training sessions, interviews, visits to health promoters and their families as well and the questionnaire.

Keeping Andean health knowledge a secret

Very few if any of the health promoters appeared confident in engaging and negotiating with both their own cultural medical beliefs and those of biomedicine. In fact the promoters seemed reluctant to discuss their own local knowledge despite many of them or their relatives having considerable experience and competency in health care. For instance, it transpired later that Carolena frequently diagnosed and treated family members using her local knowledge:

Her young brother had bad diarrhoea last year and they went to the *posta* (local state clinic). He was given *suero* (ORS⁸) but it didn't help. Instead they used local plants that everyone here knows about. Also *pepa de palta* (avocado stone). (Research diary 11th August 2003.)

Felipe had difficulty in talking about Quechua names for causes of diarrhoea.

Interpreter	What names in Quechua do you know for the causes of diarrhoea?
Felipe	K'echelera... K'echelera, that's all
Interpreter	K'echelera, because they say the child is with <i>orejasqa</i> ⁹ , not so?
Felipe	Orejasqa, that's all... k'echelera, orejasqa.
Author	When children fall, is there a name? Hurt their coccyx?
Felipe	Sipi Chupasqa. ⁷

(Interview with Felipe. [translation] ¹⁰)

This was despite his mother being well informed having learnt from her grandmother:

Author	Did she learn from someone in her community or from her grandmother?
Interpreter	Yes, her grandmother. Her grandmother treated everything, including a baby or child with constipation. She put a little bit of matchstick in and they would start.
Author	Where did her grandmother learn this information, here or did she go and train somewhere else?
Interpreter	Her grandmother has always known and she does not know from where. But she (Angela, Felipe's mother) learned from her grandmother. Her grandmother was always teaching her, she'd say, 'When I die you are going to do the treating!'

(Interview with Felipe's mother, Angela. [translation] ¹¹)

CODIGO trainers

The possibility that CODIGO's health promoters were using different forms of health knowledge separately despite CODIGO's aim of integrated health focussed attention on how the trainers approached learning and what content they included. For instance there was a lack of synthesis between the training modules 'Process of Health and Illness and 'Managing Common Illnesses'. The former links the trainees' previous knowledge with the biological and socio-cultural determinants of health. The latter addresses the prevention and treatment of disease. Given the aim of an integrated health approach it would seem appropriate for these modules to refer to

each other. However for some of the staff integrating the modules would not be consistent with their religious beliefs and previous biomedical training. The ‘Managing Common Illnesses’ module leader was the clinic doctor, an Evangelical preacher who refuted the metaphysical basis of Andean Knowledge. Thus this module took a biomedical approach inconsistent with the facilitation of mutual cultural competency.

Pervasion of Biomedicine

The integrity of CODIGO’s strategy of integrated health is also affected by the different approaches to health that the promoters may have experienced in other contexts. Visits to OSL the NGO who had sponsored Felipe to do his training and with the auxiliary nurse at the health clinic where Carolena sometimes worked, evidenced a standard biomedical approach. This reinforced a separated approach to health care and dismissal of local health knowledge. For example, the research diary records observations at OSL:

Classes of diarrhoea - cholera, dysentery, salmonella. Repeat, repeat and reinforce, but is this the best way?... The emphasis on dehydration is very important but I think it could be better linked to beliefs and practices? (Research diary 16th November 2003, OSL monthly training meeting.)

The auxiliary nurse at Carolena’s local clinic suggested that practitioners have limited time to do anything other than that stipulated by the Ministry of Health.

Author	Do you offer any service for disability or only respiratory infections, diarrhoea, vaccinations and IMCI?
Nurse	More the Ministry programmes, 100%, very few other issues....almost nothing.

(Interview with auxiliary nurse at Carolena’s local clinic [translation]¹²)

Access to learning opportunities

The examples above will have a direct affect on what a trainee learns in the first place and whether they are able to put such learning into practice. Other issues observed may have an indirect effect by affecting the ability of the trainees to learn. Approaches to gender equity are an example. CODIGO interprets gender sensitive and inclusive learning to mean groups of trainees with mixed-gender and education levels and the use of Spanish to improve competency in the *lingua franca*. The consequences appear to be that men, better-educated women and first-language Spanish speakers dominate group work and plenary sessions that put others, especially rural women such as Carolena, at a disadvantage.

The guys are still taking the lead but there is more participation from the women (I wonder if this is to do with the subject - Nutrition?) In one group the girl in modern dress was writing and contributing a lot, although the 2 guys were dictating a fair bit. The other girls look disengaged or have disengaged themselves. (Research diary 11th March 2003)

Another example is of the extent to which CODIGO is able to develop its trainees’ practical skills. Observations of sessions suggested limited opportunity to practice. For example, how to make oral rehydration solutions (ORS).

She goes through the process and then gets people into 4 groups of 3 or 4 to prepare the solutions. What I don't think she did well was saying how to level off the spoons. She used her finger and the inside of the plastic bag, and in so doing, pressed the salt down. We always used to skim off with a knife as you don't pack down, that way and don't add extra in. It is very important to get the salt balance correct. The practice took ages and people had to watch the other groups and no one was able to do the whole procedure themselves. (Research diary 3rd September 2003)

Economic and material barriers

CODIGO's training programme has not been popular with donors. This is because of differences between CODIGO's philosophical stance to health and training and the biomedical market orientated perspectives of the donor agencies. Money for items such as textbooks, equipment and extra staff is restricted with the outcome that the trainers are often not able to carry through on their intended objectives.

Also talked to Roxana and Juan Carolos about funding... They can't get funds for salaries- training team especially hit. XXX charity wants to fund its own suggestions. (Research Diary Friday 14th February 2003)

On a national level Bolivia's infrastructure is weak. Roads for example are often impassable because of flooding. Stark socio-economic inequalities have led to high levels of political unrest resulting in strikes and road blocks. During my year with CODIGO five courses out of a possible fifteen were cancelled, as were many follow-up visits to the promoters' homes.

I had to begin the first complementary level of the course. However, because of the demonstrations, strikes and roadblocks in the Morachata area, 12 health promoters failed to arrive. (Training team coordinator's November 2003 report [translation]¹³)

The promoters may have to interrupt their training to attend to the planting or harvesting of crops.

At the end of the GM (genetic modification of crops) workshop there was a discussion about the problem of why not many promoters had turned up - practical reasons are that the date was changed at short notice, it is potato planting time and the weather has been good over the last few days. (Research diary 20th Sept to 2nd October 03 Cocapata workshop)

The findings presented here reveal that to work and live in the context in which CODIGO and its health promoters find themselves involves negotiation of a range of complex, interlocking factors. These factors constrain what is possible to achieve, especially objectives that go against the norm, such as actively wanting to enable mutual cultural competency and through this, health care practice that integrates Andean and biomedical health knowledge. These constraints can be at the philosophical level of a health worker's habitus as a biomedical practitioner, relate to socio-cultural differences across gender, or materially, in terms of lack of resources or seasonal farming calendars. From a Bourdieuan perspective these constraints reduce the possibility of developing an 'enduring secondary habitus'. They also encourage 'symbolic violence' by working to maintain 'misrecognition' of the importance of biomedicine at the cost of Andean health knowledge (Bourdieu 1989; Bourdieu, and Passeron 1990).

Discussion

This paper has sought to understand why CODIGO, despite its excellent qualities, was unable to facilitate a mutual cultural competency (May 1994) in its trainee health promoters and through this enable them to practice socio-culturally appropriate health care. Why mutual cultural competency might be difficult to develop can be explored through looking at the complex range of interlocking factors from a Bourdieuan perspective.

Partially different secondary and primary habitus may be behind the differences in the ideology that has led to a clash in understanding between the various actors, in particular with CODIGO's staff. For example, the lack of continuity between the two modules 'Process of Health and Illness' and 'Managing Common Illness' has in part arisen out of the differing religious and medical beliefs of the CODIGO directors and the doctor involved in the training programme. A further example is the tension between CODIGO's approach and that of other actors and agencies that might influence the health promoters, e.g. OSL's clear biomedical stance on Felipe. It would seem that not only are CODIGO staff misrecognising the cultural dynamics at play but are furthering the capacity of the trainees to misrecognise their own local health knowledge.

Many NGOs secure funding by aligning themselves with current international and national strategies and therefore the field of the health-related international development agencies. CODIGO has not wanted to be aligned to such work, for instance by not collaborating with the Cochabamba SEDES (local health authority). CODIGO may well be being true to its political and ideological beliefs, but through this has weakened itself economically, losing the opportunity to influence the dominant biomedical habitus and prevent symbolic violence.

Misrecognition may also exist with regard to the secondary habitus of competing fields, such as the biomedical form of the state-trained staff of the local health clinic. The clinic staff, the promoters and the members of the community may all view the biomedical field as more legitimate than local/traditional healthcare. For Carolena and Felipe this is compounded by socio-cultural factors of education level, gender and age. Both Carolena and Felipe might agree tacitly with their communities that they are too young, or the wrong gender to be a health promoter. Neither Carolena nor Felipe completed their state school education. This probably relates as much to economic survival as to traditional roles within Andean communities. However, women are more likely to have left school with far less education than men. Carolena's brothers have been able to continue at school to secondary level while she and her sister left after only five years' primary education (See Arnold, and Yapita 2000).

At another level the primary habitus of the health promoters is stronger than the secondary form emerging through their training with CODIGO. In order to achieve an enduring secondary habitus CODIGO would need to strengthen its support of promoters on return to their communities, through more frequent follow-up. The organisation also needs to think through how it can meet the various educational needs of its promoters, especially the less well-educated women from rural areas.

Lack of time and resources can restrict what may realistically be achieved, e.g. promoters may make the pragmatic decision to finish planting potatoes rather than attend a CODIGO course. CODIGO's follow-up programme has been limited by lack of finances to employ more staff. It does not have the human and financial resources to address the mixed educational and linguistic needs of the promoters. These pragmatic decisions directly affect CODIGO's ability to encourage an enduring secondary habitus in their trainees and while also strengthening possibilities of gender and age related socio-cultural misrecognition.

The different factors produce the environment in which the hidden power dynamics can be maintained and affect the development of an enduring habitus in the promoters. For instance, CODIGO's ideological stance relates to the political economic consequence of reduced financial

support, which in turn is linked to CODIGO's pragmatic decision to reduce learning support to the minimally educated non-Spanish speaking trainees. The result is that CODIGO's power to influence is relative and limited, for example by the short space of time that the health promoters actually spend doing its courses, and therefore come into contact with CODIGO's particular ethos. In the final instance CODIGO is not able to produce durable or consistent changes in the habitus of the health promoters it trains. When health promoters leave CODIGO and return home, the Andean field re-exerts its more powerful influence. In these circumstances CODIGO is not able to support its promoters to use both Andean and biomedical knowledge. Instead, the health promoters' knowledge is used separately in their different fields. This would indicate that CODIGO has not enabled its health promoters to develop socio-culturally appropriate practice and consequently valuable opportunities may have been lost to improve access to primary health care. The socio-cultural relationships that encourage misrecognition and hinder mutual cultural competency are compounded and maintain the disadvantage of rural/indigenous women especially.

As an ethnography of a particular context, the specific findings are not intended to be generalisable (Kuper et al. 2008). Nevertheless the paper does offer insights for settings with diverse socio-cultural populations and politico-economic inequalities similar to Bolivia. The trilingual nature of the research (English, Spanish and Quecha), along with its cross-cultural nature, clearly places limitations on the research findings. The use of a snowballing technique to recruit participants also has its limitations as the networks may dry up (Bloch 2004). This was countered by finding other contacts using the internet. Every attempt was made to ensure the quality of the findings through the use of multiple methods, participant checking and back translation of transcripts.

The paper attempted to unravel the complex dynamic of different factors that interrelate to hinder the development of mutual cultural competency in health care workers and thus the provision of socio-cultural sensitive health provision, especially within diverse inequitable settings, such as Bolivia. To achieve this, a diverse body of literature has been used to draw attention not only to the hidden macro-level power dynamics at play in current primary health care practice (Kelly, and Charlton 1995; Navarro 1984), but also, interrelating factors at the micro-level that affect community health worker training in low and middle income countries (Bastien 1990; Fals Borda 1985; Freire 1996). While the data explored in this paper was gathered in 2003, it remains pertinent and adds a new perspective to existing literature. The need to increase access to health care, particularly in poor, marginalised communities, has meant that training people to provide relevant care at the local level still remains a pertinent issue - not only in low and middle income countries, but increasingly in countries with high levels of resources (Davis-Floyd 2000; Goodman et al. 2006; Janovsky, and Peter 2006; Lewin et al. 2009; Replogle 2007; Sheikh et al. 2006; UNAIDS 2006; Warsame et al. 2007).

Finally these findings would suggest that those wishing to develop training programmes in such complex circumstances need to be mindful of the possible macro- to micro- related factors and attempt to make pragmatic decisions of what can and cannot be done in the circumstances. That is, training programmes should be implemented with as clear as possible understanding of the socio-cultural and politico-economic aspects of their own context and more importantly that of the trainees'. This is important not only to ensure the training is relevant and accessible but also to give the programme implementer a realistic understanding of the programmes strengths and weaknesses.

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Notes

- 1 CODIGO is a pseudonym as are all names and places directly associated with it.
- 2 These are coarse categories, and there exists variation within each. However, the variations seem less than that between them and so the categories are useful for the analysis here. The various lowland indigenous peoples in Bolivia are not considered.
- 3 From this point CODIGO refers to CODIGO Bolivia
- 4 It could be asked why I have not used Friere's work to analyse my data. I did not rule Friere out it was merely that the way the data emerged seemed to lend itself more to Bourdieu.
- 5 OSL and RIPE are pseudonyms.
- 6 ¿De dónde o de quien han escuchado o aprendido algunas informaciones/conocimientos sobre IRAs y EDAs antes de venir a CODIGO?
- 7 Sipi chupasqa is a form of diarrhoea said to occur when a child falls over when learning to walk and bangs the base of their spine.
- 8 ORS = Oral rehydration solution.
- 9 Orejasqa is the same as orejado – diarrhoea cause by the smell of a dead animal.
- 10 Interpreter: ¿Con qué otros nombres conoces en quechua cuando hace las causas diarrea?
Felipe: k'echelera, k'echelera, no más.
Interpreter: k'echelera pero la wawita está con orejasqa ¿dice no ve?
Felipe: orejasqa no más, k'echelera orejasqa.
Author: Cuando los niños se caen de traserito ¿hay un nombre? ¿Se daña su cóccix?
Felipe: sipi chupasca.

- ¹¹ Author Es...de la comunidad or por su abuela?
Interpreter Sí mi abuela, mi abuela curaba de de todo. Dice cuando incluso un bebe o nino venía con estreñimiento, le pone un palito de fósforo, se va a empezar.
Author Solamente aprendió esta información aquí o fue para capacitarse?
Interpreter Su abuelita sabía siempre, no se sabe de dónde. Pero ella (Angela) ha sabido de su abuelita. Su abuelita siempre le enseñaba a ella. ‘Cuando me voy a morir, volvas a curar’.
- ¹² Author ¿tu llevas en una manera un sistema de discapacidad o solamente IRAs, EDAs, PAI, AIEPI?
Nurse Más programas de ministerio, cien por cien muy pocos otras temas caci nada.’
- ¹³ Tenía que empezar el primer nivel complementario, sin embargo debido a las movilizaciones, paros y bloqueos de los pobladores de Morochata no pudieron llegar 12 promotores, ya estaban nueve promotores del norte Ayopaya.

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I would like to thank Dr Caroline Dyer, Dr Jude Robinson and the anonymous peer-reviewers for their comments and support during the process of writing this paper and the staff and health promoters of CODÍGO for allowing me to do this research with them in the first place.

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OPINION PIECE

Survival and Subversion: Biting the hand of funders and collaborators?

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I have a nightmare vision of banks of researchers sitting in a shabby open plan office cold calling potential funders in a virtual 'Dragon's Den' environment. The source of such imaginings is no mystery as I've just come from yet another meeting where I've been asked to update on 'successful' and 'failed' bids. Increasingly the focus appears to be exclusively on the amounts involved; only rarely is one asked about the topic and never about the theoretical significance. Such musing could easily be dismissed as the disgruntlement of someone (almost but not quite) approaching retirement. Should I, instead, be addressing a letter to the sadly departed 'Aunt Marge' or simply stepping aside gracefully?

An alternative – and possibly more productive - response would be to claim the license to treat such 'private troubles' as 'public issues', and seek understanding through considering these in their broader context, as advocated by C. Wright Mills. 'Know that many personal troubles cannot be solved merely as troubles, but must be understood in terms of public issues - and, in terms of the problems of history making' (Mills, 1959, p.226). Although few are better equipped than are sociologists to undertake the challenge of providing an explanation that links the 'micro' and the 'macro' in this way, we have been curiously silent on such issues – apart, that is, from the inevitable grumblings at the conference bar. Critical and productive debate is long overdue with regard to the impact on individual careers and research practice of the political and funding climate, the job market, the publication imperative, and even the way in which Universities are run. Invoking no less a theorist than Bourdieu, we need to engage in what Bourdieu & Wacquant call 'reflexive sociology' (1992), belatedly turning our gaze on our own discipline in order to understand the effect of the researcher's 'particular location in social space'; the conventions of the researcher's particular academic discipline and the researcher's 'position in the scholastic universe' (Bourdieu, 2004, p.94).

Historically the concerns, indeed, anxieties, of medical sociology, as an emergent sub-discipline, related to the potential for sociological enquiry and focus to be hijacked by the

medical profession and its demands (see, for example, Scambler, 1987). As Chris Yuill observes, medical sociologists have, indeed, often been the ‘statistical servants’ of the medical profession, ‘providing more epidemiological rather than sociological analysis of health and medicine’ (2004, p.29). Almost half a century earlier, C. Wright Mills cautioned us to resist what he termed the ‘illiberal practicality of the bureaucratic ethos’. Even if few have gone as far as did Ronnie Frankenberg in denouncing the ‘facile, triumphalist optimism of hard science and evidence based medicine’ (Frankenberg, 1998, xiv) we continue to live in its shadow. More recently, Moreira (2007) has highlighted the reification of ‘facts’ that is a feature of the practice of systematic reviews and meta-analysis and how this impacts on ‘knowledge making’. However, in the current funding climate, with lucrative funding streams beckoning and research managers at our heels, we ignore such opportunities at our peril and engaging in critical commentaries on the social construction of knowledge may for many of us be a luxury best indulged ‘on the sidelines’ once we have successfully secured enough research grants to buy us some time out. Such observations, however, serve only to underline the marginal position in which we find ourselves as medical sociologists – even, I suspect, as senior researchers in well-established and respected units. Within our lifetimes we have seen the ‘bureaucratic ethos’ transfer to the academy – mirroring the experience of medicine - in the form of managerialism with a trend towards employing non-academics in such roles (Bourgeault, 2007). This has led to a growing focus, at least in some quarters, on grant capture as an end in itself.

Medical Sociology Online has recently encouraged debate about whether medical sociology should be seeking to professionalise (Dixon-Woods, 2007). Although I concur with the envious glance that Mary Dixon-Woods reserves for health psychology, I am of the view that we would be mistaken to attempt similar tactics. Medical sociology – and sociology in general - is a very different project, one of our defining characteristics being our ability (perhaps even our remit) to de-mystify and question the taken-for-granted. There is still something inherently subversive about sociology; if not in its products, then, certainly, in its potential. The professionalisation route necessitates, at worst, a degree of complicity with other professional groupings and mutual respect, at best. This makes us uneasy bedfellows, or ‘cuckoos in the nest’ (Barbour, 2003) prone to ‘biting the hand that collaborates’. Mary Dixon-Woods herself acknowledges that one of the reasons for the non-professionalisation of medical sociology lies in sociology’s own role in commenting – sometimes unsympathetically - on professionalisation (Dixon-Woods, 2007, p.18). Sociology does not even necessarily treat with reverence the products of its own academic endeavours, since it is uniquely placed to ‘continually turn ... back upon itself the scientific weapons it produces’ (Bourdieu & Wacquant, 1992, p.214) – at least in some incarnations of the sociological project.

Another development that is part product and part architect of medical sociology’s current malaise is the growing separation between ‘problem-oriented’ and ‘theory oriented’ research (Harding & Gantley, 1998). ‘(I)n recent years, social scientists in pursuit of research grants have increasingly become aware of the need to temper an emphasis on analytical or exploratory research with pragmatism’ (Harding & Gantley, 1998, p.77). Just the other day I came across another example of a funding body proudly proclaiming: ‘We do not fund blue skies research’. Such a stance would, doubtless, be applauded by many (although by no means all) of my nurse-researcher colleagues, some of whom have been heard to state that they have no truck with research that ‘produces knowledge for its own sake’. Curiously, I have even heard some sociologists disparagingly use the term ‘blue skies research’, adopting what, in my view, is essentially a management mantra, which allows for the denigration of that which is not readily understandable. The split between pragmatic (or applied) and theory- oriented research is tangible in the growing polarisation and divergence of interests between medical sociologists working in health services research and those employed in sociology departments. Sociology has long been an ‘exporter’ discipline, but what are the consequences of what could perhaps be

seen as an ill-advised attempt at ‘professionalisation by the back door’? Of course many of us seek to do work across the applied-theoretical boundary, but this is increasingly difficult.

Some of us – myself included – have attempted to take refuge under the umbrella of methodological expertise, in the hope that this will allow us to span diverse but productive - comparatively speaking - sets of substantive topic areas, which promise rich pickings in terms of the potential for theoretical generalisability. (However, this is probably an option open only to medical sociologists taking a qualitative approach.) By such subterfuge it may yet be possible to pursue disciplinary concerns whilst still bowing to the need for pragmatism. However, even this strategy has its downside in the form of what I have termed ‘technical essentialism’, whereby our methodological contribution is acknowledged by our collaborators but simultaneously diminished through the refusal to recognise the equally important role of our disciplinary knowledge. Using medical sociology in pursuit of applied research is also likely to limit the capacity to build on serendipitous findings and, thereby, the exercise of ‘sociology by stealth’ that has so often characterised my own – and, I am sure others’ – research endeavours. Smaller budgets and tighter timetabling make this more challenging, as does that ‘elephant in the closet’ - contract research. Whilst embracing the idea of solidarity with jobbing researchers (having for many years found myself in a similar situation) there are some unwelcome truths that we are often loathe to address. One of these relates to the sometimes questionable quality of data generated by ‘jobbing researchers’ who, through no fault of their own, may not necessarily be versed in our disciplinary concerns or attuned to the focus and rationale of specific projects. Successive programmes of Medical Sociology Conferences attest to the continued pursuit of theoretically-informed analysis, but I do wonder how many of these papers go on to be published in peer-reviewed journals (especially for those of us ‘exported’ to medical faculties with their emphasis on a narrow range of high impact factor journals) and whether we are, in fact, largely speaking to ourselves?

Health services research finds itself at the interface between ‘the illiberal practicality of the bureaucratic ethos’ and ‘the liberal practicality of the moral scatter’ – both of which C. Wright Mills urged us as sociologists to avoid (Mills, 1959, p.226). Like many of my medical sociology colleagues I have, over the years, collaborated with colleagues engaged in health promotion and had viewed such involvement as essentially benign, if seldom sociologically exciting. Such projects, moreover, tend to attract funding. However, I have experienced growing unrest in the context of two recently completed research projects, both of which have, in retrospect, involved somewhat uncritical acceptance of the supposed ‘evidence base’. One has involved eliciting the perceptions of women with regard to taking folic acid supplements pre-conception and during the first 12 weeks of pregnancy. I was invited to collaborate because of my methodological expertise, but, as I subsequently read around this topic, I came increasingly to question some of the assumptions underpinning this project – and the use to which the data we generated were ultimately to be put. Despite Department of Health guidelines having been issued, it appears that the evidence is somewhat flimsy, deriving from a study of women who had previously given birth to babies with neural tube defects – and, even then, supplementation succeeded in preventing such defects in only 70% of cases (MRC, 1991). Nor is it fanciful to flag up such concerns – especially in the week that sees the *Lancet* retracting Wakefield’s 1998 MMR paper. The women we talked to may have had a more balanced view than the health care researchers involved, recognising the ‘prevention paradox’ in operation and pointing out the situational factors mitigating against following this new advice, such as unplanned pregnancies and those not detected until after the 12 week cut-off. Other commentators (e.g. Boon & Hull, 1995) have described the DoH recommendations as ‘impractical’ and potentially wasteful of resources. The impact on the efficacy of anti-convulsant drugs of folic acid supplementation aside, there is considerable potential for a study such as ours to heighten anxiety levels and even induce guilt in women who may not have taken folic acid as recommended, as the impact on children does not

necessarily confine itself to the immediate post partum period. The second project involves generating focus group data to contribute to developing an intervention designed to achieve weight loss in post-partum women. Again, on the face of it this looks harmless enough. However, we simply do not know that being overweight at this particular stage in one's life (whether or not one subsequently loses the excess weight) is likely to lead to significant morbidity at a later stage. Although various cohort studies are in progress it is too early to draw such conclusions and the justification for this research begins to look more like a case of 'moral panic' portraying women who have gained weight during pregnancy or post-delivery as being at the start of a 'slippery slope'. Both projects may well have an impact – whether this results in REF 'brownie points' or not – but this may be a negative impact, if the studies are, indeed, based on unfounded and potentially misleading assumptions.

So where does all this leave us in terms of strengthening the position of medical sociology and ensuring that we retain our critical scholarly focus in the light of these many and varied challenges? Rather than seeking an answer in mobilising medical sociology practitioners struggling on the shop floor perhaps we should be looking elsewhere for an answer. The movement towards appointing non-academics as managers notwithstanding, there is a significant number of sociologists (even some medical sociologists) who have now been appointed as Deans, and Vice Chancellors. Are they powerless to address our plight due to over-riding management imperatives or could the BSA be exploring ways in which we can open up a meaningful dialogue with such individuals, in order to influence agendas and derive benefits from having representatives in high places? After all what is the point of 'upward mobility' (Dixon-Woods, 2007) – whether this is the goal or simply a happy accident – if we do not take advantage of such opportunities? In the meantime, I don't think I'll be submitting this paper to my REF panel, although I might not be averse to some discrete 'ear bending'.

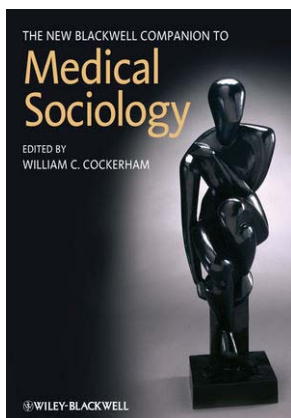
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BOOK REVIEWS



William C. Cockerham (Ed.)

The New Blackwell Companion to Medical Sociology.

Wiley Blackwell, 2009, £110 (hardback)

ISBN: 978-1405-1-8868-5

616 pages

Reviewed by Yves Laberge, Université Laval Québec, Canada

This impressive *New Blackwell Companion to Medical Sociology* will soon take the place of the previous *Blackwell Companion to Medical Sociology* (2001) with a totally different list of topics and renewed contents. While the older version (also edited by William Cockerham) focused mainly on the regional perspectives of medical sociology in five continents, this new interdisciplinary book provides 24 cutting edge chapters on core topics: social inequalities, social relationships, health and disease, health care delivery, new developments in bioethics, genetics and neuroscience. Like any handbook, we get in every chapter some basic notions, ongoing debates, current ideas, and some quotes from recent publications in each sub-field. Therefore, this new edition is not just an ‘updated version’ of the previous *Blackwell Companion to Medical Sociology* (2001) (which must not be seen as obsolete in any sense), and both should not be confused one with another, despite their common editor, same publisher, similar title and format.

In their efficient ‘Introduction’ chapter which concentrates on ‘Medical sociology and sociological theory’ (3-26), editor William Cockerham and Professor Graham Scambler argue that ‘sociological theory allows medical sociology to remain unique among the health-related social and behavioral sciences’ (3). They reaffirm and demonstrate the fact that medical sociology is not atheoretical, even though this discipline was often understood as such in the past (3). As all sociologists should do, the two scholars also reflect on the sources of funding for research in medical sociology, noting that most agencies were looking for the immediate usefulness of research and efficiency and not for theoretical demonstrations in medical sociology (3). The main portion of their chapter situates medical sociology in the traditional theoretical paradigms on social sciences: functionalism, symbolic interaction, conflict theory; according to the thought of Max Weber, critical theory (the Frankfurt School and Jürgen Habermas), and some most recent trends like social constructionism, postmodern theory and critical realism. Although it is a dense piece, this opening chapter is essential to fully appreciate the whole book, especially for non-sociologists, because it explains what sociological thinking can bring to health sciences in its conceptual and theoretical dimensions.

The second chapter is as important as the first. Focusing on ‘Health and culture’, Stella Quah highlights the links between a predominant culture and individual behaviour. The discussion mentions classic authors like Erving Goffman, but whenever some particular aspects were overlooked or later completed by another sociologist, the text clearly provides the related research on values, beliefs, symbols, and the institutional aspects of medical care (31). One clear example quoted here about the relationship between health and culture is the 1999 study of Germaine Greer on the dramatic female genital cutting (FGC) that is prohibited in Western

countries but still preserved in some African communities because of this rite's symbolic and traditional meanings (31). On similar themes, the third chapter is about the sociology of the body; chapter 7 links health and religion.

Many sections of this handbook are innovative in their focus and approach, or are simply useful because they provide clear updates. Introducing Pierre Bourdieu's concept of 'habitus' in just a few pages (175-7), Professor William Cockerham's chapter 8 on 'Health lifestyles' is full of valuable data and accurate observations, like these results of a study which confirms that 'married women, for example, were found to adopt the same drinking patterns of their husbands, unless they were in an older age group or had children' (165). I would however disagree with Professor Cockerham and bring more nuances to the previous observations regarding the healthy sides of moderate, daily wine drinking for health (177). Elsewhere, some chapters, like Fred Stevens' piece on 'The Convergence and Divergence of Modern Health Care Systems', keep a comparative approach as in the previous *Blackwell Companion to Medical Sociology* (2001), offering an overview of the organisations of health care services for North America (Canada and USA), Latin America, Europe, Asia and South Africa (434-54). Because institutionalisation and legitimation are important sociological concepts, Hans Baer devotes an entire chapter on alternative medicine and alternative therapies, understood as a part of 'medical pluralism' and 'holistic health'; he provides a typology of complementary and alternative medicine (CAM) (373-90).

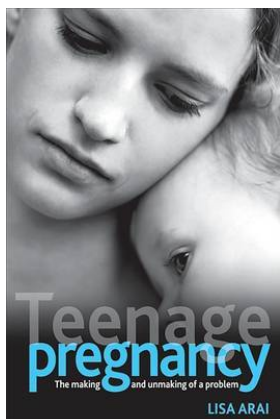
Many contributors do not hesitate to acknowledge and discuss the previous and ongoing frictions between disciplines, and sometimes dare to oppose medical sociology with social sciences and health sciences; for example in chapter 22, providing 'A Sociological gaze on bioethics', Kristina Orfali and Raymond Devries argue that 'The sociology of bioethics has thus mostly been a critique of bioethics' (499).

This comprehensive *New Blackwell Companion to Medical Sociology* will be instructive for graduate students in social sciences (especially sociology of science), but also for undergraduates in health studies. Scholars, scientists and personnel from laboratories will surely learn from this handbook. The extensive bibliographies at the end of every chapter always include many recent works (that is, from 21st century). However, one question appears: should physicians and surgeons read this heavy handbook? If they do (as they should), they will probably find the explanation in conceptual and theoretical terms of what they might have experienced in their surgeries in terms of ethnicity, the possible challenges of the physician-patient relationship (see chapter 16), and the recent mutations of the medical profession. As in any handbook, the subdivision into 24 thematic chapters (instead of regional sections as in the older *Companion*), plus the two indexes will make easier the quick consultation on a specific topic or question for those professionals who lack of time. Incidentally, most contributors of this *Companion* are not working in hospitals; they are rather sociologists teaching health studies in universities.

The high cost of this hardcover book (£110.00) — compared to, say, a paperback version that would be priced about half of it — will probably make it difficult for most graduate students to afford it. Therefore, this *New Blackwell Companion to Medical Sociology* will be more appropriate for university libraries.

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Lisa Arai

Teenage Pregnancy: The Making and Unmaking of a Problem

Policy Press, 2009, £22.99 (pbk)

ISBN: 978-1-84742-074-9

177 pages

Reviewed by Deborah Morgan, Cardiff University, UK

In *Teenage Pregnancy: The Making and Unmaking of a Problem* Arai explores the research and policy context of teenage pregnancy over the last few decades. The aim of the book is to critically explore the way teenage pregnancy has been depicted as a social and public health issue and to explore how policy makers, academics and the media have responded to the issue. The author notes that policy makers' interest in teenage pregnancy is a relatively recent phenomenon and argues that broader social changes have been the main driver for the change in attitude, which in turn has resulted in teenage pregnancy being socially constructed as problematic in public perceptions.

Arai's book is divided into two parts; the first addresses the making of a problem. The first part of the book begins by exploring the policies of successive Governments which have framed adolescent pregnancy as a problem that requires intervention before moving on to critically examine the data on both teenage pregnancy and teenage fertility which the author notes is an important distinction that needs to be made.

In the second chapter the author explores the broad patterns around the question *Who has a Baby as a Teenager?* The chapter begins with three broad caveats; acknowledging that although broad patterns do exist in relation to teenage pregnancy they are not exclusive. Secondly that the factors associated with teenage pregnancy are not the same as those associated with teenage fertility, and finally that the chapter is based on recent research and therefore does not seek to make comparisons with teenage mothers from previous decades. It is these caveats that make Arai's work interesting as throughout the book Arai seeks to make the distinction between teenage fertility rates and teenage pregnancy rates. In addition while she acknowledges that broad patterns do exist in relation to teenage pregnancy, her analysis challenges the stereotypes that exist around young mothers.

The chapter then goes on to explore the literature on the factors associated with teenage pregnancy in the developed world. These factors are broadly defined as structural, demographic and psychosocial.

A particular strength of Arai's work is that she addresses the often forgotten young fathers, noting that fathers are often irrelevant in both policy and research. Arai notes that men who father children with teenage mothers often are older and are from a similar socioeconomic background as the mother. The author also addresses another serious omission in the research literature, that of children and young people who have been in the care system. Arai notes that many of the factors that are associated with teenage pregnancy, such as low socio-economic background and low educational attainment are experienced by children and young people who have been through the care system, placing them at greater risk of early parenthood.

In the third chapter Arai explores the way teenage pregnancy is depicted in contemporary media. Through close scrutiny of media stories and the data that form the basis for media depictions, Arai unpacks the relationship between media representations of teenage pregnancy and the policy

response as well as public perceptions of teenage mothers.

In the fourth chapter Arai explores in depth New Labour's approach to addressing the problem of teenage pregnancy by reframing teenage pregnancy as a consequence of external factors and social exclusion. This is achieved by a critical exploration of New Labour's seminal policy document *Teenage Pregnancy*.

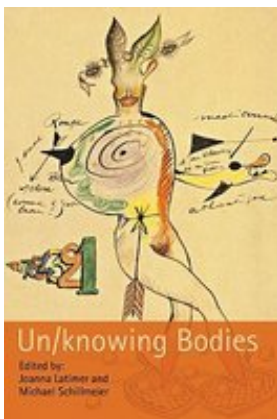
The second part of the book *Unmaking a Problem* begins by examining the consequences of teenage pregnancy. This is achieved by giving an overview of the literature in tabular form on the socioeconomic and health related outcomes of teenage pregnancy.

This is followed by a discussion in chapter six of the context of teenage pregnancy. In this chapter it is argued that discussions of teenage pregnancy are often decontextualised as an issue because these discussions bear no reference to the unique social, demographic and economic landscape in which teenage pregnancy is experienced. The decontextualisation of teenage pregnancy is also evident in the use of international comparisons, which it is argued has implications for cross-national transferability of interventions because the context in which teenage pregnancy takes place will vary across nations and even neighbourhoods.

Chapter seven focuses on two political periods; the Conservatives and New Labour and considers how policy and social attitudes are informed by social norms and anxieties. This is achieved by a critical exploration of social constructionist and other related ideas and the relationship between these and the policy making process.

The final chapter draws together Arai's key points and makes some recommendations for both policy makers and researchers.

Arai's book is a thoughtful and insightful look at the issue of teenage pregnancy. It clearly highlights the unhealthy relationship between the media and policy and demonstrates how this relationship can distort the research evidence and lead to the marginalisation of a vulnerable group of young people. This book has a wide appeal and will be of interest to policy makers, academics and students in sociology, health policy and social policy.



Joanna Latimer and Michael Schillmeier (Eds.)

Un/knowning Bodies

Wiley-Blackwell, 2009, £17.99 (pbk)

ISBN: 978-1-4051-9083-1

272 pages

Reviewed by Lorraine Ritchie, University of Otago, Christchurch, New Zealand.

This book forms part of the Sociological Review Monograph Series and brings together a collection of papers originally presented at a research meeting held in Cardiff in 2007. These papers have now become chapters and all are authored by leading international researchers on the topic of body and embodiment. The contributors are drawn from a diverse range of disciplines including management, psychology, anthropology, nursing and sociology. A useful section: 'Notes on contributors' at the end of the book gives the reader details on the authors' backgrounds and research interests.

In her introduction, Joanna Latimer explains that the main intention of the book is to present research on the 'lived' body as a 'knowing' entity rather than the body as an object of knowledge. Arthur Frank (1990) is credited with bringing the lived body 'back in to vogue' and Latimer tells the reader that there has been an increase in social science writing on the body over the years, although she cautions that not all researchers agree on how they view the body. The body as a source of study has moved from object to subject, to lived body, and finally to a knowing/unknowing body performing in its own context. The way bodies are viewed has evolved over time and bodies can be viewed from a wide variety of perspectives and meanings, as Latimer describes: thin bodies once meant hard work; 'consumer' bodies now exist as a type of body worthy of study; Bourdieu wrote of 'collective bodies, that is, groups of bodies within cultures. An aim of the book is to recognise the body as more than just a means or a conduit. Each chapter contributor helps illuminate a different kind of knowing/unknowing body.

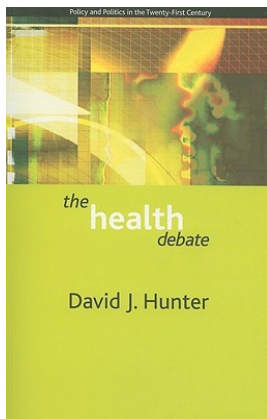
Topics of each chapter are assorted and cover the body in relation to: Persistent vegetative state (PVS), burns, dementia, deafness, mastectomy, old age, amputation and death. While in my reading of this book I found each focus and interpretation of the body fascinating, I was particularly attracted to two chapters in the book and will focus on these.

The book is divided into four sections: 'Opening up the body', 'Moving worlds', 'Bodies & Technology' and 'Absences and Presences'. The second chapter of section three is written by Kraeftner and Kroell and is entitled: 'Washing and assessing: multiple diagnosis and hidden talents'. The authors describe an experiment which they conducted in a neuro-rehabilitative care setting where 'physically dependent, medically vulnerable and cognitively impaired people spend many years of their lives'. The experiment occurred when the researchers convinced the nurses caring for this PVS group of patients to add another therapy to one which they already performed daily, the full body wash. The new assessment used a tool called The Sensory Modality Assessment and Rehabilitation Technique (SMART). As opposed to the hour long full body wash performed by the nurses, a researcher (assessor) observes the reactions and response of the PVS patient to certain stimuli such as loud noise, and documents these. Nurses also observe patients during their body wash but their observations are more intuitive and subjective; they thus have a different way of knowing the unknowing bodies in their care and the chapter occupies itself with debate and discussion over these two differing world views on how to observe, touch/not touch, approach the unknowing body. The authors achieve an admirable level of insight and reflection into their own behaviour, the impact that their experiment has on the neuro-rehabilitative ward and the consequences of conducting an experiment on the health professionals, their patients and ultimately the body.

The second chapter of section one is authored by Joanna Latimer and is entitled: 'Unsettling bodies: Frida Kahlo's portraits and in/dividuality'. In this chapter Latimer examines the self-portraits of the Mexican painter Frida Kahlo. Kahlo painted many self-portraits throughout her life which were painted in the 'naïve' style of art and are influenced by family, tragedy, politics, illness and romantic relationships. She was of German, Jewish and Mexican heritage and experienced many challenges throughout her life including polio and debilitating pain due to a traffic accident. Latimer discusses the unsettling nature of Kahlo's paintings which mix foetuses, body parts, breast milk, and blood among other symbols and motifs from her life events. Latimer's main thesis in her paper is that although Kahlo's 'subject-self' paintings offer us a different vision of embodiment, they are not one of a divided self (although her paintings sometimes display a multiplicity of Fridas), but rather perform an idea of 'dividuality'. Latimer borrows the concept of 'dividuality' from the work of Strathern (1992) and applies it in this context to describe how Kahlo's paintings 'perform an idea of 'dividuals' whose relationality is what makes them up as always in 'partial connections', who can never be entirely settled into wholes...' (Latimer, 2009: 58). Latimer's interpretation of Kahlo's work and bodily presentations is convincing and intriguing and is accompanied by colour prints of two of Kahlo's

paintings.

Each of the authors in this book identify that bodies are hard to define. Bodies are discussed, theorised, examined and viewed from multiple perspectives. The book offers refreshing and challenging intellectual stimulation by pushing boundaries and moving into new directions as to what the body means to different people in different contexts, not only how the body is observed, but how it is felt and performed in society.



David J. Hunter

The Health Debate

Policy Press, 2008, £12.99 (pbk)

ISBN: 978-1-86134-929-3

240 pages

Reviewed by Edwin Griggs, Birmingham University, UK

This book offers an introduction to a number of recent issues in UK, or perhaps more specifically English, health policy. It is one of a series of short books, each devoted to specific social policy areas; earlier volumes have included texts on pensions and education. The material is divided into seven chapters, amounting to 200 pages of main text. Two are concerned with 'policy challenges' and meeting these challenges; there is a chapter on 'models' of health system reform and then three more specialised chapters are devoted to choice and competition, priority setting, and public health. A concluding chapter summarises Hunter's views of present developments and sets out his preferred alternative, so the text aims at policy recommendation and prescription as well as description and analysis. There is an index and a list of references. The aim of this and the other texts in the series is to provide a lively and critical commentary on current developments and to acquaint readers with the main issues at stake in contemporary debates.

Hunter's is certainly a critical account of recent health policy developments, at any rate in England; he is deeply unhappy with the course taken by policy makers at least since the 1980s. The real problem with the system, it might seem from reading this book, is the insensate desire of politicians to meddle with it. Politicians have apparently, according to Hunter, behaved in a destructive, or at least unhelpful, way towards the NHS in recent decades. They have 'reformed', they have meddled, and they have interfered. They listen, for policy advice, to the wrong people; they are influenced by wrong ideas and policy prescriptions, principally what Hunter refers to as 'neo-liberal' ones.

Insofar as one can discern any sort of causal paradigm underpinning Hunter's view of things, other than heavy reliance on Alford's 'structural interests' model, it seems to be about the dominance of ideology and of a particular hegemonic ideology, 'neo-liberalism'. But this just provokes further questions. Where does ideological hegemony come from? Why should 'neo-liberal' ideas, if that is what they are, have been influential in recent decades? And how important are ideas anyway, as opposed to a desire on the part of politicians to win and retain office? Concepts such as 'neo-liberalism' and its derivatives are never examined in any detail.

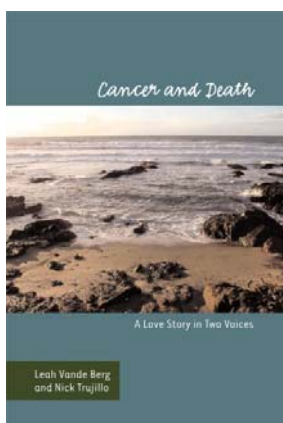
The term becomes a kind of talisman, a symbolic marker that some kind of political position is being staked out.

Hunter is almost entirely concerned with UK, more particularly, English, developments. It would be interesting, in this context, to know more about, for example, the German, Dutch and French health systems, which have substantial private components both in terms of funding and provision, appear to permit significant consumer choice and some degree of public participation, while at the same time being strongly public in terms of values and regulation and apparently achieving successful outcomes. Where does ideology come in all of this? These continental systems are, arguably, more decentralised and market-like than the UK systems, but 'neo-liberal' ideology, whatever that may be, has played no role.

It is hard to see how Hunter reconciles his belief in 'neo-liberalism' as a dominant ideology in relation to UK, or at any rate English, health policy with the facts about recent trends in health service funding. Instead of cutting health service funding, or allowing it to languish, governments since 2001 have substantially increased funding to around the European average. Health service funding suffered more, if anything, in earlier periods when the dominant ideology was presumably anything but neo-liberal – the 1950s (under Labour and then under the Conservatives after 1951) and 1970s (under Labour), for example.

Hunter's conclusions might appear to be: nothing works. Markets, choice and competition are no good, for familiar reasons, and according to authorities cited by Hunter, people don't want choice anyway. But hierarchy and top-down governmental bureaucratic control, with its authoritarian culture of centrally-imposed targets, are no good either. And certainly professional control, with its associated culture of paternalistic dominance, will not do, as such episodes as the Bristol Royal Infirmary paediatric cardiology scandal of some years ago and the Shipman case seem to bear witness. Nor does Hunter seem much interested in a greater degree of local democratic accountability as a means of overcoming some of the dilemmas - a major theme of the NHS Commission study of 2000, chaired by Will Hutton. One might think that these exhaust the universe of possible modes of health service organisation. Hunter is optimistic, however, suggesting that there are as yet untried ways of running a health service, and he places faith in what he calls 'responsible professionalism', talking of patients and members of the public as 'co-producers' of health, citing, amongst other authorities, Julian Tudor Hart and the example provided by his practice as a GP in a South Wales mining community. For the ideologically-motivated Communist GP Tudor Hart, 'public spirit' or the 'public service ethos', in the sense of a desire to serve the health needs of the proletariat, was incentive enough. How far might such motivation be generalisable to the rest of the profession?

As an introduction to current debates about health care organisation and delivery in the UK, this book falls short. It is as if we have dropped in on an ongoing conversation amongst a bunch of policy insiders who are familiar with the issues and who already have a shared point of view about it all. The book's material is poorly-organised and its mode of argument relies heavily on repetition. There is a general sense of going round in circles and of endlessly revisiting the same points. This is a shame, because there is a worthwhile case to be made. Hunter is not (necessarily) wrong in his feeling that current policy, for England at any rate, is misguided. As a critique of government hyper-activism in health policy, it has merit.



Leah Vande Berg and Nick Trujillo

Cancer and Death: a love story in two voices

Hampton Press, 2008, \$23.95 (pbk)

ISBN: 978-1-57273-851-5

163 pages

Reviewed by Ruth Bridgens, independent researcher, UK

Cancer and Death: a love story in two voices by Leah Vande Berg and Nick Trujillo is a cancer narrative written jointly by a married academic couple at Sacramento State University about the wife's 14 month struggle with ovarian cancer. It is a personal narrative, not a straightforward academic book. There is no sociological analysis, perhaps because it was thought that this might detract from the immediacy of the experience. The couple have also ignored the enormous symbolic significance of cancer in our society, and the concomitant plethora of self-help books, websites, alternative treatments, self-help groups, psychological theories and biographical writing. The two stories cover remarkably the same ground with no contradictions or confusions, but the narrative styles vary enormously. It might have been helpful for the reader to have had an explanation of how the book was compiled, as it is mentioned that Leah taped her story, and there are also group e-mails to friends, and comments by friends and relations, interspersed between Nick and Leah's stories. Although on one level the book is very much about two people, love and death, it is, on another level, Nick's book, completed several years after Leah's death, with several chapters on his grieving process.

For me, the importance of this multivocal story lies in the imbalance between Nick and Leah's authorship of the book and the remarkable differences in the two narrative voices. Reminded of Susan Sontag's kingdoms of the well and the sick, I felt that these two narratives were coming from very different places, one related by someone who was still living in this world and one by someone who had already left (Sontag, 1990). Leah had been told in October 2003 that she had ovarian cancer which had already spread to her liver and possibly to her heart. She died 14 months later. However positive she was about her chemotherapy, she seems, in her sparse, to-the-point style of telling the story, to be separating herself from her past, her family and friends, who describe her as an immensely lively, sociable person. In contrast to this, her writing often seems emotionless. When she mentions her mother's death in the 1980s she only writes 'I flew home that day, but unfortunately my mum died while I was on the plane. She was only 55 years old' (Vande Berg and Trujillo, 2008: 34). Unmentioned is that her mother's death from heart failure, diagnosed the year before, mirrors what happened to Leah, who was also 55 when she died. This brevity could partly stem from her very strict and stoical Midwestern small-town Calvinist upbringing. Her belief that everything was God's will may also have made introspection difficult, but it seems that from the moment she realised she only had a short time to live, she was already in another world. When she first heard the diagnosis she said, 'I was absolutely frozen in time as the doctor went over the diagnosis. It seemed like I was outside of my mind and my body and this was happening to someone else, except it very clearly was happening to me' (Vande Berg and Trujillo 2008: 42). Sadly, her belief in God's will led her to feel that she was dying because she had not led the life God wanted her to lead, and instead of concentrating on teaching and helping others, she should have focused more on religious growth

itself.

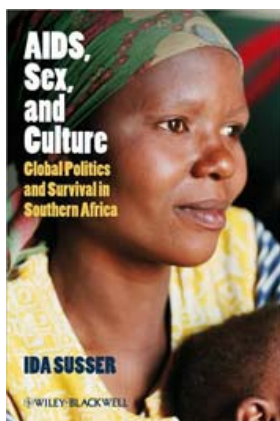
In the final chapters, Nick describes how grieving affected him, his attempt to grieve in ways that friends suggested to him, and his annoyance that people often told him how he must feel rather than asking him how he felt and listening to his reply. He might have explored more fully the meaning of the question 'How are you?', whether it invites a reply, and whether ill or grieving people want to reply, sometimes or ever. In an article on resonance, the anthropologist Wikan quotes from a newspaper interview with a Norwegian poet grieving for his daughter, who interprets 'How are you?' as a message of empathy and explores the answer 'Fine':

'How are you?' people ask. It can be a gentle way of approaching, a light brush across the cheek, words that wish to remove bandages gently so the wound will not start bleeding again. And I could have answered with long explanations, I could have told of all the rents in the fabric we call life, I could have told everything. But I answer: '*Takk, bare bra* -- Fine, thank you.' Each in our own way we know it so well. And it is good to have everyday trivialities to cover it with. (quoted in Wikan, 1992: 477)

An interesting comparison with *Cancer and Death* is another multivocal cancer narrative, Ruth Picardie's *Before I Say Goodbye* (1998), which is a compilation of e-mails to and from friends, her *Observer* columns (the last finished by her sister), readers' replies to the articles, and an introduction and conclusion by her husband. Ruth was 32 when she was diagnosed with metastasised breast cancer, had one-year-old twins, and died one year later. In her e-mails and newspaper column, Ruth tries, sometimes with extreme black humour, to remain in this world, but also faces her unknown future and the future after her death. 'I think life will continue just fine. It's just that I'll miss it so' (Picardie, 1998: 59). One of her readers writes, 'Your words pack no mean punch and leave the reader in no doubt as to the utter horribleness of your illness, but you do so in such a way as to remind us that this is happening to a real flesh-and-blood human being, and not one who has been mysteriously transformed into some serving apprentice angel with a foot in two worlds' (Picardie, 1998: 55-6). On the other hand, her husband writes, 'Cancer changed everything: it put us on different tracks, stretching our grasp of one another to the limit and eventually forcing us apart. In the end, I could not reach her, and it felt like a failure in me. And then she was gone' (Picardie, 1998:103-4). Reading these two books side-by-side suggests a possible undeveloped theme in the sociology of dying, implied by Leah's matter-of-fact style and Ruth's husband's conclusion: that of the continuum negotiated by dying people between the two worlds of flesh-and-blood human and 'apprentice angel'.

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Ida Susser

AIDS, Sex and Culture: Global Politics and Survival in Southern Africa

Wiley – Blackwell Publications, 2009 £20.99 (pbk)

ISBN: 979-1-4051-5587-8

277 pages

Reviewed by: Keerty Nakray, Queen's University, Belfast, Northern Ireland

Ida Susser makes an important contribution to the growing research on gender and HIV/AIDS in Southern Africa. The author develops a theoretical framework for an understanding of the culture and politics of gender with respect to AIDS. According to her, HIV/AIDS in Southern Africa is an effect of the deadly paradigm of globalisation and it is closely linked to the social processes of migration and violence of rape and general disruption of communities. HIV/AIDS epidemic has led to the repetitive portrayal of African women as passive, ignorant, suffering and stigmatised. This book seeks a departure from this portrayal and focuses on the avenues of hope by reflecting on the small changes that poor women have introduced in their households and communities and the links between their actions and global politics.

Chapter one reflects on the historical invisibility of women in HIV/AIDS epidemics. As initially, 'gay men' or 'patients with haemophilia' were at the centre of the Western epidemic. The exclusion of women was not merely representational; they were excluded from the initial drug trials because of their possibility of becoming pregnant, which eventually led to the neglect of treatment possibilities for women and infants. Another area of neglect was the 'mother-child dyad'; the author highlights the fact that only recently has it become clear in many African countries that exclusive breast feeding, allowing mother's immune responses and hormones to be transmitted to the baby, has saved more babies over time than the provision of formula.

Chapter two examines how President's Emergency Plan for AIDS Relief (PEPFAR), has a direct impact on women in Southern Africa. The policies have minimal orientation to 'harm reduction' and promote the idea of 'Abstinence Only, Be Faithful and Use a Condom' (ABC) which focuses on heterosexual relations in spite of increasing evidence demonstrating that marriage is a risk factor for women. PEPFAR's ABC strategy is instrumental in shaping Uganda's AIDS policy and also it shares links with religious institutions. Several women's groups are fighting against this conservative agenda.

Chapters three and four focus on South Africa and the effects of racism, colonialism, modernity and 'millennial capitalism' on the perception of women's sexuality in society. The end of apartheid created a hope of transformation. However it also saw the emergence of contradictory forces of fundamentalist religious beliefs and accusations of sorcery which added grist to the culture of suspicion and repression which further undermined women in the tribal areas. The onslaught of structural adjustment programmes for the economy had a detrimental impact on women in the context of HIV/AIDS. On a positive note, structural reform programmes led to reduction of international debt and also in 2007, through the National Strategic Plan, new efforts were made to roll out highly active anti-retroviral treatment (HAART).

Chapter five is written by Sibongile Mkhize and it presents a poignant picture of HIV/AIDS

based on her personal experience of losing a sister and a brother and being witness to a sobbing father who lost seven of his nine children to HIV/AIDS. She concludes the chapter with a reflection that one can be overwhelmed with hopelessness; however there is glimmer of hope when young children are testing negative bringing cheer to the lives of their grandparents or other relatives.

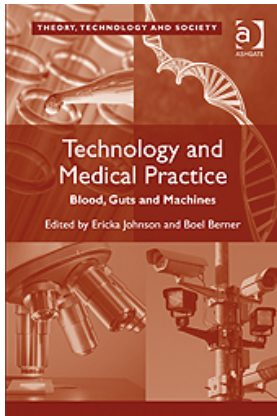
Chapter six and seven describe the possibilities for transformative action among women coping with the epidemic. The author notes the role of 'organic intellectuals' like Zanele, instrumental in the formation of a child support group where children of those affected could come together to deal with their situation. An insightful and charismatic grassroots leader she was able to transform the situation for a few parents and children.

Chapter eight examines how female condoms were launched in April 2001 and were sold in unprecedented numbers in Namibia. Susser describes women's struggles to manifest 'practical sense' about condoms and AIDS and provide advice to their children in the face of contradictory messages, sometimes promoted by institutionalised religion. She also traces the roots of the concerted demand for the female condom by non-governmental organisations (NGOs) and grassroots women's groups.

Chapters nine and ten discuss an interesting case-study of Ju/'hoansi women, a linguistic group amongst the San people, who live in the Kalahari Desert that crosses the borders of what are now Namibia and Botswana. An egalitarian society, Ju/'hoansi women enjoyed autonomy over their work and also shared child rearing with their husbands. The onslaught of eco-tourism, migrant workers, lack of investment in public transport threatened the well-being of women. Intervention by women and men in positions of power resulted in a positive change in the community. The author concludes that the adverse effects of privatisation could be reversed by a long term cooperative investment from the community itself.

Chapter eleven affirms that globalisation is not a one way process of oppression; individuals and communities have campaigned against corporate interests. For example: pharmaceutical companies have had to permit lower pricing for poor countries and allow the manufacture of some drugs outside of world patent laws. South African AIDS policy has also been challenged and the government forced into concessions as a result of a powerful combination of local and international protests. The author concludes in chapter twelve with reflections on the invisibility of women and the argument that women's experiences should be conceived in their broader social framework either in the treatment or prevention of AIDS.

The author has successfully encapsulated global and local politics which underpin the 'feminisation of HIV/AIDS'. However, the most important contribution the author makes is in understanding of the role of women's agency in mitigating HIV/AIDS in Southern Africa. The author provides excellent pragmatic examples in how the understanding of 'social determinants' of health can be applied in communities and in policies.



Ericka Johnson & Boel Berner (Eds)

Technology and Medical Practice: Blood, Guts and Machines.

Ashgate Publishing, 2010. £55.00 (hbk)

ISBN: 978-0-7546-7836-6

214 pages

Reviewed by Casimir MacGregor, Macquarie University, Sydney, Australia.

As part of the Theory, Technology and Society series by Ashgate, this edited collection *'Technology and Medical Practice: Blood, Guts and Machines'* considers the impact of new technologies on social, cultural, economic and political relationships. The book itself is an examination of medical technologies through the lens of medical practices, but also a study of medical practices as refracted through an examination of medical technologies (p1). The book uses the notion of practices to problematise the idea of medical technologies as universally applicable and bodies and practitioners as neutral users (p1).

In recent years the black box of science has given way to 'science in the making': it is against this backdrop that the book theoretically straddles interdisciplinary conversations between feminist science studies and science and technology studies (STS). From feminist science studies the book draws inspiration from theoretical discussions about female body politics and reproductive health, the (ab)normal between medical technologies and practices. From STS the book takes as its foundation that medicine is not a coherent whole, but rather 'an amalgam of thoughts, a mixture of habits and an assemblage of techniques' (Berg & Mol 1998:3 cited p3). Also in the spirit of STS the collection utilises a number of methodologies such as ethnography, social history and discourse analysis. The diversity of methodologies provides insight into the differences and tensions around the flexibility of technologies, as well as the practices they influence.

The book is split up into three parts focusing on the three tensions at the heart of technologies and medical practices: the judgement of bodies; the technological simulation of bodies; and the linking of bodies and machines. I will now examine each of these sections in greater detail.

Part 1, 'Judging bodies', deals with medical practices and technologies: how they are used to uncover and create knowledge about patient bodies and how they interact and are used to create certainty/uncertainty in medical practice. The first chapter in part 1 by Celia Roberts provides a discourse analysis of how pubescent bodies are defined in contemporary biomedical discourses. Roberts argues that some pubescent bodies understood as 'pathological' are becoming sites for biomedical interventions, while those bodies classified 'normal' are left to develop without such intervention (p13). Roberts stresses that pubescent bodies are not just biological, but are configured and lived through interactions between a range of actors that are subject to hierarchical circles of significance (p26).

Chapter 2 is written by Kerstin Sandell who undertook an ethnographic study of routine ultrasound screening in Sweden. This chapter focuses on how professional vision in routine ultrasound scanning during pregnancy is attained, with a focus on how midwives learn to see the distinction between the normal and the pathological in their everyday work practices. Sandell argues that negotiating the boundary between normal and pathological and maintaining it is one of the central activities in medicine. As Sandell notes, the pathological/normal is not a contested

distinction, as drawing the boundary between them is a major reason for doing routine ultrasound scans (p30) and suggests that midwives adopt a method of coding as a part of their professional vision. Coding is therefore a way of highlighting what is classified as abnormal. Learning to do ultrasound through the acquisition of a professional vision is about learning to see and accept the boundary between the normal and abnormal (p49).

Chapter 3 is the final chapter of part 1 and is written by Dawn Goodwin and Maggie Mort, who draw upon an ethnomethodological analysis of anaesthesiology practice in order to interpret technological ways of knowing the body. In this chapter Goodwin and Mort examine how accountability is achieved in medical practice and demonstrate how routines and norms signify accountable practice, but also show the complexity and uncertainty of clinical practice. Goodwin and Mort also show how practitioners maintain accountability within a paradigm that expects certainty in knowledge and practice, and how routines and accountability are practised even in the face of ambiguity. (p11). By tracing the different manifestations of 'accountability communities' eg policy makers, clinicians and patients, the authors suggest it is possible to discern how and why disunities must be addressed, 'but in some way be comprehended so that *actions can be made accountable*' (p71, original emphasis).

Part 2, 'Simulating bodies', examines how patient bodies are represented by medical technologies in various contexts. The three chapters comprising this section all examine the simulation of female reproductive organs and offer three different approaches to analysis. Chapter 4, by Rachel Prentice, is based upon ethnographic fieldwork conducted at an interdisciplinary medical informatics laboratory which built a gynaecological simulator. Prentice's chapter highlights how studying the construction of a medical teaching technology can reveal aspects of surgical practice that are not apparent when observing operating room instruction. Prentice concludes that the simulator reveals the multiple technical knowledges of human bodies where patients' and users' bodies in surgery also integrate knowledge of those relations of surgical skill into the student's body (p95).

In Chapter 5 Jenny Sundén examines a realistic simulator, S575 Noelle™, a female body that is made of rubber and mechanical parts, can bleed and even pushes out a simulated baby. Sundén's chapter explores simulations of birth, the appearance and techno-corporeality through a close encounter with S575 Noelle, a primarily blonde, white birthing machine (p99). The focus on the design of the simulator (not its clinical use) was a way to think about design for medical practices and the ways design processes and practices always inscribe and anticipate use and users in certain ways. By closely examining the simulator and looking at historical parallels, Sundén addresses the politics of simulation, against a background of sexual and ethnic politics. As the editors assert, her work is a 'feminist intervention' in the sense that it synthesises how the bodies of the simulators are materialised, and stabilised/un-stabilised within medical practice (p76).

Chapter 6, by Ericka Johnson, examines a simulator that physically recreates the female reproductive organs in rubber and silicon, allowing medical students to be trained in giving a specific type of gynaecological exam. Johnson argues that 'simulators are not reproducing ontologically pre-existing anatomies' (p76). These simulators are *recreating* context specific medical practices that allow and create disciplinarily and culturally produced knowledge of the body. Johnson suggests that simulator developers and users may like to think about how these practices are intimately linked to the epistemological and ontological interrelationships with the simulators and medical practices.

Part 3 of this edited volume, 'Linking Bodies and Machines', examines how bodies and machines are linked together and the relationships that this creates. A main focus of this section are the everyday attempts to localise artefacts within local networks of tools, practices, professionals and patients in order to make treatment possible in health care (p141).

The boundary between machine and human appears in the analysis of electronic foetal

monitoring by Petra Jonvallen, in chapter 7, the first in part 3. Jonvallen undertakes an ethnographic study within a Swedish hospital birthing centre. Jonvallen seeks to understand how a new method of foetal monitoring, STAN, was introduced into birthing practices, to build an understanding of why its introduction was difficult despite the scientific evidence of its merits (p145). Jonvallen makes visible the emotional work performed by doctors, midwives and parents in order to make the best of a birthing situation. She suggests that when examining new technologies we must also examine them as an emotional practice. The author further suggests that new technologies are merely one element about which information is needed in order to judge a specific situation within the work of doctors and midwives, a process that involves coordinating between different kinds of evidence: the measurable, the sensory, the experimental and the emotional.

Chapter 8, by Corinna Kruse, explores, through ethnographic research in Sweden, how the roles of humanness and machines are played out within a genetic laboratory and are incorporated into the laboratory practices of generating data from samples in genetic research. Kruse argues that humanness and machines are intimately linked to the laboratory's central concern of producing valid data and that machines are important tools for attaining this validity (p161). Kruse suggests that the laboratory staff incorporate machines into their work in two ways. First, when talking about humans and machines, laboratory staff attributed behaviour to a machine's individual personality, in effect re-classifying these machines as almost people instead of machines. Second, Kruse highlights the cut between human and machines which makes mechanical objectivity possible. In other words, machines were incorporated into laboratory practices as tools for making the data produced in those laboratories as facts rather than the products of human interpretation (p177).

Chapter 9, by Boel Berner, discusses how the meaning and practice of blood transfusions were constituted within local assemblages of artefacts, practices and people in Sweden from 1915-1950. In this chapter Berner suggests three ways in which the meaning of blood donation as a socio-techno-medical construct was reconstituted. The first of these was the reordering of relationships where early cases of blood transfusion involved the physical and social closeness of the donor to the patient side by side. This close physical and social relationship gave way to a position where the act of blood donation was disconnected from the actual transfusion and mediated through a special donor service and blood banks. The second relates to the changing of donor identities from an initial ad hoc collection to a fully organised system of blood donor recruitment. The third aspect of blood donation that Berner highlights is the shift from the act of donation being thought of as concern of individuals such as surgeons, donors, hospitals etc, to its becoming a Swedish national resource centred on notions of citizenship, solidarity and a wider public policy concern (p198).

The book concludes with an epilogue by Lucy Suchman based upon the issues raised in this volume. Suchman highlights the fact that the coherence of 'medicine' is an effect of professional and bureaucratic discourses which enable institutional arrangements, but also obscure the messy contingencies, internal contradictions, affective complexities and practicalities of doing medicine-in-practice (p206). Suchman also concludes that in order to do justice to the realities that are illuminated in this volume, an intimate examination of the entanglement between bodies and machines in contemporary biomedicine is required. This entails an examination of medical technologies and practices in their multiple forms of engagement, from specific locations (historically, culturally and power structures) and a concerted effort to create theoretically informed reflections on conceptual, practical, cultural and political implications (p206).

Submitting a book review

MSo welcomes the submission of reviews of books that are of relevance to medical sociology. A list of books available for review is published in each edition, but the editorial team will also be happy to consider reviews of books not listed, provided they are of relevance to the medical sociology community. Please contact the editorial team if you would like a copy of a book for review. 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. Reviews should be no longer than 1000 words. Completed reviews should be submitted as a Word document via email to mso@liv.ac.uk. Book reviews will not be subject to peer review, and the decision to publish them will be made by the editorial team. The editorial team also reserve the right to edit articles prior to publication.

Books available for review

Ellen Balka, Eileen Green and Flis Henwood (Eds.) (2009) *Gender, Health and Information Technology in Context*. Aldershot: Ashgate.

Colin Barnes and Geof Mercer (2010) *Exploring Disability - 2nd Edition*. Cambridge: Polity.

Mildred Blaxter (2010) *Health - 2nd Edition*. Cambridge: Polity.

Monika Büscher, Dawn Goodman and Jessica Mesman (Eds.) (2010) *Ethnographies of Diagnostic Work: Dimensions of Transformative Practice*. Basingstoke: Palgrave Macmillan.

Geoffrey Cockerham and William Cockerham (2010) *Health and Globalization*. Cambridge: Polity.

Jean Hartley and John Benington (2010) *Leadership for Healthcare*. Bristol: Policy Press.

Ananya Mukherjea (Ed.) (2010) *Understanding Emerging Epidemics: Social and Political Approaches*. Bingley: Emerald.

Alison Pilnick, Jon Hindmarsh and Virginia Teas Gill (Eds.) (2010) *Communication in Healthcare Settings: Policy, Participation and New Technologies*. Oxford: Wiley-Blackwell

Graham Scambler and Sasha Scambler (Eds.) (2010) *New Directions in the Sociology of Chronic and Disabling Conditions - Assaults on the Lifeworld*. Basingstoke: Palgrave Macmillan.

Jonathan Tritten, Meri Koivusalo, Eeva Ollila and Paul Dorfman (2010) *Globalisation, Markets and Health Care Policy - Redrawing the Patient as Consumer*. London: Routledge.

PROPOSED CHANGES TO THE CONSTITUTION OF THE BRITISH SOCIOLOGICAL ASSOCIATION MEDICAL SOCIOLOGY GROUP

The committee of the British Sociological Association Medical Sociology Group are proposing some alterations to the constitution, subject to agreement by the AGM at Durham University on Sept. 2nd 2010. Apart from recognising the replacement of the Newsletter by Medical Sociology Online (MSO), these largely address our evolving position in relation to the BSA itself:

- i. our closer financial relationship means that a separate role of treasurer is no longer required;
- ii. sub-groups now report directly to the BSA rather than to the committee.

The text of the proposed constitution (with additions highlighted in red and removals highlighted with red square brackets) will also be distributed to all conference delegates for their consideration.

* * *

Constitution of the BSA's Medical Sociology Study Group

1. The Group shall be called the Medical Sociology Study Group. The objects of the group shall be to foster the development of teaching and research in the sociology of health and illness and communication between persons interested in these areas. In pursuit of these aims the group will organise an annual conference, encourage and support the establishment of regional groups, publicise its activities through **Medical Sociology Online (MSO)** [a Newsletter] and other media outlets, and undertake such other activities to promote these objects, provided that these activities are legal and legally charitable.
2. Membership of the group shall be open to any British Sociological Association (BSA) member. Persons who are not members of the BSA shall be allowed to participate in group activities subject, where applicable, to payment of the appropriate fee for non-BSA members.
3. The Group shall have the power to charge its members fees to cover the costs of holding events or publications in furtherance of the objectives of the group. When such fees are charged there shall be a higher charge made for attendance at events for persons who are not members of the BSA.
- 4.(a) The Group shall be managed by a committee **of ten members (excluding ex-officio members) consisting of two co-convenors**[a treasurer] and eight members elected at an Annual General meeting (AGM). All committee members shall be fully paid up members of the BSA. All terms of office shall normally commence and end at an AGM. A quorum of five members, who may include the **co-convenors** [and treasurer] but not any other ex-officio members, shall be required to conduct committee business.

(b) The Group shall choose a **co-convenor**-elect at the end of each second year in a **two** [three] year cycle who shall serve as **co-convenor** for a **two** [three] year term of office. The **co-convenor** will normally be selected by the committee from among present or previous members of the committee and their selection will be presented for ratification at the AGM prior to commencement of their term of office. If they are not an ordinary committee member they will

serve as an ex-officio member of the committee for the year prior to their becoming co-convenor.

(c) The senior (first elected) co-convenor will act as the Group's treasurer. [treasurer shall serve for one three year term of office as an ex-officio member of the committee. They will be selected by the committee and their selection presented for ratification at the AGM prior to the commencement of their term of office.]

(d) Calls for nominations for committee membership shall normally be announced in the pre-conference issue of MSo [the Group's newsletter], on the website and circulated via the jscmail list and may [should] be received before or at [prior to] the AGM[, although they may also be received at the AGM].

(e) The committee shall have the power to co-opt members to fill vacant committee places and to co-opt to ex-officio membership of the committee any person of their choosing provided there is complete consensus of agreement among them as to their choice. Such co-options shall be presented to the next available AGM for ratification.

5. The editorial team of MSo [the Group's newsletter], while retaining editorial autonomy, shall be accountable to the Group committee for the management of MSo [the newsletter]. A member of the editorial team shall have ex-officio membership of the committee.

6. In pursuance of its objectives, the Group will strive to maintain its collegial relationship with the independent journal The Sociology of Health and Illness (SHI).

(a) Two members of the editorial board for SHI will be elected at the Group's AGM.

(b) A member of the SHI editorial team shall have ex-officio membership of the committee.

7. The duties of the co-convenors are to oversee the programme of activities of the Group, to ensure the activities of the Group comply with its constitution and legal requirements and to liaise with the BSA and other bodies as required.

8. The Group will provide financial support to regional sub-groups whose activities are consistent with the objectives of the Group provided they:

(a) have a convenor and treasurer who are members of the BSA and a programme of activities

(b) provide [submit] an annual statement of income and expenditure to the Group Treasurer and a written statement of their activities to the BSA [presentation to the Group's AGM]

9. (a) The Group's financial year will coincide with the financial year of the BSA.

(b) The administration of the finances of the Group shall be the responsibility of the staff at the BSA office. A 'designated' fund will be held on behalf of the Group within the BSA's main accounting system.

(c) The accounts of the Group shall be audited by the auditors of the BSA.

10. The Group may incur expenditure on the production and distribution of information and/or materials, the hire of rooms for the conduct of meetings, and the cost of speaker's expenses, provided such expenses fall within the pursuance of the objectives of the group.

The BSA shall pay the costs incurred by committee members associated with committee meetings of the Group and attendance at the annual conference, including any travel and administrative expenses. The BSA may also pay any costs incurred by persons representing or

acting on behalf of the Group. No payments shall be made without appropriate written accounting of expenditure.

11. The Annual General Meeting of the Group will be held each year at its annual conference. Notification of the AGM, together with an agenda, will normally appear in the pre-conference issue of MSo [the Group's newsletter]. The business of the AGM will be to:

(i) receive the report of the senior co-convenor on the activities of the Group

[(ii) receive written reports from regional and any other sub-groups]

(iii) receive the Treasurer's report and the accounts of the Group

(iv) receive a report from the editorial team of MSo [the Group's newsletter]

(v) receive a report from the editorial team of SHI and elect two members to its editorial board.

(vi) elect ordinary members to fill any vacancies on the group committee (as per 4d above)

(vii) ratify any co-opted membership of the committee

(viii) ratify the selection of co-convenor [and treasurer, as required]

(ix) The minutes of the AGM shall normally be published in the post-conference issue of MSo [the Group's newsletter], on the website and be circulated by the jscmail list (and sent to the BSA for its information).

12. Attendance and participation at the AGM is not confined to members of the BSA but, in accordance with the rules of the BSA, only fully paid up members of the BSA may vote at Group meetings. A quorum of 15 BSA members shall be required to conduct the business of the AGM.

13. Constitutional changes shall normally be published in MSo [the Group's newsletter], on the website and circulated via the jscmail list prior to the AGM at which they are to be discussed and be made available to the convenor for insertion into conference delegates' information packs together with any written resolutions received by the due date.

14. Any matter not covered by this constitution shall be referred to the Group committee for action.

15. In the event of the winding up of the Group, all monies and assets of the Group shall revert to the BSA.

16. This revision of the Group's constitution was adopted at the 2010 [2001] AGM of the Group.