

Missing Connections: Medical Sociology and Feminism

Ellen Annandale

University of Leicester

Plenary Presentation at the BSA Medical Sociology Group Conference 2005

Originally published in MSN Volume 31, Issue 3, Winter 2005

INTRODUCTION

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

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

(Wiltshire 1997: 16)

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

But what of the other side of the coin - medical sociology; is it fair to say that medical sociologists have lost their connection with feminism? On first glance it seems simply wrong to say this – after all, a scan of journals such as *Sociology of Health & Illness*, *Social Science Medicine* and *Health* will quickly reveal scores of really interesting articles on gender and health: on topics such as health inequalities, the experience of illness, reproduction, the delivery of health care, and so on. There is then no shortage of research and no shortage of publications on gender and health within sociology and the wider social sciences. The problem as I see it is that gender is everywhere and it's nowhere. Although it would be imprudent to stretch the point too far, 'gender' has become somewhat taken-for-

granted. So much so that we seem rarely to reflect critically upon what concepts like gender, patriarchy – even feminism itself - mean for us anymore. When medical sociologists use the term 'gender' in reference to women's health it typically connotes potential or actual disadvantage (the same often now applies, of course, to the growing body of men's health research). But the reasons for how and *why* this disadvantage comes about are often rather murky. All too often, research focuses only on a cluster of proximate causes (be they quantitatively or qualitatively defined) and the relationship between gender and health loses its structural moorings. Without these moorings we are left with similarities and differences in women's and men's health status, and similarities and differences in their *experience* of health and illness, for which we have no real explanation beyond a generalised sense that they are related to women's and men's positioning within society.

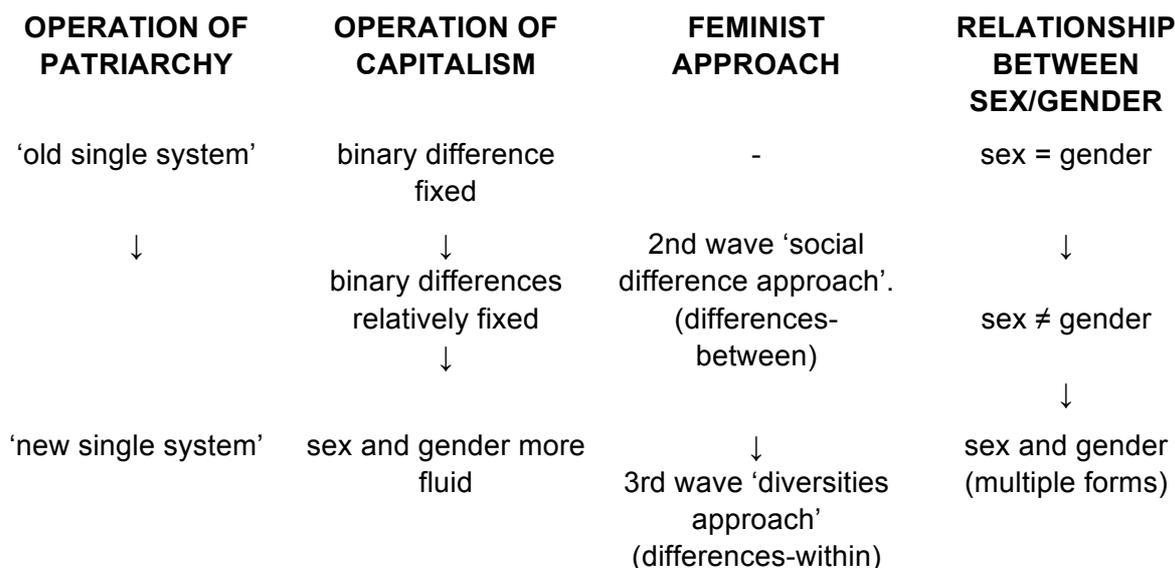
As I will discuss in more detail later, as what has conventionally been thought of as 'biological sex' and 'social gender' become less fixed and more fluid, the traditional distinctions between male and female experience are breaking down and being reconfigured in new, more complex and highly problematic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

Thinking about sex and gender

The story of how and why medical sociology and feminism came together, how they parted, and how they might be brought back together can be told through changing conceptualizations of the relationship between sex and gender. As far back as the seventeenth century, women writers were acutely aware that mind/body dualism had enabled men simultaneously to define themselves as rational agents, while equating women with a defective biology that excluded them from agency. It therefore made perfect sense for feminists, centuries on, to challenge this biological determinism with a new dualism of their own: the distinction between sex and gender. This distinction enabled them to argue that women's oppression is *socially* caused, rather than *biologically* given. The conceptual distinction between sex and gender, the biological and the social which took off in the 1970s, has proven unshakeable¹. Even those who appeal for an appreciation of the interdependence of sex and gender in the production of health and illness persist in using the terms and, in effect, try to parcel out when sex (biology) is most important, when (social gender) is most important and, when they are equally important (e.g. Krieger 2003). Effectively, researchers are calling for greater precision in the use of these concepts, rather than a fundamental questioning of them.

The sex/gender distinction is as equally well embedded in the wider consciousness of society as it is in social scientific thought. This means that it is an object of enquiry as well as a conceptual tool. It is the lens through which debates on women's oppression and liberation have been refracted for many years (and increasingly the focus for understanding men's health in gendered terms). In this respect it is important to appreciate that the meanings attributed to 'sex', to 'gender' and to their inter-relationship have varied over time. I wish to suggest that they are intimately tied to particular configurations of patriarchal capitalism.

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



Patriarchy has traditionally operated by conflating sex and gender (that is, sex equals gender) - through what I will term the 'old single system' of patriarchal capitalism. Within industrial capitalism, production and consumption were predicated on a relatively fixed binary difference between men and women (that is, male 'biological sex' maps onto male 'social gender' and female 'biological sex' onto female 'social gender'). This 'old single system' benefits patriarchy insofar as it is male sex and its associated social gender that enjoys the benefits of political and economic primacy. Gender follows directly on from sex and women's inferiority is a natural product of her (inferior) biological make-up. The heyday of this old single system in the West was probably the 1950s when production and consumption depended on a relatively fixed binary difference between men and women. Men were the producers, women the consumers. Products and services were targeted to a segmented gender market, but it was women who were incited to do the purchasing and servicing for the household. Slicing through the tight connection between sex and gender (that is, arguing that sex does *not* equal gender) provided what I will loosely call 'second wave' feminisms of roughly the 1970s onwards, with the conceptual wherewithal to challenge the old single system of patriarchal capitalism. It enabled them to argue that women's relatively poor health is the result of social (or gender) oppression, not biological inferiority. The sex/gender distinction was truly a conceptual treasure trove for sociological research on health and health care, spawning influential work in areas such as reproduction and childbirth and gender equalities in health.

Problems with the sex/gender distinction

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

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

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

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

The 'new single system' of patriarchal capitalism

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

As discussed earlier, during the old single system of industrial capitalism, sex (as biology) and (social) gender were seen as dimorphic with biological sex determining social gender. Typically men earned the family wage, while women, when not drawn into the workforce as a reserve army of labour, worked unpaid in the home. But this dichotomy doesn't make sense for late capitalism which relies heavily upon fluid and malleable identities formed equally, if not more, in the sphere of consumption as the sphere of production. The social body is being reformed as the once steadfast roles of male breadwinner, female homemaker and all that

accompanied them in attitudinal and behavioural terms are being torn apart by far-reaching changes in employment, education, family and household structure, leisure and consumption (although of course this varies enormously by factors such as 'race', social class and age).

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

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

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

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

Gender neutrality: 'There has been a convergence of taste and consumption: women get tattoos, like football, watch strippers, buy erotic fiction and go on lone holidays while men learn to use cosmetics, do aerobics, cook and read magazines.' (Guardian 2000)

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

It is not just young women who are implicated. Women are construed as irresponsible whatever their age and circumstances. In a recent survey Mintel Marketing Intelligence identifies, 'two new types of women behind' what they call the bad behaviour trend among thirty- to forty- somethings: on one side is a new group of women who are single or divorced, who are fed up that they can't find a partner or have just left one and are saying 'to hell with the whole thing and rewarding themselves with things they enjoy like alcohol and cigarettes', and on the other side are married women for whom the pressure of work and home life is growing all the time. These are the women who it is said are struggling to live up to media icons like Nigella Lawson who is seen to have a top career and a home life.

A no-win situation then: women are in dire straits whatever their circumstances. The clear message is that liberation has let them down and in the process generated a lucrative market of unstable identities and individual women who need to be shown the light. My argument is that this fluidity of identities is actively fostered through the new single system of patriarchal capitalism. The drinks industry for example, actively positions women in multiple contradictory ways. Mintel currently values the UK drinks industry at £38 billion and identifies women as a fast rising consumer group. Although young people remain the key market drivers, persons in their mid 50s to mid 60s are identified as a vital rising market too – the very age cohort of women whose health (as I will discuss later) appears to be suffering a downturn relative to men. The recent World Health Organisation's report, *Women and the Tobacco Industry* (Samet and Yoon eds. 2001) makes clear that tobacco companies need to recruit 4,000 new smokers a day worldwide to maintain their current market size. Selling tobacco products to women currently represents the single largest product marketing opportunity in the world.

The impact on morbidity and mortality

As mentioned earlier, within feminism discussion about the remaking of sex/gender has typically been concerned with the body's *surface*. Yet the changes associated with this protean 'economy of differences' of the 'new single system' of patriarchal capitalism, self-evidently extend *beneath* the surface. They reach deeply into the interiors of the body and change traditional health profiles. As health problems that were once largely the province of men begin to increasingly affect women (for example, lung cancer), and vice versa (for

example, melanoma), the materiality of the body is modified and takes on characteristics more typical of the so-called 'opposite' sex (the damaged lung, skin lesions and so on).

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

Table 1: UK Life Expectancy

Years:	1961	1971	1981	1991	2001	2003	Overall gain
age*							
Males	67.8	69.1	70.8	73.2	75.7	76.2	8.4
Females	73.6	75.3	76.8	78.7	80.4	80.5	6.9
Gap	5.8	6.2	6.0	5.5	4.7	4.3	
Healthy years**:	1981	1991	2001	Over-all gain			
Males	64.4	66.1	67.0	2.6			
Females	66.7	68.5	68.8	2.1			
Gap	2.3	2.4	1.8				

* United Kingdom, ** Great Britain Source: Social Trends 35, table 7.1 (2005)

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

Somewhat ironically then, the 'old single system' of patriarchal capitalism may have conferred a mortality advantage to women. Binary difference may have kept them away from the dangers to life and limb that cut male lives short. Now, as differences between men and women attenuate and inequality is reconfigured, women appear to be losing out and men gaining². Interestingly, very little popular attention has been given to men's improvement at older ages. Ironically, the tendency of the UK men's health lobby to draw attention to the historically invisible character of men's ill-health may unwittingly have contributed to this.

Figure 2: Major mortality

<p>Lung cancer</p> <ul style="list-style-type: none"> • Male rates still higher. But since mid-1970s, rise for women, decline for men in many western countries (e.g Griffiths & Brock 2003). • In 1950, lung cancer accounted for 3% all female cancer deaths, by 2000 it accounted for 25%. Overtaken breast cancer (US Surgeon General, 2001). • Opinion that women are 'in the throes of an epidemic of tobacco-related disease' which is yet to reach its peak (US Surgeon General, 2001). <p>Heart Disease</p> <ul style="list-style-type: none"> • Coronary heart disease (CHD) is major cause of death of women and men in UK (UK women amongst highest rates in world). Concern that CHD is incorrectly perceived to be a 'male disease' (British Heart Foundation 2003)

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

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

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

Similarly, Jacques Vallin *et al.* (2001) claim that there has been a convergence in life expectancy due to a 'convergence of behaviour patterns between men and women'. Researchers point out that the so-called 'gender paradox' whereby women live longer, but are apparently sicker than men throughout their lives, has been a product of blinkered thinking, a product of research designs which set out to *find* male/female differences (a point made earlier in this paper). Recognising the complexity, McDonough and Walters remark that

Rather than fixed paths, we see multiplicity and diversity in the relationships among gender, stress and health that call for more refined conceptualisation of 'gendered reality' The research challenge is to explore the ways in which gender continues to be an important representation of inequality, while recognising the diversity of experiences within genders (2001: 556, 557).

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

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

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

The drug *Zoroc Heart-Pro*, the world's first over the counter statin is niche marketed to a range of target consumers. The message is geared to a segmented market of males and females and different age groups. *Heart-Pro* is considered to be a key industry test case because it is now sold over the counter to healthy people as a preventative medicine. A suite of magazine advertisements has been directed to women. One such advertisement shows a woman holding up a 55th birthday card. The wistful look on her face suggests that the occasion is as much worrisome as it is a cause for celebration as the copy advises that she

is now of an age when she needs to think about taking *Zoroc Heart-Pro* to prevent a heart attack (even if she doesn't have risk factors like high cholesterol or high blood pressure). Even if she exercises and eats healthily, it can still help her.

Conclusion

If I can then return to my starting theme: the missing connections between medical sociology and feminism. Back in the mid-1980s, Ellen Lewin and Virginia Olesen (1985) felt confident in claiming that more than any other domain of life, 'health 'embodies almost all the crucial elements necessary to achieve an understanding of ...society itself'. 'Health permits the revelation of most of the elements of western cultures which bear most directly on the construction of gender and its consequences for women, men, and the larger social order' (p. 19). While other domains - such as religion or the law - provide insights, Lewin and Olesen make clear that none take us as far as health does, precisely because health is so all encompassing. Many feminists seem to have forgotten this and pushed health and illness out of view. Medical sociologists in their turn seem perplexed by the increasingly complex social relations of gender in the west, and unable to fully account for health-related change, in good part - I would argue - because they have lost their original anchor in feminist thought. They often work with vague derivatives of feminist theory, failing to appreciate the significant differences between them, and the implications of this for their research. I therefore argue that there is a need to bring feminist theory and gender-related research on health and illness within medical sociology much closer together than they are at present. Contemporary health-related changes are highly complex and reach deeply into the interiors of the body. They are part of what Teresa Ebert (1995) - writing outside of the domain of health - refers to as 'an economy of differences'. What we know as social (gender) and (biological) sex are drawn into a new symphysis within the 'new single system' of patriarchal capitalism. Within this new single system the common experience of health-related oppression is produced differently, and experienced differently, through systematically driven processes of sex/gender fragmentation. *Together*, medical sociology and feminism provide us with the wherewithal to reflect critically on this process.

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

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

References

- Aapola, S., Gonick, M. and Harris, A. (2005) *Young Femininity. Girlhood, Power and Change*. Basingstoke: Palgrave
- Annandale, E. (2003) 'Gender and health. Does biology matter?', in S. Williams, G. Bendelow & L. Birke (eds) *Debating Biology: Sociological Perspectives on Health, Medicine and Society*. Routledge.
- Annandale, E. and Clark, J. (1996) 'What is gender? feminist theory and the sociology of human reproduction'. *Sociology of Health & Illness*, 18 (1): 17-44.
- Bartley, M. (2004) *Health Inequality*. Cambridge: Polity Press. Beck, U. & Beck-Gernsheim, E. (2002) *Individualization*. London: Sage.
- Birke, L. (1999) *Feminism and the Biological Body*. Edinburgh: Edinburgh University Press.

Brettingham, M. (2005) 'Men's' life expectancy is catching up with women's', *British Medical Journal*, 331, 24 September, p. 656.

British Heart Foundation (2003) *Take Note of Your Heart. A Review of Women and Heart Disease in the UK*. London: British Heart Foundation.

Charles, N. (2002) *Gender in Modern Britain*. Oxford: Oxford University Press.

Coward, Rosalind (1999) *Sacred Cows*. London: Harper Collins.

Delamont, S. (2003) *Feminist Sociology*. London: Sage.

Dickens, P. (2000) *Social Darwinism*. Buckingham: Open University Press.

Ebert, T. (1995) 'Writing the political: resistance (post)modernism', in J. Leonard (ed.) *Legal Studies as Cultural Studies*, NY: State University of Albany Press.

Evans, M. (2003) *Gender and Social Theory*. Buckingham: Open University Press.

Griffiths, C & Brock, A. (2003) 'Twentieth century mortality trends in England and Wales', *Health Statistics Quarterly*, 18: 5-17.

Hennessy, R. (1993) *Materialist Feminism and the Politics of Discourse*. London: Routledge.

Hennessy, R. (2000) *Profit and Pleasure*. London: Routledge. Hughes, C. (2002) *Women's Contemporary Lives*. London: Routledge.

Klein, R. (1996) '(Dead) bodies floating in cyberspace: post-modernism and the dismemberment of women' in D. Bell and R. Klein (eds) *Radically Speaking. Feminism Reclaimed*. London: Zed Books.

Krieger, N. (2003) 'Gender, sexes, and health: what are the connections – and why does it matter?', *International Journal of Epidemiology*, 32:652-657.

Kuhlmann, E. and Babitsch, B. (2002) 'Bodies, health, gender – bridging feminist theories and women's health,' *Women's Studies International Forum*, 25 (4): 433-442.

Lewin, E. and Olesen, V. (1985) *Women, Health, and Healing*. London: Tavistock.

Lury, C. (2002) 'From diversity to heterogeneity: a feminist analysis of the making of kinds', *Economy and Society*, 31 (4): 588-605.

McDonough, P. and Walters, V. (2001) 'Gender and health: reassessing patterns and explanations.' *Social Science and Medicine* 52: 547-559.

Marshall, B. (1994) *Engendering Modernity. Feminism, Social Theory and Social Change*. Cambridge: Polity Press.

Martin, E. (1999) 'The woman in the flexible body', in A. Clarke and V. Olesen (eds) *Revisioning Women, Health and Healing*. London: Routledge.

Pilcher, J. (1999) *Women in Contemporary Britain*. London: Routledge. Roiphe, K. (1993) *The Morning After*. Boston: Little Brown.

Samet, J. M. and Yoon, S. (2001) *Women and the Tobacco Industry*. Geneva: WHO.

Shildrick, M. & Price, J. (1998) 'Vital signs: texts, bodies and biomedicine', in M. M. Shildrick and J. Price (eds) *Vital Signs. Feminist Reconfigurations of the Bio/Logical Body*. Edinburgh: Edinburgh University Press.

Skeggs, B. (1997) *Formations of Class and Gender*. London: Sage.

U.S Surgeon General (2001) *Women and Smoking*. Rockville, MD: U.S Department of Health and Human Services.

Vallin, J., Mesle, F. and Valkonen, T. (2001) *Trends in Mortality and Differential Mortality*. Strasbourg: Council of Europe.

Walby, S. (1997) *Gender Transformation*. London: Routledge. Whelehan, I. (2000)

Overloaded. London: The Women's Press.

Wiltshire, J. (1997) Jane Austen and the Body. London: Cambridge University Press.

Wolf, N. (1994) Fire with Fire. London: Vintage.

© 2014 BSA Publications Ltd Registered in England and in Wales. Company Number: 01245771. Registered Offices: Bailey Suite, Palatine House, Belmont Business Park, Belmont, Durham, DH1 1TW. VAT Registration Number: 416 9612 43. BSA Publications Ltd is a subsidiary of The British Sociological Association.

Please note that the views expressed in Medical Sociology online and any links or advertisements are not necessarily those of the BSA Medical Sociology Group, the British Sociological Association (BSA) or BSA Publications Ltd. While every care is taken to provide accurate information, neither the BSA, the Trustees, the Editors, nor the contributors undertake any liability for any error or omission.