CONTENTS

****

My thanks to Arthur and Jim for their reprographic work, to Jean for her excellent typing and to our two mothers to be in the Design Unit, for help in the production of this issue. (Ed.)

MEDICAL SOCIOLOGY NEWS

Newsletter of the BSA Medical Sociology Group : Vol. 8, No. 1, 1981.

THE HOWARD KIRK MEMORIAL ISSUE

EDITOR:
Mike Kingham, School of Behavioural Science, Northumberland Building, Newcastle upon Tyne Polytechnic, Newcastle upon Tyne, Tel: 0632 26002 Ext. 503

TREASURER:
Malcolm Colledge (address as above)

GROUP CONVENOR:
Anne Murcott, Dept. of Sociology, University College Cardiff, P.O. Box 78, Cardiff. Tel: 0222 44211

****

I had toyed with calling this issue of Med Soc News, the Malcolm Bradbury memorial edition, after all it was Bradbury who created the now 'infamous' Kirk. I thought our hero had died a literary death somewhere in the early seventies, you know the post political sociology period when the intellectual trendies of the sixties looked back with nostalgia and remembered with 'pleasure' the sit-ins, the Campus politics, the atmosphere of 'activism', anything but the renascence of bourgeoise scholarship and the apolitical purity of the social sciences in the seventies. And, anyway, even if it wasn't like that, we all remember Stan Cohen's Scholarly burial of the Kirk Stereotype! So, I for one wasn't sure which world I was living in when the media caught up with Kirk some nine years on and serialised his 'doings' in a glossy production, beamed out to the nation at peak viewing time. The production was greeted with some nervousness by colleagues; "oh my God, said one, thats all we need now, it will reinforce the Directors' prejudices against this faculty and we can expect more cuts." The SSRC were trying to live it down, "we don't talk about that production here," said an executive at the top. "By the way (sotto voce) did you know that the book makes it clear that Kirk was the recipient of an SSRC award", (nervous giggle on other end of phone). But then like all good dramas, rescue was at hand, the public learned of 'Structuralism', the McCabe affair came to centre stage and Cambridge English was systematically taken apart.

There seems to be a silent conspiracy in the sociology community to forget Kirk, tis a far far better thing to let the public wallow in the impending wedding of the 'Royals'. But my students are getting restless, their experience of 'realistic conservatism' (as Bradbury describes the period we are living through) is turning the litmus paper of their academic experience to red again. Will Mr. or Mrs. Howard Kirk ride again?

And now, after my indulgent opening remarks, to business.....

This years Med Soc Conference will be at York (see details elsewhere in this issue) and the call for papers is on, please let Roger Lightup have your abstracts. The main BSA Conference in April this year, has as its theme, 'Inequality'. Dave Field (Sociology Department, University of Leicester) is looking after the organisation of the Medical Sociology Contributions to the Conference, so if you want to utilise one of the available slots for a presentation, please contact him. I have received a book in German called the 'Aktive patienten' by Dr Manfred Dechmann and his colleagues, which discussed the development of a patient-centred approach to recording aspects of the patients experience of hospitalisation. (You will find it mentioned in the books received section). They say in their letter that they would appreciate some reactions to it 'from a country with a long lasting tradition in the activation and reanimation of the patient'. Is there an English Medical Sociologist with a good knowledge of German who can review this for us?

Finally, I have managed to give this issue of Med Soc News a theme - that of research. I am delighted that Raymond Illsley has offered us his paper on Medical Sociology research, which was 'delivered' at the Royal College of Obstetricians and Gynaecologists before christmas, and was related to his new book 'Professional or public health, Sociology in health and medicine' (Rock Carling Fellowship 1980, published by Nuffield Provincial Hospitals Trust). In contrast to this paper, Madeleine Simms and Hilary Graham have written us an imaginative piece on research in the health field, which developed from a workshop they held at the last Med Soc Conference.

My thanks to all the contributors, I hope you enjoy this edition.

Mike

B.S.A. MEDICAL SOCIOLOGY GROUP

A N N U A L C O N F E R E N C E

CALL FOR PAPERS

VENUE : University of York

DATE : 25th - 27th September 1981

THEME : Inequalities in health and health care (in Britain and Europe)

Titles and abstracts of papers should be sent to:

Roger Lightup
3 Leyland Avenue
Irlam
MANCHESTER
M30 6HG

Change of address:-

Professor Uta Gerhardt is now at:

Zentrum fur Psychosomatische Medizin
Abteilung Medizinische Soziologie
Freidrichstrabe 24
63 GIESSEN

SUGGESTIONS WANTED

In his recent article in 'Network', Mike Milotte, organiser of the B.S.A. Book Club observed that suggestions of titles for future selection would be welcome.

Since the Medical Sociology Group is probably the largest of the B.S.A. Study groups, it represents both a good source of suggestions and a reasonable market. This might successfully persuade both the book club and publishers to take them up.

It seems most sensible if I invite members to write to me (address on first page) with their suggested titles, and I'll forward a composite list to Mike.

Anne Murcott

PROFESSIONAL OR PUBLIC HEALTH?

When the Trust established this series of monographs and lectures in honour of Sir Ernest Rock Carling, they provided the opportunity for a succession of scientists and practitioners to review the state of their art. In picking upon medical sociology this year it was not merely (I hope) that the Nuffield Trust, in their long series, had run out of unreviewed relevant disciplines. Over the last 30 years a growing (and now substantial) number of sociologists have applied their theory and methodology to issues of health and medicine. They have as an important by-product developed and refined their own discipline within that field. I cannot review their contribution in this brief session - for that you will have to read the monograph published today. Instead I have chosen one theme, only loosely related to my title, to illustrate the distinctive approaches of medical sociology - itself a somewhat unfortunate disciplinary description because we are concerned with the sociology of health and not only of medicine. I have chosen to look at the concept and practice of evaluation as it is applied to health policy and health services. My major reason for so doing is its topical relevance in a society with expanding health needs and with no expectation of additional resources.

Evaluation, as it is conventionally used in medicine and the natural sciences, is already a sophisticated scientific technique. In a previous Rock Carling lecture, Archie Cochrane described and argued eloquently for its most elegant manifestation, the randomised controlled trial. The existing battery of formal evaluative techniques was mainly developed within the natural sciences where, in laboratory conditions, strict control could be exercised over the relevant parameters of an experiment. Such techniques have been brought out of the laboratory into medical practice and, where

applicable, they have proved valuable. I am asking how applicable they are in the much messier world of policy and of health service practice. It has now become apparent that, in the scale and costs of their consequences, we need to evaluate the assumptions, decisions and activities of politicians, administrators, professionals and other service providers rather than limit ourselves to the evaluation of controllable technical innovation. It will be my theme that in these open systems of action, as opposed to the more closed conditions of the laboratory or the hospital ward, conventional techniques are frequently inapplicable or inappropriate. I shall further argue that evaluation is not an experimental technique but a research activity, using all available methodologies, and carried out with the intention of attaching comparative value to policies, to the process of implementation and to the administrative organisation of services. Sitting on research-funding committees I see too many proposals bite the dust because the applicant dares to mention evaluation without adopting the conventional techniques appropriate to quite other conditions. Equally I see many policy and service issues remain unresearched because the criteria necessary for RCTs and other formal experimental methods do not exist and cannot be created.

To assist me in exploring the relevance of alternative methodologies to the evaluation of policy and health service organisation, I have identified five sets of conditions ideally required for formal or experimental types of evaluation. I shall take each, in turn, not in any sense to devalue conventional techniques, but to examine their relevance to open systems of action.

The first requirement is that "the primary objective of the intervention can be unequivocally specified". This requirement can be met at certain stages of the development and testing of a new drug or of a surgical procedure. How far is it applicable to activities at Downing Street, the Elephant and Castle, St. Andrews House, or the offices of Area Health Boards? This is

not (at least, not primarily) a snide criticism of policy makers and administrators. Policies rarely have a single identifiable objective. More usually they result from a process of accommodation, between what is and what ought to be, between needs and resources, between short- and long-term goals, between the different and perhaps competing interests of individuals and of organisations whose situations and functions give them varied perceptions of the public good, and between the interests of those who operate the system and those who are presumed to benefit from it as consumers.

Policies are, of course, often accompanied by a formal statement of objectives and theoretically it is possible to evaluate outcomes against such formal statements. There are reasons for doubting whether policy statements truly embody objectives and whether they should be evaluated at face value. The World Health Organisation has recently pronounced a policy of Health-for-All by the year 2000. It is clearly (or perhaps unclearly) unrealistic. It is more probable that the objective was to reach international agreement to underpin the continuing life of the Organisation and that such agreement could only be reached by postponing the outcome for two decades. When, nearer home, we consider the contrary and mutually contradictory actions of DHSS, the Treasury and the Departments of Environment, Employment and Industry on such key issues as smoking, alcohol, environmental pollution and unemployment we must, I think, reach the same conclusions about the policy reality of such statements as the 1976 pamphlet, 'Prevention and Health: everybody's business'.

It is not, however, only at this level that clear, unequivocal objectives are hard to identify. Specialisation involves the creation of a chain of services, with both vertical and horizontal links, each of which embodies a rationale and direction of its own. Particular objectives tend to supersede the common goal, so that, in effect, co-operation means the accommodation of interests. Use of the word 'teamwork' to mean the attempt to mitigate the consequences of continuing conflict has been noted by many

sociological observers.

Evaluation of policy and service operation in these circumstances must involve the location of a policy within a cluster of competing policies; examination of the unstated assumptions upon which policies are based; and assessment of the inconsistency between different objectives and between intentions and the machinery of implementation. It also means the identification, at each horizontal and vertical link, of the countervailing pressures, their origins and effects.

As an example I cite work carried out by Dr. David Hunter on the processes through which policy is implemented. He drew a distinction between central government policies and priorities, and the pressures emanating from the existing local balance of professional priorities and their resource demands. He tested his theory by studying, in several Health Boards, the process by which new development funds were actually allocated compared with the accepted policy of strenghtening the Cinderella services. He documents an administrative process whereby all existing service providers are requested by their Board Officers to list their needs and hence their claims upon such funds, the resulting claims being cumulated and discussed at various levels. The final allocations were made through a trading-off procedure such that they reflect the continuing pressure of past allocations and priorities. The shift in resources towards the new priorities could have been no other than a small residual. This study is not remarkable for its evaluation of outcomes but for its evaluation of the adequacy of machinery for the implementation of stated policy. Hunter's data consisted of the study of records and strategic committee minutes, interviews with interested parties, observation of key meetings between chief officers, supplemented by casual chat around canteens and corridors and questionnaire data from Health Boards not intensively studied. The triangulation of these many different kinds of data does not constitute experimental proof, but work of this kind has immense explanatory or illuminative power. To my mind the evaluation of

policy and health service organisation must consist of repeated studies of this kind at each stage of policy formulation and implementation.

The second requirement for experimental evaluation is that "the effectiveness and/or efficiency of a given product or process can be compared with no intervention or alternative interventions".

If governments, health organisations and practitioners used a frankly experimental approach so that, e.g. before they implemented a new measure in full, alternative approaches were introduced into selected areas, monitoring machinery established and results compared with each other and with control areas, this requirement (though not necessarily the others) could be met. Except however at clinical level, where the relatively autonomous authority of the medical service-provider often permits experiment, change is usually introduced in one piece as a result of legislative or administrative action, financial pressures, political ideological pressure, fashionable thought, and so on. Sometimes we can mount opportunistic research quickly to give a rapid documentation of the pre-change situation. Sometimes previous research mounted for other purposes may provide background data. For the most part, however, the impact of legislative and administrative action or of structural change can only be evaluated by the comparative study of variations arising naturally between areas, services and populations during the course of implementation. Chance variation is thus substituted, often precariously, for deliberate experiment.

Waiting for chance or for deliberate experimental opportunities is a good research game, usually profitable when possible, but it tends to elevate evaluation to the status of prose, or even poetry, a separate and different enterprise from research. Policies and services are continuously in being and the objective must surely be evaluation-in-action, taking services as they are, and developing and applying techniques for their assessment as the routine accompaniment of the uninterrupted provision of service. Preoccupied with pure scientific methodology, research workers often wish to impose upon the

routine provision of service, conditions which are administratively troublesome, which cause ethical anxieties and which reduce the freedom of clinical decision-making. For reasons of experimental proof, the research worker may require the maintenance of an experiment, in its pure state, long after it has become clear, on commonsense grounds, that modifications must be made. This creates resistance to evaluation, and tension between research and service.

As an example of a continuous process of service evaluation I cite studies of ante-natal care carried out by Dr. Marion Hall and her obstetric colleagues in Aberdeen. Advocates of RCTs have long regretted their inability to set up a satisfactory clinical trial of antenatal care because almost none of the experimental requirements can be met. This leaves open the field for advocates of more and more antenatal care on the grounds of our falling position in the international league table of perinatal mortality - despite the very strong possibility that our falling health ranking may well reflect our equally unenviable relative fall in living standards. Ante-natal care, however, is a complex series of inter-acting events adapted to individual needs and disagreement exists on objectives, because, on the whole, patients would prefer less but better and more sensitive care. Using a comprehensive data bank Dr. Hall and her colleague did an epidemiological analysis, for several years, of the major events of ante-natal care - from stage of first visit, through the number and phasing of visits, the number and status of doctors seen, past medical and obstetric histories, gestation at delivery, birth weights, deaths, major complications etc. Each was examined separately for class, parity, age and marital status groups. They then analysed, for one of these years, the case records of every patient attending the Maternity Hospital for ante-natal care; they noted all examinations and investigations made, all major complications and all booking procedures (and their reasons) and all emergency admissions and transfers between the main specialist hospital

and associated maternity homes. The result was an assessment of the productivity of each examination, investigation and visit in terms of abnormalities detected and of true and false-positive predictions of risk, of avoidable emergencies and transfers. Their results also indicated where the non-use or mis-interpretation of clinical data had caused unnecessary emergency transfers. This enabled them to draw up a revised schedule of ante-natal care more adapted to the needs of at-risk groups and making fuller use of the knowledge of skilled midwives. A parallel study of patients' perspectives by a sociologist, Dr. Macintyre, suggested that more time could be profitably spent in giving the information about ante-natal care and childbirth required by patients and about their own role and participation in childbirth. The new schecule, implemented simultaneously for all new patients, is being similarly monitored by clinicians and sociologists and additional studies are being carried out on care provided by general practitio This evaluative exercise has aroused controversy in other areas because it has resulted in fewer consultant examinations for normal asymptomatic patients and a diversion of resources towards the patient groups shown to require extra attention, and towards advice, education and discussion. I cite the work as an example of combined clinical and sociological investigation carried out as a continuous process, each research phase resulting in selected and informed modifications of service based on findings from local practice. Overall, the study demonstrates that successive partial evaluations and reforms are superior to perfect trials which demand such stringent conditions that they cannot be carried out.

The third requirement is that "the nature and quality of the input can be precisely controlled and measured".

'Input' is a difficult term. As a measured dose of a precisely defined substance, administered at stated intervals, its meaning is clear. In terms of policy and health service structure, however, the meaning of

input is often far from clear. Policy is notorious for its ambiguity - indeed it is sometimes argued that it is necessarily ambiguous in order to allow for contextual variations, to permit flexibility in its application, or to avoid creating hostile resistance from semi-autonomous bodies and professional practitioners. The input into policies which have no sanctions or targets is often no more than exhortation, or variably-perceived administrative pressures in the face of equally variable countervailing pressures. At the sharp end of service-delivery which, in some circumstances, approximates to closed systems, input is more precisely measurable. Many sociological studies, however, now document the highly idiosyncratic application of knowledge and of commonly agreed criteria by individual service-providers. Health work is increasingly and particularly in primary care, concerned with counselling, advice, therapeutic listening, re-definition and referral, with the behavioural, as well as the physiological, aspects of health. A consultation is best regarded as a process rather than an indicator of content. What emerges is the result of an interaction between persons who each bring, and each take away, something distinctive from the encounter. Their subsequent accounts of the purpose, content and outcome of that encounter often differ widely. Input is therefore variably perceived and the subjective perception of input is inherently difficult to control or measure. In more complex situations, such as a health education programme or the varying use made by medical, psychiatric, nursing or social work professionals of a single facility such as a day hospital, or the informal criteria used in decisions about abortion or adeno-tonsillectomy, the input is neither precise nor measurable. A necessary pre-requisite of evaluation, in situations requiring professional judgment, is the detailed examination, by observational methods, of the range of variation in practice, rather than reliance upon formal agreed criteria which, in the process of reaching agreement, acquire a degree of looseness incompatible with experimental precision.

I cite as an example a study carried out in Scotland by a sociologist and an epidemiologist into the decision-making processes which lead to gross variations in adeno-tonsillectomy rates. The authors comment as follows: "To reach adeno-tonsillectomy, children must be perceived as sick by their parents, be seen by a family doctor who believes in the beneficial nature of the operation, attain that level of illness which the family doctor considers an indication for referral, have willing parents, be referred to an ENT specialist, be considered by the specialist to merit operation, and suffer sufficiently between the time of the decision to operate and that when the bed is available for the child's admission, for all concerned to agree to the operation". A comprehensive evaluation would require study of each decision point, and documentation of the variations occurring at each possible point of divergence. The epidemiological study revealed some of these variations (but not their causes). The sociologist concentrated upon observation of ENT consultations, and analysed the search procedures and decision-making rules of a range of specialists. He noted their routine idiosyncratic assessment practices, and he found variations in the particular clinical signs taken into account, in the weight placed upon examination evidence compared with the clinical history, in the search procedures used in history taking, in the decision rules applied to the history, in the propensity to defer for later review and in the account taken of the child's age. Outcomes, in the sense of decisions to operate, were shown to proceed from the variability in search procedures and decision-making rules. In laboratory sciences the equivalent sources of variability have been examined and hopefully eliminated before experiment begins. In social situations, such variability is the norm of professional practice and must be built into the evaluation rather than excluded.

The fourth requirement of experimental method is that 'extraneous influen can be excluded by research design or their effect precisely measured'.

The aim, which when achieved, is scientifically profitable, is to convert, so far as possible, the open, changing and heterogeneous conditions of social relationships into the controlled conditions of a closed system. By taking advantage of naturally-arising experimental opportunities, or by enlisting the motivation of scientifically minded practitioners, this aim can be, and is, achieved. One doubt and one problem deserve discussion. The doubt must be the extent to which results obtained in artificially closed conditions can be validly generalised to the spontaneously arising activities and influences of a pluralistic world. This is a question requiring extended discussion for which there is insufficient time today. It has been a hotly disputed question for many years in the social sciences and particularly between sociologists and the more experimentally-minded psychologists. Even if the results cannot be generalised, or if the restrictions required for the experiment are unacceptable in normal policy and service operation, the experiment may nevertheless be useful in setting goals for achievement - although the degree to which action, particularly at policy level, is influenced by information is itself open to doubt.

The problem to which I referred, is a more technical one, of designing experiments in the social world which exclude social influences. I have frequently been asked for advice by medical colleagues about how to 'control for social class'. Indeed I sometimes think that one of the few objectives shared by medical scientists and by Karl Marx is their common desire to eliminate social class. I first remember thinking seriously about the problem when I was asked to specify controlling variables in order to identify a group of non-delinquent adolescents as far as possible identical in social composition with a group of first offenders. I finally decided that, if I succeeded perfectly, my control population would consist of first offenders who had not yet been caught - and this was not the object of the exercise. In my most recent attempt I controlled for occupation and for four other

class-related variables in a study of the parents of low-birth-weight and heavier babies. Yet when I compared the experimental and control groups for another important class variable, which had not been specifically controlle the two populations were quite remarkably different. This finding, of course, had important aetiological implications, but it also illustrated my consistent experience that I had never yet met a class-controlled study of a strongly class-related phenomenon in which I was convinced that the outcome variables were truly class-free. The alternative technique of randomising experimental and control populations, where it is practicable, is a more effective method, but it does not necessarily eliminate social influences other than those relating to patients.

The problem of excluding extraneous variables is more acute in relation to policy and structural issues at the macro level. If policy is ambiguous, if implementation machinery is deliberately vague and flexible, and if the implementors are professionals with wide discretionary powers, it is even difficult to decide what is extraneous and what is integral. In any case, to the sociologist the vast area of warts is often more interesting than the small areas of smooth skin - a characteristic we share with clinicians.

The fifth requirement is that "the criterion of success should be uncontroversial and able to be measured along a single dimension".

This is perhaps the most difficult requirement. Policy is essentially the balancing of alternatives and of non-comparables in the pursuit of a tenable position. The organisation of services involves the flexible allocation of resources and the management of organisations and professions with a built-in tendency towards the autonomous pursuit of competing ends. As with the other requirements previously discussed, this requirement is also most difficult to meet at the levels of general policy and easiest at the point of delivery. Essentially the problem boils down to the proposition that health is a social concept, whose nature is differently defined and

perceived from one decade to another, from one social group to another, and which has a different significance for patients and for each sub-division of the treatment and caring services and professionals. Whilst doctors like to think that they treat each patient objectively and impartially, the packaging of doctors and other health professionals into a policy-directed structure is inevitably a political business extending well beyond the confines of the official health system.

When I wrote the monograph from which these remarks are loosely drawn, the volume on Inequalities in Health, prepared by Sir Douglas Black's Working Party, had unfortunately not been published. That volume, because of its frosty official reception, its rumoured under-printing, as well as its intrinsic excellence, is rapidly attaining the rare, sought-after, Lady Chatterly-like quality of a scientific obscenity. Yet, over the last century, similar results have poured forth from the Registrars-General and a multitude of epidemiologists as well as from social reformers and pressure groups. Its basic thesis is that society itself creates inequality in health, sickness and death by virtue of both its health and its socio-economic policies. The data are incontrovertible in their totality if not in their detail. They become controversial by virtue of their policy - and their political - implications, namely that quicker and larger reductions in ill-health and unnecessary death would be achieved by moves towards an egalitarian society than by the application of vast resources to the medical treatment of created illness. This is perhaps an extreme example arising at an extreme political moment, but it is paralleled by a host of other controversial issues involving disease prevention, health promotion, the shifting of emphasis from treatment to care, from hospitals to the community, from the young episodically sick towards the chronically sick, the handicapped and the elderly. Every such shift of policy and resources benefits some population groups more than others and involves a relative change in the power and status of the services and professions who depend upon them for their

livelihood.

Nor is this merely true of broad general policy and of inter- and intra-professional and organisational conflict. In any large structure, and particularly one composed of experts, the health of the professional comes to be equated with the health of the public. This is perhaps less true of the National Health Service than of almost any other health system. Yet our mechanisms for ensuring that, what service-providers consider to be benefits, a similarly seen by patients and potential patients are extremely rudimentary. Occasionally latent discontent erupts into controversy. The changed role and status of women, which showed itself in discontent about birth control services and the monopolistic medical embargo on abortion and later in anger about the technological management of childbirth revealed a deep-felt disagreement about whose benefit was being met. One wonders how far the fashionable and economic policy of family care coincides with family attitudes and particularly with those of women who are still the traditional carriers of family burdens.

Evaluation of health policy and health services needs a much more continuous and sensitive exploration of the perceptions and satisfactions of the population. An immense reserve of gratitude towards the health services and its staff undoubtedly still exists in Britain and criticism is muted. But I often feel that, in that detailed intimate fashion which constitutes true understanding, we know less about the health beliefs, attitudes and behaviour of the many sub-groups of our population than we do of certain well-studied tropical islands. It requires detailed, multi-faceted research which taps the needs, priorities and perceptions of policy and service and which amounts to fundamental research. Such work is being carried out by sociologists in small-scale studies throughout Britain, but the volume is tiny compared with the time and resources devoted to the technical concerns of medical scientists. It is an essential pre-cursor of evaluation and without it we cannot make too many assumptions about non-controversial criteria of suc

Taking all the 5 requirements together, I am forced to conclude that the applicability of traditional concepts of evaluation is limited, that the concept needs broadening so that methods are applied to health policy and health services research which spring from the nature of the problems themselves, rather than being derivative from another field. I see it being concerned, not so much with the comparison of final outcomes in measured health - important though that is, but with steps in the formulation of policy across the whole range of health-influencing activity; in identifying contradictions in policy; in studying the mechanisms for implementing policy (from legislation through service structures to the point of delivery); in identifying barriers and constraints on implementation arising within the services themselves; and in assessing the relevance of service to the sensitively documented perceptions of patients and families.

Experimental evaluation may be possible, but the current and urgent need is for the equivalent, in health services terms, of that long history of well-financed fundamental work carried out in laboratories and hospitals throughout the world which eventually made both experiment and evaluation possible in medical science. Moreover, I do not see evaluation as the accompaniment of experiment so much as the continuous application of research, research that is, with an evaluative intent, to the constant operation and modification of the services and the development of policy.

Much of that research is about social structures, social processes and social relationships and will have to be undertaken by social scientists using the full range of their scientific methodologies. We are a long way from that goal. Three final points need to be made about our research capability - and here I speak specifically about sociology and the field of health. First methodology. Even whilst admitting that much needs to be done, I am not in the slightest apologetic about sociological methodology. What natural scientists often consider to be hard data, because they conform to their own

research experience, are frequently incredibly soft, insensitive and misleadi when applied to human values, behaviour and perceptions. Sociology, in its best practice, is so conscious of epistemological issues that it sometimes stands almost paralysed by the multiple meanings that can be derived from a simple social encounter. Sociologists are perhaps too eager to produce useable results oblivious of the fact that their natural scientific colleague spend most of their time on methodology rather than being directly useful.

Secondly, research capacity. You would doubtless expect me to say that there are too few medical sociologists, too few jobs and too little support. I will not disappoint you, there are too few considering the relevant tasks I have discussed today, similar tasks in other health fields which I have deliberately and selectively ignored, and considering too the need for that fundamental knowledge about societal functioning required to permit the informed application of the discipline to everyday problems of policy and service. We do not however require more birds of passage who, between thei Ph.D. and a later career in University teaching, do a transitory research assistantship in the health field. Instead we need more stable research un in which research staff build up a long-term knowledge of health problems an health work, and in which research programmes, whether critical or supportiv evolve out of easy familiarity with practice, practitioners and policy-maker Such familiarity is particularly necessary if we are to identify the right problems and adapt our research findings so that they appear relevant and practicable to the policy maker and the administrator.

Finally - access. Many clinicians have been remarkably helpful in inviting sociologists to observe and analyse their practice and have been equally tolerant of critical findings, some of which may have been ill-infor In one sense policy is made at the periphery by the everyday actions of health practitioners and such access has been invaluable to the development the discipline. Formal policy, however, is made in Government Departments a

Health Boards and here we have been less welcome - except in the provision of funds to evaluate others lower in the hierarchy. The evaluation of the policy process, from the inside, by external researchers, is still relatively rare. That perhaps is why it remains an obscure speculative area. The documentation and analysis of the policy process must be our next major step.

Raymond Illsley,
Aberdeen.

University of Surrey

Master's Degree in
SOCIAL RESEARCH METHODS

one year course

This new full-time MSc course is aimed at graduates in sociology and related disciplines who want a thorough grounding in research design, methodology and conceptualisation to equip them to take up research posts in the private and public sectors or as a preparation for higher research degrees. The course features:

- ★ **a wide coverage of research techniques from survey research to ethnomethodological research**
- ★ **a short placement in one of a number of active social research Units**
- ★ **participation in a research project during the course**
- ★ **advanced courses in sociological theory and statistical data analysis**
- ★ **options in the sociology of medicine, education, industry, and the social services**
- ★ **a course on research in developing countries.**

The course is one of the three MSc courses in sociology to be given quota studentships by the UK Social Science Research Council. The Department of Sociology at Surrey, consisting of two professors and fourteen other members of staff, also runs a highly regarded part-time MSc in Social Research and is very active in research, with fourteen externally funded research projects covering a wide spectrum of applied sociology currently underway.

The prospectus and application forms are available from

Department of Sociology (SRM)
University of Surrey
GUILDFORD GU2 5XH
United Kingdom

DON's DIARY

Thursday

I'm not quite sure why I've been asked to write this diary, as I've not been very involved with medical sociology since the days when annual conferences were held at decaying seaside hotels in the middle of Winter. Indeed, it was at one such meeting that I made the remarkable discovery that three other regulars (David Oldman, Bill Bytheway and Robert Dingwall) had all been to the same school as me. As far as I know, this astonishing social fact has yet to attract any serious sociological attention, though I'm sure we would all be willing (for a small fee) to act as consultants to any budding historian of the discipline foolish enough to pursue the matter further.

I suppose the invitation could have had something to do with the focus on research in this particular issue of the newsletter. Perhaps it was thought that as an employee of SSRC who is also on its Sociology and Social Administration Committee, I might be good for a few Deep Throat style revelations about the ongoing situation at Head Office. Unfortunately, however, anyone who thinks that such a person must be well placed to know things worth leaking has already made a basic error in his analysis of how the organisation works. The only news I can report with confidence is that very few moles seem to get far enough along the tunnel to learn anything they didn't know already.

Friday

On returning to full-time research, I'd forgotten just how depressing Fridays can be. When teaching, one can at least look back on the week and reflect that, if nothing else, the requisite number of contact hours have been put in. But for researchers it is all too frequently the case that there's nothing much to show for a week's work other than a bin full of failed attempts to get the latest study down on paper. It's a regular and anxiety provoking reminder that, in the absence of "a heavy teaching load", there is no readily available excuse for non-delivery. And, without any lecture notes to dress up for publication, there are no easy substitutes either.

Viewed in these terms, today marks the end of quite a good week, as I've nearly finished putting together the demonstration tapes for a seminar next Tuesday. A nice bonus has been that the search through hours of recorded speeches has resulted in the identification of another device for eliciting applause, which appears to work just as effectively and in the same way as the others. The new observation is beautifully consistent with some recently reported findings based on conversational

data, and a next step will be to see if instances are also to be found in court-room interaction. Meanwhile, I actually get to do a bit of unofficial teaching today. A group of linguistics graduate students are apparently worried that their courses are not giving them enough contact with empirical materials, and I've agreed to put on some data sessions in conversation analysis for them. Sociology is by no means the only discipline that gives theorising higher priority than detailed observation.

Monday

Handouts have to be xeroxed before driving North for the seminar. On balance I think it helps an audience if they can read transcripts while listening to the recorded examples, but there is always the risk that someone will complain that we're not using a phonetic system. This is the linguists' equivalent of the psychologists' "But why don't you do an experiment....." the philosophers' "But if we imagine someone saying....", and the sociologists' (macro) "But what about power....." and (micro) "But what about context....". While interdisciplinary interest in conversation analysis is a welcome and promising sign, such responses usually guarantee that the research just presented never gets discussed. Indeed, they work in such a similar way and tend to recur in such similar sequential positions (first question post talk completion) that I'm beginning to develop a technical interest in them. They have the look of devices for avoiding direct discussion of the data and/or analysis, and I am in the market for a less cumberso way of referring to them (as well as more polite ways of neutralising them).

Before leaving I have to arrange to borrow a gown for Wednesday night, when I'm going out for dinner in one of the medieval colleges. These feasts can be very enjoyable providing one does a little research about local customs and personalities beforehand, a precaution I failed to take on my first such outing. It was an arranged meeting at All Souls, where I was supposed to be going to discu my interest in legal procedure with a very distinguished academic lawyer. No one thought to tell me that my host had a reputation for being able to drink all comer under the table, nor that shop talk was frowned on for the duration of the many stages of the dining ritual. The result was that, after four hours of tucking in to all the food and liquid placed before me, I was just about able to stagger back to my host's rooms where, slumped in an arm chair, I was issued with brandy and a cigar. The last thing I remember was the sound of a voice coming out of the haze with the immortal words "Now then Atkinson, perhaps you'd be good enough to tell me what ethnomethodology is all about."

Tuesday

The University where the seminar is to be given is in the town where the aforementioned gang of four went to school. I therefore have an opportunity to attend to extended family obligations, which this time must include my grandfather. He has eight months to go to his hundredth birthday, and can only be described as disgustingly fit. The rest of the family grudgingly has to admit that this may have something to do with the fact that he has never smoked, and has not been inside a pub this century (the last time was in 1898, on which celebrated occasion he left without even having a drink). Today he is more than usually irate about the state of the country, and it is not clear whether his frustration has been prompted by Mr Scargill's latest antics or the weather, the latter having prevented him from taking his regular half mile walk down the road to the local cattle market.

At the seminar I discover that I have a few too many examples for an hour's talk, and that it would be better to phase out the audio-recordings in favour of the much more impressive video ones. Someone asks why I don't design some laboratory experiments (the visit is to a psychology department).

Wednesday

Back in Oxford we have one of our regular weekly data sessions with colleagues from Warwick. Next week it will be our turn to go up there and, while transport is always a problem, the continuity is very valuable from the point of view of research training and general morale.

My dinner host is a zoologist who's into human-animal interaction, and who thinks we might be able to help in a study of how people talk to their pets. On the face of it, this sounds like the sort of thing which many sociologists would glibly dismiss as trivial, but for medical sociology the results thus far look most intriguing. While stoking cats and dogs, the blood pressure of humans can fall below the level achieved in transcendental meditation. Compared with people who have no pets, pet owners are twice as likely to be still alive a year after a first heart attack. When a sample of pensioners were given free budgerigars, the frequency of their visits to the doctor dropped spectacularly. Clearly there is scope here for massive savings in public expenditure, though it is doubtful whether any political party would have the guts to campaign on a platform "Free budgies for old people". What remains to be seen is how SSRC would react to the sort of policy oriented action research proposal that is so obviously implicated by these challenging claims.

J. Maxwell Atkinson,
Senior Research Fellow in Sociology,
SSRC Centre for Socio-Legal Studies.

UNIVERSITY OF CAMBRIDGE

WELLCOME UNIT FOR THE HISTORY OF MEDICINE

M.PHIL. (ONE-YEAR COURSE) IN THE HISTORY OF MEDICINE

This is a new course, intended mainly for those who wish to broaden their understanding of medicine, to undertake historical work as an adjunct to their professional practice, or to train for further work in the history of medicine. It is designed for doctors at a relatively early stage of their careers, for medical students who are already graduates, and for graduates of other appropriate disciplines.

The core of the course will comprise:

INTRODUCTION TO HISTORICAL TECHNIQUES

SURVEY HISTORY OF WESTERN MEDICINE

DETAILED CASE STUDIES

These will aim to give candidates insights into the historical development of medicine. The teaching will consist of lectures, seminars and individual supervisions. For the examination, candidates will be required to submit three long essays based on the core material and a dissertation (15,000 words) based on original research undertaken during the year.

The course also presents an opportunity to study in a related field with other Cambridge University departments, since candidates are required to study an ELECTIVE TOPIC (provisional list as follows):

- Historical demography
- Chinese and Japanese medicine
- The recent conceptual history of psychopathology
- The history of health education
- Social aspects of medicine
- History of science
- Philosophy of science
- Ancient Greek medicine
- The history of psychoanalysis
- Images of the body in Victorian literature

Candidates will be required for the examination to submit a long essay on one elective topic.

The course will begin in September 1981. It is possible that financial assistance may be available in certain circumstances. Enquiries in the first instance may be addressed to The Director, Wellcome Unit for the History of Medicine, Free School Lane, Cambridge CB2 3RF. Formal application is to be made through the Board of Graduate Studies, 4 Mill Lane, Cambridge CB2 1RZ, from whom further details may be obtained. Intending candidates should apply before the end of March, if possible.

CUTS AND CONFERENCES

Last summer the committee of the B.S.A. Medical Sociology Group decided to attempt some practical assessment of the extent to which economic stringencies were affecting group members.

Accordingly those who attended the conference at Warwick in September 1980 and those who received the November 1980 issue of the Newsletter were invited to complete a brief questionnaire. Below is a result of that information from the 85 completed questionnaires (out of 200 issued at the conference), and the 4 (out of 650 copies of the newsletter circulated), returns received by 21 January 1981.

The committee is grateful to those who completed questionnaires and to Gary, Nick, Bill and Toby for the help in sorting them out. The convenor and these four teenage workers finally concluded that while instructive, this information warranted no more commentary than as follows:

	CONFERENCE	NEWSLETTER
Female	51	3
Male	34	1
Age		
Under 24	4	0
25-29	18	1
30-34	24	2
35-39	18	0
40 and+	21	1
Employment Contract		
Temporary	47	2
Permanent	34	2
Length of Temporary contract		
3 mths- 1yr	10	0
1½ and 2yrs	6	1
2½ and 3yrs	18	1
4 years	6	0
5 years	4	0
6 years	1	0

CONFERENCE	NEWSLETTER
Estimated chances of renewal of temporary contract,	
None 16	0
Low 7	0
Fair 5	2
Good 17	0
DK 2	0
23 people report taking some action to get help with their position, with one of the following:	Both report taking no action to help their position.
Trade Unions 5	
Funding Body 13	
University 5	
OTHERS 8	
Conference Expenses	
59 had not had to fund any part of the conference expenses themselves. Discounting the students, 23 people claimed from their Poly/University and 42 from a funding body.	2 1 claimed from Unit, 1 from project budget.
Of the 25 people who had personally to pay part or all of the cost of the conference 15 (60%) were in permanent jobs, while of those who were able to re-claim all the cost 39 (68%) had temporary contracts.	2 sometimes has to pay, None of the 4 did not attend the Warwick conference because of lack of fund
Of most people paying for themselves, only 7 contributed more than	

CONFERENCE	NEWSLETTER
¼ of the cost, more than half of them contributed ¼ or less.	
As to eligibility for re-claiming conference expenses, only 8 reported the imposition of any conditions.	No one reported the imposition of conditions.
Most people had attended more than one conference during the 1979-80 academic year :	
One only 26	0
2 25	3
3 16	0
4 12	1
more than 4 6	0
Only 15 people reported that this number had been curtailed by cuts but 7 of these had attended just the one.	None curtailed by cuts.

Anne Murcott.

of funds

Better late than never.....

Margaret Mead Award

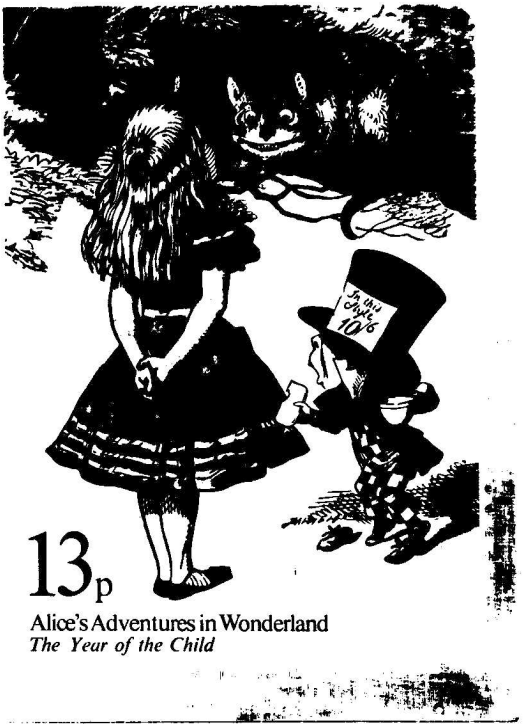
THE SOCIETY FOR APPLIED ANTHROPOLOGY is accepting nominations for the 1982 Margaret Mead Award, given to a younger scholar whose work interprets anthropological data and principles in ways that make them meaningful to a broadly concerned public.

Nominees should be individuals who are under 40 or who have received the PhD within the past 10 years. The nominee must have demonstrated (1) an ability to conduct research in such a way as to have an effect beyond the discipline of anthropology; (2) the ability to introduce an anthropological point of view among persons engaged in the application of knowledge who may not necessarily be anthropologists; (3) the capacity to reach out and influence a concerned public outside anthropology and (4) a capacity to apply principles of anthropology to the resolution of issues of contemporary human concern. Individuals may be nominated for a book, film, monograph or unusual service, which must be well documented.

Letters of nomination must be accompanied by a curriculum vitae for the nominee and address to the Award Committee Chair for 1982, Virginia Olesen, Department of Social and Behavioral Sciences, School of Nursing, University of California, San Francisco, 94143. DEADLINE IS FEBRUARY 1, 1981.

Also serving on the Committee are Lucy Cohen, Barbara Frankel, Sue-Ellen Jacobs, Ellen Lewin, John Ogbu, Barbara Pillsbury and John Singleton.

THE MEDICAL SOCIOLOGY PARLOUR GAME 1981



devised and edited by Hilary Graham and Madeleine Simms

INDEX

PREFACE

At the British Sociological Association's eleventh Medical Sociology Annual Conference held at the University of Warwick in September 1980, a workshop was advertised with deliberate ambiguity to preclude too much premeditation. This attracted some 40 participants who handed in some 30 contributions. These entirely spontaneous projects, with the exception of a totally illegible handful, are now published, together with some comments and reflections by the instigators who thought up the game in the course of a railway journey. This is another way of saying that their respective academic and research institutions bear no responsibility for any of the provocation contained within these pages. Neither, of course, does the B.S.A.

We are grateful to all who joined in and contributed ideas. These include Denise Batt, Ann Cartwright, Brian Clarke, Jean Cleary, Neal Davies, Judith Gray, A GP, Ruth Hawker, Bernard Ineichen, Ilona Kikbusch, Joyce Leeson, Sally Macintyre, Michael Meacher, G. Person, Colin Rees, Helen Roberts, Yvette Rocheron, Jill Russell, Alex Scott-Samuel, Lucianne Sawyer, Myra Thomas, Heiko Waller, Alison Watt and a number of others who preferred to remain anonymous, or simply forgot to add their names.

One of these projects is already being set in motion by another researcher who was intrigued by it, and a second is being considered. Perhaps we should have called this collection : One Person's Fantasy is Another Person's Reality?

Hilary Graham
Madeleine Simms
Winter, 1980

Introduction 1 : The Advertisement: Invitation to the workshop as printed in the Conference programme.

TITLE:

"I'll believe in you if you believe in me" : whats possible in medical sociology?

ABSTRACT:

Leave behind your : copies of Durkheim, Marx, Weber and Parsons, preconceptions, references, footnotes, overarching perspectives, ongoing dynamic inter-relationships, confrontation situations and other baggage.

Bring with you your : subconscious, imagination, inspiration, sideways thinking kit.

Clue : 'Well' said Alice, turning to the Mad Hatter, 'What would you do, if you could do anything in the whole world?

Introduction 2 : The Sociological Parlour Game

The game depends upon a long cherished notion that all really creative social researchers carry around with them in their subconsciousness a half-formulated secret research project that they have been longing to do for years but never had the opportunity.

What we are asking you to do now, is to pretend you have won the proverbial football pool of around £1 million and are therefore free to undertake any research project that is close to your heart for whatever reason. Please note that the reason does not have to be a good one. It may even be a rather disreputable one - sheer curiosity for instance. Moreover, having so much money available you can afford to be lavish with your research team, and thus need not be perturbed by any of the usual methodological difficulties in your path. No vulgar reasons of economy need stand in the way of finding your sample. The Official Secrets Acts, the Population Statistics Act and other such legislation can be swept aside in your case. What we want to find out is what research you would most want to do if you had an absolutely free hand and were not constrained by the usual financial, methodological, ethical or political considerations that normally dog us all.

We shall allow you only 10 minutes. Please write freely and without inhibitions. Give us a few lines of background to the project to explain what it is about, tell us your hypothesis or why it is of interest to you, explain what the obvious problems are about carrying it out. To accomplish all this in 10 minutes flat means not fussing about style or detail.

Please then hand in your paper so that we can publish a collection of these projects, showing what the Medical Sociology Research Community in Britain would be occupying itself with if it were entirely free to do what really interested it most.

Had we similar collections for 1960 and 1970, as well as for 1980, who knows what swings of sociological taste, intellectual fashion and political concern this simple device might uncover?

Introduction 3 : This is a Workshop

Madeleine and I planned this session bouncing along on a suburban train last June. As we bounced, we decided on two things. We decided, firstly, that we wanted an opportunity to discuss what was happening to the world of medical sociology. Secondly, we agreed that we didn't want this discussion to take the form of a paper on the existential angst of the medical sociologist (or some such). Instead, we wanted our discussions to reflect the conversational asides and fantasies that go between (and particularly during ?) the formal sessions and plenaries.

Having decided what we wanted, we needed to find a way of elevating these unofficial aspects of conference life onto the official conference agenda. What we came up with, as Madeleine has said, was the idea of a parlour game. A sociological parlour game is, to me, what a workshop should be. It is not something where a paper is presented - however informally - by one or two individuals and consumed by an audience. To me, a workshop, like a game, is something everyone enjoys and gets involved in, its something where people take turns at being producers and consumers of knowledge and ideas.

Knowing what we wanted to do, and how we wanted to do it, all that remained was to find a way of getting other people to come and do it too. We felt if we announced it as a participatory workshop - or worse still as a parlour game - we'd be left doing it on our own. So we wrote an outline for the paper which conformed to the conventional title - and - abstract format, but which hinted that all was not as it seemed.....

Introducing Innovation in the Ward

The greatest problem of the hospital service is that of marrying optimum patient care with desirable staff working conditions.

I would like to investigate ways in which nurse training and work organisation, in particular, can be changed to produce a human and therapeutic environment which satisfied the clinical, psychological and social needs of all the participants and to explore alternative environments.

The reason for this interest arises from periods of ward observation, and in particular the difficulty of introducing innovations which are not perceived as threatening and which will not fade away as soon as the original impetus has gone and the investigator been promoted.

Cross Cultural Study of the Family's Role as Carer in Sickness

I would like to extend my present work concerning nurses and relatives within a general hospital, and look at ways in which, in spite of Westernised medicine, the family has in many instances been able to retain the caring role within the system. This might interestingly be related to the family's role in sickness in other countries, thus extending the fieldwork outside the area of the British hospital.

Attitudes to the Caring Role

This project is based on what I believe to be inadequately considered assumptions about 'Community Care':

- in reality this policy is based on assumptions about womens' roles as unpaid carers
- we need to look at social policy since about 1900 in relation to society's expectations of women's roles, and to interview both men and women to determine the factors which lead to acceptance or rejection of the caring role.

The Uses of Research

There are very many under-used research findings which could valuably be used for practical purposes.

Sample : Take 100 research projects
Interview the researchers :-

How much time and effort did they put into getting the implications of their conclusions genuinely considered by planners/administrators/policy makers?

Interview a sample of administrators, planners and policy-makers and examine:

1. Were they aware of this research?
2. If so, how did they try to use it?
3. If not, how could they have used it, had they known about it?

Conclusion : Funding should take into account ideas for implementation.

Open Access

Look at the effect that changes in the availability of certain health resources would have on improving general health levels. Take up of services has been shown to be influenced by, amongst other things, availability - in terms of the location of certain facilities and the times at which access can be gained to the facilities.

The Aim : would be to see the extent to which service provision can effect genera health and attitudes towards the use of services, i.e. would going to the doctor become just like going to the corner shop for a tin of beans?

Methodology : To select certain services, e.g. ante-natal clinics + classes, child health clinics, outpatient clinics, GP surgeries, and run them on a 15 hours a day open-access basis, e.g. 8am to 11 pm. Evaluation would consist of taking certain indicators, e.g. morbidity/mortality plus individual assessment of health state.

Patients' Opinions of Me Their Doctor

Take all the patients in my practice and put them to sleep giving them a marvellous truth drug and then ask them all about the surgery. Say to them something like:-
'Try to remember every encounter with me - what I said - what I did to you!'

I aim to get at their deepest fears and fantasies about me as a doctor.

Then I think I would have to retire and become a medical sociologist instead, so as not to damage any more people.

If doctors really knew what their patients thought of them, how many, I wonder, would retire?

Researchers and their Research

This is a project about the relationship between the personalities of social researchers and their research projects. My main thesis is that by selecting a particular subject and method they try (maybe subconsciously) to solve personal problems which they either won't admit or don't somehow know how to solve directly.

The sample should be a large group of successful researchers ('successful' in terms of the academic community).

Method : Intensive interviewing and participant observation with the researcher, at work and in private setting.

Role Playing: Researchers' Experiences of Interviewing in the Health Delivery Process

1. Teach people action-oriented research
2. These people then become 'ill' and develop own theories to explain symtoms and prognoses and how they intend to manage their treatment.
3. Collect all these action research write-ups, i.e. peoples' experiences of attempting to intervene in the health delivery process.

All this would lead to collective awareness of patients' power, alternative technology, culture boundedness, historical determinism, etc.

One scenario for instance might be a person with a vague feeling of unease who then consults friends, relatives and other members of his referral network - but instead of the usual diadic nonsymmetrical relationships, information is given in many directions thus enriching the commonly held body of cultural experience of other than medically oriented healing.

Method : We may need TV / Camera or helicopter to follow people through all experiences.

Emergency Rescue Services

Participant observational study of various emergency/rescue services (none of which would actually involve fatalities one would hope). This would involve travelling in helicopters etc to mountain or sea rescues, crewing in lifeboats, going out to ship rescues. I might have a huge team of researchers, but really

the point is that I selfishly want to do this project, and to feel very actively involved in the rescues, emergencies, etc. and to feel that I have actually done something in the world (like saved lives, delivered babies in a snowstorm, etc.).

I would also like to be the helicopter pilot on these trips.

Health in an Egalitarian Society

My million pounds (at 15th century exchange rates) permits me to work within a wider scope than other researchers. With a small fraction of this money, I should purchase a total environment (perhaps an island) there to establish a decentralised egalitarian society hopefully devoid of status based on age, sex, race, mental or physical disability or beauty.

My study of the health experience of this Erehwon would be intended to demonstrat the substantial basis of present day health in the aforementioned factors.

The Nuclear Debate

1. How is medical information about the effects of nuclear warfare on individual and public health silenced, transformed and controlled?
   (a) by nuclear industry
   (b) by political structures

2. To what extent are peoples' fears about potential nuclear warfare related to
   (a) educational attainment
   (b) sex
   (c) class

3. How are people affected by the ways in which medical information is presente in the media?

The Lifeline Research Project

Lifeline and Life Housing Trust have developed out of the Life anti-abortion political pressure group. These organisations aim to give practical aid, comfor and counselling to girls in distress over pregnancy. The Department of the Environment now gives an annual grant of £7,500 to Life Housing Trust and more than 40 local authorities have passed to it housing from their housing stock.

The DHSS issued a famour Circular on Counselling in 1977 in which it is stated that 'counselling should be both non-judgemental and non-directional'. The women I have spoken to who have had dealings with Lifeline have told me that they were informed that even an early, legal abortion is dangerous, though they have not been told that childbirth is more dangerous. Last year Lifeline claimed to help' 14,000 women. It has 9 offices around the country. Its services to women are free. Its costs however amounted to £68,000. So somebody else paid them.

I should like to interview and follow up a 1 in 10 sample of these 14,000 women to ask them in what frame of mind they visited Lifeline, as a result of what advertisement or recommendation, what were they told at Lifeline, how consistently were they supported and for how long after deciding to continue with the pregnancy, and what happened to those who decided they wanted an abortion. I should like to know how they viewed the counselling they were given in retrospect and how they felt about the decisions they made then, two, three and five years later. I should like also to interview a matched control group of women who sought help from the two abortion charities, BPAS and PAS. (Unlike, Life Housing, these receive no government subsidy. Any organisation that does, should be available for public scrutiny).

Feminism and Nursing

Examine why nurses tolerate the oppressive nature of their work, both occupational and medical, - linking this to the structure of patriarchal domination.

Look at intake : background (social and educational)
age
reasons expressed for entering nursing

Discuss / analyse why so few inroads of feminist development into nursing when in health field generally, comparatively large feminist strides have been made.

Inject feminism into nursing via teaching and consciousness-raising.

Observe what happens to nurses/professional divisions of labour, women's health in general.

Hypothesis : Delivery of health care and state of women's health would alter radically if nurses became feminist.

How Some Religions Ended

We know something about how some religions started but very little about how some ended. Ideally, the technique would involve some kind of time machine. Probably some new technology would have to be invented.

(Not carried around in my head for years; thought out new!)

Would Medical Sociologists Prefer to be Medical Doctors?

Hypothesis : The criticism of medicine by medical sociologists arises out of personal problems (of sociologists), (e.g. envy?).

Method : Recruit medical sociologists into medicine. Compare their habits, behaviour, values before and after.

Conclusion : If the hypothesis is sustained, medical sociologists may continue their medical careers so that medicine can rid itself of its critics.

N.B. The above research is supported by the BMA.

Study of the Dead

Background

This is designed as a supplement to my book Life Before Death in which I looked at the last year of life of a random sample of people who had died. Information was obtained from relatives, doctors and district nurses. Unfortunately we had to omit the most important sample - the people who had died, and the aim of this project is to fill this gap.

Study Design

While the identification of the sample is straightforward there are some problems about the means of communication. I am unhappy about Spiritualism which might get a biased response. To wait until the day of resurrection might take too long, produce problems of recall, and problems about members of the sample that had been cremated. If the interviewer left until the after life, this poses problems about the recruitment of the interviewers, and also of how to transfer the material to computers for analysis....

Content

What did the dead feel about the care they received, and how did they view

the carers, their relatives and the organisations involved....

Hypothesis

There might be differences between what the carers thought of the care they had offered, and how the dead perceived it at the receiving end....

A Longitudinal Study of Women's Health

A large sample of girls be identified before leaving school, and offered access to an ideal 'well women' provision for life involving:

1. Full information, discussion etc about their bodies, problems, worries etc.
2. Best possible health/social care, informed by feed back and directions from users.
3. In general, users would be asked to help investigate the nature, origins and answers to their problems. They would have at their disposal every useful and acceptable method of investigation.

A study of popular literature on alternative medicine and alternative health ideologies (including a study of old wives tales) in popular literature

Methodology : Reading ! It would be interesting to carry out a comparison of UK and USA literature - (especially Californian) and to fit the emerging ideas and issues into the broader social context.

The Study : An emphasis and increased awareness of alternative views of health and health care may be an important way of deflecting concentration away from the medical model.

(As this research would be very cheap - just the cost of books, I'd spend the other £900,000 ... travelling the world ... !!)

'Femininsts in White'

Financing a team of committed feminists to enter medical school and spend time as participant observers and then follow this cohort of women through their experiences as doctors with matched controls for sex and age (i.e. non-feminist female entrants and male entrants) over the next twenty years. In addition to data from their own personal experiences and participant observation, a team of invisible obervers would be recruited to observe them both at medical school

and in subsequent doctor-patient interaction. Failing the appointment of such invisible workers (money no object) bugging devices would be used.

A Cross Cultural Study of Reproduction

A project covering several years and as many countries as possible. The chance to look at pregnancy and birth and early childrearing in very different countries. I would do this by staying in one place for as long as necessary and following midwives around (if they exist) (wide definition of midwives). I would be limited by language : I'd like to go to USA, India, Brazil, China, Indonesia, Finland/Sweden/Norway ? S. Africa and maybe other places (? need to learn Spanish, Chinese - that will take a few years so I will need support while I do). I would take pictures, record advice given by women to women, observe births, and whatever else seemed necessary.

The Occupational hazards of Academics

Hypothesis

That contrary to commonly held beliefs, it is not coal miners and steelworkers, domestic staff and housewives whose occupations hold enormous occupational hazards but academics. I should like to look at stress related diseases among academics - not the illnesses we commonly feel to be associated with the trade - nervous breakdowns, ulcers, piles from too much sitting around, but what effect does the photocopier have for instance on the chances of developing cancer, does chalk dust cause pneumoconiosis. In short a project on the occupational hazards of academics.

People's ideas of health and illness

Firstly, I'd do pilot study after pilot study, until I'm reasonably satisfied that I know where to start. I'd have access to as many co-operative advisors as I feel I need who would do me the justice of at least taking my improbable requests seriously, and <u>focus</u> on them, instead of their own pet theories/areas (large bribes needed!)

The pilot studies would try to reach people to find out what their notion of health/illness is, and in some way to ask to what degree the medical institutions play a role in their feelings of health/illness - when, why, then, how, do they feel healthy/ill, and with what sort of feelings?

To test the hypothesis than an individual's sense of health, their body, their

self is related to their immediate environment, and that medical care and medical institutions are only of limited relevance to this environment.

The study would look particularly at women, at different ages, children (a longitudinal study) and medical sociologists.

Anti-psychiatry and alternative medicine : A Participant Observation Study

1. A continuation of Wilhelm Reich's orgone therapy
2. Anti-psychiatry of R.D. Laing & Esterson : establish communes.
3. Fringe medicine, eg herbalism and homeopathy : establish centres.
4. Yoga and meditation : conferences in various centres, eg Krishnamurti at Brock Wood Park.
5. Trip to the USA - Berkeley College in California - to continue with participant observation of what happened in 1-4.

Experts and 'real people'

As a recent undergraduate in psychology, I am worried about the fragmentation of knowledge and the failure to confront the consequences of what is learned - my impression is that its much the same in sociology and other ologies.

Method : sample of practitioners of various ologies (including medicine) and a sample of 'real people.' These samples would be mixed up in various combinations into a series of consciousness raising groups, video-taped and recorded. They would all then be forced to see the videotapes, to see how they appear and how others see them.

Filming health within the home

We know a considerable amount about the social factors which contribute to the health of a household (and to the health of different household members). We know of the importance of the household's economic position in determining its command over 'health resources' - housing, heat, food, space etc. We know also of the importance of sexual divisions - of the role women play in distributing these resources (if necessary by going short themselves).

What we lack is information/insight/understanding about how class divisions and sexual divisions influence the day-to-day distribution of resources (ie we have a general but not a specific understanding of the way health is mediated through home and family). So.... this study would make a film record of the daily activities of a sample of households over a long period of time - rather like a large-scale

version of the Television series 'The Family'. Through unobtrusive cameras installed in every room of these households, the study would hopefully provide information on the division of the goods and services which govern health - on who gets what in terms of time, food, leisure, spaces, warmth, conversation etc.

The ideal research project : no research

Why no research? Because I don't trust us, social scientists, anymore probing into people's lives - even with an alternative ideology. I suppose I'd do the least harm just living it up on the money.

Theoretical background (if you want an excuse) : critique of the human and social sciences - Castel, Foucault, Donzelot, Illich. Perhaps - on second thoughts - I'd thus find the time to live a kind of old-fashioned scientist's life in my huge library sitting by the fireside, reading away.

The worksettings of Medical Specialists

A non-participant, longitudinal observation study of the structural and cultural aspects of the worksettings of a diversity of medical specialists. Looking at their behaviour towards patients, their attitudes, their motives.

'Being Healed'

Being a mere student myself, my aims would be philanthropic. The prospect of being shortly an unemployed sociologist would compell me to take on a team of fellow student unable to get research jobs because of 'lack of experience'.

Nonetheless, as this is fantasy, the idea of combining travel/pleasure with work appeals. Thus, a project entitled 'Being Healed' would enable us to examine the philosophy of non-western societies and the form that these healings take. As in all good research projects, we would include a comparative study of Western Societies.

(I'm sure we would change our minds half way through - so requiring more time to pursue our individual, obscure interests).

Summing Up : Two Post-scripts

First Post-script

The research projects necessarily crudely outlined in this booklet cover a wide range from the minute and pragmatic to the outer limits of fantasy. But even the fantasy often has an underlying serious core. The author of 'Emergency Rescue Services' for instance, hints at an unease with the research role which is not uncommon within the research community. Is doing something more useful (and heroic) than mere research ? Research may be stimulating, revealing, and much else besides, but, truly, it is rarely heroic. So, perhaps, this is the element researchers try to compensate for in other parts of their lives. At a more mundane level the (unheroic) thought occurs: how efficient anyway are these rescue services, how much do they cost per person rescued? When those rescued have been engaged in purely frivolous and dangerous activities like mountaineering or potholing, ought they be required to contribute to the cost of their rescue according to their means. If so, what about motor cyclists, Sunday motorists, smokers and drinkers and their assorted accidents and ills?

The Health in an Egalitarian Society project nags away at the key nature versus nurture question which has dogged several branches of research for generations. Would the author of How Some Religions Ended like to know more about this, one wonders, in order to help a few more on their way? Certainly, some religions have had and still have a baleful effect on health, especially of women. Roman Catholic attitudes to birth control and abortion are the obvious examples, and it is difficult to think of any good that religion can be credited with that comes near to compensating for the huge tide of unnecessary misery, ill-health and death for which it is directly responsible. Death and dying, hospices and euthanasia are the relatively unploughed and now fashionable research territories. The Study of the Dead, despite certain methodological problems outlined, points to a perfectly rational concern with outcomes and evaluation. Alas, in this instance, unlikely to be fulfilled. Feminists in White, likewise, points to a perfectly respectable intellectual concern. Does a feminist improve professional performance in medicine (and other fields). If so, in what respects? If not, ought it in fact be expected to do so?

One feature seems to be common to a number of projects. They delve into taboo subjects that funding agencies prefer to avoid or evade. The taboos are social, political and religious.

The ones I find particularly interesting are those that challenge the comfortable assumptions and complacent rhetoric of 'community care' which the present government is so anxious to foster for economic reasons. ("More elderly people were being looked after by their families today than at any time in our history, and it was right that this should be the case, Patrick Jenkin, Secretary of State for Social Services, said yesterday" reported The Guardian on 9 October 1980, ..."One of the gravest social problems in Britain was the rising number of the very elderly people suffering from dementia. He estimated there were now some 700,000 such people - but of these only 13,500 were in hospital".) Katharine Whitehorn once observed that to her 'community care' meant being looked after by 'some middle aged woman with too much to do already'. One thing is certain. Mr Jenkin would not now be a Secretary of State if he had taken much time off to nurse his demented granny. It is hardly surprising that this concept should have turned into the new orthodoxy at a time of recession and high unemployment, for it fits the times perfectly. Community care depends upon unemployment, particularly female unemployment. But, in the backwash of the great feminist revival of the past decade, fewer women than ever before actually choose to stay at home to tend the lame and the sick, the mentally deranged and the senile. For, contrary to popular and ministerial rhetoric, it is an exhausting, isolating, poverty-stricken and rarely fulfilling way of life. Women, like men, prefer to go to a convivial work-place, and pay someone else to do the looking after for them. The women who have had a genuine choice in the matter, middle class professional women, have always done this. Even in Germaine Greer's ideal republic, it will be recalled, the children were looked after by the obliging peasantry, while their mothers wrote feminist tracts and grew wholemeal wheat. How the aged were cared for it not disclosed in those pages. But in a society that asserts platitudes about the Sanctity of Life, while being quite unprepared to pay the very high wages that alone make some of the less attractive forms of this care sustainable, what solution is there but euthanasia or the exploitation of the carers (nearly always women)? Hence the anxious preoccupation in these pages with nursing, with women as carers, with the role of the family in sickness, and so forth.

We have not advanced very far towards solving the problems of community care in an ageing population. The central problem is not who will advise on the care of those afflicted by senile demntia and other conditions, nor who will research into their care, but who will actually care, in a society where there are real working alternatives for women? As Michael Meacher hints, any relevant research has probably long since been done and filed away, its practical implications

forgotten. But it is easier to set in motion new research projects than to apply the results of the last one.

At time of writing, the real working alternatives for women (and men) are shrinking rapidly. We must hope that by the time of the 1990 collection of these research projects, our social and economics situation will have improved to such an extent that answers to these intractable problems of caring will once more be in urgent demand.

Second post-script

At the end of her postscript, Madeleine drew attention to the changing social climate of Britain in 1980's, and the particular vulnerability of health researchers and health workers to the current restructuring of the Welfare State. I want to pursue this issue a bit further, by looking at the content, and the form, of the research proposed in the workshop.

The research proposals suggest to me that the medical sociologists who attended the workshop are motivated by a common set of questions and issues. There is a recurrent concern with the economics and political content of health, with the impact of sexual divisions on health and health care, and with alternative ways of organising both society and the structure of health care. These concerns appear to reflect less what is going on within medical sociology and more what is going on beyond it : less what medical sociology, as a tradition and a discipline gives to its students, and more what its students bring to the discipline. In other words, these common concerns appear to reflect a common biography that the project-writers share, a common set of assumptions which propelled us into research initially and which is central to our continued commitment to it. Many of us, saw (and see ??) sociology as a discipline in which we could explore, in a systematic way, ideas and issues which were personally and politically important to us. Margaret Stacey picks up on this in a paper she wrote on the teaching of research methods to graduate students. She suggests that student research interests :

> 'emanate from a combination of the social changes, conflicts and tensions which the students are experiencing in their own lives and which are the expression for them of the 'political as personal.' (Future SSRC Policy on the Graduate Teaching of Research Methods, 1979, p.5).

The hope that the personal and political is also the sociological seems to me to be very much alive in the research proposals printed here. (The trouble, of course, is that they are simply 28 people's fantasies : nevertheless, they may serve as a sharp reminder to the current nature of reality).

The epithet that the personal is the political is the sociological is reflected not only in the content of the research projects. I can see its influence too in the form the research process is intended to take. Central to both the Women's Movement, and to the community organisations which have developed over the last decade, has been a commitment to evolving new ways of working - ways which are non-elitest and non-alienating. These currents are strongly in evidence in the research proposals. There is, for example, an emphasis on personal experience. Personal experience is at the core of 'Patients' opinions to me, their doctor'

and 'A longitudinal study of womens health'. In the former, a GP hopes to get patients to describe their encounters with their doctor; in the latter, the researcher aims to design a consumer-based health service on the personal experiences of its users. Personal experience play an important part in the design and methodology of the research programmes. A commitment to collective and non-hierarchical forms of organisation is also apparent. In the example above, 'A longitudinal study of women's health', the traditional division of labour between researcher and researched is broken down : it is the respondent who comes up with the answers to the question of what an ideal well woman service would look like. Similarly, in 'Feminists in White', we read that the participant observation study would be carried out by 'a team of committed feminists', while the study of 'Being Healed' would involve 'a team of fellow students unable to get jobs'. (The author of 'Emergency Rescue Services' comes clean, however, and admits that despite 'a huge team of researchers' 'I selfishly want to do this project').

I've suggested that the attempt at breaking down traditional and hierarchical structures in social research, like the priority given to personal experience, reflects a broad commitment among the contributors to changing the form (as well as the content) of medical sociology. A third feature of the research proposals reveals this commitment in another, and perhaps more fundamental way. I'm thinking simply of the fact that the projects were contributed at all. A large number of people gathered in a small room, listened and laughed as the purpose of the workshop was revealed and then proceeded to share their (often long cherished) ideas with the group. Many of the participants were even less proprietorial about 'their' ideas : they handed in their scribbled notes so Madeleine and I could present them as a shared enterprise and a collective contribution.

General Practice Revisited

A second study of patients and their doctors

ANN CARTWRIGHT and ROBERT ANDERSON

Ann Cartwright's earlier book *Patients and their Doctors* was a vast study, carried out in 1964, of general practice and the attitudes of patients and general practitioners to it. In this new book Ann Cartwright and Robert Anderson compare the views and experiences described in the earlier study with those revealed by a second survey carried out in 1977.

In the intervening period there were a great many changes in the organization of general practice. This study shows how the basic patient-doctor relationship has been affected by these changes.

256 pages
Hardback 0 422 77360 3 £11.50

Symptoms and Illness

The cognitive organization of disorder

DAVID LOCKER

The aim of this book is to discuss common understandings of health and illness and the way these may be used to structure our experience of the world. Contemporary sociological theory is used to distinguish between 'disease' and 'illness', and to demonstrate that there is no necessary relationship between events in the biological realm and the social meanings imputed to them: illness is seen as a social phenomenon constituted by the meanings doctors employ to make sense of observed or experienced events. Dr Locker uses detailed case studies to identify some of the interpretive procedures involved.

about 200 pages
Hardback 0 422 77460 X £12.00

TAVISTOCK

radical community medicine

A journal of the politics of health

Original articles published in 1980 include:

Mental health and social control : Janet Johnston

Setting up a birth centre in Melbourne : Judith Lumley

Trade Unions and primary health care : Steve Harrison

The Politics of health - a case study : Andy Alaszewski and Daniel Vulliamy

Public health aspects of abortion : John Ashton

A community development approach to health education : John Hubley

Sharing primary care : Tom Heller

Also book review, news, comment.

Four issues per year. 1981 subscription £6.00; back issues of RCM 1-4 £1.00 each. Cheques payable to "Radical Community Medicine".

Alex Scott-Samuel
5 Lyndon Drive
LIVERPOOL 18

THE CONSULTATION

Ruth Dearden and Deborah Edwards, Pre-Clinical Students, University College Cardiff

A woman is in the waiting room of a doctors' surgery. She is aged about 45, is slightly overweight and appears to be short of breath. She coughs frequently and clutches her chest as she does so. Her face is drawn and tired.

The receptionist calls for the next patient to see the doctor. The woman stubs out her cigarette, glances nervously at the blank, staring faces around her as if in the hope of receiving some encouragement. She rises slowly and painfully to her feet and pauses at the consulting room door:

Knock knock.

D. (Bored): Come in.

W. Good morning doctor I.Rate. (cough)

D. Name please.

W. Mrs. Pressed. Mrs. D. Pressed (cough)

D. Sit down please. Now, what do you want?

W. Well I didn't really want to bother you doctor, but I keep on getting these pains in my stomach. It's nothing much, but my mother-in-law kept on at me to come. (cough) I was only able to come today anyway because the 8 kids are back in school. Oh, the school holidays are terrible aren't they doctor? Have you got any children?

D. I don't really think that this is relevant. (interrupted)

W. I don't suppose you would really being a doctor and all that. No, your sort wouldn't have the problems we have.

D. I don't really think that this is relevant Mrs. Pressed. Can we get back to your gastralgia.

W. What? Oh, you mean the pain in my stomach. I was coming to that. Yes, well it started a week, or maybe .... was it a fortnight last Friday? (cough)

D. And where exactly is this pain?

W. In my stomach. I just told you.

D. Where exactly is your stomach?

W. Just here.

D. Ah, I see.

W. It's a sort of shooting pain - it goes right up into my chest!

D. (Sarcastic) Oh, I, see, the pain is in your chest as well as your stomach.

W. And along my shoulder and after about 2 hours my arms really begin to ache.

D. I see, and does this pain spread anywhere else apart from your arms? (bored)

W. Oh, no!

D. (pleased) Ah, I see.

W. It's just that I have blurred vision after that.

D. (confused) I see. Anything else? (crossly)

W. No, but that's when the rash starts.

D. Ah, I see. (crossly) Anything else?

W. There is just one more thing, a pain when I cough.

D. (excited) Ah! So you have a cough then?

W. No.

D. (crossly) But you just said you coughed.

W. Did I?

D. (crossly) Yes, and you have been coughing all through this consultation.

W. Oh, that's not a cough, it's only a smoker's cough.

D. (triumphant) Ah, so you smoke then!

W. Yes, I told you that last time, but you've forgotten.

D. You must realise that I see a lot of patients Mrs. Pressed. Can't be expected to remember them all.

W. And then there's .....

INTERRUPT

D. I've written you a prescription, here you are. Can you take tablets?

W. Yes

D. Good. There you are then.

W. But aren't you going to examine me?

D. Good day Mrs. Pressed.

W. What if it's something serious?

Sigh. I'm always being ignored.

D. Next please!

Conference News:- past present and future

ADVANCE NOTICE OF A FORTHCOMING CONFERENCE

THE BRITISH SOCIETY OF GERONTOLOGY

WOMEN IN LATER LIFE

TO BE HELD AT:	NUNN HALL, INSTITUTE OF EDUCATION, 20 BEDFORD WAY, LONDON WC1H OAL
ON:	29 - 30 JUNE 1981
COST:	£13 for 2 days; £9 for 1 day

Some of the themes to be addressed at this conference include widowhood, the menopause, retirement and sexuality in later life.

CONFERENCE PARTICULARS & APPLICATION FORMS AVAILABLE FROM:

Eileen Fairhurst
Geigy Unit for Research in Ageing
University Hospital of South Manchester
MANCHESTER M20 8LR

Tel: 061-445 8111 Ext. 2535

Completed applications to be received by 12TH JUNE 1981.

British Medical Anthropology Society

A meeting, together with the British Chapter of the Nutrition Section, International Union of Anthropological and Ethnological Sciences, is being organized on:

FOOD: THE PROFESSIONAL'S MODEL AND FOLK MODELS

Saturday, 7 February 1981

London School of Hygiene and Tropical Medicine,
Keppel Street (Gower Street),
London WC1E 7HT

We are requesting papers for this meeting. Some suggested topics might be: conceptual categories of food, food concepts of the British, food and health, medicine as food and food as medicine, meal patterns, obesity and body imagery, 'acceptable' food behaviour, child feeding, health and nutrition education, etc.

A fee of £2.00 will be collected at the meeting to cover postage, printing and porter's gratuity.

Please write if you wish to volunteer a paper. Also, if you wish to have the completed programme sent, fill out the tear slip and send it to the meeting organizer:

Erica Wheeler,
Department of Human Nutrition,
London School of Hygiene and
Tropical Medicine,
Keppel Street,
London WC1E 7HT

I shall be attending the British Medical Anthropology Society Meeting on the 7th February and would like to receive the programme.

Name ..... (Please print)

Address .....

.....

.....

.....

University of Warwick

Coventry CV4 7AL

Telephone Coventry (0203) 24011

Department of Sociology

18th December, 1980.

Dear Friends,

We are planning to hold a meeting of the BSA HUMAN REPRODUCTION STUDY GROUP in the Spring around the theme -

"THE POLITICS OF REPRODUCTION: THEORY AND PRACTICE"

We hope that people either doing research related to this area or generally thinking about the possibilities for political strategies around the issues of reproduction, would be interested in such a conference as a means of generating discussion and ideas.

We would welcome any suggestions for papers that people might have. At present two papers have been offered. Jalna Hanmer (Bradford) will talk on 'Sex Predetermination, Artificial Insemination and the Maintenance of Male Dominated Culture', and Hilary Thomas (Cambridge) will talk around the themes of 'Contraception and Sexual Relationships'. If you are interested in the proposed meeting and/or would like to give a paper, could you fill in the slip below and return it to the above address as soon as possible.

The meeting will be held in Oxford on Saturday, 28th March (please note the change from the date originally decided). If there are sufficient contributions offered, the meeting may be extended to Sunday, 29th. Further details of exact agenda and venue will be sent out to those who have indicated an interest in the event.

Hoping to see you in March,

In Sisterhood,

Sheila Roche & Hilary Homans.

I AM INTERESTED IN COMING TO THE HUMAN REPRODUCTION STUDY GROUP IN MARCH.

Name:_____

Address:_____

_____

_____

I WOULD LIKE TO GIVE A PAPER, OR INTRODUCE A DISCUSSION ON:_____

_____

CONFERENCE ON THE SEXUAL DIVISION OF LABOUR IN HEALTH CARE

DEPARTMENT OF SOCIOLOGY, NORTH EAST LONDON POLYTECHNIC, MARCH 6th & 7th 1981

The development of interest in sexual divisions in sociology, social policy and history in the past decade has identified health care as a crucial area for study. It has become something of a sociological commonplace to assert that health care is primarily women's work but controlled by men. There is a growing body of literature on the gender order in e.g. nursing to focus attention on the sexual division of labour as a whole.

The intention in organising this conference is to explore some of the issues and problems we face in developing adequate conceptual frameworks and methodological tools to understand the extent, origins and change in the sexual division of labour in health care in Britain. Thus, among the general questions to be examined are:-

i. the extent to which sexual divisions have shaped processes of occupational development and professionalisation in different occupational groups in health care including changing relationships between lay and expert "workers";

ii. the implications of a reformulation of the conceptual frameworks of the division of labour which adequately incorporates work in the private domain and client work;

iii. the interrelationship of sexual divisions with class and race divisions in health care in Britain.

PROVISIONAL PROGRAMME

March 6th

10.30 Coffee and Registration

11.00 Introduction

11.15 Prof. Margaret Stacey, Department of Sociology, University of Warwick, "The Division of Labour, or Overcoming the Two Adams".

12.15 Eva Garmarnikov, Department of Sociology, Institute of Education, "Historical Perspectives on the Nurse-Doctor Relationship".

Lunch

2.00 Michael Carpenter, Department of Applied Social Studies, University of Warwick, "Sexual Divisions in Asylum Nursing".

3.00 Margaret Versluysen, University of London, "The Development of Midwifery as a male medical speciality".

March 7th

10.00 Sheila Roche, Celia Davies, Christine Buswell, Department of Sociology, University of Warwick, "A case study of health visiting".

11.30 Coffee

11.45 Janet Finch and Dulcie Groves, Dept. of Social Administration, University of Lancaster, "Women Caring for Women: community care policies and equal opportunity".

Lunch

2.00 Paul Atkinson, Department of Sociology, University College, Cardiff, "Girls and Boys in White, are sexual divisions reinforced in the reproduction of medical knowledge?"

3.00 Lesley Doyal, Geoff Hunt, Imogen Pennel, Department of Sociology, Polytechnic of North London, "Migrant Workers in the National Health Services: The relationship between racial and sexual divisions".

NORTH EAST LONDON POLYTECHNIC

Faculty of Human Sciences
Department of Sociology
Head of Department
M J Rustin BA

Livingstone House
Livingstone Road
London E15 2LJ
01-590 7722

The Sexual Division of Labour in Health Care

An informal two-day conference is being organised by the Department of Sociology at North East London Polytechnic on March 6th and 7th, 1981.

A provisional programme is enclosed. It is hoped to circulate some papers in advance.

Venue: Duncan House, Stratford High Road, London, E.15 (near Stratford Tube Station)

Conference Fee: £2.50 per day. (£1.50 students, unwaged) (includes tea and coffee)

Please make cheques payable to North East London Polytechnic.

Lunch: On Friday this will be available from the Duncan House canteen. On Saturday a buffet lunch will be provided at £1.50 per head.

Childcare: will be provided but we must know ages and numbers beforehand.

Travel Expenses: The Equal Opportunities Commission has given us a small grant to assist with travel expenses for those who cannot get these met for them. Please indicate below if you wish to apply for financial support.

Registration: Please fill in the tear-off slip below and the enclosed booking form, and send it with the fee to the Special Courses Assistant, North East London Polytechnic, Special Courses Office, Livingstone House, Livingstone Road, Stratford, London, E.15 2LL, by February 20th, 1981.

For further details, contact Mary-Ann Elston, Dept. of Sociology, at the same address. Tel. 01-590 7722 Ext. 5030.

(Please note the course number is 52910)

Booking Form: The Sexual Division of Labour in Health Care

Name:.....

Address:.....

I shall be coming to the Conference on Friday, March 6th ☐ (please tick)
Saturday, March 7th ☐

I shall require lunch on Saturday at £1.50 ☐

I would like child-care facilities for: Friday - No. of children ☐ Age .....
Saturday - No. of children ☐ Age .....

NORDIC RESEARCH SYMPOSIUM
FOLK MEDICINE AND HEALTH CULTURE -80
ROLE IN THE MODERN HEALTH CARE
27-28 August. 1981 in Kuopio

The symposium is arranged in the University of Kuopio to bring together the research workers studying the anthropological, nursing science, psychological, physiological and sociological aspects of the present day folk medicine and its current role in the health care. The program of the symposium consists of review lectures as well as free communications as posters (deadline June 10th, 1981). The presentation language of the papers will be English, since a few experts outside the Nordic Countries will participate. The discussions will be carried out in addition to English also in Scandinavian languages. No interpretation will, however, be provided.

Application and abstract forms as well as further information:
Mrs. Pirkko Merilainen, Department of Health Care Administration, University of Kuopio, P.O.B. 138, 70101 Kuopio 10, Finland, tel. 971-162 689 or
Ph.lic. Tuula Vaskilampi, Department of Social Administration, University of Jyvaskyla, Finland, tel. 941-292 210.

STOP PRESS

NEWS OF THE BLACK REPORT .....

At last September's AGM I was asked to write to the DHSS expressing concern at the manner in which the 'Black' report Inequalities of Health had been published. I did so accordingly, and received a reply pointing out the difficulties of successfully anticipating demand and inviting me to report any difficulty members may have in obtaining a copy. I immediately responded, reporting an instance of a seven week delay from sending a pre-paid order (all DHSS orders now, we are reminded, need - not unreasonably I think - to be prepaid) to the date, 1st December, of my reply. At the time of writing, i.e. 19 December, there has been neither further response, nor receipt of the order.

Should any other members have similar difficulty, please let me know, and I shall duly report to the DHSS. I shall keep you posted.....

Anne Murcott

BIRTH CONTROL CAMPAIGN

Information

Private Members Ballot

Once again the 1967 Abortion Act is under attack! Mr Timothy Sainsbury MP, Cons. (Hove) has drawn first place in the ballot for Private Members Bills. To date he has told the press that he intends to introduce a one clause Bill to reduce the upper time limit for abortion from 28 weeks to 22 weeks. Alternatively he may seek to widen the conscience clause. However, he has also said that he will take a public indecent displays Bill if number two in the ballot, Mr Donald Stewart MP, SNP (Western Isles).

We will not know which Bill Mr Sainsbury will take until 14 January when the title has to be given and the second reading will be on 30 January. Undoubtedly, during this time he will come under intense pressure by the anti abortion pressure groups to include both these restrictions to the 1967 Act, or they may try to persuade him to restrict the ground for abortion.

May we urge you to write to Mr Sainsbury at the House of Commons, London SW1, as soon as possible drawing his attention to the disastrous effects any restrictions to the 1967 Act will have on the lives and health of women. Although those presenting late for abortions are small in number (1¼ per cent of all legal abortions in 1979 were performed from 20 weeks onwards) they are often the most tragic cases who deserve all the sympathy and care that is available.

* I enclose two pamphlets which should assist you in the forthcoming campaign. Why Late Abortions? published by BCC is especially relevant. It contains all the arguments against lowering the upper time limit and is illustrated with case histories. Abortions in Britain before the Abortion Act, published by the Birth Control Trust, is a useful historical review of the way in which abortions have always taken place in this country, regardless of their legality.

It is just possible that if Mr Sainsbury receives enough letters before 14 January advising him not to make any restrictions to the 1967 Act he may decide to take a Bill on indecent displays instead..

I hope you will do all you can in the next few weeks to stop any attempt to amend the 1967 Abortion Act.

Yours sincerely

Dilys Cossey
Chairman

* Pamphlets available from:

BCC
27-35 Mortimer Street
LONDON W1N 7RJ

PROBLEMS OF ORGANISING SOCIAL RESEARCH: A CONSIDERATION OF THE SOCIAL RESEARCH ASSOCIATION WORKING PARTY RECOMMENDATIONS.

The SRA* was founded in 1978 after a series of open meetings in London designed to test interest among social researchers in the formation of an association covering all areas of research activity. The general aims of the association as outlined in their application form are:

(i) provide a forum for discussion and communication about social research activity in all forms of employment

(ii) encourage the development of social research methodology, standards of work and codes of practice

(iii) review and monitor training and career facilities for social researchers and the organisation and funding of social research

(iv) encourage the use of social research for formulating and monitoring social policy.

At the beginning of 1979 Stuart Blume, Ann Bone, Jennifer Platt and Ken Young were invited by the executive committee of the SRA to carry out a brief inquiry into the 'terms and conditions of social research funding in Britain'.[1] The findings were published in 1980. The report outlines the structure of social research funding noting the extent to which research has become dependent upon funds from central government. In the second section the report describes the terms and conditions under which grants are funded by the major agencies. Finally, the group address themselves to the issues that emerge from the evidence they collected and which they felt would be important to bring to the attention of social researchers. The central issues that emerge in the report are access to research funds, monitoring and control of research, professional careers, limits on publication, copyright and ownership of data.

The authors begin by looking at the historical position of funding through the sixties and seventies, noting the level of activities and the increase in funding following the Heyworth Committee[2] and the setting up of the SSRC. Combined with these changes was the decline in foundation funding and an expansion of central government departments interest in research. Attention is drawn to the increased formality of research applications following the white paper accepting the recommendations made by Lord Rothschild in 1971[3]. Prior to this, single individuals in government departments had autonomy in allocating large sums of money suggesting that funding could depend on the individual interests of applicants and the gate-keepers to the resources. Following the procedures established after CMND 5046[4],

* Social Research Association, 35 Northampton Square, London EC1V OAX
Tel: 01-250 1866

the working party drew attention to the setting up of the Research Liaison Group at the DHSS and the Research requirement committees at the DOE, emphasising 'relevance' as a key component of tenders submitted. This development based on the customer-contractor principle has, according to the report, served to bind social research to the current interests of government departments. The outcome of these measures is that research proposals tendered which address a problem across two departments may have difficulty in getting funds. Also individuals with specific interests may find it difficult to achieve success in applying for funds unless relatively well known.

The second section of the report dealing with the terms and conditions of funding is an excellent guide through the requirements of the major funding bodies. Of particular value are the tables which lay out clearly the terms and conditions of funding by the major government departments taking into account eligibility, forms of application, deadlines, supervision, flexibility, copyright and ownership of data. This information is repeated for the main foundations including among others, Nuffield, Leverhulme, Rowntree. For the would be applicant searching for a suitable institution to fund their project this section could be of great value in deciding which institution would meet their requirements, for flexibility, publication etc. No details are given as to local authority funding and the business sector because of the diversity of practices in funding and the latter not representing a major source of extra mural support for social research.

Discussing the issues that emerge from their findings Blume et al express concern about the way certain funds are available to only certain kinds of institutions or individuals and that the trend towards competitive tendering either open or closed raises ethical issues and an unfair distribution of resources and they quote what Robert Merton[5] called the Matthew principle - "to him who hath shall be given, and from him who hath not even that which he hath will be taken away". Attention is drawn to the view held by some social scientists that sponsors of research are becoming more 'interventionist' at all stages of project development, and the group view this as a dangerous trend because the close supervision of experienced researchers sometimes by officials with an inadequate knowledge of research and social science is unlikely to lead to value for money.

Security of research workers is another long standing issue and the report outlines the many problems the researcher faces working on short term contracts (issues well known to many readers of Med Soc News) and how the needs of research may conflict with the career needs of researchers.

The right to publish is outlined from a legal perspective followed by an examinatio

of the procedures of the major funding agencies, emphasising the fact that publication is an important criteria for promotion and confers status on individuals in the eyes of their profession.

Finally, the authors of the report make a number of recommendations based on concern for some of the issues outlined above:

1. That all government grants and contracts should have added to them provision for three months of uncommitted time on the part of the researcher paid from these grants and contracts. The Group argue that such support would facilitate the transition between contracts and allow for the preparation of new proposals, thus easing the burden on individual researchers and organisations.

2. As far as tendering is concerned it is recommended that when open tendering is felt appropriate, the procedure should be initially to solicit brief outlines from interested researchers, organisations. Funds should then be made available to those short listed for the preparation of detailed proposals on the basis of which contracts would be awarded. On ethical grounds it is recommended that closed tenders be avoided. If unavoidable a minimum number invited to tender is suggested, i.e. six.

3. Concern is expressed that bodies like 'quangos' with often limited experience of research will adopt unnecessary restrictive or unappropriate conditions, and due to the difficulties researchers and organisations face in negotiating research grants and contracts it is recommended that the SRA seek to draw up a list of desirable and undesirable contract conditions, and that steps should be taken to secure agreement of such a list.

4. The final recommendation is that when the SRA review of research training has been completed, the association seek to bring together all interested parties with a view to establishing the proper dimensions of policy towards individual development of researchers, role of employers and funding bodies in such a policy. (N.B. A move to develop a link has been established between the BSA Research Committee and the SRA, following a discussion of the report at the last meeting of the former, on Friday, 23rd January 1981.

The report sets out as we have seen a number of issues, some which will be familiar to many researchers, following their experiences with some of the organisations outlined in the report. The publication of the findings is a welcome contribution to the debates at a political and ethical level that are currently facing the medical sociology community. Also the report is a

valuable source to the would be applicant for funds and a 'Which' type guide to funding agencies.

Malcolm Colledge,
Principal Lecturer in Medical Sociology,
School of Behavioural Science,
Newcastle upon Tyne Polytechnic.

1 Terms and Conditions of Social Research Funding in Britain. Report by the Working Group. SRA October 1980. Copies available from SRA (see address previously cited).

2 Report of the Committee on Social Studies (Heyworth Report). CMND 2600, HMSO 1965.

3 A Framework for Government Research and Development (Rothschild Report). CMND 4814, HMSO 1971.

4 A Framework for Government Research and Development. CMND 5046, HMSO 1972.

5 Merton, R.K., The Matthew effect in science', Science, 159, 1968. pp59-63. Matthew 25 XXIX.

REGIONAL NEWS

London Group:

To be held in Lecture Room, Dept. Community Medicine, University College Medical School, 88-96 Chenies Mews WC1 Nr. Corner Gower St/Tavistock Place - Tubes Warren St. Euston Sq. Goodge St. On Wednesdays at 6.00 p.m.

Jan 28th "Medicine and Patriarchal Violence"
Evan Stark and Ann Flitcraft, Yale University - on Sabbatical at University of Essex.

Feb 25th "The Problems of Pregnant Asian Women in Britain"
Hilary Homans: Hereford and Worcester Health Education Department.

March 25th "Historical Paralysis: Some problems in Sociological History of Medicine"
John Gabbay Dept History & Philosophy of Science, University of Cambridge.

April 29th "The expansion of Psychiatry in the 20th Century"
Joan Busfield, Dept Sociology, University of Essex.

May 20th "Health and Safety in the N.H.S."
Geraldine Healey, Dept Management Studies, Polytechnic North London.

June 24th "Contraception and the Medical Profession in the 19th Century
A Socio historical Account". Linda Marks, U.S.H.P. London.

July 22nd "The Dilemmas of the Preventive Approach"
John Carrier, Dept of Social Administration, London School of Economics.

Sept 25th - 27th Medical Sociology Annual Conference University of York. (Details will be published Med Soc News, or contact Anne Murcott, Dept Sociology, University College Cardiff).

Oct 28th "Perceptions of Health and Illness in Bethnal Green"
Jocelyn Cornwell Queen Mary College London.

Nov 25th "Health and the Media"
Anne Karpf. London.

Dec 9th "Sociological Aspects of Surgery"
Phil Strong Dept of Social & Community Medicine, Oxford.

Meetings begin at 6.00 p.m. with presentations up to one hour, followed by discussion, with adjournment to local pub. All comers are welcome.

There may be unavoidable changes to this programme and we cannot notify all members by post. If necessary, check for particular session by phoning:

John Dennis 407-7600 x2995; Barbara Harrison 928-8989 x2380; Jenny Popay 486-7071; Marion Prince 607-2789 x2369.

Return to: Barbara Harrison, Dept of Social Sciences, Polytechnic of the South Bank, Borough Road, London, SE1 0AA.

PLEASE KEEP ME/PUT ME ON THE MAILING LIST FOR M.S.G. (stamped addressed envelope please)

Name: .....

Address: .....

.....

North West (Manchester Medical Sociology Group and medical history workshop)

According to Roger Lightup they haven't had any meetings yet this year. However, two speakers are being lined up for next term, so thats good news for the N.W. group.

South West and Wales Medical Sociology Group

Colin Rees (0222 20561) reports a successful conference last December. A major meeting of the group is being planned for May, if anyone in the area wants to volunteer a paper, Colin would be delighted to hear from you.

North East Group

The local Newcastle Medical Group has had three interesting meetings planned,

"Too Many Doctors Not Enough Nurses? Medical and Nursing Manpower, Contrasts and Parallels" on Monday, 26th January at 5.30 p.m. in the R.V.I. New Lecture Theatre, when the speakers will be Professor J. Parkhouse and Mr. A. J. Carr and the Chairman will be Professor J. H. Walker.

"Death and its Effects on Children" on Tuesday, 24th February at 5.30 p.m. in the Clement Stephenson Lecture Theatre when the speakers will be Dr. Vera Bailey and the Chairman will be Dr. Christine Cooper.

"Perinatal Mortality and Place of Birth" on Monday, 16th March at 5.30 p.m. in the R.V.I. New Lecture Theatre when the speaker will be Mrs. Marjorie Tew.

and the University Health Care Research Unit held a meeting on the 22nd January to hear a paper on 'changing images of middle age' by M. Featherstone (Dept. of Social Studies, Teeside Polytechnic) and M. Hepworth (MRC Unit, Aberdeen). The main Medical Sociology Group are planning a series of meetings for the summer term, topics to include, 'planned and unplanned care in nursing', the interpretation of regional unemployment and its relationship to health.

Scotland

David May phoned (0382 60111, Ext. 2406) to give me news of the conference arranged for 13th March at the Medical Centre, Ninewells hospital. Speakers will include:

Phil Strong : The Academic Encirclement of Medicine
(This paper is 'travelling' so well, that I am inclined to retitle it the 'Academic Encirclement of Sociology', no offense Phil)

David Hughes : Doctor-patient interaction on a Cardiology Unit.

Kate French : Attenders and non-attenders at a breast screening clinic.

Kath Melia : Nursing Research

The next main meeting is scheduled for 18th December. David would like to hear from anyone with an interest in giving a paper.

* Please note, if any Regional Group has not claimed its £50.00 allowance from the main Medical Sociology Group funds please contact Malcolm Collesge.

CRISIS IN THE HEALTH SERVICE: THE POLITICS OF MANAGEMENT

Stuart Haywood
Andy Alaszewski

Croom Helm 1980 £11.95 154 pages Hardback

Crisis in the Health Service is a lively and provocative critique of health policy and its implementation in the United Kingdom since 1948. It also charts the successive failures of the Department of Health and Social Security (Ministry of Health until 1974) to exert any effective control over the process of allocating re sources and shaping the pattern of delivery of services.

In the early days of the service it was easy to attribute the faults of the system to its structure, the tripartite division between general practitioners, hospital services and the community services. Since 1974 and the re-organisation of the structure it is possible to see more clearly that the structural argument was weak. It failed to locate the real locus of power and decision making. It is the contention of Haywood and Alaszewski that effective power over the disposition of resouces if found at the local level of the NHS, where it is exercised in the name of clinical judgement and autonomy. As the authors of this book observe the NHS re-organisation 1974 is now sidely acknowledged to have been a disaster. The Royal Commission has recently advocated a degree of de-centralisatio breaking the line of command between the DHSS and the Regional Health Authorities. The new Secretary of State under the banner "Patients First" has endorsed the de-centralisation thesis on the grounds that central bureaucracy and administration are an necessary impediment to the delivery of health care which is best left to the personal discretion of members of the healing profession themselves. The argument of this book, however, is that these organisational changes disruptive as they undoubtively will be, will also be largely irrelevant to the main problem of the National Health Service. The major problem is how to curb the self-interested exercise of power on the part of the medical profession, not only as a collectivity but as a dispersion of individual decision makers insulated from central policy debates and from the earnest priority declarations of health ministers and their advisors at the DHSS.

The strength of this book, like the earlier report to which one of its authors contributed (Children in Liverpool: Who Cares) lies in its careful examination of arguments about the locus of power and the rationality of the

decision making process in the National Health Service. The authors' analysis serves as an important reminder that research into the professional politics and the nature of medical power is as important to bringing about improvements in health in Britain as research in the social aetiology of disease and disability.

But like the doctors they critise, Alaszewski and Haywood are better on diagnosis than on cure. Their discussion of the nature of medical power is all too brief and their list of strategies for change amounts to little more than a series of warnings arising out of their analysis of the existing structure. It is, however, far easier to call for total revolution as a solution to prevailing problems, much more difficult to show how it might be possible to get from where we are now to where we would like to be. The worth to this book lies in the elaboration of the formidable obstacles which will be encountered on route. It is a very readable account and can be recommended without researvation.

Nikki Hart,
University of Essex.

SERVICES FOR THE MENTALLY HANDICAPPED IN BRITAIN

Nigel Malin, David Race and Glenys Jones.

Croom Helm, 1980. **Hardback: £11,95 Paperback: £6,95 266pp.**

As the authors of this book note "services (for the mentally handicapped) are patchy and parochial and responsibility for their provision is shared between several large statutory organisations and smaller isolated voluntary ones". Any book then which promises, as does this one, a comprehensive and comprehensible picture of those services meets a real need and is assured of an enthusiastic reception. And indeed this is a useful little book which in many respects fully lives up to its promise. In seven informative chapters it describes and critically assesses the whole range of services available to the mentally handicapped and their families, from residential provision to home-based support. It also summarizes, in an admirably clear and straightforward fashion, a mass of research bearing upon the operation of those services. An over-long, four chapter introduction which discusses in a rather sketchy manner the classification, causation and epidemiology of mental handicap and the development of the services contains little of originality, apart from some interesting, but exceedingly brief observations on the continued medical domination of the institutional sphere, and altogether sits uneasily alongside of the main part of the book. Yet even this will no doubt find favour with those students at whom the book is principally aimed; an invaluable companion on those long nights writing essays or preparing for exams.

Others, I suspect, will find this book somewhat less satisfying. The problem lies as much in conception as in execution since an introductory text, which is essentially what this is, rarely lends itself to any sustained treatment of issues or analysis in depth - and this book is no exception to that general rule.

David May,
University of Dundee.

THE EMPLOYMENT OF NURSES

G.M. Mercer Croom Helm £10.95

The title is assisted by the book's sub-title "Nursing Labour Turnover in the NHS" which provides a much clearer indication of the subject matter. There is no doubting the perennial topicality of this manpower issue as well as the complexity of what constitutes "turnover", however it is measured.

Issues of the measurement of turnover I found extremely tedious although the book provides definitions and formulae which presumably would be useful to those concerned with measuring the concept including nurses or others in NHS personnel divisions who wish to keep track of labour movements. I doubt that the book was intended for nurse managers however, otherwise terms like "positively skewed, unimodal, leptokurtic distribution" would not have been included. However, later there is reference to the magical No. 7 with no indication of its referrent. It is not clear for whom the book is intended. It is certainly no news to nurse managers that nurses who are women and have domestic obligations pose problems for the organisation in terms of movement out and return to work. Little harm can be done by stating the obvious - including that profits can be reaped by facilitating the return and recruitment of already qualified nurses.

The study does clearly demonstrate that if managers wish to forecast movement or stability of nurses by far the best guide would be to ask their staff what they propose to do over a defined time scale. The qualitative data in the study which examines the individual nurse's priorities across work and non-work lives is much more illuminating than "crude empiricism where the statistical effect of turnover's correlates has been elevated above their explanatory virtue."

In short the book provides no answers but expands on the complexity of the issues involved. This includes the positive elements of job mobility, not just as inevitable but as broadening of experience since the NHS gains as a whole and not just a particular D.G.H. Incidentally, the particular D.G.Hs sampled showed a much narrower range of geographical mobility than would have been predicted - perhaps a freak of Yorkshire.

I am not sure whether I have learned a new word from the book or a consistent misprint was included. Can anyone enlighten me as to the "monopsonist" position of the NHS?

Senga Bond
Nursing Research Liaison Officer
Northern Regional Health Authority

CAN SOCIAL WORK SURVIVE?

C. Brewe and J. Lait
London: Temple Smith, 1980, £9.95, 235pp.

It is always difficult to come as a reviewer to a book which has already been widely discussed. On the other hand, the lapse of time may permit a somewhat cooler appraisal of the work. This is particularly relevant in the present case when we are presented with a text which seems to have engendered a state of near-apoplexy among social workers. It seems to me, however, that the evaluation of a book should not properly proceed in terms of its contribution to the rate for cerebro-vascular accidents so much as on its own intellectual merits.

Brewer and Lait's main theme is that social work has become an overblown pretentious and imperialistic occupation, which should be cut down to size by a medically-dominated Royal Commission. In documenting this contention, they attempt to cover a great deal of territory, although, in view of their ambitions and the space allowed by their publisher; the coverage is surprisingly selective. Their examples draw mostly on medical and psychiatric social work to the neglect of, particularly, child care. The discussion ranges over the history of social work, its training and academic base and its practice. Social work is charged with indolence, not spending sufficient time in client contact; with anti-scientific attitudes, in disregarding the early writings of Karl Popper and the methodology of the hard sciences; with radical Utopianism, fomenting revolution on the rates'; in sum, with perpetuating a massive confidence trick on the British taxpayer. The Rogues Gallery of tricksters includes Dame Eileen Younghusband, Baroness Serota, Sir Frederick Seebohm, Peter Leonard, Case Con and Sir Derman Christopherson (as Chairman of CCETSW), some turncoats like Jerry Morris and some, like Olive Stevenson and Phyllida Parsloe, who are not wholly beyond redemption - to be hung in effigy perhaps. The authors' heroes are an oddly assorted group. Among them are numbered Sir Karl Popper, Baroness Wootton (or occasionally Wooton), Paul Johnson, Stanislas Andreski, Matilda Goldberg, Patricia Morgan and Sir Keith Joseph. If these lists are somewhat redolent of the Philosophers' Football Match in the much-lamented Monty Python show, the resemblance is not altogether coincidental. Their whole treatment owes much to what we must nowadays call a Great Person theory of history.

This is one of the core weaknesses of the book. Its attacks are predominantly ad personam and based on the rhetoric of academic theorising and the pronouncements of the professional association. It is like trying to write about medicine using Gray's Anatomy and BMA press releases. The authors completely fail to come to terms with the everyday realities of social work practice in local government. In my own research, for instance, I have been deeply struck by the bureaucratisation and accountability of social workers. It seems clear that, on the whole, communities or, perhaps more precisely, local authorities get the social services they deserve. If social work is in a mess, it is to councillors and managers that we must look, for their failure to manage an organisational structure which is designed to respond to their centralised policy-making. One might also point to the absence of documentable imperialism in practice. As Strong has so forcefully observed, imperialist ambitions are located in particular occupational segments. Watching practitioners, it is clear they they have, and use, a great variety of rationing devices to limit client demand. If one is going to give an account of the rise of social work in the U.K., one needs to pay as much attention to central and local government demand as to occupational ambitions.

These criticisms are, however, trivial compared with the wilfully misleading presentation of evidence. The authors have systematically ignored research which conflicts with their initial prejudices, have rigged their statistics and misrepresented the historical record. If this review is not to take up the whole of this newsletter, I shall have to confine myself to three examples. First, the 1979 social workers' strike in Tower Hamlets is discussed in some detail. Brewer and Lait cite a BBC radio programme as their main evidence for its lack of direct effects which is taken to indicate the general uselessness of social workers. They ignore the DHSS' own investigation, published before the end of 1979, which points to quite specific adverse effects, particularly in work with children. Second, CCETSW is made to appear a dramatically expansionist body by quoting the rise in its budget between 1972-73 and 1976-77 in money terms with no attempt to correct for the rapid inflation of that period. Third, this book has practically nothing to say about the child care service. Whatever else can be said about social workers, there seems every reason to argue that the handling of the 'children of the State' improved dramatically after 1948. It is also quite apparent that post-Seebohm practice owes more to Children's Department approaches than to either almoning or psychiatric social work. Similarly, the merging of welfare and delinquency concerns in the 1969 Act was merely the culmination of a process which started in 1908. (In fairness, since the authors obviously regard themselves as the

spiritual heirs of Dicey, they may well agree with his view that the decay of the British nation started around them).

I do not want to expose myself to the charge of professional self-interest by complaining about their treatment of sociologists, although I should have thought Malcolm Bradbury was at least as authoritative as a source as either Johnson or Andreski. I am bound to say, though, that if I were a social work academic, I would feel pretty offended by the sneering, sarcastic tone of the book with its bad jokes, laboured humour and carping asides. In particular, I think that their treatment of Stevenson and Parsloe verges on the libellous. The latters' major study of area teams is variously described as 'ill-designed', 'erratic', and 'inadequate' without a single specific criticism being adduced. Indeed, Brewer and Lait rely on it rather heavily as data on social work practice. As a citizen, I am also rather disgusted by the cynical morality of the authors when they urge the adoption of an espionage model for research. Social workers have as much right to the chance of giving informed consent as anybody else. If Colin Brewer were to treat his research subjects like that, I should hope he would rapidly find himself in front of a disciplinary hearing.

Can I commend anything about this book? Actually, there are three comparatively moderate and useful chapters (8-10) which deal with the principles of clinical trials, the literature on effectiveness in social work and the problems on evaluating psychotherapy. These are certainly worth looking at but not worth buying the book for. Otherwise, I would only consider assigning it to students as a case study in how not to construct an acceptable academic argument.

The authors, of course, may choose to disregard the distinction between academic and polemic modes of work: Mrs Lait's consultees at the Social Affairs Unit have, I note, described this as an 'empirically vacuous dichotomy'. However, to those of us, in the post - Howard Kirk generation, who are seeking to resurrect certain notions of scholarship, such an attitude can be seen to be the cause of the parlous state of British social inquiry. This book and its authors do nothing to contribute to arresting the decay they identify: they merely conjure up its mirror-image and a pretty contemptible one, at that.

I understand the publisher has recently sold out his business. If this is typical of his product, I hope the buyer was paid to take it away.

Robert Dingwall
Centre for Socio-Legal Studies,
Wolfson College, Oxford.

SOCIAL AND ECONOMIC IMPACTS OF CORONARY ARTERY DISEASE

Eds. Edgar D. Charles and Jennie J. Kronenfield.
Lexington Books, 1980, £11.50. 138 pages including 16 figures and 15 tables.

Using a multidisciplinary approach, this book represents an interesting, if brief contribution to contemporary debates regarding the technical aspects of professional cardiological practice.

The aim of presenting, 'in a timely manner the technical information about the causes and natural history of coronary artery disease, its treatment and its social and economic costs', (p.105) is, for a medical readership, competently realized. However, sociologists, medical economists and others may encounter difficulties in comprehending the abundant medical terminology which permeates the six chapters. How many sociologists for example, understand the meaning of 'left ventriculography'?

What sociology there is in the book remains elementary and at best under-developed, though to be fair, the construction of a sociology of coronary artery disease is not central to the authors' project.

The authors do provide, however, a useful guide to recent American epidemiological material (chapter 2), and a lucid overview of contemporary pharmacological and surgical innovations in the treatment of coronary disease with particular reference to angina pectoris (chapters 3 and 4).

Social scientists will find the longest chapter, 'Economic and Sociological Issues', of particular interest, combining as it dies short introductory reviews of established work on the social consequences of coronary disease (Croog et al., Finlayson and McEwen etc.). with the tentative results of empirical work carried out at the Birmingham Medical Centre, Alabama. This work examined the economic cost of medical therapy, those characteristics of patients requiring surgery after earlier medical therapy had failed and the personal, familial and societal effects of unstable angina pectoris.

In the sixth and final chapter William Bridgers discusses many ethical and political problems surrounding the acceptance or rejection of new therapies. This discussion contains little that readers will not have encountered elsewhere. However, those seeking an introduction to randomized trials will benefit from

Bridgers' concisely written contribution. His review of the policy implications of adopting bypass surgery serves as a thoughtful conclusion to this interesting collection.

Doug Rae
History of Science and Technology
UMIST

PREVENTION IN MENTAL HEALTH: RESEARCH, POLICY AND PRACTICE

Edited by Price, R.H., Ketterer, R.F., Bader, B.C. and Monahan, J.
(1980) Sage Publications Inc., California. Price: £12.50 (Hardback) £6.25 (Paperback)

A consensus is emerging that prevention is more important to the prospective psychiatric patient and his family than the provision of hospital based treatments, although these will probably still be required for a very long time. It is hard to say why this is happening but it could turn out to be because prevention programmes are likely to be both more effective and somewhat cheaper than hospital care.

It is against this background that Price and his colleagues review the impact of the preventive mental health movement which has grown up in the United States in response to the Community Mental Health Centres Act (1963). The Act led to the setting up of hundreds of community health centres throughout America as well as to the growth of hospital based community mental health services. The effectiveness of these services is difficult to assess directly because of the possible influence of factors such as neighbourhood networks, families, kinship systems, churches and voluntary associations which may occupy an intermediate role between programmes and their recipients. Another difficulty is the problem of evaluating prevention strategies in terms of their effectiveness in the short, medium and long term.

This books fifteen chapters are almost equally divided between conceptual, policy and research issues. Attention is given to domestic violence, the prevention of child maltreatment, the long term implications of stressful life events in the children of divorced parents and to prevention strategies in schools. Delinquency prevention programmes are also reviewed and there is a disappointing chapter on prevention policies in industrial settings.

Most of the contributors approach issues in prevention via the well known and not very helpful model which distinguishes between primary, secondary and tertiary services. The first sets out to reduce the incidence of mental illness, the second to reduce the severity and duration of specific disorders and the third to promote rehabilitation. Leaving asise the emphasis that this model places on the diagnostic approach, the problem with all of this is that insufficient is known about the causal factors which produce specific disorders to enable prevention strategies to be anything more than hit and miss acts of faith.

The inadequacies of this model have contributed to the shift of attention from

predisposing (individual) to precipitating (environmental) factors that stress the importance of trigger mechanisms which translate high risk situations, rather than high risk persons, into illness and illness behaviour. Another change of emphasis which arises from similar criticisms is the development of programmes which are less concerned with the incidence of specific disorders, say schizophrenia or endogenous depression, than with the promotion of more general aspects of health and mental health.

Prevention strategies are, however, still very much in their infancy, they are usually under resourced and there are a number of other obstacles to the development of practice - relevant knowledge. Policies and guidelines tend to lag behind attempts to develop effective prevention services and the funding of programmes can be uncertain and pragmatic. Without coherent policies and guidelines little real progress can be made.

There are bound to be high and low spots in a book of this length (320 pages). One of the better chapters, in my opinion, is Jasan's discussion of behavioural approaches to primary prevention strategies in schools. He gives a clear, succinct account of the applications of classical and operant conditioning, systematic sensitization and cognitive restructuring techniques. His discussion is not, however, entirely concerned with person-centred, approaches as he also draws attention to the health implications of classroom settings, the effects of varying th size of first school classes and the benefits of relatively high pupil turnover. There are also short sections on the use of peer support groups, the characteristics of teacher-pupil relationships and the affective effects of innovative teaching methods. The point of the chapter is to argue that community and behavioural psychologists can and should benefit from collaboration aimed at determining the impact of different models of service delivery.

Catalano and Dooley provide another well written chapter which looks at the relationship between economic change and the need for primary prevention strategies. This chapter is notable because it is the only one which attempts to examine issues in primary prevention from a macro perspective. The authors are, however, not surprisingly unable to make up their minds about whether there is a causal relationship between economic trends and the incidence of mental disorder, or whether downturns in the economy merely uncover an illness burden which was previously unrecognised. The chapter touches on the significance of structural unemployment, boring work and the effects of disparaties in regional resources on the health status of different socio-economic groups. This is clearly an important area, but one which may have been more usefully explored if the authors had questioned their assumption that the severity of economics downturns are unavoidable.

In the final chapter, Heller, Price and Sher attempt to provide a pay-off for the book as a whole by examining the role of research and evaluation in primary prevention. They argue for what they call a "boot-straps" (creeping incrementalist) approach and try to make the case for a policy commitment to evaluation research. They take the view that such research can be used to justify programmes in their early stages when they are at their most vulnerable to the sponsor's axe. This approach may be too conservative for some tastes and tells us more about the researchers and their sponsors than about prevention programmes. On a more optimistic note, Heller and his colleagues advise those of us who are interested in evaluation research to resist the temptation to provide answers to questions which are of immediate interest to politicians and administrators.

There are few occasions when the practical implications of this book are made so explicit, but what ever it lacks in conclusions it should be read by anyone interested in the prevention of mental illness. It could, therefore, be usefully read by all of us whose daily work brings us into contact with other people - but the division of labour is what it is, so it will probably be read by community psychologists and, perhaps, by a few social workers, community psychiatric nurses and teachers.

Michael Clinton,
School of Behavioural Sciences,
Newcastle upon Tyne Polytechnic.

NEW BOOKS PUBLISHED IN ASSOCIATION WITH SSRC

PRINCIPLES OF ECONOMIC APPRAISAL IN HEALTH CARE

M F Drummond (Lecturer in Economics, Health Services Management Centre, University of Birmingham)

Oxford University Press Medical Publications (£4.95 (paperback)
ISBN 0 19 261273 5

Increasing pressures on the resources available for health care have emphasised the need to judge alternative strategies, in treatment and planning, from an economic perspective. However, existing cost-benefit and cost effectiveness studies in the health field vary greatly in quality and can present a confusing picture for the health professional wishing to learn more about the economist's approach.

This book outlines in the simplest possible terms the methodology of economic appraisal as applied to health care, pointing out pitfalls for the unwary. It is written for the medical researcher, epidemiologist, or clinician already engaged in the evaluation of health care alternatives, and for those whose planning or administrative responsibilities require them to understand existing economic appraisals and assess them critically. The book should also be of use to economists new to the field of health care.

A companion to this volume, STUDIES IN ECONOMIC APPRAISAL IN HEALTH CARE, will analyse the cost-benefit studies in health care - from all over the world - that have been undertaken up to the beginning of 1980.

A CYCLE OF DEPRIVATION? A CASE STUDY OF FOUR FAMILIES

Studies in Deprivation and Disadvantage No 2
Frank Coffield, Philip Robinson and Jacquie Sarsby
Heinemann Educational Books for DHSS and SSRC £11.50 (hard covers)
ISBN 0 435 82145 8

Despite substantial economic advances and improved welfare services in Britain since the Second World War, there has been a conspicuous persistence of deprivation and maladjustment. In June 1972 Sir Keith Joseph, then Secretary of State for Social Services, drew attention to this. In particular it seemed to him that social problems tended to recur in successive generations of the same families - to form a cycle of deprivation. Subsequently the DHSS, through the SSRC, made available a sum of money for a programme of research into the whole problem.

The first volume, CYCLES OF DISADVANTAGE (1976) by Rutter and Madge, provided an overview of existing knowledge. Subsequent volumes of this extensive research programme will deal with intergenerational continuities and discontinuities in deprivation and disadvantage, drawing upon the findings of both psych-social and economic research.

Medical Sociology Research Centre
University College Swansea

MOTHERHOOD IN SWANSEA

A study of the sources of information used by first-time mothers

by
Jean Cleary and Billie Shepperdson

The results of this research will be available in three parts:-

1. The Presentation of Motherhood: a survey of printed and other media materials dealing with pregnancy, delivery and early aspects of child-rearing. £3.75

2. Expectations and Reality: a survey of mothers' beliefs about and experiences of their new role. £3.75

3. Supplementary papers which deal with ideas and hypotheses which were secondary to the major research intentions.

   (i) Mothers' Attitudes to Future Home Deliveries £1.25

   (ii) The Ffynone Fathers: a study of the changing role of fathers in South Wales £1.75

   (iii) Preparation for Parenthood: the approach of ante-natal classes £1.25

   Supplementary papers 1 and 2 are now ready and will be followed first by 'The Presentation of Motherhood'.

Copies are or will be available from:

The Secretary,
Medical Sociology Research Centre,
Department of Sociology and Anthropology,
University College,
SWANSEA SA2 8PP

and will be invoiced on despatch.

ROCK CARLING FELLOWSHIP 1980

This year's Rock Carling Fellow is Professor Raymond Illsley, CBE, BA, PhD, Director of the MRC Medical Sociology Unit and Professor of Medical Sociology at the University of Aberdeen.

On Thursday, 27th November 1980 Professor Illsley gave a lecture at the Royal College of Obstetricians and Gynaecologists to introduce his monograph: PROFESSIONAL OR PUBLIC HEALTH? Sociology in Health and Medicine.

This book discusses the tension between the medical and social definitions of health and their respective implications for the organisation of health services. A hundred years of falling death rates, attributed, rightly to wrongly, to the application of medical science, placed disease and its treatment at the centre of modern health systems and produced a powerful medical profession whose ideologies and methods dominated thought and action relating to health. Social and economic conditions, however, produce their own distinctive patterns of health and illness. Contemporary conditions, allied to past reduction in premature death and the more competent management of disease, create a new set of needs and expectations of well-being to whose satisfaction traditional and prevailing medical conceptions of health are less relevant. The major problem facing today's health services is how to adapt and implement policies relevant to current needs within a stiff-jointed system created for other purposes.

The social definition of health stresses well-being rather than the absence of disease. Its attainment requires a policy which reduces inequality in living standards; which uses taxation to change behaviour rathern than raise money; which regulates industrial and living environments conducive to disease and maldevelopment; which mobilises the range of relevant employment, housing, social work, social security, and medical services to promote health and to provide care for the chronically sick, weak and handicapped. Current policies are obscure in intention, mutually contradictory, diluted and distorted in implementation, centred upon disease and hospital medicine and hampered by inter-organisational and inter-professional conduct.

These are problems, not of medicine, but of social structure, social processes, and social relationships and the analysis is drawn from the now substantial research of medical sociologists. The author calls for more empirical evidence on health needs and health behaviour and for more power evaluative examination of how health policy is formulated and of how internal contradictions within the

system impede policy implementation and the shifting of resources. The relevance of sociological theory and methodology is documented and its deficiencies in practice are critically examined.

PROFESSIONAL OR PUBLIC HEALTH? Sociology in Medicine was published by the Nuffield Provincial Hospitals Trust on Friday, 28th November 1980.
(ISBN 0 900574 33 X)
PRICE:

£6 plus 60 pence postage and packing (inland)
53 pence (overseas)

Available from: The Nuffield Provincial Hospitals Trust,
3 Prince Albert Road,
LONDON
NW1 7SP

BOOKS RECEIVED:

LAW AND EMERGENCY CARE	James, E. and George, C.V., Mosby 1980.
TEXTBOOK FOR MEDICAL ASSISTANTS	M. Murray Lawton and Donald, F. Foy., C.V. Mosby 1980.
THE CLINICAL EXPERIENCE (The construction and reconstruction of medical reality)	Paul Atkinson, Gower, February 1981.
WOMEN IN THE HEALTH SYSTEM	Marieskind, H. C.V. Mosby 1981.
HEALTH, DISEASE AND MEDICINE IN LANCASHIRE 1750-1950 (four papers on sources, problems and methods)	Ed J.V. Pickstone. UMIST occasional publications, 1980.
OPERATIONAL RESEARCH APPLIED TO HEALTH SERVICES	Ed Duncan Boldy. Croom Helm, January 1981.
AKTIVE PATIENTEN	Dechmann, M., Bisiq, R. and Buser, M. Schriftenreike der S.G.G.P.,1980
WESTERN RESERVES EXPERIMENT IN MEDICAL EDUCATION AND ITS OUTCOME	Greer Williams, O.U.P. 1980
SEX DIFFERENCES: MENTAL AND TEMPERMENTAL	John P. Seward and Georgene H. Seward, Lexington, February 1981.
UNDERSTANDING ABUSIVE FAMILIES	James Garbarino and Gwen Gillian, Lexington, February 1981.
WOMEN, HEALTH AND REPRODUCTION	Ed Helen Roberts, R&KP, April 1981.
PHARMACEUTICALS AND HEALTH POLICY (International perspectives on provision and control of medicines)	Ed Blum, R., Herxheimer, A., Stenzi, C. and Woodcock, J. Croom Helm, February 1981.
MEDICAL WORK (REALITIES AND ROUTINES)	Ed Atkinson, P. and Health, C. Gower, February 1981.
WEIGHT CONTROL (The Behavioural Strategies)	Michael D. Lebow, John Wiley 1981.

Because of the number of requests by colleagues to review books, may I suggest that you phone, rather than write to me (if possible) then I can let you know immediately if the book has gone. It saves me time on correspondence. Thankyou.

Michael Kingham, Newcastle 26002, Ext. 503.

Medical Sociology in Britain:

A Register of Research and Teaching

Third Edition

Edited by SARA ARBER, for the B.S.A. Medical Sociology Group

September 1978, 384 pages, £2.50 (£3.50 incl. p & P)
ISBN 0 904 56902 0

MEDICAL SOCIOLOGY IN BRITAIN is a valuable reference book for medical sociologists and all those involved in research or teaching on health-related subjects. This edition follows a similar format to the 1974 edition by Malcolm Johnson.

MEDICAL SOCIOLOGY IN BRITAIN contains four sections:-

Section A: Personal Details and Publications - contains the names, addresses, research interests, titles of research projects and publications since 1970 of over 260 medical sociologists in Britain. This provides a comprehensive bibliography of recent publications in medical sociology.

Section B: Research Projects - gives details of approximately 500 current or recent research projects. These are categorised thematically into 18 groups, e.g.:- Health Beliefs and Behaviour; the Health Professions; Patient-Practitioner Communications; Social Epidemiology; Disability, Chronic Sickness and Rehabilitation; The Elderly; Pregnancy and Childbirth; Mental Illness; Alcoholism and Drug Dependence.

Section C: Teaching - gives details of about 100 courses in medical sociology in universities, polytechnics and medical schools.

Section D: Research Centres and Institutes - details the staff, research studies and other work being undertaken at eleven major centres of medical sociology research in Britain.

Copies of MEDICAL SOCIOLOGY IN BRITAIN can be ordered from Sara Arber, Department of Sociology, University of Surrey, Guildford, Surrey GU2 5XH

Cheques/Postal Orders should be made payable to B.S.A. Medical Sociology Group, and should be included with order.