MEDICAL SOCIOLOGY GROUP
ANNUAL CONFERENCE

The British Sociological Association Medical Sociology Group's 1998 Annual Conference will be held at the University of York, from 25th to 27th September.

The Plenary speaker will be Paul Atkinson who will talk on 'Gothic bodies and hysterical narratives'.

Booking

A booking form is included with this issue of Medical Sociology News. Further details can be obtained from BSA, Unit 3G, Mountjoy Research Centre, Stockton Road, Durham, DH1 3UR.

Non-waged/low waged/students

Please note that there are subsidies for conference fees and travel for those without institutional support.

MEDICAL SOCIOLOGY NEWS

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EDITORIAL

This issue announces some changes in the Editorial team. Having started out with a team of six, we have decided to return to the Warwick model of three!! In case you hadn't already gathered, producing MSN can be an administrative nightmare and we feel the job might be made easier by having fewer people take on more responsibility. We would like to acknowledge and extend our grateful thanks for the past editorial assistance and support of Scott Reeves, Hanna Weir and Anthony Pryce. We have no doubt that their names will appear again in association with MSN, either by proxy or as new editors, when our editorship is over. That is unless they get knocked over, in the rush of enthusiasm, by others wishing to fulfil this wonderful role! It appears that Readers like the new format for MSN, so all that is left is to draw your attention to the announcement of new charges which appears in Stop Press!!

Once again, this issue has attracted some interesting material and we are very appreciative for contributors' time, effort and willingness to submit copy and meet impossible deadlines. Our only regret is that, as we scramble to cope with the increasing number of emails, faxes and post, we are not always in a position to respond in person. So to the contributor who wrote: "Have you stopped talking to me?", please forgive and I'll buy you a drink in York!!

We were particularly pleased to receive a response, from John Eversley, to David Cox's letter published in the January issue of MSN, in relation to social scientists from black and ethnic minority communities. The Letters Page aims to promote discussion and debate; although we do not expect to receive any comments on the proposed Student Health Status Questionnaire submitted for this issue by the Year 4 Medics!!

News and notices report on some future funding opportunities (Wellcome Trust) and on a new international scholarly journal (Health, Risk and Society). We have also received a couple of conference reports from Rachel Grellier (Consumer Involvement in the NHS R&D Programme) and David Hughes (International Qualitative Health Research Conference).

Our congratulations, this issue, go to Jane Seymour and Joanne Coyle on being awarded their doctorates and we look forward to receiving other recently awarded PhD abstracts, in the spirit of disseminating new research quickly.

David Hughes stays in touch with his Internet Tips, which focus this time on how to keep communication channels open whilst engaged in international travel. International travel continues as a theme with Graham Scambler reflecting on his experience of "Teaching, Medical Sociology and the USA", but it has to be said that he makes no mention of the need for any technical support during this study tour!! Instead he traces his links with Emory University back to Margot Jefferys, who encouraged him as a PhD student to co-ordinate a summer programme on "Comparative Health Care" for a group of undergraduate students visiting London. As Margot remains very much in our thoughts, we should celebrate the network of friendships developed through Medical Sociology and give thanks to those who have a particular gift of helping others to move on in their work and thinking.

The Day in the Life of a Medical Sociologist has been provided by Nicki Thorogood, who works at the Dental School, UMDS. Having had contributions in the past from a PhD student and a new university professor, it is good to have a contribution from a Medical Sociologist with responsibility for teaching students whose first subject is not Sociology. We also thought we would seek permission from the Times Higher Education Supplement to reproduce "Don's Diary" (27 February 1998) to give insight as to how other sociologists get through a working week!!

For this issue, Gareth Williams has kindly critiqued Zola's classic paper "Medicine as an institution of social control", in light of changes in medicine and health care over the last 25 years. We have had a lot of positive feedback on this section of the journal and feel confident that Gareth's paper will not be a disappointment.

The Department of Sociopathic Studies, University of Trumpton has submitted a piece for the Report from Research Centre, which outlines their preparations for the RAE. Other departments wishing to move from grade 2 to 5* in the next RAE should take note.

Linda Aiken has synthesised the paper she gave in March, at the London School of Hygiene, for the Annual Health Services Research Lecture. Her work, which has developed over a number of years, focuses on the effects of hospital organisation on patient outcomes.

Robert Dingwall has written a short piece reflecting on Graham Hart's proposal to restructure MSG on membership lines and to market the conference more aggressively. He expresses a concern that we know will be held by others, in relation to where the sociology has gone from in MSG conferences. Perhaps others might wish to respond?

As "Our Healthier Nation" green paper is out for consultation, we thought it important to include a report from the Focus Group on Older People. This focus group was one of several, set up by North Thames Regional Office, to feedback comments to Tessa Jowell and the Health Strategy Group at the Department of Health. Other focus groups included "Poverty and Health", "Ethnicity and Health", "Housing and the Environment" and "Inter-Agency" It was clear to those attending a meeting with Tessa Jowell, at Regent's College in February, that the Focus Group on Older People had some grave concerns about the document, in particular that proposed OHN targets did not include older people in all the targets.

Responding to the work of others is an important role of any academic discipline. We are therefore delighted to be able to publish a response by the Centre for Research in Health, Medicine and Society at the University of Warwick to the consultative document "Cloning issues in reproduction, science and medicine" This document was produced by the Human Genetics Advisory Commission (HGAC) and Human Fertilisation & Embryology Authority (HFEA) in January 1998 and has stimulated much debate. This article is followed by another from Sarah-Cunningham Burley, also writes on a similar theme in relation to the BMJ's series on the new genetics.

Finally we share Readers' reviews of books. The book list has been updated and Readers are encouraged to request books for review to report in future issues of MSN.

The Editorial team wishes you well and draws your attention to the booking form for the Annual Conference (25-27 September), which has been inserted with this issue. The next issue comes out in August and no doubt it will be too late to remind you of it then!! Looking forward to seeing you in York, even if the nostalgia ain't what it used to be.

The Editorial Team

PS. Readers might like to note that MSN now how has an ISSN. We thought it might add status to our medical students' academic talents!!

The Editorial Team includes: Julienne Meyer, Jane Sandall & Paul Godin at City University

Acknowledgements: The Editorial team is particularly grateful for the help and support of Emily Harris (Contents Co-ordinator) & Rachel Beadle (Design).

STOP PRESS!!!

You may have noticed as you register for this years conference that the price of Medical Sociology News has increased. If you were at the AGM at the conference last year, there was some discussion about the cost of producing the Newsletter and to what extent it should be subsidised. This issue has become more apparent since we took over the production and have worked out the costs in detail, and have had to pay secretarial staff.

At the moment, it costs £4.45 a copy or £13.35 a year to produce and post out the newsletter These costs are based on 400 copies similar to the last issue which had 50 pages and was spiral bound. The costs include secretarial and AVU staff time, printing, envelopes and postage.

The current price for the newsletter is

Overseas	£10
Institutions	£10
Waged	£6
Unwaged	£3

At the moment we get from our waged subscribers £6 a year for a newsletter that costs £13.35 a year to produce, and the group has been subsidising the difference. The price of Medical Sociology News has been the same for at least eight years and the committee has agreed that some degree of price increase is appropriate. The new prices are:

Overseas	£15
Institutions	£15
Waged	£10
Unwaged	£5

So the newsletter is still subsidised and the unwaged subscription has been kept as low as possible. We hope that you understand that this increase is reasonable and that you will continue to enjoy, and subscribe to the newsletter.

If anyone wants to talk in more detail about this then please call me

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LETTERS PAGE

This section allows Readers to share their thoughts and ideas, not only in relation to MSN but also the discipline of Medical Sociology. We hope that the letters written will encourage further correspondence.

Dear Editors

Re: Social Scientists from Black and Minority Ethic communities

David Cox's letter (MSN Vol. 24 No 1) raised the important question of how to ensure researchers and organisations of researchers reflect Black and Minority ethnic communities. He offered three suggestions (not necessarily as alternatives). I would like to comment on each of them.

The first one was to organise student conferences where people would 'be invited to hear experts in the field talk about their work' Although superficially this might seem to be a 'bottom up' approach, it is potentially another way in which inequality will be reinforced. As work by the Policy Studies Institute[1] and analysis of the statistics produced by the Higher Education Statistics Agency shows, the pattern of Black and Minority Ethnic community presence in higher education is very uneven with some communities 'over-represented' in proportion to their numbers in the population; others are 'under-represented' This is true of students and practitioners of nursing and medicine specifically. By focusing on present students and practitioners, people who have not managed to get into the system, would be excluded. Also , it might be presumed that the 'experts' are the established (generally White) researchers who are 'educating' 'the people' It is often the other way round. In East London, where I am based, these problems were very clear a few years ago particularly in relation to the Somali and Bangladeshi communities. People from local Black and Minority Ethnic communities were very critical of research being done 'on' them, not with and by them. A Community Research Network was set up in Tower Hamlets which offered the opportunity for established researchers to start a dialogue with community workers and activists about what health research is done , by whom and how. There is no presumption that the established researchers have a monopoly of real knowledge but nor are people from Black and Minority Ethnic communities put on the spots as 'experts' Out of the network have come a number of fruitful collaborations but there is still chronic under-representation of these communities in research jobs and at the postgraduate level. Meanwhile there has been a very significant increase in the number of Bangladeshi graduates, some with social science degrees, some of whom who would like to get into research jobs or postgraduate working. Staff at QMW and City University are now looking at partnerships with local health services trusts, to create post-graduate studentships; training in research methods and other ways in which people from Black and Minority Ethnic communities can be involved in designing and doing research. There is also work going on to look at undergraduate entry and progression.

David Cox's second strategy was to co-opt a senior Black researcher on to the Editorial Board of Sociology and Health. There isn't space here to elaborate on all the arguments for and against it but I would like to suggest that it is unlikely to work in this context – able Black researchers are very likely to be overloaded; some would not want the label 'Black and Minority ethnic sociologist representative' and it is unlikely that one person could be or would want to be a role model, focal point, advocate, go between etc.

The third suggestion was that Med Soc could enter into correspondence with Black doctors and nurses groups and engage them in dialogue. It may be that some such groups have

got other priorities but that others would be interested. One group which is particularly under-utilised is refugee professionals such as doctors and nurses. We are in touch with literally hundreds of refugee doctors, most of whom want to be recognised as clinicians but many of whom are having to do non-clinical work, meanwhile.

In short: there are no quick fixes but there are practical, local things which can be done which are about dialogue with local communities and looking at entry and opportunities from the undergraduate level onwards at our own institutions.

Yours Sincerely

John Eversley
Senior Research Fellow
Public Policy Research Unit
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London E1 4NS

[1]Modood, T and Shiner, M .. Ethnic Minorities and Higher Education. PSI.1994.
Modood, T· Qualifications and English Language in Moddod et al: Ethnic Minorities in Britain, PSI
1997

Dear Editors

We've just done a module all about doing research, which has helped Henry no end with his project on liver disease - he has great plans for an RCT of 'snakebite and black' versus 'oatmeal stout' (two types of alcoholic beverage we consume copiously on weekday evenings here at Med School). Anyhow I remembered that my brother (Mark) does all this social research using questionnaires and stuff and so we decided to apply our newly gained research expertise to the development of the definitive med school student survey. We piloted it (bet you didn't think we knew how!) on Crispin, Henrietta, Stinky, Piers and Prabjot, and Henry has the results somewhere in his rucksack if you're interested. Mark suggested that we could charge a fee for using the questionnaire but in the interests of academic freedom and because we like your rag we decided to waive this right.

THE SPENCE- JONES/FERGUSSON STUDENT FORM 6 INDEX (S/F SF-6)

1. During the **past week** have you had any of the following thoughts **as a result of being at medical school**? (Tick one box on each line)

	Yes	No
a) I consider McDonald's "real food"	[ ]	[ ]
b) I actually like doing laundry at home	[ ]	[ ]
c) 4:00 AM is still early on the weekends	[ ]	[ ]
d) Two miles is not too far to walk for a party	[ ]	[ ]
e) I would rather clean than study	[ ]	[ ]
f) Minesweeper is a way of life	[ ]	[ ]
g) Blacklights and highlighters are the coolest things on earth	[ ]	[ ]
h) Rearranging my room is my favourite pastime	[ ]	[ ]

How often have you done the following, **during the past week?**

None	All of the time	Most of the time	A Good bit of the time	Some of the time	A Little of the time	of the time
Worn dirty socks 3 times in a row and thought nothing of it	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Said, "Oh f*** how did it get so late!" more than once a night	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Woken up in someone else's bed and considered this normal	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Scheduled your classes around sleep habits and soaps	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Gone to sleep when it's light and got up when it's dark	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Taken a shower without shoes on	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

3. Please choose the answer that best describes how **true** or **false** each of the following statements is for you. (Tick one box on each line)

	True	False
I know the pizza boy by name	[ ]	[ ]
I live for getting email	[ ]	[ ]
I have started thinking and sounding like my roommate	[ ]	[ ]
The weekend lasts from Thursday to Sunday	[ ]	[ ]

4. **Compared with life before medical school**, how would you rate the humour of prank phone calls?

Much funnier [ ]
Somewhat funny [ ]
About as funny as I used to [ ]
Somewhat unfunny [ ]
Much less funny [ ]

5. In general, would you say that looking out the window is a form of entertainment?
Yes [ ] No [ ]

6. How many uses does a milk crate have? (Insert exact number) [ ]

Yours sincerely
Jonathan Spence-Jones & Hugh Fergusson
Year 4 Medics, The Dickins Penthouse, Butler's Wharf

NEWS & NOTICES

This section reports on news and notices. Readers are encouraged to write in with information of potential interest to other Medical Sociologists.

** Many congratulations to Professor Sally Macintyre who was awarded an OBE in the New Year's Honours List for services to Medical Sociology and has also been elected to the Royal Society of Edinburgh as an Honorary Fellow. **

Wellcome Trust
Future funding

The Wellcome Trust held a two day seminar in January 1998 on Biomedical Advance and Public Policy: Bridging the Gap. The Trust plans to spend £1 million on a programme of social and ethical research, probably about genetics and neuroscience. The Trustees invited about 40 people to advise on possible topics, methods, aims and disciplines to be considered for the programme. Those present - such as scientists, clinicians, leading people in law, philosophy and policy, journal editors, and the chief executives of two research councils - were taken to represent "providers" of ethical research, "users" of the research or funders. As usual on such occasions, social scientists were notable for their absence (I was invited as a member of a voluntary organisation, Consumers for Ethics in Research). For two days, we debated whether there is a small or large group of social (meaning the 20 or so disciplines covered by the ESRC) and bioethical researchers willing and able to work on neuroscience or genetics. Some said there are too few social researchers to merit a large grants programme. Some said that applications to the planned MRC programme on social aspects of genetics a few years ago were too weak to be worth funding. Others said there are, or could be, many more competent social researchers in these areas, if only they could get funding and crawl out of the cracks or chasms between all the funding bodies which now entrap them. They include researchers working in areas closely related to genetics, such as kinship, living with disability or chronic illness, and reproductive health, and also on many aspects of mental health. The good news is that it is highly likely that Wellcome and the ESRC plan to set up bioethical social research programmes of £1 million each - tiny in comparison with amounts granted in the US to address the many social and ethical issues associated with developments in genetics and neuroscience. The point of this report is to alert all researchers who might be interested. There are several ways of raising your chances of obtaining funds, according to these discussions, although they were only at an early stage and the final plans may be different. It will probably be months before applications are invited, but preparation before writing applications will also take time. They will sound rather obvious, but here are some points drawn from the main discussion which are likely to strengthen your proposals.

1. Contact clinicians, probably in psychiatry and genetics, find out their dilemmas and questions linked to social, ethical, economic, legal or political aspects of their work. Begin to liaise with them on these questions, on planning social and bioethical research and on increasing mutual understanding such as of research concepts and methods. Whenever possible, use methods which offer convincing ways of obtaining practical answers to the questions. I am not advocating clinician-led social research, but suggest making links with clinicians who are willing to share their practice-based concerns, expertise, contacts and help with access. The trustees are wary of wasting funds on social researchers they perceive as ignorant or impractical. Links between research findings, policy and practice

need to be explicit. This need not preclude innovative theoretical work but means that this should not be the main or sole outcome.

2. We have to negotiate the fine line between knowing too little about the relevant clinical speciality, and knowing so much that we lose an independent perspective. Another fine line to work on is the place of overt theorising in research: between seeming to exploit the research mainly to support theoretical work of no obvious practical relevance, or else of producing atheoretical telephone directory style reports.

3. Contact researchers in other social sciences, in ethics, policy and/or law, and plan some kind of team collaboration. Multi-disciplinary applications will be favoured, although they are, of course, likely to cost more.

4. Contact "users" like health policy makers, related voluntary organisations, and members of related medical, nursing, counselling or advocacy groups who will support and inform your research.

5. If you are new to these topics, read the medical and scientific literature. I know this sounds patronising, but the few odd words can so easily sabotage a good proposal, hence the value of writing as a multi-disciplinary team. Perhaps arrange a seminar for all interested collaborators, including clinicians or scientists and service users, to discuss how much expertise is needed to do the research. The trustees tended to assume that quite high levels of scientific knowledge are essential to merit a grant, levels which social scientists are unlikely to reach until they have some relevant research experience. This catch 22 has to be addressed by social and medical scientists educating one another, and negotiating agreements on what kinds of knowledge count and why.

6. Social scientists have to be more active in explaining the importance of their work. At the Wellcome meeting, doctors would say, "We need research about ---, no one's done any." The few researchers would sigh and say, "A lot has been done but we cannot get our reports into your journals." The journal editors complained that papers submitted were crude or soft. Gaps to be bridged became clearer through the meeting, between disciplines and specialities, and between different research theories and methods. We discussed how funders and also reviewers for grant giving bodies and for scientific and clinical journals can become more receptive to social and ethical research.

7 Some open meetings may be held while the Wellcome programme is being designed. I hope they will move beyond introductory lectures to critical inter-disciplinary debates. Perhaps the Medical Sociology Group could liaise with Wellcome and the ESRC on the content and format of research planning meetings. They could use formal debating and jury formats, carousels and varieties of small group discussions in which clinical and social scientists each have to justify their views.

The two proposed programmes could provide valuable ways of bridging the gaps between the social and medical sciences, especially if we treat them partly as opportunities to increase mutual trust and understanding.

Dr Priscilla Alderson (written in February there may be more definite news by the time you read this),
Social Science Research Unit
University of London

NEW FROM CARFAX FOR 1999

Health, Risk & Society
ISSN: 1369-8575
Editor: Andy Alaszewski, University of Hull

CALL FOR PAPERS

Health, Risk and Society is a new international scholarly journal devoted to a theoretical and empirical understanding of the social processes which influence the ways health risks are taken, communicated, assessed and managed.

Public awareness of risk is associated with the development of high profile media debates about specific risks. Although risk issues arise in a variety of areas, such as technological usage and the environment, they are particularly well developed in health. Not only is health a major issue of personal and collective concern, but failure to effectively assess and manage risk is likely to result in health problems. Health, Risk and Society aims to stimulate wider study of the issues by providing a focus
for study and publication by academics and practitioners on the relationship between health, risk and society.

Health, Risk and Society will be an interdisciplinary and intersectoral journal. Contributions are welcome from a range of social science disciplines, including economics, sociology, psychology and management. The journal particularly encourages the submission of articles exploring the ways in which risk is handled at a variety of levels, e.g. in the community, within various organisations and at national and supranational levels. Articles should be accessible to a variety of audiences, including practitioners and policy-makers.

Readership: The journal aims to bring together social scientists, practitioners and policy makers who have an interest in risk issues relating to health. These disciplines include: sociology, social policy, management, economics, political science, social and clinical psychology, anthropology, education, social and public health medicine, nursing, social work, law and psychiatry.

Health, Risk and Society will be a fully peer-reviewed journal. Papers should make a theoretical, policy or empirical contribution to the study of risk and health and should be of interest to an international audience. Papers which focus on risk and health in developing countries are welcome especially those which offer a critical review of recent trends and developments. The following will be of particular interest:

- communicating health risks
- public perceptions of health risks and safety
- media and health risks
- risk taking and substance use
- promoting and managing user risk-taking
- professional accountability and risk
- risk, behaviour and health promotion
- risk management by health and social care agencies and professionals
- risk, health and policy
- vulnerability, danger and risk in relation to service users and carers
- risk assessment in mental health and forensic services
- health disasters and risk

REPORTS ON CONFERENCES, MEETINGS & EVENTS

It is not always possible to attend relevant conferences, meetings and events. This section encourages Readers to write in with reports to help disseminate information to those not in a position to attend.

Reports from Regional Groups

Bristol & South West

For further details, please contact:

Norma Daykin, Health and Social Care, University of West of England, Glenside Campus, Bristol, BS16 2JP

London

London Medical Sociology Group

Venue: Room B18, King's College London ,Waterloo Bridge House, Waterloo Road, London SE 1 8WA. Nearest tube and rail: Waterloo.

MEETINGS 6PM - 7PM
Everyone is welcome to attend LMSG meetings - the group has no formal membership. At each meeting there is a presentation by a speaker, followed by a discussion (which often continues over drinks and/or supper). To help meet speakers' travelling expenses those who attend meetings are asked to make a voluntary contribution of 50p each.

10 June 1998	**Ethnicity and Medicine: A Short History** David Armstrong, Dept of General Practice, UMDS, London
8 July 1998	**Deconstructing the Discourses of Denigration: A Look at Evidence Based Medicine** Michael Traynor, Centre for Policy in Nursing Research @ LSH & TM
9 September 1998	**Bangladeshi People with Pain: Negotiation, Understandings and Treatment** Shamsul Alam, Dept of Sociology, London Guildhall University
14 October 1998	**Social Theory, Post Modernism and Health: Costs and Benefits** Graham Scambler, Dept of Psychiatry, UCL Medical School, London
11 November 1998	**The Quality of Qualitative Health Research** David Silverman, Dept of Sociology, Goldsmiths College
9 December 1998	**Gender, Class and Health** Sally Macintyre, MRC Medical Sociology Unit, Glasgow

Copies of the programme are available from Nicky Britten, Dept of General Practice, UMDS, 5 Lambeth Walk, London, SEI 6SP (0171 735 8881/2 x227 or 221, email: n.britten @ umds.ac.uk
Meetings may be cancelled due to circumstances beyond our control. If in doubt please contact Anne Jones (0171 872 3213) or Barbara Johnson (0171 872 3013).

Joint* LMSG *Organisers: Nicky Britten, Paul Godin, Barbara Johnson, Anne Jones, Margaret Rogers, Jane Sandall, Clare Williams (Convenor)

Northern Ireland

For further details, please contact:

Sam Porter, Dept of Sociology and Social Policy, The Queen's University of Belfast, Belfast, BT7 1NN Tel: (01232)245133 x371/3 - 371 5/6 Fax: (01232) 320668

North & East Midlands

We have just completed an interesting series of seminars covering issues related to health service provision to minority ethnic communities; problems of moving services from secondary to primary care and the use of NHS ethnic monitoring data. Our next series of meetings will hopefully start in Feb 1999. All our seminars are informal and supportive: new post-graduate research is particularly welcomed.

For further details, please contact:

Jane Seymour, University of Sheffield, Palliative Medicine Section, Royal Hallamshire Hospital, Sheffield, S10 2JF Tel: 0114 271 3992 Fax: 0114 271 3991

North West

The North West Group is still in existence, but is in abeyance. Watch this space for further details.

For further details, please contact:

Carl May, Dept of General Practice, University of Manchester, Rusholme Health Centre, Walmer Street, Manchester, M14 5NP Tel: 0161 256 3015 Fax: 0161 256 1070 e-mail: cmay@fs1.rgp.man.ac.uk

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Wales

The Next Meeting will be held on Friday 29 May at 2.00 pm, in the Blue Room, Parc Beck, Sketty Road, Swansea. The Speakers are:

Cathy Pope, Department of Epidemiology and Public Health, University of Leicester
The Practice of Surgery

Martin Powell. Department of Social and Policy Sciences, University Of Bath
Policy failure and the NHS: The Case of Social Class Inequalities in Health Care

There are plans for a further meeting in June, but we are not yet in a position to confirm speakers.

Parc Beck is on Sketty Road, Swansea, on the main route from the city centre to the Gower, near the northern end of Singleton Park. Parking is available on Sketty Road.

For further details of meetings please contact Lesley Griffiths on 01792295729, David Hughes on 01792280646 ext. 8544 or Susan Philpin on ext. 8561. Details of the programme and other useful information appear on the BSA Med Soc Group website. Http://nursing.swan.ac.uk/bsa/medsoc.htm.

Scotland

Unfortunately the annual 9-10 May conference at Loch Rannoch has been cancelled this year due to lack of interest. The convenorship of the Scottish Group is about to become vacant. Please contact Anne Kerr, Science Studies, Unit 21, Buccleuch Place, University of Edinburgh, EH8 9LN, Tel: 0131 650 4258, email; A.Kerr@ed.ac.uk if you are interested in taking on the role of Convenor.

West Midlands

EVERYONE WELCOME
Thursday 28 May 1998 at 4.15 pm
Viola Burau
Department of Politics
University of Edinburgh
'Who decides what nursing does'

The above seminar will be held at the University of Central England. Room 314 Cox Building, Perry Barr, Birmingham B42 2SU (Map enclosed)

For further information please contact Professor David Cox on Telephone 0121 331 6181
e-mail address: david.cox@uce.ac.uk University of Central England, Ravensbury House, Westbourne Road, Edgbaston, Birmingham. B15 3TN

Reports from Study Groups

HIV/AIDS Study Group

Neil Small acts as a post box for the above mentioned group which meets at the annual BSA Medical Sociology Group conference.

For further details, please contact:
Neil Small, Trent Palliative Care Centre, Sykes House, Little Common Lane, Abbey Lane, Sheffield, S11 9NE Tel: 0114 262 0174 Fax: 0114 236 2916

Human Reproduction Study Group

The Human Reproduction Study Group met at the BSA Annual Conference in Edinburgh (6th - 9th April). Our session was entitled 'Images and Representations of Motherhood and Pregnancy' Kath Woodward and Julie Kent each spoke about their own work in this area. Their presentations and the images that others of us had brought stimulated a lively and interesting discussion.

Our second meeting this year will be in June at Warwick and will focus on 'Real womanhood' and the links between this status and reproduction. For this meeting Annily Campbell and Sheila Hunt have both agreed to speak but as usual we hope that people will come with a lot to say. I have written to study group members with details, but if you are not a member and are interested please contact me at the address below.

Gayle Letherby, School of Health and Social Sciences, Burges House, Coventry University, Priory Street, Coventry, CV1 5FB Tel: 01203 838 104 e-mail: g.letherby@coventry.ac.uk

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Nursing Research Support Group

For more details, please contact:

Lesley Mackay, Hebden Bridge, West Yorkshire
Tel: 01422 845 260
e-mail: L.E.mackay@leeds.ac.uk

REPORTS FROM CONFERENCES

'RESEARCH: WHAT'S IN IT FOR ME?'

January 28th, 1998

The first conference held by the Standing Advisory Group on Consumer Involvement in the NHS R&D Programme was held on 28th January. This coincided with publication of their first report, 'Research: What's in it for Consumers?' (NHS Executive, 1998).

Professor John Swales (Director of Research and Development, Department of Health) gave the first keynote speech. While defending the need for hospital protocols to be based on systematic reviews of effective research he argued the need for greater consideration of research results on both patient and carer. Professor Swales pointed out that the exclusion of 'unsuitable' patients from clinical trials creates questions about research results in terms of who benefits and at what cost.

Baroness Jay (Secretary of State for Health) followed. She emphasised the significance of the term 'consumer', used widely within the NHS, arguing that 'user' was a honest term. She pointed out that consumer/user involvement already plays an important role in health care, naming 'Changing Childbirth' and HIV/AIDS as important examples. She felt, however, that there is a need for greater involvement of ethnic minorities in doing research.

Baroness Jay's wise words led me to the workshop on 'Research and Ethnicity' This started with papers by Mark Johnson (Centre for Research in Ethnic Relations, University of Warwick) and Michael Chan (Visiting Professor in Ethnic Health at the University of Liverpool). These gave rise to a discussion about ethnic affiliation being more complex than usually assumed, for metaphors of pain vary and can suffer in translation. Also, some types of treatment may not have an equivalent in translation. Concern was loudly voiced about the lack of ethnic minority involvement in research and within the NHS as a whole; with ethnic minority groups being used as subjects of research rather than involved in its implementation, designing and evaluating. It was also pointed out that participants at the conference were overwhelmingly white, middle-class experts; as were the keynote speakers and members of the Standing Advisory Group.

Following a highly entertaining and interesting soap-box session over lunch I attended a workshop on 'consumer involvement in outcome measures and evaluation' Sarah Berry (North West MIND) reported research findings of a study into on staff responses to emotionally distressed patients within a GP group practice. Members of Mancunian Community NHS Trust described the Trust's work in developing an effectiveness agenda with service users, while Charlotte Paterson (GP) gave an interesting presentation on the development and evaluation of a patient-generated outcome measure. This showed how difficult it is to design an outcome measure which incorporates the differing subjective lived experience of patients with very varying conditions of illness.

The workshop discussion again demonstrated audience frustration. This related to progressing from a rhetoric of user involvement, to participation in large scale funded projects. One member of the audience involved in research evaluation felt no one had addressed the fundamental issue of how to include consumers in formulating research evaluation. He felt there was a need for research to explore the dynamics and processes of consumer involvement. There was a general consensus that funding for this type of research is difficult to obtain and that a greater number of consumer referees on funding councils would be beneficial.

In the penultimate key note speech Ian Chalmers (Director of the UK Cochrane Centre) highlighted how important it is for research to address problems appropriately by exploring issues important to service users. He described the National Childbirth Trust (NCT) and the Manic Depression Group as two consumer groups carrying out their own high quality research.

In the concluding plenary Harry Cayton (Executive Director, Alzheimer's Disease Society) said that the themes of: information, communication and attitude had been particularly important throughout the day, and asked both researchers and user groups to avoid unnecessary use of esoteric language. He speculated that user involvement tends to be initiated at times of crisis, which are usually the result of poor public relations; the formation of a powerful consumer lobby; or sympathetic and influential individuals. He went on to argue that evidence based medicine should be consistently based on the evidence of users as well as researchers. His closing comments raised a final question: what is the real purpose of user involvement? Is it to provoke, irritate, obtain specialist resources for individual interest groups; or is it invited as tokenistic gesture to enable academics to obtain funding for their own research?

I went away thinking that although the government policy might be attempting to improve the involvement of users in health research, the reality is that there is still a long way to go before existing structures and practices reflect this ideal.

Rachel Grellier
City University

The 4th International Qualitative Health Research Conference, Vancouver,

February 19-21, 1998

The biennial QHR Conference is one of the largest of the regular events for qualitative researchers, and has close links with the Sage Journal of the same name, the web site QUALPAGE, and the International Institute for Qualitative Methodology at the University of Alberta. After previous events in Edmonton, Hershey and Bournemouth, the 1998 conference was held in the spectacularly beautiful city of Vancouver, British Columbia. It attracted about 600 delegates from over 20 countries, with a full programme of plenaries, workshops and papers in parallel sessions. The invited speakers included Barney Glaser, Janice Morse, Max van Manen, Dorothy Smith, Julianne Cheek and Kathy Charmaz. The latter was a late replacement for Norman Denzin, who cancelled his scheduled plenary.

With such a full programme even the most discriminating medical sociologist would have been certain to find something of interest. The conference was certainly a superb networking opportunity, with plenty of structured breaks, poster sessions and workshops to promote interaction. There were a wide variety of papers, including panels on focus groups and narrative analysis, which went down particularly well. Joan Anderson's excellent workshop on critical interpretive approaches deserves a special mention. I also enjoyed a sparsely-attended but interesting session on qualitative approaches to health policy research. But there were also disappointments. In my view these included the plenaries, which with a few honourable exceptions, did not contain much original analysis or even evidence of much preparation. A kind of inverse performance law operates at many conferences, so that the bigger the reputation of the speaker, the smaller is the content of the talk, but at QHR the degree of self-indulgence of the most famous went beyond anything I had observed elsewhere. And in other ways too the conference stirred misgivings about the way qualitative health research is

developing and the possibilities for productive engagement between the different communities represented.

One of my pet theories (which I think emerged from a very successful joint meeting of the Scottish Group and the Society for Medical Anthropology in the early 1980s) is that there are groups of health care researchers in different disciplines or national associations who have similar interests, but do not know of each others' work and could profit from dialogue. Part of the excitement for me of attending international conferences in recent years has been to explore some of this common ground, for example between the ASA and BSA MedSoc groups, and between the British group and the Canadian sociologists and anthropologists attending the Qualitative Analysis Conferences. It might be said that the QHR Conference grew out of a conscious effort to build bridges between different qualitative research communities - notably in nursing, anthropology, education and sociology - and to promote interdisciplinary cross-fertilisation. The problem is that QHR may be the example that proves that this kind of mutual engagement does not work as well in practice as we would like to think it should, because in this case engagement has not led to harmony.

I detected a perceptible difference between the truly multi-disciplinary Hershey conference of 1994 and the two more recent conferences. In Vancouver fewer sociologists were present, nursing emerged as the lead discipline, and there seemed to be less theoretical and methodological variety. Put shortly, an awful lot of the papers were based on in-depth interviews, used a version of grounded theory or "latent content analysis", and sought to delineate the subjective perspectives of carers or sufferers. The success of the research enterprise was seen to turn largely on the researcher's ability to empathise, to describe, to understand, and only secondarily on the adequacy of analysis of social interaction, social organisation or social structures. Many were less than sophisticated in their conceptualisation of the nature of subjective perspectives and their linkage to action, their selection of data to represent those perspectives, and the analysis of those data.

Too many delegates engaged in a certain discourse about qualitative research - emphasising its "richness", its sensitivity and fidelity to its subjects - which came across as over-romanticised and even maudlin to British nurses and sociologists. This reaction continually surfaced in conversations. A formidable Northern Briton, who knows all about "telling it as it is", was heard wondering why speakers uttering the word "phenomenology" invariably shifted to a hushed and honeyed tone. A Welsh midwife, with a fondness for the focus group method, said she cringed at the "sugariness" of some presentations. A researcher from a leading British sociology department commented on the paradox of travelling 5000 miles only to discover that the best papers came from near home.

Enthusiasm for the qualitative project sometimes led to the suspension of critical debate. Several papers by leading American researchers were punctuated to a quite unusual extent by expressions of approval from the colleagues and students. A British delegate said that she found it surprising that basic points covered in any decent social research methods text from 15 years ago were received with adulation as innovative insights. It was difficult to escape the impression that QHR is not just a forum for promoting and disseminating a particular style of research, but also a charismatic social movement.

When I talked about these things with others who had attended the conference, several suggested that we were seeing the effects of a cultural divide which left the reserved Brits and the more demonstrative North Americans in a state of mutual non-comprehension - a kind of academic parallel of the Louise Woodward case. No doubt Professor O'Hear would be relieved to discover that the British are still less comfortable with the discourse of feelings than their North American counterparts. I think that this probably does account for a lot, but the things I have mentioned were much more apparent at QHR than several other North American conferences that I have attended. There are also issues of what counts as rigour, and the

vision of the enterprise of qualitative research, that cannot be fully explained by cultural differences.

It seemed to me that the QHR enterprise is rather short on vision. There were few fresh insights that might help the MedSoc community to improve the rigour of its research or convince funding agencies that qualitative research is worth funding. I suspect that many have already reached the same conclusions, and that this is reflected in recent changes to the QHR editorial board and some notable absentees from the conference. From the other side there are attempts to develop academic networks and publishing outlets that will support a version of QHR unlikely to find favour in sociology journals. I find this parting of the ways profoundly depressing, but the problem seems so intractable that it is difficult to see easy solutions. The divide is touched upon obliquely in several recent papers by British sociologists and I predict that you will hear much more about it in future.

For all this I found the conference a most congenial experience. It was good to renew acquaintances and make some new friends Vancouver is a wonderful setting, and such things as the Museum of Anthropology at UBC, the pavement cafes of Gastown, the unsteady walk across the Lynn Canyon suspension bridge, the ferry ride to Victoria, and an idyllic lunch in Whistler, will stay with me as pleasant memories. One fascinating part of the conference entertainments was a pair of very elegant sopranos on stilts, whose operatic arias enlivened the conference banquet and several coffee breaks (the absent Paul Atkinson missed a golden opportunity for comparative ethnography).

My favourite conference tale involved some women colleagues from South Wales who were awakened at 2.00 am by a fire alarm in one of the overflow conference hotels. They rushed down multiple flights of stairs from their 14th floor rooms, and emerged somewhat disoriented into the chilly February night. Eventually word came that they could re-enter the building and they joined a slow-moving queue. It was only when the young man behind told my informant how much he "dug" her pink nighty, that she noticed the neon sign above the door of the hotel's basement nightclub that they were moving towards.

David Hughes,
School of Health Science,
University of Wales, Swansea.

NEW PhD ABSTRACTS

This section celebrates the success of colleagues who have recently been awarded their PhD. In addition, it seeks to disseminate research that might take a longer time to be published

Seymour J.E. (1998) Caring for Critically Ill People: A study of Death and Dying in Intensive Care. The University of Sheffield.

The aim of this research was to produce a detailed insight into the management of critically ill and dying people within intensive care units. Intensive care captures, reflects and lays bare for analysis many critical issues of relevance to current debates about he care of severely ill and dying people within contemporary society and within the modern hospital. This research illustrates one way of approaching the methodical and ethical problems involved in the study of illness and death within contemporary society.

The data on which the thesis is based are drawn from fourteen detailed case studies, each of which follows the course of an individual's critical illness from shortly after admission to intensive care, to beyond death or recovery. The case studies were compiled by ethnographic methods in two hospitals in one large city during 1995 and the first two months of 1996.

The negotiation and interpretation of a complex and potentially contradictory range of legal, ethical, socio-cultural and emotional factors areas studied in two ways. Firstly, by an examination of the social interactions occurring around individual patients. Secondly, by an analysis of how the management of each patient's illness and death is represented subsequently during interviews with their companions and with the staff responsible for their care. An enduring theme within the thesis is an attempt to highlight issues of broad theoretical interest, while representing their real, *experiential* consequences for the individuals involved with dying people in intensive care.

The specifically sociological implications of the research are four-fold. Firstly, the study contributes to recent analyses of the production of 'medical knowledge' in complex, highly technological contexts. Therefore the focus is predominantly on group activities and inter relationships rather than the doctor-patient relationship emphasised in earlier studies. Secondly, the study attempts to address the issue of 'embodiment' and its relationship to social action, giving some sense of the agency and emotions of individual social factors. The study shows, for example, that application of a medical technical discourse is achieved only by the active 'work' of feeling, interacting individuals. In this work personal and intuitive feelings, which must be subsumed to a large extent, are shown to be integral to the direction of social action. The focus on embodiment is continued with an analysis of the meaning attributed to the unconscious bodies of ill and dying patients by the nurses caring for them. The thesis is an empirical example of the management of dying and bodily deterioration by those who must, on a daily basis, give intimate care to those approach death. The third area of related relevance is the discussion of the concept of 'good death' and its formation within such an environment. Lastly, the analysis of the inter-relationships between medicine and nursing, and between medicine, nursing and patients' comparisons, is a contribution to debates concerning the constitution of clinical work, and the 'negotiated order' produced during such work.

In its discussion of the implications for the organisation and delivery of care to critically ill people, the thesis highlights the position of intensive care at the apex of a system of hospital

organisation which is increasingly specialised and isolated from other forms of care delivery. Intensive care is shown to carry the responsibility for the disentanglement of complex end of life problems, and the thesis describes the difficulties of the medical and nursing staff as they attempt to care for dying people and their companions in a humane and appropriate way. New practices are recommended that can be incorporated into clinical routines and education which partly address some of the entrenched problems which beset the care of critically ill and dying people within intensive care and the wider hospital environment. The suggestions are focused on: enabling the continuity of care between intensive care and the wider health care system; enhancing team-work and staff support within intensive care; and the re-examination of the involvement, participation and support of companions and families during the process of care decision making and in the period following death and critical illness. Work is currently in progress to establish a reflective practice group with local intensive care staff as a means of providing an opportunity to discuss these issues, proved social support and identify areas of educational need.

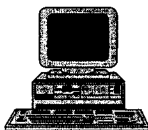
Jane Seymour
Department of Palliative Medicine
The University of Sheffield.

Coyle J. (1997) **Exploring the meaning of dissatisfaction with health care: Towards a grounded theory** South Bank University

Over the past two decades patient satisfaction and dissatisfaction with health care has been extensively researched. However, doubts have been raised about the validity of the findings. Researchers have identified many methodological problems which have resulted from the lack of clarification of concepts and inadequate theorisation. The aim of this study is to explore, and clarify the meaning of dissatisfaction, through a qualitative study of users' experiences of healthcare. Forty-one people who had experiences problems in health care, were identified from a household survey of users of health care. They were interviewed in depth. A grounded theory approach was used to construct a framework inductively from their accounts. The results suggest that the constructs of satisfaction and dissatisfaction cannot adequately accommodate the range of feelings, beliefs and values people experience around illness and health care. An alternative concept, that of personal identity threat, was identified from respondents' accounts. It is argued that this concept captures the complexity of the feelings and views expressed. Personal identity was perceived as being challenged through experiences which were felt to be disempowering, dehumanising and devaluing. A variety of factors were identified as contributing, such as practitioners' use of typification and stereotypes to classify patients; their perceived failure to listen to carers or patients; to take their anxieties seriously; provide adequate medication and treatment; to conduct thorough investigations. The lack of availability and access to services were also referred to. Gender, class and race differences emerged in respondents' perceptions of identity threat. Women, working class people and people from ethnic minority backgrounds were more likely to feel they had been stereotyped. There were also gender differences in the extent to which problems were perceived as disempowering. Interviewees responded to the problem of identity. This involved identifying with, and adhering to the duties and obligations of particular social roles. A framework was thus developed which explained the meaning of untoward experiences in health care.

Joanne Coyle
Department Management and Social Sciences
Queen Margaret College
Edinburgh.

INTERNET TIPS



The team at Swansea has created and continue to maintain the MSG's Web Page (http://nursing.swan.ac.uk/bsa/medsoc.htm). In addition, David Hughes writes a regular feature on Internet Tips for Medical Sociologists.

Staying in Touch

Okay, so you got the money for that North American conference, and even managed to re-schedule your teaching so that you can take a week's leave to explore afterwards. The prospect of time away from the 'phone and the unexpected knock at the office door is deeply appealing. But then a nagging doubt enters your mind: what about your e-mail? You will probably get a communication from the editor of that overseas journal about urgent final revisions to your article, and what if the speaker for the regional MedSoc meeting two days after you get back has to change her schedule? You decide that you need to find a way of staying in touch.

The traditional solution would be to take you notebook PC (with internal modem) and use the ordinary telephone lines to log into your E-Mail server via the University's dial-in service. The problem is that transatlantic telephone charges are pretty hefty, particularly from a hotel bedroom, and all the more so if you have to wade through the usual junk e-mail before getting to the important messages. However, there is a low-cost alternative in the shape of e-mail via the world-wide-web, which is available from the many University and public libraries, or from the modestly priced "internet cafes" that you will find in most US and Canadian towns and cities.

If you are using Internet Exchange for e-mail and your University has standardised on this system, it will probably be a simple process to type in the address of your e-mail server at the web browser, and when the opening screen of your site appears, to enter your user name and password. Unfortunately, although my departmental e-mail server supports Internet Exchange, it refuses to connect to distant sites, and many colleagues are anyway still using older programmes like Pegasus Mail which will not work over the web. But even here there is a solution in the shape of the free web-based e-mail services provided by companies like Lycos, Excite and Yahoo. These allow you to forward messages from your usual mailbox to the new e-mail address, so that you can read them from anywhere in the world. Arranging your new e-mail account is easy. For example, in the case of Lycos just go to the Lycos home page (http://www.uk.lycos.de/) and click on the dialogue box that says "e-mail" You will be taken to the e-mail log-in screen and required to enter some personal details in an onscreen registration form. You then select an address from the free options and your new mailbox is created. To access the e-mail service in future you will need only to remember how to get back to the Lycos site, and the e-mail address and password you specified.

Before leaving for your overseas trip you will need to arrange for your regular e-mail to be forwarded to this new address. For example, if you use Internet Exchange do the following. From the Tools menu, choose "Inbox Assistant", and then select "Add Rules" At the next

screen click the boxes for "sent directly to me" and "copied to me" Now click the box "Forward" A new box will open in which you type the address of your new internet mailbox.

The result should be that when you sit down at a PC in that small town library in rural South Carolina, all your e-mails are waiting for you, and you can reply there and then to the urgent messages.

Having gained access to the PC (perhaps at the cost of spending a few minutes filling in the library's application form), you might want to take advantage of some other free services for keeping in touch with people at home. Of course, if everybody you need to contact has access to e-mail you already have the solution. But there are also ways of communicating with those with access to a fax or a mobile digital telephone.

There are now quite a large number of sites that offer free internet fax services. Unfortunately there is no single service that covers all destinations. A variety of private and public sector organisations have joined in to offer a series of experimental web-fax gateways, and each specifies the (destination) area it is willing to cover Some include an advertisement at the top of the fax as their payoff for providing the service. One "co-operative" that covers the whole of the UK as well as much of the US and Canada is *The Phone Company* (http://www.tcp.int). TCP does not seem to be a commercial company: those who run it say it originated out of research into integrating the global internet with special purpose devices like fax machines. They suggest that those who want to understand the name see the film, *The President's Analyst*. You send the fax by filling out a web form, which will of course need to include the correct dialling code and number of the fax machine you are calling. You also need to specify an e-mail address, so you can receive an e-mail confirming that the fax has been sent. A TPC FAQ (frequently-asked questions) document, which provides information about their service and similar services offered by other organisations, is available from http://www.tpc.int/faq/tpcfaq.html.

It is also possible to receive faxes, though to the best of my knowledge all services of this kind involve a fee, in some cases payable by credit card. The user can receive a fax at a special number, which is then scanned and sent to his or her e-mail address. *Digital Mail* is one company offering this service (http://www.digitalmail.com/). Another useful FAQ document, which gives details of some of the commercial services available can be found at: http://www.savetz.com/fax/

The final service that I want to mention works well for closer friends to whom you need to convey a routine message, that they wouldn't thank you for passing on by regular telephone in the small hours (i.e. if you forget time zone differences). It allows you to send a message to a recipient with a mobile digital phone by using its SMS messaging facility. Your message will appear in the scrolling LCD text box that is found on digital phones available through *Vodaphone*, *Cellnet* and *Orange* (it is not applicable to analogue mobile phones). From your PC you fill in a web form similar to those used for sending faxes, and a short message is transmitted to the phone. This will be displayed when the recipient checks for waiting messages. As with the faxes, some providers send you an e-mail saying the message has been delivered.

Again no single provider offers universal coverage and you will need to check to see what cellular network exchanges they cover in the relevant country. Since this is another free service, many providers place a quota on the number of messages they will allow through various routes on their system in a given time period, and once in a while you will receive an e-mail saying that the message could not be sent. I have found *Mobile Telephone Networking* (http://www.mtn.co.za/regulars/sms) to be good for *Vodaphone* in the UK. They allow messages up to 150 characters and tack the name of their sponsors on the end, as a kind of advert. A list of other SMS gateways can be found at:

<http://www.kecskemet.com/tiberias/gsm/gs02000.htm>. Or do a web search on "SMS messaging"

I have usually concluded these articles with a short topical tip, and though this may seem less applicable when this issue's offering contains little else but tips, I can't resist the temptation. A service that caught my eye recently is AltaVista's Translation Assistant. Have you ever (like me) come across the German Society for Medical Sociology's site and found that you couldn't understand a word? Perhaps you are more erudite. But if not, this provides an easy way of getting the gist. Translation Assistant uses a version of Systran's commercial translation software to instantly convert WWW sites (or your own pasted in text) between English, French, German, Italian, Spanish, and Portuguese. You can use the service by going to the Translator site (http://babelfish.altavista.digital.com) and then typing in the URL of the WWW site that interests you. Try the German (DGMS) site (http://www.uni-freiburg.de/medsoz/Dgms.htm). Note that this URL is case sensitive. The translation isn't perfect but it is no problem to fill in the odd gap..

David Hughes,
School of Health Science,
University of Wales, Swansea.

INTERNATIONAL SECTION

This section normally includes a paper from a visitor from abroad outlining their research interests. The purpose is to facilitate networking between medical sociologists and to invite visitors to reflect on differences in perspective between countries. In the past we have had contributions from Peter Conrad (USA) and Eero Lahelma (Finland). The MSN team would be keen to learn of any other visitors who might be interested in contributing to future MSN issues.

TEACHING, MEDICAL SOCIOLOGY AND THE USA

It was Margot Jefferys who in 1976 invited me to co-ordinate a summer programme on "Comparative Health Care" for a group of 20 or so undergraduate students visiting London under the supervision of Dick Levinson from Emory University in Atlanta, Georgia. A PhD student anxious for any work with a fee attached to it, I accepted. Margot did me a bigger favour than either of us realised at the time. It was the start of a delightful friendship with Dick Levinson (and, later, several other Emory sociologists) which continues to this day and which culminated in an invitation to Annette and I to visit and teach in the Department of Sociology as visiting professors during the spring semester of 1998. The impressions and reflections collated here issue from my experience teaching medical sociology classes to undergraduates at both Emory and its associated College at nearby Oxford, and a social theory class to graduates at Emory, and from a somewhat wider exposure to contemporary academic and popular culture in the USA over this limited period. I should perhaps stress, though it hardly seems necessary, that this is a personal statement not to be mistaken for any kind of systematic report.

The USA is of course a huge country. During an impromptu drive "west" (mostly along the old "Route 66") from Atlanta during the spring recess in March, we discovered, as perhaps one only can by driving, just how vast and varied it is. Intending initially to visit the Grand Canyon via Memphis, Oklahoma City and Santa Fe, we just "kept going", in one long, long day departing from a snowy Flagstaff to turn right at Phoenix for Los Angeles, then left to a balmy San Diego. We subsequently took a circuitous route back to Atlanta via Tucson, El Paso (and its Mexican twin, Juarez), San Antonio and New Orleans. It was a wonderful 12-day 5000+ mile journey, during which we not only accommodated three time zones, but experienced dramatic changes of climate, landscape and culture which will take more time to digest than we have yet had available.

Medical sociology in the USA, it might be argued, is no less comprehensive and diverse than are the territories and character of the country itself; nor is it less stimulating. At least as many perspectives and approaches as are found in Britain and Europe are represented in the US, and many of the same topical quandaries seem pertinent. My selections merely reflect what has struck me during my brief stay and the constraints of space.

It is apparent that the failure of Clinton's Health Security Bill in 1993-94 has had a marked impact, not least because it is to the state that US liberals, even radicals, look for fundamental social reform. Debates among medical sociologists and others about why the Bill was so rapidly and comprehensively aborted, and about the plausibility or otherwise of socially inclusive health reforms in the future, continue. In the meantime the very real "crisis of American health care" is escalating not receding, with coverage remaining unacceptably far from universal and the costs of treatment and care for individuals and as a proportion of GDP still spiralling. While the local temptation to blame either Clinton's appointees to the Task Force on Health Care Reform (especially Hillary Clinton and Ira Magaziner) or the intransigence or "stupidity" of the American people for the latest flawed initiative remains

strong, the explanation is clearly more complex (Skocpol, 1997). Having been invited by *Critical Public Health* to review the latest volumes of Luhmann, Habermas and Elias while in the US, I am led to wonder if Elias's (1996) - potentially unifying - concept of "habitus" (referring to "second nature" or "embodied social learning") might be helpful here: arguably, at least part of the explanation for the failure to rectify a conspicuously inadequate and costly health care system lies in as yet under-researched aspects of the American habitus.

A further observation concerns the uncertain role of American medical sociology in the general context of the demise of Clinton's reform package. This uncertainty has been highlighted recently by Pescosolido and Kronenfeld (1995: 5), who maintain that "while sociology stands as one of the earliest social sciences to systematically study the health care arena and create a health-focused subfield, there is a perception, not without support, of a desertion of identity from within, an encroachment by other areas from without, and abandonment by the parent discipline" These authors make a solid case for an urgent re-assessment of the significance of medical sociology for understanding change and reform in health care; of its significance for the general sociological enterprise; and of the significance of general sociology for medical sociology's agenda for research. It is surely a case which might be made with equal plausibility in Blair's Britain.

On a different level, I have noted the seemingly inexorable rationalisation of academic teaching and assessment across most disciplines and "subfields" in the US. First degrees continue to offer students a "general education", although disciplines pursued as "majors" (and even "minors") may prepare them for further study or for particular fields of work. It is at graduate level that more lasting disciplinary foundations are typically laid. I have found teaching "social aspects of health and illness" courses (each involving approximately 40 lectures of 50 minutes each) to undergraduate classes of 61 (at Emory) and 26 (at Oxford) rewarding and fun, which is not to say the students would describe being taught by a "resident alien" in the same terms. But what is interesting too is the vigorous and "instrumental" attitude of many - I want to add, "paying" - students committed, above all else it often appears, to keeping their "grade point average" up. This leads them to question the award of any grade lower than, say, *B+* (and, if they are "pre-med", any grade below *A*). That there is widespread "grade inflation" is not surprising: universities have a vested interest in their students' success and futures (and therefore in their grade point averages); faculty are evaluated course-by-course by their students; and faculty's salaries can be increased as a direct result of receiving good evaluations or their progress to tenure questioned as a result of bad. What one sometimes observes in consequence are elaborate and ritualised forms of strategic action on the part of both students and faculty as final grades are negotiated. Like most, I think, I have settled for a mix of integrity and damage limitation. I do not yet feel as constrained (or accountable?) in London; but perhaps it is a matter of time.

Graduate study is inevitably more intense, and I have thoroughly enjoyed teaching a course on "basic theoretical problems" (involving 15 seminars of 3 hours each) to a group of 9 students on the Emory Department of Sociology's "masters programme" Graduate study in sociology in the US seems to be geared predominantly to imparting those skills thought to be most relevant for gainful employment in increasingly competitive academic and related markets, namely, statistical and computing skills pertinent to the multivariate analysis of large data sets. I am aware that many of my British colleagues would commend such an orientation, and I acknowledge that we have some "catching up" to do in relation to these skills in British medical sociology; I am less critical than concerned. I see a danger in committing too great a portion of our resources to preparing sociology graduates to join the rapidly expanding ranks of a characteristically uncritical and bureaucratic technical intelligentsia. What I have here presented as part and parcel of a broader process of rationalisation in American universities - in relation to the teaching of undergraduate and graduate sociology - is gathering pace too in Britain; in this sense just as Britain's health

care system is being "Americanised" (Mechanic, 1998), so to is its system of higher education.

There is of course an arbitrariness in this handful of impressions, although the issues they signal are, I believe, real enough. What I want to stress, however, is the friendliness and generosity of colleagues at Emory and the gratitude Annette and I share for such a rare opportunity to experience - through a kind of institutional immersion - another culture and system of higher education. If I am critical of some - even many - of America's social institutions (what else does one expect from a sociologist asked to comment?), I remain appreciative of those who have made us feel at home, many of them strangers.

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DAY IN THE LIFE OF A MEDICAL SOCIOLOGIST

Medical Sociologists work in a variety of settings and contribute in many different ways to the discipline. This section invites Readers to share, either a typical or special; day, week or year in their life as a Medical Sociologist. It is hoped that this section may help Readers understand the breadth of Medical Sociologist's work and foster a spirit of collegiality.

A day in the life....

Well, there is no typical day in this life, which does at least mean there is variety...

Eight twenty five am and I have made through rain and public transport to the lifts serving Guy's Tower. Negotiating the thirty floors can take anything between 3 and 15 minutes depending on the time of day. This is just in time to beat the rush. Stagger up the stairs to the portacabin on the roof (literally) where my office is. This is floor 32 where the lifts don't go and there are no toilets or running water. Great view though, looking north over the Thames out as far as the M25. You can see my home town of Hackney from here as well as watching the progress on the Millenium Dome. Naturally the view has served to provide hours of happy distraction from what ever deadline is currently pressing.

Kettle on for some filter coffee and first stop is checking email (more delaying tactics). There are 152 messages which have been sitting there unread since before Easter. I scan through for personal/interesting ones. One from 'The Angel of Death' looks promising. This turns out to be from a second year dental student keen to do an intercalated BSc in Sociology which we are no longer running in London. I am currently scouring other Universities for possible alternatives.

This year sees the merger of our institution with King's College and the nightmare scenario of planning a new joint curriculum across three sites to begin in the Autumn. Retrieve relevant papers for our meeting this afternoon. Somewhere on my overcrowded bookshelf is the student handbook with all the current course aims and objectives. Some careful stacking and restacking of the piles of journals results in the shelf finally collapsing altogether. Its an ill wind however as the handbook I was looking for floats down onto the top of the heap. No point in putting the shelf back as we are scheduled to move into our new suite of offices on floor 18 in a few weeks. Indeed I have the happy task of choosing my new chair today. From a catalogue, naturally, so you can have no idea of how comfortable it is until you own it. I guess it had better be the blue one then.

Nine - thirty, time to head off to the floor 21 for the weekly department 'briefing meeting' (makes it sound like LA Law, sadly, that's as close as it gets). Take with me empty 2 litre bottle in the last BSA Conference bag. They have a kitchen with running water on floor 21 (and other mod cons, like a toilet). Still, not long before we move and my days as a water carrier are over.

Ten - thirty, meeting over and time to check my post, which comes into the Secretary's office on this floor. More things I haven't done. More flyers for books I never have time to read.

It turns out that there is a dispute over tutorial time between us (Dental Public Health) and Minor Oral Surgery (which is clearly Very Important as it has Surgery in the title). This is why half of my tutorial group were missing last Tuesday morning. I now have to locate them and find out exactly what they were told and by whom. Meanwhile a colleague approaches me for advice as, being an AUT Equal Opportunities rep, I am a 'named contact' on the

'Harassment Document'. She has two students suffering from harassment. One (male) feeling constantly 'got at' by the female students in his group. The other (female) having had lewd remarks made to her by a patient she was treating. Both wish to remain anonymous. I will write to the personnel officer who organises the Equal Opportunities Committee logging these incidents. More difficult is knowing how to prevent these things from continuing whilst maintaining their anonymity.

At this time of year we have the annual occurrence of the 'Exam Paradox' This means that although most of the teaching is over paradoxically this is the time you see most students - particularly the ones you haven't seen all year. Consequently I am beset by phone calls and visits from fourth year students who want to know the difference between sovereign and disciplinary power and why this has anything to do with dentistry...

12.15 and time to meet a friend in the canteen on the lower ground floor (basement to you). This resembles a BHS restaurant and is open to all, staff, students and patients, still you can get beans and chips for under a pound (staff discount) and I do this about once week for a treat. Otherwise its a sandwich at my desk whilst reading the email backlog.

On the way back up I meet the missing half of the tutorial group in the lift and establish that the oral surgeon demanded that they attend his clinic last Tuesday "I've let one group go to DPH and that is enough" (it is our timetabled time). The matter will have to be raised at the Year 4 committee. This is one of the problems of being seen as a marginal discipline and a relic of having been a sub - unit of another department without our own 'ring - fenced' teaching time.

One - thirty. Peace at last and time to work on the (hopefully final) draft of a paper The big project on the oral health needs of ethnic minorities in South Thames is just drawing to a close and this is a report of some of the focus group findings. I am finding it increasingly difficult to balance health services research with sociology. Strongly suspect that I am losing my grip on 'sociology' whilst failing to properly grasp 'health services research'. Still, no chance to worry further as at three o'clock the phone rings and it is a student in crisis (big time). This takes until four forty -five when I take off to try and catch the Dean at the end of his clinical session to discuss the matter.

Five - thirty, finally back in the office and just check my email before returning to the 'ethnic minorities' paper. Find message from MSN reminding me I had agreed to write this piece and that the deadline is now... send final email to a friend: subject 'Help!!'

Nicki Thorogood
April 1998

DON'S DIARY

Friday
A big presentation to give in Buenos Aires next Wednesday: 8,000 people. I have been invited by the Organisation of Services for Company Directors, a medicare foundation, to talk about work trends. There will be 1,000 people in the auditorium. The 90-,minute talk will be broadcast by satellite to audiences in seven cities, who can fax questions after. I am often invited to talk but never on this scale. How do rock stars cope?

Saturday
I check my presentation disc. it is in Powerpoint Version 7 - with plenty of graphics and visual movement. Important when you are talking to a non-English-speaking audience. It is even more important when your talk is being broadcast by satellite.

Sunday

A glorious day. I have developed denial symptoms about the presentation. Instead of 'internalising' it so I would need notes, I sunbathe in the garden. Right until the taxi arrives for the airport at 4pm. Which airline am I flying with? The boarding card is Air Canada, the livery of the plane is Viva Air and the ticket code is Aerolineas Argentinas. That is the problem with strategic alliances. Business class with seats that almost collapse into beds, ideal for a good night's sleep.

Monday

Two am and I am still not asleep because the cabin crew insist on excelling in customer care. I decide to learn the presentation. Arrive in Buenos Aires at 1.20pm but by adjusting my watch to local time, I am back to 8.20am. I may have arrived but my luggage has not. Panic- - my suit is in there. A group of us go to the officer in charge of baggage reclaim expecting confrontation but we get charm. No problem, this happens every Monday morning "The luggage will be here in 30 minutes on the next flight from Madrid." For some strange reason there are two flights from Madrid within 30 minutes of each other. Probably another result of strategic alliance. But sure enough, our luggage arrives.

I am met and driven to the Intercontinental Hotel in Buenos Aires. My suite of rooms are huge. I also check out the area where I will be giving the presentation. It is big. Spend the rest of the day touring the city, which is not what I expected. I conclude Buenos Aires is an upmarket version of a Spanish-speaking Italian town. But as everybody tells me, Argentina is not really South America.

Tuesday

I am introduced to my host organisation, the foundation, which has grown rapidly and is expanding into other countries in South America (the "real" South America, I am told). Five years ago, it organised one seminar with an invited international speaker. Today, thanks to sponsorship, it arranges an event every three months. I am told that this is the biggest event so far, and that all tickets went six weeks ago. This just makes me anxious. Can I deliver? No way can I let so many people down. I hope the computer graphics do the trick. There are posters with my photo on them everywhere.

In the evening, it is rehearsal time. There are two huge screens on either side of a large elevated stage. One for the Spanish and the other for the English version of the presentation. There will certainly be nowhere to hide. There are TV cameras and a control box for lights, sound, transmissions etc. How much is this costing? I run through the graphics. Everything is fine. Everything is ready, but is my head? Today for me is no alcohol day.

Wednesday

Wake up at 5am. Still not recovered from jet lag. Have breakfast. Take a swim. Do anything to relax. At 11am I am interviewed for a feature in a national newspaper that will appear on Sunday. The talk is scheduled for 3pm but by 1pm people are arriving.

At 3pm to the second, a television presenter introduces me. On cue, I get up from the audience and walk towards the stage. I start talking and press the mouse that kicks the graphics into action. We are off. My topic is the way in which information technology is leading to a fundamental restructuring of the global economy. Geography does not count, and medium and large-sized companies in Argentina can compete with European businesses for markets in Europe. Ninety minutes later - it seems like ten - it is over. Everything is now plain sailing. At 6pm the event closes. The delegates and the foundation seem happy. The interpreters collapse in exhaustion and I take the lift up to my room. I have a drink. And another. At 9pm my charming guide takes me to a "themed " tango nightclub.

Thursday

Lunch with senior foundation personnel. Everyone is relieved. In the afternoon I'm taken on a guided tour of Buenos Aires. It is a great city. In the evening I catch the night flight for Madrid, then on to London. On Monday it is back to the University of Kent for part one undergraduate seminars. Someone has to do it.

Richard Scase

Head of Marketing and Recruitment and Professor of Sociology and Organisational Behaviour at the University of Kent at Canterbury.

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CRITIQUE OF A CLASSICAL PAPER

This section invites Readers to send in critiques of classical papers. Often these papers have profoundly influenced the thinking of the writer, or are notable in some other way. Such critiques are personal and would not always be published in other journals. However, they have proved to be of great interest to Readers, who frequently draw on them for ideas for themselves or their students.

Revisiting a Classic Paper:

Irving K. Zola (1972) Medicine as an institution of social control, **Sociological Review**, 20, 487-504.

I first encountered Irving Kenneth Zola at 51 Harley Street, London W1 in 1978 or 1979. Neither of us was seeking a second opinion for a troublesome complaint, nor were we engaging in a participant observation study of private medical practice. Indeed, my encounter was not actually with Irving K. Zola in the flesh. I was a student on the MSc degree in 'Sociology with special reference to the Sociology of Medicine' which was then taught in the Social Research Unit of Bedford College Annexe at that address. Zola was a name on one of the many reading lists by which I and the other students were besieged in what turned out to be a most edifying and enervating academic year

I cannot claim to have a pungent, Proustian memory of my first reading of the paper I have chosen, which was published over a quarter of a century ago. But I do remember that its arguments entered my consciousness some time during that year and I have continued to live with me ever since. The central contention of the paper is made plain in three opening sentences which have the power to burn themselves into your brain:

> 'The theme of this essay is that medicine is becoming a major institution of social control, nudging advise, if not incorporating, the more traditional institutions of religion and law. It is becoming the new repository of truth, the place where absolute and often final judgements are made by supposedly morally neutral and objective experts. And these judgements are made, not in the name of virtue or legitimacy, but in the name of health' (487).

For a young man brought up in a context of radical non-conformity, touched in adolescence by existentialism and the Rolling Stones before being seduced by marxist humanism and critical theory, and for whom 'Sociology of Medicine' sounded suffocatingly respectable, Zola's words hinted that the discipline might, after all, be about more than pragmatic and well-meaning attempts to help doctors do their jobs better. Moreover, with its engaging admixture of anecdote, opinion, data and argument, the paper suggested that sociological writing could be fun.

Zola set out to refute the idea that the involvement of medicine in the management of society and' social pathology' was less punitive or more exculpatory than religion or law. taking his cue from Freidson, he used the essay to explore four ways in which society was becoming medicalised: through the expansion of what in life is deemed relevant to the good practice of medicine; through retention of absolute control over certain technical procedures; through the retention of near absolute access to certain 'taboo' areas; and through the extension of what in medicine is deemed relevant to the good practice of life.

None of this was entirely new, and Zola himself references his indebtedness to Thomas Szasz, Philips Slater's The Pursuit of Loneliness, the Foucault of Madness and Civilisation, and, as we have seen, Elito Freidson. However, far from restricting his critique to psychiatry, Zola's appraisal was wide-ranging; public health, plastic surgery and genetics also came in for critical treatment. Like Ivan Illich, whose Medical Nemesis appeared a little later, Zola had the whole project of modern medicine in mind. The epistemological reductionism represented by the new genetics and the therapeutic holism of psychiatry and public health combined to make medicine a potentially dangerous institution of social control.

Although the essay - 'a case in progress' as he put it (488) - is argumentative, Zola was doing more than impugning the motives of doctors. Indeed, he explicitly warned against seeing the problem as one of medical 'imperialism', and emphasised that his paper was'... not an attack on medicine so much as on a situation in which we find ourselves in the latter part of the twentieth century' (502). Following Hannah Arendt's celebrated reflection on the 'banality of evil' in Eichmann in Jerusalem, Zola argued that modern medicine was the exemplar of a modern crisis '... not because the perspective, tools and practitioners of medicine and the other helping professions are evil, but because they are not' (502).

Over the last 25 years medicine and health care systems have undergone considerable change. Doctors no longer have the same degree of professional autonomy and discretion, many people have little faith in them or their potions, and governments are certainly not prepared to write blank cheques for new treatments. Why worry about medicine as an institution of social control when health budgets are so tightly controlled by politicians and managers? Does Zola's argument have any continuing relevance? These are difficult questions which I cannot address satisfactorily here. All I will say is that at least two contemporary issues- the human genome project and its implications, and the legitimacy of withholding medical and surgical interventions from people with unhealthy behavioural dispositions - are both prefigured in this classic paper. Moreover, in a twist that Zola would have appreciated, many of the managers are doctors!

Zola's analysis illuminates the ambiguities of medical power without coming to the conclusion that nothing can be done to resist. Indeed, much of Zola's later life as an activist in the self-help and disability movements was dedicated to putting into practice the arguments of his paper. It is also a classic of the essay genre because it serves to remind us that the best sociological writing neither conceals the sociologist nor obscures his or her moral and political pre-occupations. Would the editor of the Sociological Review find space for it today? If not, then I hope that the editors of Sociology of Health and Illness would.

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REPORT FROM RESEARCH CENTRE

Keeping up to date with all that goes on in the research world is difficult enough at the best of times. This section aims to report on the current activity of research centres undertaking work of relevance to Medical Sociologists. It seeks to keep Readers informed and foster good networking.

UNIVERSITY OF TRUMPTON, DEPARTMENT OF SOCIOPATHIC STUDIES
Internal Memorandum

From: Prof Ron Beria 03/01/98 9:23:15 PM To: All academic staff.

The Pro-Vice Chancellor (Human Resources and Quality Outplacing) has now concluded his shadow Research Assessment Exercise for the department. All colleagues will be aware that our objective is to move from grade 2 at RAE 1996 to 5* at RAE 2004. To achieve this objective nothing less than total commitment will be required from academic staff and the four students currently taking the MRes/PhD in Sociopathy. In addition, the department is to be restructured. While we did well in the TQA the extra teaching assistants that we were given in the lead up to that exercise have now been redeployed to provide technical support for the post-graduate Neurosurgery department. This has left us with moderately high teaching loads (45 contact hours pw for lecturers; 30 hours pw for part-time postgraduate tutors) and to compensate for this academic staff will now work through four research centres with a view to enhancing their value at RAE 2000 and 2004. Research centres will be staffed on Wednesday afternoons. *Our main task now is to improve staff and student publication rates.*

1. **The Centre for Sudden Criticism**: Staff attached to this unit will scan major journals for key articles. Once located, a minor and inconsequential feature of such articles will be identified and subjected to searing criticism on the grounds that it is a fatal flaw. Critical commentaries will be dispatched to the journal concerned within 48 hours. Staff concerned should use the MATE-CITE bibliographic database to ensure secondary referencing of their colleagues' previous work. After rejection, such commentaries may be sent to *Int J Traumatic Manicure.*

2. **The Centre for Misrepresentation(s)**: There are now a sufficient number of Journals and Periodicals to ensure that virtually all published work goes unread. This means that major review articles and position papers can now be written and submitted to journals in the confident expectation that peer-reviewers will have no knowledge of their substantive topics. We should exploit this by a major thrust into postmodernity. Staff concerned should use the SELF-CITE bibliographic database to establish their academic authority to comment, and should consider either *Tormented Relations* or *Despair* as destinations.

3. **Unit of Prolix**: The burgeoning literature on post-modernity and post-modern theory offers unparalleled opportunities for staff publication. Recognising that this is not an area of current expertise, staff rotating into this unit will have access to GLOSSOLALIA: a database of terms commonly used by post-modern philosophers and theorists. By using the command PRAXIS staff will be able to list off a random selection of such terms (and supporting citations) which they can then link together using only moderately contorted prose. The department of Epidemiological Poetics has had unparalleled success with such a database, although theirs can also randomly insert complex equations and denies the very possibility of the subjunctive. Staff rotating through this unit are reminded that references to the life and work of Virginia Woolf are no longer fashionable, except in the *Journal of Metadiscourses of the Skin*, and *Cultural Praxis and Migraine.*

4. **Centre for Sociopathic Behaviour**: There is no doubt that, as a department, we have failed to exploit our research students effectively in the past. In future all essays and dissertations will be submitted for publication. In keeping with normal practice in other departments of Sociopathy, the HoD will be lead author, supervisor second author, and student third author (e.g. Beria *et al*). As part of the franchising arrangements for our intended MSc in Sociopathy, we have an arrangement with the *Journal of Pyrrhic Victories in Primary Care* for such papers. Colleagues are advised that *Fulminations in Grounded Theory* is a suitable destination for student projects if these demonstrate any evidence *at all* of even basic literacy skills.

Some colleagues have already begun preparations for the RAE, and I wish to draw positive attention to the work of those in the department who have themselves founded a new journal, *Critical Neurasthenia.* In addition my own book *Tight Lyotard: The Postmodernity of the Addictions and the Constricted Self* will shortly be published by the Trumpton University Press.

New research centres and units will formally reside in the new grey filing cabinets outside of the departmental General Office. The Pro-Vice Chancellor (Human Resources and Quality Outplacing) has determined, after careful consideration of the results of the shadow RAE, that the Centre for the Systematic Study of Empirical Data will cease operation within the next four weeks. Audit and evaluation of the new units will be ongoing throughout 1998, but will conclude in time for the Faculty Human Resource Outplacing Assistance Committee meeting on 24 December. All staff are reminded of the key point in our mission statement: *Our aim is to develop sociopaths in an environment defined by excellence and equal opportunities.*

ARTICLES

Readers are encouraged to submit articles that they feel would be of interest to their Medical Sociology colleagues. MSN has a substantial Readership (350), including individuals and institutions both in the UK and abroad. As a newsletter, it is generally read from cover to cover. MSN is not peer reviewed and so these articles are not likely to contribute significantly to the RAE. Typically, we receive material from eminent colleagues who wish to share matters of great importance with other Medical Sociologists. Other times, we publish material and encourage Readers to give individual feedback to authors, in the tradition of academic critique.

The Effects of Hospital Organisation on Patient Outcomes: Synthesis of the Annual Health Services Research Lecture given at the London School of Hygiene and Tropical Medicine, 10th March 1998.

In our recent work, we have attempted to determine how nurses and, more importantly, patients are affected by the organisation of nursing care in the units and hospitals where the care is rendered (Aiken, Sochalski, & Lake, 1997; Aiken, Lake, Sochalski, & Sloane 1997). We have taken advantage of the "natural experiment" created by the establishment of dedicated AIDS units in American hospitals to explore whether and how the outcomes of AIDS patients are affected by segregating them on specialised units rather than by mainstreaming them in general medical units (Aiken, Sloane, Weber, Lake & Sochalski, 1998). We have also, in related studies, compared outcomes of patients in hospitals that incorporate a professional nurse practice model - magnet hospitals - with outcomes of patients in conventionally organised hospitals (Aiken, Smith & Lake, 1994). We will be soon beginning a new study that exploits the unusually comprehensive hospital discharge and staffing databases in Pennsylvania to study patient outcomes across all hospitals in that state, and this study will dovetail with studies of patient outcome sin Canada, England, Scotland and Germany.

A number of questions we are posing in these studies are quite standard in that they involve how patient outcomes, like mortality and satisfaction with nursing care, and nurse outcomes such as work satisfaction, turnover and burnout are affected by nurse/patient ratios, nursing skill mix, and so on. What distinguishes our work and makes it distinctly sociological, however, is out attempt to measure how the organisational attributes of hospitals, and hospital units, both directly affect the patients and nurses therein, and how they may, we hope to show, mediate the effects of staffing, nurse skill level, and like variables.

Our approach to measuring these organisational attributes is unobtrusive; we derive the organisational attributes of greatest theoretical and practical interest by aggregating individual level data (i.e., nurses' responses to questionnaire items). We have found the nursing Work Index (NWI), a set of 65 survey questionnaire items originally designed by Kramer and Hafner (1989) to measure job satisfaction among hospital nurses, to be a very useful tool to measure organisational attributes relevant to clinical nursing practice. We depart from the more conventional use of survey data and treat the hospital, or in some cases a nursing unit within the hospital, as the unit of analysis instead of the individual nurse (cf. Aiken and Hage 1968). The trait is the organisational feature indexed by a particular item in the NWI, or by a cluster of like items that can be combined to form a

scale. The role of repeated measures falls not to items, but to individuals - in this case the constituent nurses. The average response to an item or cluster of items within a hospital, or within a nursing unit, is analogous to the scale score for an individual in the traditional survey measurement of attitudes. An organisational trait is measured reliably when the variability in evaluations between nurses within a hospital or unit is small relative to the variability in the average evaluation across hospitals or units.

We have, at various times, used individual items from the NWI, and have also developed four summary scales which measure organisation attributes that we think represent the kinds of organisational attributes that are likely to affect how well nurses practice and, as a result, how well patients fare. One of these is a global scale, derived form ten NWI items, that we have referred to as organisational support; the other three subscales measure nurse autonomy, nurse control over the practice setting, and relations between nurses and physicians.

Work we have completed with our samples of hospitals with dedicated AIDS units, magnet hospitals and conventional hospitals matched to them has shown that the AIDS units and magnet hospitals are alike in being marked by much higher levels of organisational support, nurse control and nurse autonomy, and more favourable relations between nurses and physicians (Aiken, Sloane, & Lake, 1997). We have also shown that patients in the AIDS units and the magnet hospitals have lower mortality and are more satisfied than patients in other units' and that nurses in those units and hospitals are show less emotional exhaustion (Aiken, et al., 1998; Aiken & Sloane, 1997 a;b). While the limited numbers of AIDS units and magnet hospitals in these studies had made it difficult to establish firmly that it is the presence of these organisational characteristics that accounts in all cases for the favourable nurse and patient outcomes in these units and hospitals, we do have evidence that some of the difference across units and hospitals in nurse burnout is related to differences in organisational support, and that some of the difference in patient satisfaction is accounted for by the amount of control that nurses have over their practice environment in the different units and hospitals.

Our research over the next several years will allow us to determine, with a broader and international sample of hospitals, whether these organisational attributes of nursing care operate to produce favourable outcomes in hospitals independent of their designation as magnet hospitals, and whether these organisational attributes mediate or interact in a meaningful way with nurse staffing to affect both nurse and patient outcomes. Research to date on magnet hospitals has been conditioned on selection of study hospitals by designation type, either magnet or non-magnet. These studies underestimate the "magnet" hospital effect because many comparison hospitals are likely to have some, or even most, of the organisational attributes associated with magnet hospitals. The methodology we have developed allows us to empirically document the presence of organisational attributes common to magnet hospitals independent of designation by surveying all nurses in a geographically defined area and aggregating their responses by place of employment. The large numbers of hospitals in the international study will enhance our ability to refine this methodology, and thus to determine more accurately the effect of the characteristics common to magnet hospitals on patient and nurse outcomes. In addition, if the same attributes that are common to magnet hospitals in the U.S. can be empirically documented to be related to better outcomes in hospitals in Canada and the U.K., we will have the basis for international replication of a successful hospital nurse practice model.

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What is the Medical Sociology Group *or* Nostalgia ain't what it used to be

As one of those with reservations about Graham Hart's proposal to restructure the MSG on membership lines and to market the conference more aggressively, it may be worth making some comments on his Out-Going Convenor's Report in the last issue and, perhaps, preparing the ground for a further debate at the next AGM. Graham poses some challenging questions and the Group is right to discuss them. However, I am still not persuaded and I hope that some better arguments might yet be advanced.

Let me make one historical point. Graham's dig at those of us who were there in the early days ought not to go unanswered. There may have been 25 people at the first meeting in York in 1969, which was not at the Viking. I don't know because I wasn't there either. I was there the first year we did go to the Viking, in 1972, and the Group was already pushing 200 participants. How do I know - the Viking only had about 100 bedrooms in those days and most of us had to share! More seriously, we ought to remember *why* the

Group was established. I think some of the founders may have envisioned a body of authority speaking to government, policy makers, professions, etc. either on behalf of a professionalizing group - us! - or on behalf of some underdog social group or groups with more limited access to the political process. I don't think that was a very widespread view. As I recall it, people came together mainly because they wanted to emphasise their identity as *sociologists*. Their work was not appreciated at other gatherings in what we then called social medicine, where people were forced to present work in a particularly atheoretical and empiricist context. York was where we could come out and be what we wanted to be. This was, perhaps, less well institutionalised than it might have been, because of the Group's uneasy relationship with the BSA but that's another story.

However, it is relevant to my doubts about Graham's programme. I don't think that I am the only one who has been wondering where the *sociology* has gone in MSG conferences. The increase in scale is a success story but we do not seem to have looked at the dilution that has gone along with it. The legendary welcome and informality of the conference has undoubtedly attracted a lot of people with some kind of interest in social aspects of health care or practitioner research in some health profession. It is an important part of the mission of the Group. I do wonder, though, whether it is not a bit like mass tourism and York Minster - that the volume of sightseers actually destroys the experience that they have come to have. My problem with the refereeing policy, for example, is less with the principle than with the practice, although I do think that capacity could still be increased by minor reorganisations of the schedule. Perhaps it is time that we screened out all abstracts that made no reference to their location in relation to some recognised body of sociological work. But then we compromise the outreach that Graham rightly values. The fact that we don't market ourselves aggressively might be the compromise that maintains whatever still distinguishes us from any run of the mill HSR conference. If we go down Graham's path what will there be to keep the *sociologists* coming - or will 25 of us need to find our own meeting place at a smaller venue in York...?

I am similarly uncomfortable with the idea of turning into a membership organisation, although I suppose we could restyle Med Soc News subscriptions as Group memberships and get a definition that way. I certainly don't think we need to generate subscription income, given the current state of the accounts! However, we should remember that our legal status is, and always has been, as a BSA section. Heaven knows I have had my own ins and outs with the BSA but it is the only game in town for *sociologists* and has become a far more professional organisation. I am sure that we should be looking for ways of strengthening that alliance and encouraging those of the Group eligible for BSA membership to take it out - perhaps this ought to be a mailing in a future Med Soc News.

All of us in the education industry are supposed to be in favour of going back to basics these days. Let's remember that the basics of the Group are that we are a gathering of medical *sociologists*, a gathering we are happy to share with others but one whose distinctive character comes from its design to service our interests. When we discuss these matters at the AGM, let's focus on the question of how we design a Medical *Sociology* Group for the new millennium. If we can get that right through the course of a civilised and mutually respectful discussion, we will leave as rich a gift to our successors as the founders left to us.

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Our Healthier Nation - what does it mean for older people? A report from the Focus Group on Older people

Introduction

How does the Government's Green Paper *Our Healthier Nation* address the health of older people? This is the question which a multisectoral group met to discuss on 9 February 1998. This report summarised the outcome of this meeting - the group's main recommendations were presented at the Regional Consultation Meeting held on 17 February 1998.

The Focus Group on Older People were first brought together by the Department of Health in August 1997 At that time, it was proposed to include a chapter on the health of older people in the Green Paper and the group were asked to advise on what should be included in this proposed chapter. The group included representatives from a wide range of organisations, including the Department of Health, the North Thames Regional Office, the Health Education Authority, health authorities, NHS trusts, general practitioners, social services departments, voluntary organisations and academic departments. Not surprisingly, they were disappointed to see that the final version of the Green Paper did not include a specific chapter on older people.

On 9 February, the group met again to discuss the Green Paper and on this occasion were joined by members of the Brent Joint Reference Group for Elders and the Harrow Joint Services Planning Team for Older People.

A wide range of views were expressed by the group - these are summarised in this report which follows the structure set out in the Green Paper. In particular, a case is made for increasing the focus on older people in the final version of the strategy.

Overall aims of *Our Healthier Nation*

The group supported the overall aims of the strategy and welcomed the intention to reduce inequalities in health. The aim "to increase the number of years which people spend free from illness" is particularly relevant to older people, as is demonstrated in Figure 1 in the document (page 8) - although life expectancy has increased to 74.2 years for men and 79.6 years for women, men can only expect to spend 59.2 years free from illness and women 62.2 years.

However, the group did not feel that these aims were fully reflected in the proposed strategy. Furthermore, the proposed targets will not enable the monitoring of progress towards these aims. The group welcome the intention to "ensure a more comfortable retirement which gives people the ability to live independently and to do things for themselves for as long as possible" But the strategy needs to say more about how this is to be achieved.

The group strongly recommend that consideration should be given to setting a specific target for improving the quality of life in older people.

The proposed approach

The group were pleased to see that this Government recognises the importance of addressing the broad determinants of health.

But many of the participants felt strongly that age should not be cited as an example of a fixed determinant - its inclusion gives a negative message to older people. Although it is accepted that, as people get older, they become more susceptible to illness, there is no scientific evidence that ageing per se is a cause of ill health. All age groups need to be treated equitably within the strategy - the group felt that *The Health of the Nation* addressed the health of older people rather better than the strategy proposed in this Green Paper.

Although the group welcome the intention to focus on primary prevention, they felt that the strategy needs to also address secondary and tertiary prevention.

The case for focusing more upon older people

A strong case can be made for focusing more on older people.

There are currently 8.9 million people of pensionable age in England. This number is increasing by around 2% per year and, by 2010, it is estimated that nearly 1/5 of the population will be of pensionable age. The most rapidly growing age group comprises those aged 80 and over. It will not be long now before older people outnumber children. This unprecedented trend in population ageing will have profound implications for society.

Sustaining a growing older population is the responsibility of everyone - including the Government and individuals themselves. A major challenge will be the maintenance - and the continuing improvement - of the health and quality of life of our ageing population. As people live longer, they will need to be encouraged and supported to prepare financially, by saving and investing more and working longer, and to take more responsibility for their own health, by adopting healthy lifestyles and taking better care of themselves throughout life.

Increasing age is associated with increasing disability and loss of independence. If the average age of onset of ill health were to remain unchanged, increasing life span would mean more years of ill health before death for an individual and a greater proportion of people with disability and increasing costs to society. Every effort therefore also needs to be made to postpone the onset of disability associated with old age as well as reducing the impact of this disability.

Healthy life expectancy is determined by a relatively limited number of chronic conditions that become more common with increasing age. These include cardiovascular diseases, musculoskeletal diseases, neurodegenerative disorders, neuropsychiatric disorders, cancers and other degenerative conditions, such as visual and hearing loss. Reduction or postponement of these conditions will not only reduce premature death and increase longevity, but will also increase the number of years which people spend free from illness and disability.

There is increasing evidence to suggest that our chances of ageing successfully are influenced by a wide range of factors, acting throughout life. For most of the conditions causing disability in old age, there is evidence for the effectiveness of preventative interventions. A strong economic case can be made for focusing more on prevention and health maintenance throughout life. Costs can be reduced by tackling the potentially preventable causes of ill health and disability in older people and reducing their impact through timely and appropriate interventions.

For example, many falls in older people are potentially preventable and yet hip fractures in older people continue to cost the NHS an estimated £160 million per year. In Brent and Harrow, around 600 people aged over 65 are admitted to hospital each year with

accidental injury, 85% of who are admitted following a fall at home. Many such initiatives aimed at reducing the likelihood of a fall occurring in the first place, including home safety risk assessments undertaken by district nurses, the correction of auditory and visual problems and the monitoring of drug prescribing.

However, an individual's ability to make changes to improve their health is determined by social and cultural factors, including income, housing conditions, access to and availability of information - as well as access to health care. Many older people are poor and isolated - older people are the largest low income group in the country and make up a large proportion of the socially excluded within society. They are often denied equitable access to care - especially those from ethnic minority groups. The social framework and policies that enable individuals to fulfil their potential and attain optimal health are therefore crucial. Older people themselves need to be involved in - and enabled to be involved in- the formulation of health public policy.

As healthy active life expectancy increases, the number and proportion of health active older people will increase substantially. There is evidence to suggest that a person's health, longevity and quality of life are improved if they have goals and structure in their life - older people should be encouraged by society to remain productive through paid work or voluntary activities. Many older people already make a positive and valuable contribution to the economy - through both paid and unpaid work. Many are carers, often caring for both older relatives as well as playing an important role in the care of grandchildren and enabling parents to continue working. Older people need to be encouraged to continue making a positive contribution to society. However, the contribution which older people make to society, including, for example, the intergenerational benefits, cannot - and should not - be measured in purely monetary terms. The role that they can - and do- play in society needs to be recognised and acknowledged.

The proposal to focus action in healthy settings

The group supported the intention to focus health promotion activities in schools and workplaces - health promotion messages, including advice on the prevention of ill health in older life, need to be delivered to people of all ages. But specific health promotion programmes also need to be targeted at older people.

All those who are not in a school or conventional workplace need to be given the opportunity to participate in health living initiatives. However, reservations were expressed about the "health neighbourhood" concept as a mechanism for targeting health promotion initiatives at all those who are not at school or in work - especially older people. The group felt that the concept of "healthy communities" might be more successful in reaching all these groups. The local communities with whom people identify are not necessarily geographically defined. For example, many people identify more with people of the same religion or culture, or with people who share common interests, who may be more geographically dispersed.

The Sharp End, a resources centre in East London which focuses on enhancing the health and well being of older people, is an example of a successful health living centre initiative. But such initiatives do not reach all older people - especially the isolated. Voluntary organisations, such as Age Concern, as well as primary care professionals, have a major role to play in delivering health promotion messages to those who are housebound and involving them in health living initiatives. And it must be remembered that not all older people choose to participate in initiatives aimed at older people as many do not think of themselves as being old.

The group therefore recommends that further thought is given to the healthy neighbourhood concept.

The priority areas proposed in the Green Paper

The group do not support the disease focus of the proposed priority areas and recommend that consideration is given to setting targets which relate to the broad determinants of health, such as housing and the social environment.

However, if after consultation it is decided to continue pursuing the disease focus for the priority areas, then the group agreed that these are the top health problems for the nation - they are also all relevant to the health of older people.

Concern was also expressed about the number of other separate initiatives referred to in the Green Paper, including those for tackling smoking, alcohol consumption, HIV and AIDS, teenage pregnancy and drug use. The group strongly recommend that consideration should be given to bringing together all these initiatives under the *Our Healthier Nation* umbrella.

The proposed targets

The group felt that the targets proposed for reducing cardiovascular disease, cancer and accidents are too broad - the targets should be more specific, as was the case in *The Health of the Nation*. They were also very disappointed in the choice of suicide as the issue to be targeted in the mental health priority area. They recommended that a target for depression would be a more meaningful target.

The group were also concerned that all the proposed targets are about reducing ill health- we also need targets for promoting positive good health, such as the target proposed earlier for improving the quality of life of older people.

But the issue which the group felt most strongly about was the decision to exclude older people from CHD/stroke and cancer targets. they felt that the justification given the Green Paper for excluding older people from these targets is both patronising and inaccurate - especially the suggestion that older people do not contribute to family life.

Although the group accept that people have to die of something, many felt that all the targets should include people of all ages. At the very least, the age cut off used in the CHD/stroke and cancer targets should be extended to 75 years at least - many felt the cut off should be extended to 80 years.

The proposal to agree contracts for health

The group strongly support the intention to set out responsibilities at all levels for taking forward the strategy - although there was some concern about the extent to which the proposed strategy really does have pan-government support. However, the group were not very happy with the term "Contract for Health", which they felt is both legalistic and open to misinterpretation. At a time when the NHS is replacing service contracts with service agreements, the group strongly recommend that consideration is given to replacing "Contracts for Health" with "Agreements for Health" or Partnership Agreements for Health.

Summary of Group's recommendations

In summary, the group's general recommendations for taking forward the strategy are as follows:

- All the proposed aims should be reflected in the strategy
- The strategy should focus on secondary and tertiary prevention as well as primary prevention
- Other related strategies should be brought under the *Our Healthier Nation* umbrella
- The disease focus for the priority areas should be reconsidered
- The proposed targets should also be reconsidered - the CHD/stroke, cancer and accidents targets are too broad and the proposed mental health target is too narrow
- The term "Contracts for Health" should be replaced with "Agreements for Health" or "Partnership Agreements for Health"

In order to ensure that the final strategy fully addresses the health of older people, the group recommends that:

- Age should not be cited as an example of a fixed determinant of health
- All age groups should be addressed equitably in strategy
- More emphasis should be placed on older people within the strategy - a strong economic case can be made for health promotion in older people
- Further thought should be given to the "Healthy Neighbourhoods" concept
- The CHD/stroke and cancer targets should include older people
- Consideration should be given to including a target for improving quality of life of older people

Finally, the groups' key messages to the Government are:

- Include older people in all the targets
- Rethink the "Healthy Neighbourhoods" concept
- Add a quality of life target for older people.

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CONSULTATION RESPONSE
to
Cloning Issues in Reproduction, Science and Medicine: A Consultation Document

Human Genetics Advisory Commission (HGAC) and Human Fertilisation & Embryology Authority (HFEA), January 1998.

by Emeritus Professor Meg Stacey and Dr. Deborah Lynn Steinberg
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April 24 1998

INTRODUCTION

That the HGAC and the HFEA have issued this document for consultation is greatly to be welcomed. The probability that it is now technically possible to clone humans as well as other mammals raises issues of serious social and ethical concern which require careful and wide consideration by persons from a variety of disciplines. The issues are not ones which can be confined to scientists or ethicists alone.

We have organised our response to the consultation by providing:
- concise summaries of each of our answers to the 6 questions outlined in the consultation document;
- substantive discussion and explanation of our responses, drawing on the material provided in the document;
- a separate response to the question raised in paragraph 9.2 (p.e 21)

We shall conclude with a summary of the key points of our overall response to the consultation.

SUMMARY OF RESPONSES TO QUESTIONS 1-6

Question 1: Would research using nuclear replacement technology raise any new ethical issues in relation to what is permitted in work with embryos in the 14 day period?
The response to this question cannot be restricted to the 14-day period. Nuclear replacement technology, as with other genetic techniques, raises ethical questions surrounding its potential implications for health, safety and existing social divisions and inequalities. These include: a) potential undesirable clinical effects, both somatic and germ-line, from the use of the technology; b) potential undesirable clinical effects from the mis-use of the technology; and c) intensification of existing as well as introduction of new forms of social inequalities such as social exclusion or marginalisation. In this context, concern arises about both social exclusion from access to the technologies and potential effects on the civil status of persons directly affected by or created through nuclear replacement technology. Neither potential clinical effects nor potential social impact has been adequately considered to date, let alone safeguards for health, safety and citizenship set in place with respect to this technology.

Question 2: Are there any medical or scientific areas that might benefit from research involving human nuclear replacement?
The question would seem to be premature to us. It would only be possible to speculate on potential benefits accruing from human nuclear replacement on the basis of prior resolution to the following questions:
a) provision of evidence to substantiate current assertions of potential benefits as outlined in the consultation document;
b) full consideration of the potential negative effects, both clinical (e.g. negative health effects and 'side effects') and social (e.g. genetic discrimination) of the practice of nuclear cloning and the provision of guidelines that would substantively obviate such effects;
c) an indication and full exploration of what would be the alternatives to human nuclear replacement.
Question 3: To what extent can a person be said to have a right to an individual genetic identity?
We are unclear on what basis the notion of a 'right to an individual genetic identity' can be claimed. While we recognise that such a concept may be assumed, it is unclear exactly what it might mean. This is problematic in relation to 'naturally' occurring multiple births. However, perhaps more importantly, there is serious danger in reducing identity to a matter of genetics

Question 4: Would the creation of a clone of a human person be an ethically unacceptable act?
The creation of a clone of a human person would be an ethically unacceptable act. No case has been made for the ethical cloning of a human person in this consultation document or elsewhere.

Question 5: Would the likely cost in terms of failures and/or malformations inevitable in developing a programme of human reproductive cloning be ethically acceptable?
The likely cost in terms of failures and/or malformations inevitable in developing a programme of human reproductive cloning, which on evidence provided is likely to be high, would not be ethically acceptable.

Question 6: What ethical importance might be attached to the distinction between artificial processes for which there are parallels in natural processes and those for which there are not?
Scientific practices cannot be ethically validated by reference to apparent parallels with natural processes.

SUBSTANTIVE RESPONSES TO QUESTIONS 1-6 and to SECTION 9.2

Question 1: Would research using nuclear replacement technology raise any new ethical issues in relation to what is permitted in work with embryos in the 14 day period?

Response Summary
The response to this question cannot be restricted to the 14-day period. Hidden in it are questions about why the research might be done and to what use the findings might be put. Research using nuclear replacement technology raises both new ethical issues and existing unresolved ethical issues in the wake of recombinant DNA technology more generally.

Nuclear replacement technology, as with other potential forms of genetic manipulation (e.g. somatic and germ-line therapy) raises ethical questions surrounding its potential implications for health, safety and existing social divisions and inequalities. These include:

a) potential undesirable clinical effects, both somatic and germ-line, from the use of the technology; b) potential undesirable clinical effects from the mis-use of the technology; and c) intensification of existing as well as introduction of new forms of social inequalities such as social exclusion or marginalisation. In this context, concern arises about both social exclusion from access to the technologies and potential effects on the civil status of persons directly affected by or created through nuclear replacement technology. Neither potential clinical effects nor potential social impact has been adequately considered to date, let alone safeguards for health, safety and citizenship set in place with respect to this technology.

Expanded explanation

In asking this question it would seem that the authors are relying on the legal need to destroy embryos used for experimentation at the end of the 14-day period. Were this not so, the procedure would appear to be a violation of the present policy that there should be no interference with the germ line. However, both existing legislation and policy are liable to change and cannot be relied on to provide protection for the future. Nuclear replacement technology by definition constitutes an interference with genetic inheritance. Thus questions about the ethics of interference with the germ line are raised and need to be addressed. This is particularly so when the ethical and other implications of such interference have not been discussed in full in previous documents.

The Clothier Report (Report of the Committee on the ethics of gene therapy. Cm. 1788, London: HMSO) made a clear distinction between somatic cell therapy and germ line therapy. It ruled out germ line therapy 'for the time being' without, however, developing in any detail the reasons for this conclusion. That lack seemed regrettable at the time, since the issue was certain to arise sooner or later.

It now appears that in this present document on cloning the possibility is being raised without any discussion of it in terms. The present document thus constitutes an (unacknowledged) reversal of previous advice.

This being so, new ethical issues are inevitably raised. One of the justifications offered for developing nuclear replacement technology is its possible therapeutic value in, for example, reducing the incidence of 'inherited diseases' Ethical issues here include:

- the serious question of how to determine what characteristics are so undesirable that they would be better not transmitted;
- how to ensure that 'desirable' characteristics are not lost along with the defined 'undesirable' characteristics in either the individual or in the society at large;
- removal of some disabling characteristics may further impair the social status more generally of disabled people. It must also be acknowledged in this context that Illness, accident and ageing will continue to disable in variable intensities and are, of course, the predominant sources of disability;
- money spent on genetic research has already been shown to reduce the flow of money to research on the already disabled.

The assertion [as in para. 3.5] that genetic procedures of direct relevance to nuclear cloning have 'long been practised' (and can therefore be presumed ethically sound and 'safe') is not of itself a valid argument. To be sound, evidence from carefully recorded evaluations — scientific, clinical, social and psychological — as to the processes and outcomes is required. None is reported here and no references are given. One cannot

assume that just because something has been done for some time, it is ethically and socially acceptable. The proposition needs testing.

As these examples show, relevant ethical questions cannot be considered without contextualising them. Serious questions of power and control arise. The danger of policies of 'ethnic cleansing' appear to be ever present. We now know that National Socialist Germany did not have a monopoly of these. Such a realistic recognition must temper judgements about what is ethically acceptable, for cultures and regimes are liable to change and along with this notions of the 'normal', the 'desirable' and the 'acceptable' also can change. Technologies once learned may be used or abused. The risk in learning human nuclear replacement technology may well be too great, especially considering the large research resources which would be likely to be involved.

Nor will the costs be solely monetary. See the response to Q.5.

The risk of unintentionally worsening the fate of the disabled has already been mentioned. The question of access to the technology may also create new social inequalities and give rise to new social exclusions. Inevitably the privileged sections of any society (better educated, better informed, wealthier) are more likely to achieve access to any resultant therapies. This would further increase inequalities between rich and poor. Globally, the wealthier nations will have greater availability than will developing countries. These two factors together could increase classed, 'racial', gendered and national inequalities.

To conclude our response to question 1: nuclear replacement technology undoubtedly raises serious new ethical issues in relation to what is permitted in work with embryos in the 14-day period. Each of these requires careful and extensive consideration before permission could be granted. Such consideration should not rely on genetics and bioethics in isolation (albeit considered alongside each other) but should include an exploration of the social, political and economic contexts within which the proposed developments would take place. The ethics inhere in the social relations which already exist and which might be created.

Question 2: Are there any medical or scientific areas that might benefit from research involving human nuclear replacement?

Response summary

The question would seem to be premature to us. It would only be possible to speculate on potential benefits accruing from human nuclear replacement on the basis of prior resolution to the following questions:

a) provision of evidence to substantiate current assertions of potential benefits as outlined in the consultation document;

b) full consideration of the potential negative effects, both clinical (e.g. negative health effects and 'side effects') and social (e.g. genetic discrimination) of the practice of nuclear cloning and the provision of guidelines that would substantively obviate such effects;

c) an indication and full exploration of what would be the alternatives to human nuclear replacement.

Explanation

Throughout the consultation paper, rationales in support of nuclear cloning are made to rest on the speculative assertion of potential therapeutic benefits from the technology[1] While such assertions may be rhetorically effective in cultivating a positive opinion about the technology in question, they avoid precisely the questions about safety, efficacy, alternatives and ethics that require substantive consideration. The case has not been made that it is ethically acceptable to assume that nuclear cloning is the only way of approaching the particular therapeutic (and production) 'needs' identified in this and other

contexts. Nor has the case been made that the pursuit, indeed *high speed* pursuit, of a risk-laden and unpredictable technological innovation is ethically acceptable in the absence of substantive consideration of health and safety risks. The identification of potential benefits in the absence of such considerations relegates nuclear cloning (and related techniques) to a moral vacuum.

We would suggest instead that the question of how to develop an adequate framework for the ethical evaluation of nuclear cloning (and related genetic techniques) is itself the primary unasked and unanswered question and the most pressing priority for the immediate future. We would recommend consultation on the following particular points:

- what are the alternatives to nuclear cloning (and related genetic techniques)?
- what are the clinical and social risks — i.e. potential negative impact on health, potential for negative social labelling and discrimination — of nuclear cloning?
- how do current proposed practices of nuclear cloning and related genetic techniques relate to or differ from early genetic practices and theories — widely critiqued for their historical associations with eugenics and racial hygiene movements?
- can nuclear cloning (and related genetic techniques) be shaped so as not only to minimise clinical and social risks, but indeed to obviate them?

Question 3: To what extent can a person be said to have a right to an individual genetic identity?

Response Summary
We are unclear on what basis the notion of a 'right to an individual genetic identity' can be claimed. While we recognise that such a concept may be assumed, it is unclear exactly what it might mean. This is problematic in relation to 'naturally' occurring multiple births. However, perhaps more importantly, there is serious danger in reducing identity to a matter of genetics.

Explanation
Establishing what might be meant by a 'right to a genetic identity' raises a number of problems. Most importantly perhaps, the claim raises the danger of reducing identity to genetics alone.

Any identity is surely a matter of relationships as well as of rights. Identical twins may be 'genetically identical' but from the time of the embryo split their environment will have begun to be different, a difference which may be more or less marked after birth depending on their upbringing (and which may well 'reshape' their biologics). Where the embryo division was spontaneous the strong similarity in the individuals is viewed as a 'happening'

When the question of making copies arises, as in the examples cited of parents wishing to 'replace' an aborted foetus, dead baby or child, deliberate human/scientific agency is immediately invoked. Questions arise about the relationship of the parent(s) to the professionals and technicians involved; of the clone to them and to the parents. In the hypothetical case of a woman simultaneously bereaved of daughter and husband, the mother would not, as the consultation document points out (8.3, bullet 1) be getting back the same child. She would, furthermore, be using the act of cloning as a way of coming to terms with her loss and grief. In this case she may not come to terms with the losses, which unresolved trauma may store up we know not what untold difficulties in the future.

The case of cloning a child to save the life of one in kidney failure would not only run counter to the moral argument about using a human being as a means to the ends of another (as is noted in 8.3, bullet 2), it would also involve many relationship complications. Would the child be reared from the outset in the knowledge that s/he was born to save her/his sib? what if the sib died before the donation could take place? what value would the parents see the cloned child as then having?

The proposal in 8.3 bullet 3, that a person may wish a clone to 'cheat death' - to achieve a spurious immortality - lays bare a difficulty which underlies much of the drive towards the development of technologies such as cloning and other human reproductive interventions, namely that we not only wish to control nature but also to beat death. In 7.2 it is suggested that nuclear replacement technology could offer insight into ageing, among other developmental processes, another attempt to deny the nature of the human being (along with all other beings) to age and die. There is no evidence that such denial will improve the human lot.

The issue of the problems involved in deciding what are 'desirable characteristics' in offspring has already been touched on in the answer to Q.1. The risks that having chosen the offspring, s/he might not come up to scratch for other reasons may be high. How would this be tolerated where the offspring has been 'chosen' in some detail?

Question 4: Would the creation of a clone of a human person be an ethically unacceptable act?

Response Summary
The creation of a clone of a human person would be an ethically unacceptable act. No case has been made for the ethical cloning of a human person in this consultation document or elsewhere.

Explanation
The consultation document points up a number of negative clinical and social risks that may accrue to the creation of human clones. These include unpredictable short and long term negative effects on the health and well being of the cloned individual; and instrumentalist treatment of cloned human beings (e.g. as experimental subjects, organic tissue banks or replacement individuals) with attendant risks of civil disenfranchisement or secondary citizenship. Such risks would seem to precisely violate accepted standards of ethical medical practice. Balanced against the largely rhetorical assertions of potential benefits, no case would seem possible to justify the production of human persons using cloning practices

Question 5: Would the likely cost in terms of failures and/or malformations inevitable in developing a programme of human reproductive cloning be ethically acceptable?

Response Summary
The likely cost in terms of failures and/or malformations inevitable in developing a programme of human reproductive cloning, which on evidence provided is likely to be high, would not be ethically acceptable.

Explanation
Our earlier responses suggest that the case for human reproductive cloning has not securely been made; on the contrary. Until such a case is made, there can be no suggestion of starting a programme. The inevitable cost in terms of failures and/or malformations underlines this. The treatment or disposal of failing or malformed foetuses raises difficult questions. Once a programme got past the 14 day stage these would be, by

law, potential human beings and after birth full legal citizens. Similarly, the necessary involvement of women in the proposed experimental practices (i.e. through processes derived from *in vitro* fertilisation, which themselves carry significant risks to health and safety) is not referred to in the consultation document. To experiment on human life, in the absence of a substantive rationale about its profound necessity, is a serious devaluation of human relationships and ethics. This problem is compounded where the impetus for and investment in such new technologies is largely confined to professional elites. It is also not clear that 'public accountability' necessarily ameliorates the problems that may accrue to what will be, effectively, closed door practices given that most lay people are not equipped to guide scientific practices.

Question 6: What ethical importance might be attached to the distinction between artificial processes for which there are parallels in natural processes and those for which there are not?

Response Summary
Scientific practices cannot be ethically validated by reference to apparent parallels with natural processes.

The use of parallels with 'nature' to justify laboratory based interventions represents flawed reasoning in a number of respects. First, there is no universal understanding of what may be meant by the indexical terms 'nature' 'artificial' or 'ethics' Rather, definitions of all of these terms are fiercely contested and culturally specific. The distinction, for example, between 'artificial' and 'natural' in this context is problematic, premised as it is on a misleading elision between ends (e.g. a twinned embryo) and means. For example, the laboratory based processes of cloning versus spontaneous *in utero* twinning are clearly not comparable. Ethical importance obviously accrues to both processes under discussion but they are not the same. This problematic is compounded by a second implicit and untenable elision of 'ethics' with 'nature'. To attribute morality to biology both denies the scientific agency (the 'artificial') under question here and effectively moots ethical evaluation of that agency. Moreover, to assume 'nature' as a moral high ground confuses the meanings of both biology and morality. Many would contest the 'nature' (and apparent naturalness) of *in utero* instances of twinning for example. Even where there may be an absence of direct scientific agency and intent to produce twinned embryos in this context, the causes of *in utero* twinning cannot be divorced from the material context in which they occur. Can we say, for example, that the effect of some drugs based on 'natural' hormones to produce multiple pregnancies is an example of 'natural' or 'artificial' processes? Does one's answer depend on the 'nature' of the hormones or on the intent for which the hormones are prescribed or taken?

Re: Section 9.2: 'We will also be advising Ministers on ways to build public confidence in and understanding of new developments in genetic techniques. We would welcome any suggestions you may have on what this advice might be in respect of the implications of human cloning.

Your request that we provide advice on 'ways to build public confidence in and understanding of new developments in genetic techniques' would seem to invalidate the purpose of the consultation. An agenda to build public confidence in new developments in genetic techniques, for example human nuclear cloning, would seem to assume the ethical acceptability of the practice as a foregone conclusion. Yet is this not precisely the underpinning concern behind the 6 previous questions raised in the consultation document?

Our advice would be that what the public requires, as a prerequisite to proper consideration of the issues raised here, is a genetics education offered in the full context

in which genetic research and applications take place. Such an education would necessarily be interdisciplinary and could not be undertaken or offered by genetic scientists, practitioners or ethicists alone.

Above we have suggested that a number of, as yet unasked, questions need to be addressed in order that sound ethical evaluation of the new technologies may be undertaken. We have further suggested that these discussions are of critical importance not only for scientists, ethicists and social scientists, but for public understanding more generally. It is our strong view and deep concern that a full and detailed case, that closely and comprehensively examines issues of health, safety, discrimination and the historical, social, political and economic context of the science has not yet been undertaken. In the absence of such a case, no acceptable justification has yet been provided to rationalise expansions to the repertoire of genetic capabilities discussed in this document.

Again, we would advise that the first question that must be addressed is how to establish an ethical framework for the evaluation of proposed directions in genetic science.

[1] *These asserted beneficial outcomes include: accelerated production of transgenic animals used to produce therapeutic proteins (p. 4); production of histo-compatible tissues and organs (p. 7); 'improved knowledge' about disease, physiology and genotype (p. 14); and use in the human reproductive context to 'avoid the transmission of inherited diseases' (p. 15).*

The University of Warwick Centre for Research in Health Medicine and Society is composed of an interdisciplinary team of lecturers, professors, researchers and consultants concerned with the social aspects of health, medicine and science.

THE NEW GENETICS: COMMENT ON THE BRITISH MEDICAL JOURNAL SERIES

The BMJ recently published a series of articles, and an associated editorial, discussing the broader implications of the new genetics[i] It is to be welcomed that the BMJ seeks to inform its Readers of developments in the new genetics and their implications for clinical medicine, and begin to consider the 'broader issues' However, the way in which these issues are defined and discussed should itself be subject to critical analysis. As medical sociologists, we should be interested in the new genetics, not least because of its relevance to health, illness and medicine. However, we should be critical and challenging - promoting a sociology 'of' the new genetics, to adapt Strauss' distinction[ii] A sociology 'in' the new genetics is likely to develop anyway, as sociologists' skills and knowledge are required to assess new services and developments.

The series started with an article by Bell on the New Genetics in Clinical Practice. This outlines the way in which genetic information will impact and change clinical medicine. It is a promotional piece, suggesting transformational change in the way in which diseases will be defined and managed[iii] It is argued that this will be beneficial to the patient in terms of better treatment, and to the health service in terms of more focused allocation of resources. The article is important because it moves the discussion about the new genetics away from a focus on issues associated with screening and testing (although necessarily has to consider both to some extent), and on to a consideration of the new taxonomy of disease which will result from an increased genetic understanding of molecular biological processes and events, such that clinical symptoms and existing biological tests will be less and less relevant for diagnosis, prognosis and identification of

appropriate treatment. Problems associated with screening and testing have tended to dominate much of the debate about the implications of the new genetics to date, and these are also well covered in the subsequent articles.

Although the promises are more muted than the hyperbole associated with the early days of the Human Genome Project, Bell remains optimistic about developments over the next five to ten years, whereas the later articles are more cautious about the current achievements of the new genetics and the problem of the 'therapeutic gap', where the development of tests for genetic diseases is not rapidly followed by effective treatment as was once hoped. For Bell, the broader issues seem to be rather narrowly defined within the clinical context - the need for good evaluation, or technological hurdles to be overcome. However, analytical consideration of the wider context of developments in the genetics should be encouraged.

Of course, one of the implications of needing to (and being able to) understand genetic information about patients, is that testing, alongside or prior to the manifestation of symptoms, becomes important. The first article raises some of the problems associated with testing where there is little evidence of benefit - for example because of no treatment or proven prophylaxis, but does not address the issue of creating ever more at risk groups, or of understanding the complex relationship between environment and genes. Genetic factors may be used alongside other risk factors, but as Bell himself notes, there is pressure for applying this information in clinical practice before good evaluation. Yet, an analysis of the complex relationship between science, technology and social institutions which might generate such pressure is missing.

The scope for avoiding controversial debates while discussing anticipated developments is great; however, the articles looking at current practice are more cautious and critical. Marteau and Croyle's paper on psychological responses to genetic screening looks at the impact of testing on individuals, with some consideration of wider societal issues. Our knowledge of people's response to screening using non genetic tests is quite extensive. It is accepted that new screening programmes must be evaluated; that there is likely to be a range of factors affecting uptake; and that screening or testing may cause psychological harm. The article is thus able to draw on a range of recent research to consider the issues raised by screening. Individual responses have varied, and importantly, it seems that having more information is related to lower uptake of services. It is important that this observation does not lead to increased paternalism, nor mask a goal of screening to be high uptake, rather than the provision of good information to enable informed decisions. Ambivalence is likely to characterise people's response to genetic testing, whatever their familiarly history, especially if no effective treatment options are available. More knowledge is likely to increase ambivalence, as people negotiate a range of uncertainties rather than certainties in making their decisions[iv]. It is important that some of these complex social and cultural processes are unpacked through sociological analyses to complement the work of health psychology, where the emphasis is on the means through which a high quality service can be provided. The focus can then shift away from a separation of science from its application, thus including both in critical analysis.

The third article by Kinmouth, Reinhard, Bobrow and Pauker stresses the need to develop genetic expertise in primary care, and to foster public and professional awareness. However, it does not really address what the public need to be aware of, or who decides what information is relevant. There is a considerable critical body of research on the public understanding of science which demonstrates how complex people's relation to science is[v] There have been many calls for increased public debate in relation to the new genetics, but as the final article shows, we are a long way from anything approaching significant public involvement in science and health policy. This piece, by Holtzman and Shapiro is more cautionary than the first, stressing the limits to genetic testing and

mentioning the associated problems of discrimination and privacy. Again, although providing an interesting comparison between the frameworks developing in the UK and the USA, the focus is on how best to establish structures which will ensure safe and effective use of tests. Wider issues of eugenics, geneticisation and use of resources remain to be thoroughly explored.

Overall, there is passing reference made to the role of environmental factors in causing disease and influencing biological mechanisms, and little discussion of what research would be required to explore these interrelationships more fully. There is no discussion of how we should deal with the issues of resource allocation, where the new genetics in clinical practice may detract resources from public health programmes or social interventions. As is typical of professional discourse, lip service is paid to environmental factors, but genetic explanations are implicitly prioritised.[vi] Similarly, the broader issues of the limits to biological reductionism are not addressed, although reductionism has been seriously challenged on social and biological grounds.[vii] Scientific knowledge is portrayed as certain and fixed rather than ambiguous and contingent. In this sense, a discourse is created that genetic explanations and interventions are better, more accurate, and thus likely to bring improved outcome for patients. Bell argues that through the development of new pharmaceuticals, tailored increasingly to specific genotypes, drugs can better match the patient's ever more specifically defined disease. Clinical trials will begin to take genotyping into account, although there is little discussion of the difficulties involved in developing good randomised controlled trials in this changing context. More broadly, the social and political context of disease construction is side-stepped, and the contentious issues surrounding behavioural genetics ignored.

A further issue which is not addressed is the economic and political context of genetic research and the ever closer relationship between academic research and commercial interests, particularly in the USA. The role of biotechnology companies is highly relevant to the direction and application of research, no matter how well the clinical applications are evaluated. Genetic technology has moved biology into Big Science[viii] and has blurred even further the boundaries between basic and clinical research, research and its application. For sociologists wanting to engage in debates about the broader implications of advances in genetics, particularly in relation to medicine, they must do so, not only by considering issues such as the impact on patients, on families, and on health care resourcing, but through a consideration of the scientific developments themselves, working within the frameworks developed within the sociology of scientific knowledge. Otherwise, articles in the medical and scientific press which aim to foster wider debate and discussion may in fact serve to reinforce a divide between esoteric, technical, scientific knowledge, and its implications for clinical practice and 'society', leaving the former immune from critical analysis.

The new genetics can be seen as the rescuer of modern medicine. At a time when scepticism of scientific authority is high, and social and health inequalities are widening, this new knowledge both extends the medical gaze, possibly redefines the role of the body and of the patients' subjective experience, and creates a new expertise, ever more distant from both lay knowledge and indeed much practitioner knowledge. Individually focused medicine, matching individual patient's genetic profile to specific therapeutic options combines with creeping reductionism and geneticisation. The individual patient is both reified in such explanations, but also reduced and discounted, as the role of symptoms, patient experience, and personal illness narratives become less and less relevant for diagnosis and treatment. The doctor-patient relationship, once cherished by medicine and sociologists alike, is likely to be affected by such developments, although this is only tangentially considered in the third article in the series which considers the role of primary care.

In the associated editorial, Gill and Richards stress that the limits of genetic research must be considered, and that scientists should contribute to more balanced media reporting, thus implicitly recognising the role of scientists in generating sensationalist coverage. The editorial also identifies the need for open debate: it is important that sociologists are part of this debate. It is a good thing that the ethical, legal and social issues are being discussed in the BMJ and elsewhere. However, these discussions need to embrace the social context and construction of science and medicine, rather than focus on the social consequences. An analysis of power and inequality, which will continue to drive the relationship between genetic research, clinical medicine and the distribution and management of health and illness, must be part of this debate.

[i] Editorial 'Meeting the challenge of genetic advance' Mike Gill and Tessa Richards BMJ Vol 316; 21st Feb 1998: 570
John Bell 'The new genetics: the new genetics in clinical practice.' BMJ Vol 36; 21st Feb 1998: 618-620
Theresa M Marteau and Robert T Coyle 'The new genetic: Psychological responses to genetic testing.' BMJ Vol 316; 28th Feb 1998: 693-696
Ann Louise Kinmouth, John Reinhard, Martin Bobrow, Susan Pauker 'The new genetics: Implications for clinical services in Britain and the United States'. BMJ Vol 316; 7th Mar 1998: 767-770
Neil A Holtzman, David Shapiro 'The new genetics: Genetic testing and public policy' BMJ Vol 316; 14 Mar 1998: 852-855
[ii] Strauss R (1957) 'The Nature and Status of Medical Sociology' American Sociological Review, 22:200-4
[iii] For a consideration of scientists promotional strategies see Nelkin D (1994) Promotional metaphors and their popular appeal. Public Understanding of Science. 3:25-31
[iv] See Kerr A, Cunningham-Burley S and Amos A (1998) Drawing the line: an analysis of lay people's discussions about the new genetics. Public Understanding of Science & 113-133
[v] See for example, Wynne B (1991) Knowledges in Context. Science, Technology and Human Values 19:1-17
[vi] See for example Kerr A, Cunningham-Burley S, Amos A (1998) Eugenics and the New Genetics in Britain: Examining Contemporary Professionals' Accounts. Science, Technology and Human Values, Vol 23: 175-198
[vii] See for example Tauber A and Sarkar S (1992) The Human Genome Project: Has blind reductionism gone too far? Perspectives in Biology and Medicine, 35,2:220-235
[viii] See for example Rose H (1994) Love, Power and Knowledge. Polity Press, Cambridge, and Kelves D J (1992) Out of Eugenics: The historical politics of the Human Genome. In Kelves D J and Hood L (eds) The Code of Codes. Harvard University Press, Cambridge, Mass.

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Along with colleagues Anne Kerr and Amanda Amos, she has been involved in a study 'The Social and Cultural Impact of the New Genetics' funded under the ESRC Risk and Human Behaviour Programme. The final report is available on request (e-mail: Sarah.C.Burley@ed.ac.uk)

BOOK REVIEWS

This section publishes book reviews written by Readers. A number of books are available for review and Readers are encouraged to write a critique, in return for keeping the book.

Nasser M. (1997) Culture and weight consciousness London, Routledge (£12.95)

Mervat Nasser is a psychiatrist whose interest in the socio cultural factors which influence eating disorders led to a doctoral study comparing scores on an eating disorders measure (EAT) of Arab women studying in London and Cairo. In this book she reviews the evidence about the globalisation of eating disorders and reflects on the nature of transcultural research.

Eating disorders have been characterised as diseases of affluence, occurring amongst the dominant ethnic groups in Western industrialised countries. Yet Nasser's examination of the literature on the prevalence in non-western countries, and among different ethnic groups within Western society, suggests that, while the incidence remains highest in the US, eating disorders are becoming a global phenomenon. There are methodological problems with these studies and I doubt that many MSN Readers will be surprised to hear that cases of eating pathology tend to be found more or less wherever they are sought, and especially where there is treatment available. A plausible explanation for some of the results may be the unreliability of the EAT questionnaire, which is widely used in translation, although the adequacy of some of the indicators of anorexia such as 'I like my clothes to fit tightly' 'I cut my food into small pieces' and 'I like to eat my food slowly' must be of questionable validity in different cultures (p 45).

However, these methodological problems do not deter Nasser from concluding that assumptions about the rarity of eating pathologies in non-white Western populations may be inaccurate. Nasser suggests, drawing on her own research, that eating disorders are particularly likely to arise when there is discordance between the values of the individual and the society in which they live.

The chapter 'The other woman - immune or vulnerable ' considers the 'thinness ideal' as a feature of other cultures. This is dominated by a lengthy discussion (some seventeen pages) of the changing role of women in the middle east including an account of the position of women in Egypt, which sometimes slips into the anecdotal (or frankly gossipy). There is an uneasy imbalance in this chapter, where in contrast Latin American women and black feminism are each awarded about a page of discussion. I would have been happier with a more detailed analysis of the limited field than the rather cursory summaries which result from this attempt to be inclusive.

Nasser needs a more rigorous editor (although I have a suspicion that a good editor would have reduced the whole book to little more than a chapter). Too many sentences began with 'It is interesting .....' to which I found myself sternly muttering 'I'll be the judge of that' Enthusiasm can be infectious, but here it contributes to the rather undisciplined character of the text. The references to art, cinema, fashion and history are too muddled and superficial to be mistaken for scholarly eclecticism. There is an over abundance of exclamation marks (a form of punctuation which I think is rarely justified) , and the following odd turn of phrase on p14 ' There are two main approaches to this problem: each has its proponents and decibels ....' (perhaps a spell check response to a misspelling of *disciples*?).

I was drawn to the book because I thought it might be illuminating, but if I found the evidence of globablisation of eating disorders questionable, I found Nasser's argument that the standardisation 'inherent in market economies' and the role tensions experienced by women were the chief culprits, even less convincing. Perhaps this was because I felt too much of her argument rests on sweeping statements such as 'What every youth anywhere in the world now wants or aspires to, are the blue jeans, the designer T-shirt, the Big Mac and the Michael Jackson albums' (p102).......though in all honesty I was probably only moved to real outrage by the Michael Jackson albums.

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14th November 1997

Bowling, A. (1997) **Research methods in health: Investigating Health and Health Services** Buckingham, Open University Press.

Advice to reviewers generally begins, 'Do *not* begin "This is an encyclopaedic book..." But this is one of those books. It is crammed with information about research methods and many other things besides. However, taking the advice, and, inspired by my local Odeon cinema, I wondered how this tome might translate to the telephone... (...with apologies to AB).

"You are through to The Research Methods Helpline. The cost of your call today, at local rates, will be between 93p and £35, depending on your requirements. If you have a touch-tone telephone press * now. If not, we suggest you get one. For medical sociology, epidemiology, demography and health economics press 1, for philosophy press 2, and for research methods explained, press 3."

The caller presses 1. The voice continues, "You have selected 'Investigating health services and health' please state the nature of your disciplinary interest after the tone." There is a short beep. The caller says, "sociology." "...Welcome to everything you wanted to know about medical sociology (abridged). We have information on lay perspectives, illness behaviour - including classics such as the sick role (recently featured in MSN) (Dingwall R. MSN 1988; 24(1):54), oh, and we've stuck in some health psychology (locus of control, health action process model etc.) as well. We explain stratification (p23), although the Registrar General's Classification of Occupations is not illustrated, (please look elsewhere for this). There is a section on 'coping' (p24) but this is about stress, Bury's work on coping strategies (SHI 1991;13:451-681) comes later (p26). We clearly distinguish this work on health from that about health services (i.e. patient satisfaction and health related quality of life). We think you will find this distinction helpful. If you require further information, please state clearly now... For philosophy, press 2, for methods, press 3..."

"You have selected 'The philosophy, theory and practice of research' Please state your area of interest clearly after the tone." The caller jumps slightly and shouts "Popper" "...Thank you for asking about falsification and the hypthetico-deductive method. Today we have a rather fine illustration of the Popperian school of thought, taken from the Guardian letters page concerning BSE. This will be invaluable to callers wanting a nice, contemporary example of Popper's contribution (p107) for their students. ...Please state your next information requirement." "...How to get research grants..." "I'm glad you asked. We have very useful guide to writing a research proposals which takes you through from searching the literature to gaining ethical approval. We also provide a handy checklist (box 6.2, p125) so you can make sure you don't forget anything. We draw your attention to our comprehensive information on reliability (next time someone tells you they've checked item-item reliability you'll know what they are on about). You may also like to use the description

of *Cronbach's alpha* here (p132), instead of looking it up in the SPSS manual all the time. If you are thinking about doing research, please state your favoured research method after the tone, or, to return to the beginning, press *. " The caller, being of quantitative inclination, says "Questionnaires" "You have asked for information on 'Quantitative research: surveys' This section assumes that you have previously accessed our comprehensive information about sampling (chapter 7). We provide a short section about the history of the modern social survey and different types of study in which surveys can be used. We have detailed information about structured, semi-structured, postal and self-administered questionnaires and the crucial issue of response rates. Press 1 now if you would like us to take you through the do's and don'ts of questionnaire design. Press 2 if you want to train someone to do interviews for you (we have lots of useful tips for this), or press 3 if you want to know how to code your questionnaire. May we humbly remind you at this stage that qualitative methods may be combined with the techniques you have inquired about today - if you require further information about this, press 4. If you would like to end this call with our hot tip of the day please press #."

The caller presses #. "Thank you. May we suggest that you consider buying a copy of the excellent textbook Research Methods in Health. This is a useful reference for students of health research, and will no doubt put our phoneline out of business..."

We leave the caller purchasing the book, (by phone of course) and notice, as we go, an old copy of Nachmias and Nachmias (1981 Research methods in the social sciences) previously on the bookshelf, is now in the bin...

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Petersen A. and Bunton R. (eds.) (1997) **Foucault Health and Medicine**, London, Routledge (£14.99)

This book comprises of an excellent collection of essays considering how Foucaultian ideas can inform the sociology of health and illness, within a British, Australian and even Brazilian context.

The book opens with a Foreword, in which Bryan Turner questions the relevance of Foucault within a world that is now seen as 'postmodern', 'deregulated' and 'risky'. Recent maro social and economic processes such as: McDonaldization, the privatisation and marketization of health and welfare, etc. are not readily explainable within the Foucaultian paradigm of disciplinary society, that largely considers the micro-politics of surveillance and control. The challenge, Turner thus argues, is to comprehend the structure and institutions of postmodern society within the conceptual apparatus of Foucault's understanding of 'governmentality'

Turner's Foreword drew me instantly to the fourth part of the book (four essays on governmentality in relation to understanding contemporary health policy and health promotion). The first chapter, by Thomas Osborn, considers how discourses of medicine and health policy stand within liberal and neo-liberal political rationalities, constantly re-creating the elusive goal of health. Health policy, he thus argues, is a creative rather than reactive endeavour.

This is followed by my favourite essay in the book 'Risk, governance and the new public health', written by Alan Petersen. He brings together insights from Castel's notion of the

'epidemiological clinic' with Rose's description of 'advanced liberalism', in which the modern citizen is an active autonomous agent in his or her government (Castel 1991, Rose 1993).

Petersen thus paints a picture of health care, managed at a distance, without the presence of a concrete subject in face to face contact with a clinical expert, for the reduction of risk, rather than the treatment of illness. Health promotion messages, disseminated in a multiplicity of ways, about how to reduce risk (towards the impossible ideal of a risk free society) merge with our own projects of self-mastery / self-regulation / risk management.

Sarah Nettleton, in the next chapter, continues this theme of the 'risky self', stressing the productive aspects of disciplinary power, whereby individuals increasingly employ 'technologies to self' to produce their own health. Nettleton, like Robin Bunton in the final chapter, consider how health promotion messages are widely and variously disseminated through: television, magazines, etc. Throughout this part of the book comparisons are made between Foucault's ideas about technologies of self and 'pastoral power' and Giddens' concept of 'reflexive subjectivity' (Giddens 1991).

Back at the beginning, two chapters (one by David Armstrong, the other by Nick Fox) discuss the issue of how Foucault's writings can be variously interpreted. Armstrong opens his chapter renouncing the practice of searching for the truth of the author within the text; declaring to have no interest in the biographies of Foucault. Armstrong then goes on to give a personal account of his reading of Foucault's writings, highlighting how others (such as Turner) have otherwise interpreted Foucault's work. In the next chapter Fox also addresses the issue of authorship, arguing that in reading we engage intertextually and thus productively with the text. The concern of an intertextual approach (which Fox attempts to understand Foucault in the light of) is with the reader rather than the writer.

The second part of the book deals with how subjects (the criminally insane, the maladjusted child, etc.) have been constituted through discourse. Deborah Lupton's chapter gives and excellent account of how the orthodox medicalisation critique can be reconsidered in the light of Foucaultian ideas. She concludes that neither offer an adequate explanation of the mutual dependencies and the emotional and psychodynamic dimensions of the clinical encounter, emphasising that the patient and clinician are not entirely rational actors. Thus she advocates a psychodynamically informed sociology of the clinical encounter.

The third part of the book contains three chapters about he relationship between the body and the self. In the opening chapter Denise Gastaldo gives a very clear account of 'bio-power' and how it can be understood in relation to Brazilian health policy. Next Jennifer Harding considers how various medical and feminist discourses surrounding hormone replacement therapy have constructed women and femininity. Lastly Liz Eckermann discusses the meaning of voluntary self starvation, proposing that it at once demonstrates super-compliance and resistance. For the self-starter simultaneously strives for the secular saintliness of pastoral power, yet defies the authority of parents, teachers and the medical profession, in search for independent selfhood. Eckermann then goes on to discuss the nature of the passive and active self, and resistance in a disciplinary society.

Every one of the twelve chapters in the book (as well as the Foreword and Introduction) are clearly written, theoretically rich and a joy to read.

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Brandt, A.M. and Rozin, P. (eds.) (1997) **Morality and Health**. London, Routledge (£15.99)

As one could expect from a collection of authors with such impeccable credentials, this book of readings represents a rigorous multidisciplinary examination of the inseparability of medicine from morals, of illness from meaning and of health from values. A major advantage of such a multidisciplinary approach is to highlight the moral origins of cultural and historical diversity in attitudes and practices related to health and illness - the central role of context of time and place to moral-health complexes.

To differing degrees each of the chapters draws variously upon issues of stigmatisation, culpability, risk and individual responsibility from the perspectives of history, anthropology, sociology and philosophy. Some of the substantive topics discussed are those which we expect to lend themselves easily to moral examination and reproof such as smoking, drug and alcohol use, teenage pregnancy and drink-driving. Others are noted within medical sociology for the interlacing of lay and professional moralities which has been applied to germ theory, food use and the causal ontology of illness.

The moral undertones of the biomedical perspective are highlighted here by virtue of comparisons with cross-culturally and historically placed analyses. From Hindu moralities of Karmic debt to Chinese folk cultural attributions of "qi" (vitality); from Protestant notions of personal hygiene in the early modern period to secular morality and its effect on twentieth century health policy - the role of morality in the effectiveness of health-related communications, attitudes and practices is comprehensively surveyed.

Richard Shweder's (and others) chapter is particularly important in demonstrating the links between moral orders and causal explanations of illness which have consequences for views on suffering and blame. It is also important that discussions around the morality of disease are balanced by health moralities; so that Solomon Katz's chapter on secular morality looks at the background to the advocacy of health and fitness while Howard Leichter brings such advocacy up to date in a discussion of the moral power of lifestyle correctness. I particularly liked Sidney Mintz's short chapter on sugar. The relative recency of its introduction in a Western diet, its implications in slavery, its association with temptation, with luxury and excess and its ascetic renunciation all illustrate how easily a moral cast can be placed on the consumption of foodstuffs. Paul Rozin's concluding piece, read in the light of preceding chapters, puts moralisation on a par with medicalisation as an umbrella concept with which to frame health-related beliefs and practices from meat-eating to passive smoking.

Much of this book could have been written at any time in the last twenty years, especially given the stature and previous work of some of the contributors. But the argument gains depth and weightier evidence from the changing individual and cultural experiences of AIDS, smoking, food use and teenage pregnancy. It is a pity that there is nothing here on moralising and the new genetics - but I am sure there will be more than enough to read on that topic emerging in the next few years. In light of that many of these chapters will bear re-

reading and prove valuable in the increasingly moralising debates related to future health and medical practices.

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10/04/98

Green, J. (1997) Risk and Misfortune: **The Social Construction of Accidents**. London, UCL Press (£14.99)

"Ideal" accidents rarely occur, people frequently contest the application of the label, and seek to apportion responsibility and blame. We appear not to believe that there is "no good reason" for most misfortunes. Moral justification for victim damage can suggest a higher order of causal attribution, while professional analyses from the law or medicine - of physical cause - lead to estimations of likelihood of the occurrence of an event, which reduces accidents to almost inevitable situations dependent upon varying probability or risk. That accidents are socially constructed in such ways is enough justification for Judith Green's attempt to redress their neglect within the sociology of health and illness.

The management of risk and accountability for untoward outcomes are too important aspects of late modernity to be left to epidemiologists and actuaries. The narrow field of the sociology of accidents is briefly but competently surveyed, covering the concepts of disaster, systems failure, negligence, industrial injury and marginalised disease among others. Green shows how the study of accidents raises issues of governance and individual responsibility, thus it is pleasing to see Pareto's views on individual influence partially resuscitated if not fully revived. With more space a fuller discussion of the relevance of chaos or catastrophe theories to the concept of chance would also have been useful.

The archaeology of concepts is necessarily partial and selective and so potentially subject to the sort of extensive critique visited upon Foucault's work by historians. A review of anthropological history produces a series of conceptual maps which would appear to preclude indeterminate misfortune - witchcraft, Jungian synchronicity and the rational cosmologies of the modern period are all considered. Green's attempt to discover when it became possible - in modern Western culture at least - to have and to speak of "accidents" is an interesting question. This is the "dominant discourse" problem. In which social categories does this discourse dominate and what is the range of variation between the legal and political status of such discourse and its differential employment in common parlance or among different sectors of society? Thus the incorporation of the accident category into the nosology of morbidity and mortality in the nineteenth century merely solved a technical professional problem of taxonomy, and its diffuse influence on legal and popular views remains difficult to trace.

Accidents are still bureaucratically defined in a marginal manner - by the absence of any obvious intent and so subject to all the problems of validity and reliability that all such socially constructed administratively defined data face. It is doubly ironic that epidemiological risk factors for accidents have been subsequently calculated on the basis of correlations from such data. Chance factors in illness, disease and disablement would seem to remove the application of any moral overtones - this, clearly, is not the case and moral blame may be accorded to sufferer and/or therapist dependent upon postulations of even minor elements of responsibility for avoidable causes or unfavourable outcomes.

Green criticises medical sociology and social theory for not having produced an adequate theory of misfortune. By her own account this is understandable since analysis, by definition, renders the unaccountable predictable in retrospect. If we had known then what we know now, we come to see the event as inevitable - given certain accompanying conditions. That would be the accomplishment of all careful analysis and it is based upon the assumption that all events have a cause and that that cause can be identified.

One major omission from this work is the placing of accidents as a technique of neutralisation within the sociology of accounts tradition. As Green does show, accidents bear a particular relationship to lack of intent and minimised responsibility, but they are not entirely devoid of blame. Accidents are an account category which allocates responsibility to some "other" whether human or environmental agency, with a minimum of blame. Thus the application of the term to a situation or event fulfils a neutralising function in interpersonal relations which remains separate from any technical definition.

There is no denying the centrality of the concept of accident or misfortune to a risk society. Health promotion and accident prevention depend upon an understanding of unintended action and outcomes. A chapter dealing with stories of misfortune demonstrates this effectively. I enjoyed reading this well written book. In an underdeveloped area of study this is an essential starting point for anyone interested in risk, responsibility and blame in health and illness.

Ron Iphofen,
Faculty of Health Studies,
University of Wales, Bangor
10/04/98

Sinclair, S. (1997) **Making Doctors** Oxford, Berg (£14.99)

I have an unease about members of the medical profession presenting social accounts of their profession (I don't think I will be alone in this). However, Sinclair is not your usual representative of the profession: he is both medically qualified *and* an anthropologist. Certainly judging from the text I think he is now leaning more toward the anthropology these days, although he does provide a couple of instances in the book where he informally helps out students with clinical answers when they are put on the spot - obviously demonstrating he has a foot in both camps. Nevertheless, I feel this book provides an interesting and readable 'insider' account of the processes involved in the professional socialisation of medical students in this country.

The book is the outcome of Sinclair's PhD study. It is based on one year's fieldwork at University College London Medical School, where Sinclair observed and interviewed groups of students during three stages of their medical course: pre-clinical, clinical and house officer. Theoretically, Sinclair usefully extends Becker's notion of 'perspectives' while he also draws upon Bourdieu's concepts of 'dispositions' and 'habitus' (pp 17-38). The fusion of these concepts produces, what Sinclair calls, *medical habitus*. Essentially, this form of habitus is based on the acquisition of a range of medical dispositions which are learnt by students (informally and formally) and adopted during their five year training period. For me, this 'new' approach provides a further dimension and another helpful theoretical handle by which one can consider how doctors are 'made' by their educational institutions.

The book demonstrates that incorporation into medical habitus is a complex social and psychological process which eventually results in a change of student perception: from lay to medical. From their initial pre-clinical through to their house officer stage, students learn the

eight medical 'dispositions' of knowledge, responsibility, experience, co-operation, competition, idealism, status and economy. In examining the intricacies of *how* students actually absorb these varying dispositions, Sinclair presents medical student life in four differing platforms during their education: official frontstage (e.g. lectures, ward rounds); official backstage (e.g. library, hospital ward); unofficial frontstage (e.g. college sports, rag week activities) and unofficial backstage (e.g. student bar, doctors mess). I particularly enjoyed the descriptions from these various platforms, which provide a good flavour of the range of 'action' which occurs in each during the students' course. For example, the unofficial backstage - the student bar:

> "Vomiting after (even during) a drinking session is not disapproved of. When I asked, I was told, 'its shows you were trying', trying, presumably to keep up with others' drinking, a good example of Competitive Co-operation." (p109)

Although, as Sinclair notes, these varying dispositions can shift and become contradictory during the different stages of the course. For example, whereas co-operation is an important disposition for all students' pre-clinical stage, it becomes particularly strained during the house officer stage where loyalty to their firm is required first and foremost, thus any sense of wider co-operation requires re-assessment. The impact of these contradictory dispositions on students is also examined. Indeed, it seems that there is a pay-back when one enters medical habitus - an increased likelihood of some form of mental illness after qualification. Certainly, from Sinclair's discussion here and the range of the studies he draws upon (pp 309-17) there is a wider problem here for the medical profession. However, as this issue is only briefly explored at the end of the book one has the sense of it being 'tagged on' and distracting the reader from the central focus of the text.

For me, by adopting this 'longitudinal' approach, although Sinclair does capture the 'total' educational event - from pre-clinical student to house officer - he loses the depth. I did have the feeling that the book provides a series of medical student vignettes which lead the reader briskly through from the start to the end of their training. Maybe this is my problem, but I did feel some of the potential richness and complexity of this form of socialisation is not fully realised. I also felt Sinclair did not offer much into his relationship with the students and how it developed during the fieldwork - this is only touched upon from time to time in the text. Likewise, issues of both gender and ethnicity and how they impact upon medical education are only hinted at.

Overall, I enjoyed this book and it offers a valuable, well written and accessible account of what it takes to become a member of that esteemed profession, medicine.

Scott Reeves, City University
14 April 1998

Wilkinson R.G. (1996) **Unhealthy societies: the afflictions of inequality**, London, Routledge (£13.99 paperback)

The central thesis of this book is that the health of the population of developed countries is associated with the distribution of wealth *within* the country rather than the absolute level of wealth. For less developed countries, absolute levels of wealth and income are important for health, but for those countries which have advanced beyond a crucial stage in economic development when living standards reached a threshold level adequate to ensure basic material standards for all (the epidemiological transition), infectious disease give way to cancers and degenerative diseases as the main causes of death. Once this threshold is reached, the health of a particular country is not related to overall wealth or income per se,

but to their distribution within that country. So a country can be twice as rich as another without being any healthier. The USA is given as an example of where the richest country in the world has life expectancy over two years less than that of more egalitarian countries (in terms of income distribution) such as Switzerland, Sweden, Norway and the Netherlands.

Wilkinson argues that the powerful influence which relative income seems to have suggest that it is not so much a matter of what an individual's circumstances are in themselves but of their standing in relation to others: of where they place a person in the overall scale of things, and of the impact this has on psychological, emotional and social life.

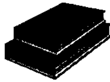
The first half of the book discusses the evidence to support the effect of income inequality on health, the second half discusses the possible mechanisms for the effect of relative income on health. The first half has plenty of graphs and figures to support the central argument, and most of the time quite complex material is handled fairly competently, making it reasonably easy to grasp the main story. The second half is very readable, not least because Wilkinson utilises a diverse range of material to substantiate his argument - one chapter is intriguingly entitled 'Baboons, civil servants and children's height'!

Wilkinson discounts, in the main, explanations such as health behaviours or health services and proffers social cohesion as the most important explanation for this central theme. He gives five examples of the way in which social structures have been associated with narrower income differences and better health. To take one example of war time Britain, Wilkinson draws on evidence showing that in the decades which include the two world wars, life expectancy increased by between six and seven years for both men and women and that this was more than twice as fast as the average rate of improvement during the rest of the century. Wilkinson argues that a narrowing of income differentials was accompanied by a greater sense of solidarity and social cohesion and that this was associated with improvements in life expectancy (for civilians). Wilkinson suggest that war may bring about social cohesion through solidarity in the face of a common enemy; a reduction in unemployment and income differences and the social division associated with them and government policy designed to foster a sense of social unity and co-operation in the war effort.

Support for Wilkinson's findings have not been universal however, Judge et al., for example, (Social Science and Medicine Vol. 46 Nos. 4-5 pp 567-579) find very little support for the view that income inequality is associated with variations in average levels of national health in rich industrial countries. The existing literature on the relationship between social cohesion and health has mainly concerned aggregate measure at the state (as in the case of the US) or county level and not at the individual level and mainly relies on proxy measure such as participation in local associations and organisations. More studies are required which directly measure 'social cohesion' to make this explanation more convincing. One point I would definitely take issue with is the assertion that poorer people in this country have a poorer diet because of 'comfort eating' (presumably to take their minds off the richer folks on knob hill) when there is a substantial body of evidence which demonstrates that the cost and availability of 'healthier' foods may be a major deterrent to people.

That said, I would recommend this book as essential reading for medical sociologists, it is thought provoking, stimulating and quite accessible. I would definitely have bought it if I hadn't got it for free for reviewing it for Med Soc News!

Anne Ellaway
MRC Medical Sociology Unit, Glasgow
April 1998



BOOKS AVAILABLE FOR REVIEW

Readers are encouraged to contact Paul Godin at City University (0171 505 5856) if they wish to review a book.

Annadale E (1998) **The Sociology of Health & Medicine: A Critical Introduction,** Oxford, Polity. (£12.95).

Angrosino M.V. (1998) **Opportunity House: Ethnographic Stories of Mental Retardation**, London, Sage.

Barbour R.S., Guro Huby (ed) 1998) **Medalling with Mythology: AIDS and the social construction of knowledge.** London, Routledge.

Baum A., Newman S., Weinman J., West R. and McManus C. (eds.) (1997) **Cambridge Handbook of Psychology, Health and Medicine.** Cambridge, Cambridge University Press.

Bendelow G. and Williams S. (1998) **Emotions in Social Life: Critical Themes and Contemporary Issues.** London, Routledge.

Bloom M. (1996) **Primary Prevention Practice,** London, Sage.

Burman E., Aitkin G., Alldred P., Billington T., Goldberg B., Gordo Lopez A.J., Heenan C., Marks D. and Warner S., (1996) **Psychology Discourse. From Regulation to Resistance Practice,** London, Taylor & Francis.

Bury M. (1997) **Health and Illness: In a Changing Society**, London, Routledge.

Field D., Hockey J., and Small N. (1997) **Death, Gender and Ethnicity.** London, Routledge.

Haggerty R., Serrod L., Garmezy N. and Rutter M. (1996) **Stress, risk and resilience in children and adolescents: processes, mechanisms and interventions.** Cambridge, Cambridge University Press.

Healy D. (1997) **The Anti-Depressant Era**. London, Harvard University Press.

Helfer M.E., Kempe R. and Krugman, (1997) 5th edition, **The Battered Child.** London, University of Chicago Press.

Holm S. (1997) **Ethical Problems in clinical practice: The ethical reasoning of health care professionals.** Manchester, Manchester University Press.

Jones C., Porter R. (eds) (1998) **Reassessing Focucault: Power medicine and the body.** London, Routledge

Landrie H., Klonoff A.E. (1997) **Discrimination against women: prevalence, consequences, remedies.** London, Sage.

Levin P (1997) **Making Social Policy: the mechanisms of government and politics, and how to investigate them.** Buckingham, Open University Press.

May T (1997) "**Social research: issues, methods and process**", Second Edition, Buckingham, Open University.

Miller G. & Holstein J.A. (1997) **Social problems in everyday life**, Volume 1 of Studiers of Social Problems Work, London, JAI Press.

Oskamp S. and Thompson S. (eds.) (1996) **Understanding and prevention HIV risk behaviour: Safer Sex and Drug Use.** London, Sage.

Ovretveit J. (1998) **Evaluating Health Interventions**, Buckinghamshire, Open University Press.

Posner T Natasha (1998) "**Herpes simplex: The Experience of Illness Series**", London, Routledge.

Robinson I. and Hunter M. (1998) **Motor neurone disease**, London, Routledge.

Robinson R. and Steiner A. (1998) "**Managed Health Care**", Buckingham, Open University Press.

Scambler G. and Higgs P (1998) **Modernity, Medicine and Health: medical sociology towards 2000**, London, Routledge.

Seymour W. (1998) **Remaking the body: rehabilitation and change**, London, Routledge,.

Warran M.A. (1997) **Moral status: obligations to persons and other living things.** Oxford, Oxford University Press.

FORTHCOMING CONFERENCES, MEETINGS & EVENTS

This section informs Readers of forthcoming conferences, meetings and events. No charges are made to non-profit making organisations for advertising. Readers are encouraged to send in details of local, national and international events, which may be of interest to other Medical Sociologists.

"WHAT WORKS": RESEARCH AND PRACTICE in Nursing, Midwifery and Health Visiting

25 June 1998
Leeds - Queen's Hotel

Presenting clinical research which investigates the effectiveness of nursing, midwifery and health visiting interventions.

Keynote speakers:

Dr Iain Chalmers, Director of UK Cochrane Centre
David Thompson, Professor of Nursing Research, Department of Health
Professor Maggie Pearson, Regional Director of R&D, NHS Executive North West

Concurrent sessions of research papers
Research skills workshops

Fee £85. To book a place at the conference and obtain details of the call for abstracts please contact: Beverley Hearris, Research Support Team, 22 Hyde Terrace, Leeds, LS2 9LN. Tel: 0113 233 5635 Fax: 0113 233 5653
http://www.leeds.ac.uk/healthcare/research/rst.conf98.html

THE NATIONAL HEALTH SERVICE PAST, PRESENT AND FUTURE

Friday 3 July 1998
9.00 am - 4.15 pm
Health and Social Research Centre
Venue: University of Brighton (Falmer campus)
A Conference to celebrate 50 Years of the NHS
Opening Address by Michael Foot
Cost: £40.00
Contact: Eleanor James on Tel: 01273 643466

"THE WORLD WIDE WEB AS AN AGENT OF INSTITUTIONAL CHANGE IN HIGHER EDUCATION"

Tuesday 16 June 1998

Venue: University of Bradford

Organised by: The Leicester TLTSN Centre
and the Learning Technology Centre
University of Bradford

This conference focuses on the new, widely accessible communications 'interface' that the WWW has brought to the HE sector. The WWW can profitably be exploited as a tool for teaching and learning as well as administration. The conference seeks to address these issues by offering practical, well-founded advice and a forum for discussion and collaboration.

Key Speakers: Professor Sir Brian Follett, Vice Chancellor, University of Warwick.
Gill Tucker, Dean of Learning and Teaching, Oxford Brookes University
Ross Chestney, Head of New Media, British Telecom
John Gray, Microsoft UK

Cost: £75.00 includes a delegate pack, lunch and refreshments

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GENDER INEQUALITIES AND REPRODUCTIVE HEALTH: CHANGING PRIORITIES IN AN ERA OF SOCIAL TRANSFORMATION AND GLOBALISATION

16th - 18th November 1998
Venue: Campinas, Brazil

Organised by : IUSSP committee on reproductive health and the population studies nucleus of University Campinas

This seminar will examine the linkages between gender inequalities in a society and reproductive health. The primary focus of this seminar will be to identify behaviours and services that enhance reproductive health and the role of gender inequality in constraining women's ability to identify their needs, engage in health enhancing behaviours and obtain services in both developed and developing countries. We are particularly interested in identifying gender specific sources of inequality and their intersection with other sources of inequality.

For further information, contact:

Maria Coleta De Oliveira- e-mail mcoleta@turing.unicamp.br
Sonalde Desai- e-mail sdesai@bss1.umd.edu
Anastasia Gage e-mail agage@usaid.gov

GOVERNMENT STATISTICAL SERVICE DISABILITY AND CARE: QUESTIONS AND NEEDS CONSIDERED

Monday June 15 1998

Venue: Skipton House, London Road, Elephant and Castle, London SE1 6LW

Organised by: Office for National Statistics and the Department of Health

This seminar has been organised in response to suggestions that harmonised questions on disability and care topics be introduced for government social surveys. The seminar aims to review existing simple questions on these topics and to discuss the needs of non-specialist users for cross-cutting data on these topics.

Cost: Free of Charge
To reserve a place, please e-mail magdalen.wiliams@ons.gov.uk

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WHAT YOU NEED IS WHAT YOU GET; OR IS IT

Wednesday 17 June 1998
Time: 9.30 am - 5.00 pm
Venue: University of Sheffield

A one day conference to explore and explain differences between use and need in health and related services. In considering inequalities in health, an important issue is whether there is equity in respect of use of health and related services for those with equivalent levels of need. The aim of the conference is to share our understanding of work to date on this topic, make links and foster collaboration, and to discuss and set up ideas for the future direction of research and of action (both local and national) in this area.

Cost: £40.00 includes sandwich lunch and refreshments

For further information please contact Dr Nick Payne, School of Health and Related Research (ScHARR) Sheffield of University, Regent Court, 30 Regent Street, Sheffield, S1 4DA

SURVEILLANCE: AN INTERDISCIPLINARY CONFERENCE

5th and 6th June 1998
Venue: Liverpool John Moores University, Liverpool

Organised by: School of Media, Critical and Creative Arts
Liverpool John Moores University

The key questions for the conference are:
Should we consider surveillance as control and coercion, as resistance, or as somewhere in between?
What is the relationship between fictions and aesthetic practices of surveillance and institutions of social control?

Are technologies and political systems of surveillance taking on a new importance in contemporary cultures?
Key Speakers: Elizabeth Stanko and Liz Stanley

Contact: Mary Corcoran or Nicole Mathews, Tel: 0151 231 5045/5054

HEALTH DEVOLUTION AND REGIONALISATION: IMPROVING HEALTH OR THE END OF THE NHS?

Tuesday 9 June 1998
Venue: St Bartholomew's Hospital, West Smithfield, London EC1

Organised by: Robert Hazell at the Constitution Unit in the School of Public Policy at University College London

The conference is for those interested in:
- The new strategies required by the public health Green Papers
- More effective cross-working at regional and local level
- The new approaches required by NHS, local government and other partners
- The implications for health of the Mayor for London and the new Regional Development Agencies.

Speakers will be from central government, health authorities, local authorities and regional organisations.

Cost: £250.00 which includes all refreshments and a conference reception after the meeting.

For further details or an application form please contact Dominic Wilkins, Programme Manager, Tel: 0171 288 3352, e-mail d.wilkins@ucl.ac.uk

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COMMUNICATIONS ACROSS PROFESSIONAL BOUNDARIES CAN TECHNOLOGY HELP?

23rd - 24th June 1998

Venue: Halifax Hall of Residence, The University of Sheffield

Organised By: The CTI Centre for Nursing and Midwifery
The British Computer Society
Nursing Specialist Education Focus Group
Institute of Health & Care Development Enabling People Programme

You should attend this conference if you are interested in, or working with, education and training of healthcare professionals.

Cost: £155 includes meals, room and conference dinner or £50.00 Day delegate rate, includes lunch.

For further details contact Gail Hible, Tel: 0114-272-8211

DECISION-MAKING IN THEORY AND PRACTICE

1st - 2nd July 1998
Venue: University College Oxford

Sponsored by the Economic Beliefs and Behaviour Research Programme of the Economic and Social Research Council

This conference will review our understanding of economic decision making and will be of interest primarily to economists, psychologists and sociologists working in this field. It will provide an opportunity for academics and others to discuss current research on the influence of perceptions of risk and uncertainty on choice behaviour, on the part played by social values, cultural factors and group identity, on the contribution of game theory and other methodological approaches, on the relevance of academic work to public policy developments involving markets and quasi-market and other related topics

Key Speakers: Professor George F. Loewenstein, Dept of Social and Decision Sciences, Carnegie Mellon University.
Professor Bruno S. Frey, Institute of Empirical Economic Research, University of Zurich.

Cost: £200.00 (this includes full board during the conference)

For further information contact Mrs Patricia Smith
Economic Beliefs and Behaviour Programme
Darwin College
University of Kent,
Canterbury, CT2 7NY
E-mail ebb.research@ukc.ac.uk

PROFESSIONAL PRACTICE IN MULTI-DISCIPLINARY WORK

One-week residential course 6th - 10th July 1998
Venue: University of Cambridge

Organised by: Group for Anthropology in Policy and Practice & Association of Social Anthropologists of the Commonwealth

The aims of this course are:
- To develop skills In working in diverse multi-disciplinary research and research-related contexts in the UK and overseas
- To increase awareness of a wide range of research and investigative methods, and their use within budget and time constraints
- To increase understanding of organisational contexts in which applied work is done
- To enhance personal and professional skills in teamworking and oral/written presentations to different types of audiences

Cost: varied fees
For further information please contact:
Inez-do-Rio, Course Administrator
16 Belfast Road London N16 6UH
Tel: 0181-806-0366

SOCIAL POLICY ASSOCIATION ANNUAL CONFERENCE 1998

14th - 16th July 1998
Venue: Lincoln
Organised by Department of Social Policy and Politics
School for Policy Studies
University of Lincolnshire and Humberside

The Conference is the major meeting for academics involved in social policy in the United Kingdom. For 1998 the Conference theme will be 'Social Policy in Time and Place'

Key Speakers: (to be confirmed)
Gail Lewis
Claus Offe
Clare Short

For further information please contact
SPA Conferences 1998
Room K113
School of Policy Studies
University of Lincolnshire and Humberside
Inglemire Avenue
Hull
HU6 7LU
Tel: 01428 440550
Fax: 01482 464376
e-mail twilkinson@humber.ac.uk

LEARNING AND TEACHING NURSING HISTORY

Tuesday 21 July 1998
9.00 am - 4.00 pm
Venue: Royal College of Nursing
Cowdray Hall
20 Cavendish Square
London W1M OAB

This conference aims to identify the key learning issues from nursing history, to share experiences of teaching nursing history nation-wide and build on successful teaching strategies. The aim is to explore the avenues of collaboration between nurse teachers and historians, and raise the profile of nursing history in the curriculum.

Cost: RCN & History of Nursing Society members £40.00
Non-members £60.00

For further details please call Sara Gorton on Tel 0171-647-3575

NEW METHODS FOR SURVEY RESEARCH

21st - 22nd August 1998
Chilworth Manor, Southampton

Organised by: *ASC- Association for Survey Computing*
CASS - Centre for Applied Social Surveys
(Southampton University and SCPR with Surrey University)
ONS - Office for National Statistics
MRS - Market Research Society

For further details contact Diana Elder ASC, 01494 793033 or visit ASC's WWW site
http://www.asursom.demon.co.uk/Events/C98

THE COMMERCIALIZATION OF GENETIC RESEARCH ETHICAL, LEGAL AND POLICY ISSUES

10th - 13th September 1998
Venue: Hotel Macdonald, Edmonton, Canada

This conference is organised by : Health Law Institute,
Faculty of Law and the Industry Liaison Office, University of Alberta.
The CRDP, Universite de Montreal
The Quebec Network of Applied Genetic Medicine
Office of Medical Bioethics, Faculty of Medicine, University of Calgary
Stanford University Program in Genomics, Ethics and Society

This conference will bring together international experts from a variety of disciplines to examine the ethical, legal and policy issues associated with the commercialization of genetic research.
Topics to be covered include:

- The commercialization environment
- Intellectual property and patenting issues
- Technology transfer and alternatives
- Conflicts of interest, confidentiality and non-publication agreements
- The regulation of commercialization
- Impact of market forces on perceptions of human genetics
- Commercialization and animal research

For more information, please contact:

Timothy Caulfield	Erin Nelson
Research Director	Project Manager
Health and Law Institute	Health and Law Institute
Law Centre	Law Centre
University of Alberta	University of Alberta
Edmonton, Canada T6G 2H5	Edmonton, Canada, T6G 2H5
e-mail-tcaulfld@law.ualberta.ca	e-mail-eneksib@law.ualberta.ca

6th INTERNATIONAL COCHRANE COLLOQUIUM

SYSTEMATIC REVIEWS: EVIDENCE FOR ACTION

22nd - 26th October 1998
Renaissance Harborplace Hotel
Baltimore, Mary Land, USA

This year's theme "Systematic Reviews: Evidence for Action" is designed to highlight the Collaboration's interest in partnering with providers, policy makers and the public to act on the evidence provided by systematic reviews. The 1998 Cochrane Colloquium will be a scientific meeting that combines both orientation, educational and working elements; the first day will serve as an introduction to the Collaboration for newcomers with subsequent days composed of small group meetings, workshops, and scientific plenary sessions. Plenaries will feature debates and presentations on key issues related to systematic reviews and evidence-based health care, with persons from both within and outside of the Collaboration

For further details , please contact:
6th International Cochrane Colloquium
c/o Courtesy Associates, 2000 L St,
N.W. Suite 710
Washington DC 20036
Tel: 1 202 973 8685
Fax: 1 202 331 0111
E-mail: http://www.cochrane.org

THE WOMEN'S HEALTH INITIATIVE WOMEN'S MINDS

6 November 1998
University of East Anglia

The Women's Health Initiative at UEA aims to provide a regional forum for women's health. This two conference is for health and social care professionals, clinicians, academics and people who are interested in issues surrounding women and their health. Social, legal, psychological and biological constructions of women/s minds/bodies will be explored.

Dr Jane Ussher
Professor Anne Oakley
Professor Mildred Blaxter

The conference fees are: £ 75.00 per day

For further information please contact:
Tracey Spinner Women's Health Initiative Conference
School of Health, Queen's Building
University of East Anglia
Norwich NR4 7TJ
Fax: 01603 593166

THE MADNESS IN METHODOLOGICAL SOCIAL SCIENCE

CALL FOR PAPERS

Saturday 14 November 1998
Keele University

The conference has been organised by a group of postgraduate research students within the Education Department at Keele University who formed a Discussion Group to act as a support network. Papers should focus on generic issues to do with how and why methods and methodologies used within the research process. The conference is focused at postgraduate students working within the social sciences. Papers are expected to reflect a range of experiences from those who are just beginning to explore methods and methodology to those who have worked through the research process and are writing it up.

For further details please contact: Richard Race
Education Department
Keele University
Staffordshire
ST5 5BG
E-mail: edd45@keele.ac.uk

'GENDER, POWER AND RESPONSIBILITY'

Saturday 14 November 1998
London Voluntary Sector Resource Centre
356 Holloway Road
London N7

FIRST CALL FOR PAPERS

Organised by
British Sociological Association Sexual Divisions Study Group

We are seeking proposals for papers or presentations around the general theme of 'Gender, Power and Responsibility' with reference to work / politics / management / sexuality / ethnicity / class etc. Both theoretical and empirical papers are encouraged.

For further details, please contact:
Mehreen Mirza
Department of Education Studies
University of Central Lancashire
Preston, PR1 2HE
Tel: 01772-893094
Fax: 01772-892922
E-mail-m.mirza@uclan.ac.uk

31st ESSEX SUMMER SCHOOL IN SOCIAL SCIENCE DATA ANALYSIS AND COLLECTION

4th July - 15th August

The Essex Summer School in Social Science Data Analysis and Collection offers over 40 Two week courses on social survey design and analysis.

For further details contact:
The Essex Summer School in Social Science Data Analysis & Collection
University of Essex
Colchester
Essex CO4 3SQ

Contact: Eric Tanenbaum 01206 872506
e-mail: **Error! Reference source not found.**
http://www.essex.ac.uk/summer98

CAQDAS NETWORKING PROJECT

QSR NUD*IST Version 4

Wednesday 10 June 1998
1 day intensive training workshop

Department of Sociology
University of Surrey
Guildford

The project runs a program of seminars which are free, at which developers and those involved in social research methodology raise issues for discussion which bear on the use and development of software in the field of qualitative data analysis.

For further details please contact
Anne Lewins
Ann@soc.surrey.ac.uk
Tel: 01483 259455
Fax: 01483 259551