

**BSA MEDICAL SOCIOLOGY GROUP**

**34th ANNUAL CONFERENCE**

**PROVISIONAL PROGRAMME**

**U n i v e r s i t y o f Y o r k**  
**27<sup>th</sup> – 29<sup>th</sup> September 2002**

# I N F O R M A T I O N   D I G E S T

## **Registration**

The conference office will be open in the Exhibition Centre from **12.00 noon** until 18.00 on Friday and from 09.00 on Saturday and Sunday. Please note that delegates should wear their conference badge at all times, otherwise you may be refused service at meals and in the bar.

## **Messages**

During the conference urgent messages can be passed on via Goodricke Porters' Lodge on 01904 433 100. In emergencies, contact Security on 01904 434 444. There will be a notice board situated outside the conference office in the Exhibition Centre where delegates can leave messages.

## **Programme Changes**

There will be a conference notice board for programme changes, general messages and announcements. It will be situated outside the conference office in the Exhibition Centre.

## **Newcomers/Postgraduates Reception**

You are warmly invited to come and have a drink and meet each other and members of the committee on Friday evening at 20.00 in room PT007, in the Exhibition Centre.

## **Meals**

All meals are served in Goodricke College Refectory. A cash snack bar will be open on Friday 27<sup>th</sup> September from 11.30 – 14.30 in the Exhibition Centre.

## **Tea and Coffee**

Tea and coffee will be served concurrently with papers in the Exhibition Centre, at the times specified in the Conference Timetable on page 6. Water coolers are available in the exhibition centre.

## **Plenary Sessions**

Dr Marina Barnard, Centre for Drug Misuse, University of Glasgow, will speak on 'Breaking into silence: the rude incursions of the sociologist' on **Friday 27<sup>th</sup> September at 17:05** in lecture theatre P/X001 in the Exhibition Centre.

Professor John McKinlay, Senior Vice president and Chief Scientist, (New England Research Institutes) and Consultant, Division of Medicine, Massachusetts General Hospital (Harvard Medical School) will speak on 'Medical Sociology: where have we been and where are we going?' on **Sunday 29<sup>th</sup> September at 11.45** in lecture theatre P/X001 in the Exhibition Centre.

## **Poster Exhibition**

Posters will be displayed in the Exhibition Centre from Saturday morning. There is a designated poster viewing time from 16:00 until 17:00 on Saturday, and presenters will be available during this time to discuss their work. Additional times may be indicated on individual posters.

### **Photocopying and faxing**

Photocopying (paper and transparencies) and faxing is available for a small charge between 08.15 – 17.45 (weekdays) and 08.30 – 17.30 (weekends) from the Conference Support Office located on the ground floor of the Exhibition Centre. The internal phone number for the Conference Support Office is x 4424. Incoming faxes should be sent to 01904 434 423. Please state clearly the title of the conference and the recipient.

### **Email**

Email facilities are available at terminals across the campus. A temporary username and password is available from the conference office.

### **PowerPoint**

All meeting rooms will be equipped with an overhead projector, screen, flip chart, powerpoint and laptop/appropriate computer. Anyone with any queries about their powerpoint presentation should contact Michael Traynor via the conference office.

### **Publishers Reception**

Publishers will hold a reception on Saturday evening from 19.00 until 20.30 in the Exhibition Centre where the Publishers' exhibition is situated. Everyone is welcome.

### **Meeting Rooms**

The parallel paper sessions will take place in the **Exhibition Centre**, rooms P/L001, P/L002, P/L005, P/L006, P/T007 and P/X001 and **Goodricke College**, rooms G/020 and G/045.

### **Jo Campling** (academic publishing)

Jo Campling will give a talk, "Getting started: For New Authors and Postgraduates" on Friday at 18.15 in room P/L001, in the Exhibition Centre. **Individual Consultations** with Jo, in room P/T107, can be booked at the Registration Desk or Conference Office.

### **Bar**

The bar at Goodricke College will be open from 18.00 until 01.00 on Friday evening. It will be open Saturday lunchtime from 12.00 until 14.00 and Saturday evening from 18.00 until 12.30. Please note that delegates should wear their conference badge at all times, otherwise you may be refused service in the bar. To provide additional seating and social space for delegates, a marquee has been erected along the lakeside between Goodricke College Restaurant and bar.

### **Entertainment**

There will be a Jazz Band from 20.30 followed by a disco on Saturday evening until 01.00 in the Exhibition Centre. A television is available for delegates to watch, in Goodricke Junior Common Room (G/JCR).

### **Crèche**

The crèche will be based in Goodricke College. Evening babysitting will be provided in James College. Any enquiries about the crèche or evening babysitting should be directed to Nicky Gibson at the conference office.

### **AGM**

The BSA Medical Sociology Group AGM will take place on Saturday in room P/L001 in the Exhibition Centre from 17.30 until 19.00. All delegates are welcome.

# DIRECTIONS TO THE UNIVERSITY OF YORK

## CONFERENCE LOCATION

The BSA Medical Sociology Group 34<sup>th</sup> Annual Conference is taking place at the University of York, Heslington. The conference site includes the Exhibition Centre, Goodricke College and James College.

**Please see below the following guidelines provided by York University on directions to York and how to reach the University of York.**

### By Rail

York is on the main East Coast Line from London King's Cross to Edinburgh. Fast trains leave from both north and south at frequent intervals. There is also a direct service across the Pennines between York, Leeds and Manchester Airport. The University is two miles from the railway station and you will need to get a bus or taxi onto campus.

An online rail timetable is available to help you to plan your journey at: <http://www.rail.co.uk>

### By Taxi

A journey by taxi from the railway station to the University will take approximately 15 minutes and cost around £5.00. There is a taxi rank just outside the station.

### By Bus

You can reach York by coach from many destinations around the country. National Express buses stop at the railway station. More details are available from their online coach timetable at: [www.nationalexpress.co.uk](http://www.nationalexpress.co.uk)

A number of companies operate buses to the University: the Nos. 4 and 5 depart from the railway station. The scheduled journey time from the railway station to Heslington is 20 minutes. Other services are the Y27, Y28, Y29, C2 and 65. The main bus station is at Rougier Street. There is an online Journey Planner for local bus services at: <http://www.ukbus.co.uk> and a bus summary for the University Bus is available at: <http://www.york.ac.uk/admin/presspr/bus.htm>

### By Car

Visitors approaching York from the A64 should turn off at one of the exits marked **University** (A19 or A1079), in order to avoid the City centre. Subsequent turns are also signposted. Visitors coming from other directions should either take the Selby road to Fulford and turn along Heslington Lane or Broadway towards Heslington or take the Hull Road and turn right at the first traffic lights into Green Dykes Lane which leads to University Road

The AA provides an online route planner for car journeys at:

[http://www.theaa.com/travelwatch/planner\\_main.jsp](http://www.theaa.com/travelwatch/planner_main.jsp).

If you are taking your car to the conference please note the University has introduced a new parking scheme. Though visitors will not be required to pay to park between 17.00 on Friday until 24.00 on Sunday, at all other times visitors will be required to purchase a ticket from a pay and display machine. Approximate parking charges:

Up to five hours £1.00    Five to ten hours £2.00    Twenty four hours £3.00

## By Bike

The University is well served with cycle paths and is currently improving cycle access and storage facilities. Cycle racks are available in most parts of campus. The City Council provides free copies of cycle route maps around the City of York at: <http://www.york.gov.uk/outabout/travelling/bike> and there is a network of cycle paths on campus. A map is available at: <http://www.york.ac.uk/np/maps/carbike.htm>

## Useful Maps

- a pdf map showing how to get from the city of York to Heslington Campus is available at: <http://www.york.ac.uk/np/maps/town.htm>
- a pdf map showing the location of buildings on Heslington campus is available at: <http://www.york.ac.uk/np/maps/hes.htm>
- a pdf map showing car parks, bike paths and bus stops on Heslington Campus is available at: <http://www.york.ac.uk/np/maps/carbike.htm>

Information is also available about parking at the University at: <http://www.york.ac.uk/np/maps/parking.htm>

An estimation of journey times follows below:

To York from:	Distance (Miles):	Average Time by Car:	Average Time by Rail:
<b>Cities</b>			
London	213	3hrs 35min	1hr 54min
Manchester	68	1hr 28min	1hr 30min
Bristol	244	4hrs 30min	4hrs
Edinburgh	197	4hrs 30min	2hrs 30min
Nottingham	77	1hr 30min	2hrs
<b>Ports</b>			
Dover	284	5hrs+	N/A
Hull	43	1hr	1hr 8min
Newcastle Upon Tyne	92	1hr 45min	1hr 30min
<b>Airports</b>			
Manchester (Airport)	84	1hr 30min	1hr 52min
Leeds Bradford (Airport)	31	1hr	40min
Heathrow (Airport)	214	4hrs	3hrs
Gatwick (Airport)	252	4hrs 30min	3hrs

# Y O R K

Places of interest include the Yorkshire Museum, the Jorvik Viking Centre, the Castle Museum, the National Railway Museum, the Bar Convent Museum and the York Dungeon. York Minster is world famous, and is well worth a visit. Much of the main shopping area in the city centre is traffic free through the day, so you can window shop or have tea in one of the many teashops without being bothered by fumes.

York operates Park and Ride services, and local buses run frequently through the day on the major routes – they are less frequent in the evenings.

**Visually impaired visitors may get advice from York Blind and Partially Sighted Society (tel. 01904 636269). Information is also available at:**

<http://www.doherty71.freeserve.co.uk/yorkblind.htm>

For details of transport concessions and facilities to assist people with disabilities, contact Environment and Development Services. Tel: (01904) 613161 ext. 1403.

The York Access Group have published an Access Booklet which complements their web site that informs disabled people and organisations about more specific accessibility to facilities like hotels, restaurants, transport (i.e. taxis and buses), public facilities, popular attractions in York and much more. Information is available at: <http://www.doherty71.freeserve.co.uk/access.htm>

**Taxis** (All York numbers, prefix with 01904)

ABC Blue Circle Taxis tel: 638787

Ace Taxis tel: 638888

Fleetways tel: 645333

Local Taxis tel: 641341

Station Taxis tel: 623332

Streamline Taxis tel: 623737

## EATING OUT

Information about accommodation and eating and drinking in York is available on the York tourist board web site at [www.york-tourism.co.uk](http://www.york-tourism.co.uk)

Information is also available on the York University web site at <http://www.york.ac.uk/> and the Alternative York website at <http://www.york-united-kingdom.co.uk/alternative/>

# BSA MEDICAL SOCIOLOGY GROUP COMMITTEE 2001/2002

## Conference Organisers (wearing yellow badges)

<b>Hannah Bradby</b>	Department of Sociology, University of Warwick	<b>Convenor</b>
<b>Davina Allen</b>	Nursing, Health and Social Care Research Centre TY DEWI SANT, School of Nursing Studies UWCM, Cardiff	<b>Publicity</b>
<b>Gillian Bendelow</b>	Department of Sociology, University of Warwick	<b>Publishers</b>
<b>Catherine Exley</b>	Department of Epidemiology & Public Health, University of Leicester	<b>Entertainment</b>
<b>Nina Hallowell</b>	Psychological Medicine, Royal Marsden Hospital, Sutton	<b>Programme</b>
<b>Jane Sandall</b>	Florence Nightingale School of Nursing and Midwifery, King's College London	<b>Programme</b>
<b>Michael Traynor</b>	Centre for Policy in Nursing Research, London School of Hygiene and Tropical Medicine, London	<b>Audio-visual and technical support</b>
<b>Edwin van Teijlingen</b>	Department of Public Health Medical School, University of Aberdeen	<b>Finances</b>
<b>Clare Williams</b>	Florence Nightingale School of Nursing and Midwifery, King's College London	<b>Programme</b>

## OTHER COMMITTEE MEMBERS

### **Sociology of Health & Illness** Editorial Team:

Robert Dingwall, Elizabeth Murphy, Alison Pilnick, University of Nottingham and Veronica James, University of Hull.

### **Medical Sociology News** Editorial Team:

Judith Green and Geraldine Leydon, London School of Hygiene and Tropical Medicine.

# T I M E T A B L E

## Friday 27th September 2002

- 12.00 onwards    **Registration for the conference [Exhibition Centre]**  
11.30 – 14.30    Cash snack-bar [Exhibition Centre]  
14.00 – 17.00    **Paper Sessions (8 Streams)**  
14.30 – 16.30    *Tea (running concurrently with papers) [Exhibition Centre]*
- 17.05 – 18.00    **Plenary: Dr Marina Barnard**  
**'Breaking into silence: the rude incursions of the sociologist'**  
[P/X001 in the Exhibition Centre]
- 18.15 – 19.00    Talk for new authors by Jo Campling [P/L001]  
18.30 – 20.00    DINNER [Goodricke College Refectory]  
20.00 – 21.00    Newcomers/Postgraduate Welcome Reception [P/T007]
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## Saturday 28th September 2002

- 07.45 – 09.00    BREAKFAST [Goodricke College Refectory]
- 09.00 – 12.30    **Paper Session (8 Streams)**
- 09.30 – 11.30    *Coffee (running concurrently with papers) [Exhibition Centre]*  
12.15 – 14.00    LUNCH [Goodricke College Refectory]
- 13.00 – 14.00    **Workshop 1: Social Aspects of Death, Dying and Bereavement Group [P/L005]**  
**Workshop 2: Teaching Sociology to Health Care Professionals [P/L006]**  
**Workshop 3: Human Reproduction Study Group [P/T007]**
- 14.00 – 17.25    **Paper Sessions (8 Streams)**
- 16.00 – 17.00    **Posters Session [Exhibition Centre]**
- 14.30 – 17.00    *Tea (running concurrently with papers) [Exhibition Centre]*  
17.30 – 19.00    **AGM [P/L001]**
- 19.00 – 20.30    Publishers' Reception [Exhibition Centre]  
18.30 – 20.00    DINNER [Goodricke College Refectory]
- 20.30            Jazz Band followed by disco until 1.00 am [Exhibition Centre]
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## Sunday 29th September 2002

- 07.45 – 09.00    BREAKFAST [Goodricke College Refectory]
- 09.00 – 11.40    **Paper Sessions (8 Streams)**  
11.00 – 11.40    **Workshop 4: Sociology of Cancer Study Group [G/020]**  
09.30 – 11.30    *Coffee (running concurrently with papers) [Exhibition Centre]*  
11.45 – 12.30    **Closing Plenary: Professor John McKinlay**  
**'Medical Sociology: Where have we been and where are we going?'**  
[P/X001 in the Exhibition Centre]
- 12.30 – 14.00    LUNCH [Goodricke College Refectory]
- End of Conference

# THE SOCIOLOGY OF HEALTH AND ILLNESS BOOK OF THE YEAR, 2002

The sociology of health and illness book prize will be awarded for the first time this year at the Medical Sociology Group Annual General Meeting (5:30pm, P/L001).

Four books have been short-listed. The particular contribution to the sociology of health and illness that the book makes is described below by the sociologist who made the nomination.

**Lynda Birke (1999) *Feminism and the Biological Body*. Edinburgh: Edinburgh University Press.**

Nominated by Carol Emslie.

Writing about 'the body' has become highly fashionable. However, few social scientists have attempted to engage with biological science. I nominated Lynda Birke's book for this prize because her biological training prompted her feminist analysis of the social and cultural construction of the body. Rather than the more common analysis of the body's surface, she engages with the way that the inner body is represented in biomedicine. She examines the abstract diagrams which represent bodies in medical texts and traces scientific ideas about the insides of bodies from dissection to reading displays on machines. I came across this book when I was writing about heart disease and I still find her case study on the heart, as a focus of metaphoric association and as a site of increased medical surveillance, particularly illuminating. The book is also extremely accessible with great pictures!

**Margaret Lock (2002) *Twice Dead. Organ Transplants and the Reinvention of Death*. Berkeley: University of California Press.**

Nominated by Ronnie Frankenberg.

"The composition of vast books is a laborious and impoverishing extravagance. To go on for five hundred pages developing an idea whose perfect oral exposition is possible in a few minutes! A better course of procedure is to pretend that these books already exist, and then to offer a resumé, a commentary".\*

I suppose many if not most people in MedSoc feel some sympathy with this ironic view of Borges's, so the first question about any book by a colleague might be was it really necessary and if so why. We can, and usually do, say what we need to in a paper or two. This book, unlike many, seems to me to be necessary for many telling reasons; Ethicists tend to prefer philosophers, theologians or even psychologists to us as advisers. This will show them what they are missing.

First, Lock provides, and makes strange in the technical sense, vivid and readable, even moving analytic descriptions of both operations involved, donor and recipient. Second she situates these procedures in the biographies of the participants before and after the event. Third she situates them in the history and tradition of Western and Oriental views of bodily death (not *orientalist* or in other ways patronising, she has studied Japanese practice and thinking at first hand, at length and in Japanese) and she is as aware of both Japan and of Canada as modern as well as traditional societies and explains why. She uses a comparative method as it should be used to point not only to similarity and difference but also to the non-inevitability of particular views and practices. It is not a matter of exoticism but of science and rational thinking applied in different ways. She demonstrates in detail the rational impossibility of absolute and uniform certainty within and between particular social and historical traditions.

Lock is, of course, alongside Scheper Hughes, Virginia Olesen, Bryan Turner and others, well known as a pioneer of the recognition of the significance of embodiment in sociological study. This book brings these particular dry bones (so to speak) to life. One of the major reasons for its importance is that its clarity makes it an ideal exemplar for both would-be medical sociologists and prospective clinicians (nursing, medical or other) to read at the beginning (and perhaps again at the formal conclusion) of their course of studies in order to see the relationship between theory and practice; humanism and science, personal and political. Finally, she accomplishes what we all aspire to, but usually fail to achieve, she makes clear and demonstrates in a way even sociological purists will find hard to refute the relevance for the general understanding of society at large, of sociology in, of and for, medicine. Medical sociology is still often despised and even its practitioners discriminated against as merely one of several narrow "applied" subdisciplines. Finally she reminds us as medical sociologists of what we can learn from writers as far apart in outlook, space and/or time as Bronfen, Bauman and Borges, Hacking and Heidegger and Hertz: Leach, Latour and Law, or Titmus, Tolstoy and Toynbee and, of course, alas only by virtue of her reporting, countless Japanese Scholars and Practitioners.

\*The Borges quotation is from the Foreword to 'The Garden of Forking Paths' (1941) reprinted in 'Fictions' (1944) which is reprinted in turn in 'Jorge Luis Borges' (1999) newly translated by Andrew Hurley Collected Fictions Allen Lane: The Penguin Press at p67. The quotation continues "That was Carlyle's procedure in Sartor Resartus, Butler's in The Fair Haven--though these works suffer under the imperfection that they themselves are books, and not a whit less tautological than the others. A more reasonable, more inept, and more lazy man, I have chosen to write notes on imaginary books. Those notes are 'Tlon, Uqbar, Orbis Tertius' and 'A Survey of the Works of Herbert Quain'."

**Stefan Timmermans (1999) *Sudden Death and the Myth of CPR*. Philadelphia: Temple University Press.**

Nominated by Robert Dingwall.

Timmermans' book is a classic ethnographic exposé of 'conventional wisdom'. The idea that CPR should be attempted universally has become increasingly prevalent, in the UK as much as in the US. Timmermans shows how few 'great saves' really occur. Doctors, patients and relatives are locked into a myth that wastes health care resources in the undignified treatment of dead or dying people. This is a shocking book, in the best sense of that word - it made me think in a very different way about something that I had never previously questioned. That's what great sociology is about.

**Tony Walter (2001) *On Bereavement. The culture of grief*. Buckingham: Open University Press.**

Nominated by David Field.

I nominated this book because it presents the first sustained attempt to provide a sociological conceptualisation of grief. The understanding of grief in Western societies has been shaped by psychological frameworks, especially psycho-dynamic ones, that focus upon the phases or stages that the grieving person passes through. Apart from Lyn Lofland's essay on loss, sociologists have not attempted to analyse the social dimensions of grief and how the experience of this emotion depends upon and is shaped by the social contexts and relationships of the bereaved. Walter's very readable tour de force utilises Durkheim's concepts of integration and regulation to discuss 'the integration of the dead and the living, and the regulation or policing of grief', drawing upon a range of anthropological and contemporary material to support his analysis. His book demonstrates the central significance of social factors in shaping of the experience of grief and the variety of ways that bereaved people reshape their relationships with those who have died. In doing so it challenges some basic assumptions of current psychological stage/phase conceptualisations of grief, especially the assumption that the grief is 'resolved' by 'moving on' from and 'letting go of' one's connection with the person who has died. The book demonstrates the contributions that a sociological perspective can make to the support and care offered by those working with the bereaved and has been well received by those working in the area of bereavement research.

Further details of the book prize can be found on the Medical Sociology Group website. <http://www.britsoc.org.uk/about/medsocindex.htm>

# PLENARY

Friday pm

17.05 - 18.00

Barnard, M.

University of Glasgow

## **BREAKING INTO SILENCE: THE RUDE INCURSIONS OF THE SOCIOLOGIST**

Empirical sociological inquiry is often undertaken on the basis of two key assumptions, one is that all knowledge and viewpoints are equally valid and two, that the research and the researcher will do no harm to the lives of those being studied. In this plenary I will use data drawn from recent research on the impact of problem drug use on parenting and child welfare to illustrate how both assumptions are problematic. The stigma of drug dependency and the fear that parents and particularly children have of separation in consequence of a parent's problem with drugs make this a highly charged area of enquiry. Not the least of this is the impulse to keep the problem hidden so that it often lies unacknowledged at the heart of the family dynamic. The inconsistencies between accounts provided by parents and by children, the obvious elisions and many silences were all testimony to the sensitivity and contested nature of this subject area. In such an arena the investigation of the problem could not assume that all viewpoints were equally valid and neither in consequence was it likely that its representation would be in everybody's equal interests.

Sunday am

11.45 - 12.30

McKinlay, J.

**Senior Vice president and Chief Scientist, (New England Research Institutes) and Consultant, Division of Medicine, Massachusetts General Hospital (Harvard Medical School)**

## **MEDICAL SOCIOLOGY: WHERE HAVE WE BEEN AND WHERE ARE WE GOING?**

This paper offers some general reflections on the field of medical sociology - theoretical, methodological and the value of certain lines of enquiry. Attention is given to appropriate levels of analysis and the need for development of an epidemiological imagination (which integrates a theoretically informed medical sociology with traditional epidemiology).

# POSTERS

Posters will be displayed in the Exhibition Centre from Saturday morning. Posters are listed in alphabetical order of first author. The abstracts below are not for reproduction without the prior permission of the author.

**Saturday pm** **1** **16.00 - 17.00**

**Cameron, W., Parry, J., Cook, D., Mathers, J., Saunders, P., Wain, R.** **University of Wolverhampton**

## **HEALTH COUNTS: FINDING SHARED WAYS TO MEASURE COMMUNITY HEALTH. RESEARCH TENSIONS AND METHODOLOGICAL CHALLENGES**

Research in progress (2001-2003) is seeking to find whether people in the community, people who work in public services and those working in the community and voluntary sectors can agree common ground in finding better ways to measure and monitor the health of the community. The project focuses on indicators other than those relating to disease and health service utilisation. It identifies and draws on a range of relevant data sets, including those collected routinely and non-routinely within the community and voluntary sectors, as well as within the non-health public sectors. The multi-method approach includes focus groups, key informant interviews and Delphi surveys.

A range of research tensions and methodological challenges are identified, which in large part mirror the multi-dimensional locus of the project and its substantial potential value and outcomes. The issues discussed include: tensions in drawing on perspectives on health, which may have different functions for people and professionals; complexities of combining different methodological approaches, particularly around social models of health, when a quantitative imperative underpins the project; the challenge and value of multi-disciplinary research; also working research strategies and responses.

The project, funded by the Department of Health under its Health Inequalities Programme, is being undertaken in the Black Country and Shropshire by a collaborative team from the Universities of Birmingham (Health Impact Assessment Research Unit) and Wolverhampton (Regional Research Institute).

**Saturday pm** **2** **16.00 - 17.00**

**Dyer, W.A.** **University of Durham**

## **IDENTIFICATION OF THE CAREERS OF MENTALLY DISORDERED OFFENDERS USING CLUSTER ANALYSIS IN A COMPLEX REALIST FRAMEWORK**

Custody diversion teams were introduced in order to divert mentally disordered offenders away from the criminal justice system and custody because of concerns about the growing prevalence of psychiatric disorder in prison populations.

This research explores the impact of one such team on the psychiatric and criminal careers of people referred to it. The framework provided by a complex realist approach, along with the technique cluster analysis, were used to identify and map the different institutional careers experienced by people referred to the Cleveland Diversion Team and the different paths their careers took as a consequence of the team's actions. Five different types of career were identified. Careers One and Two describe experiences of medicalisation - violent offenders with no psychiatric history who were referred, assessed and diagnosed but had no health or social care needs identified and were not referred again. Careers Three and Four describe experiences of criminalisation - violent offenders with a psychiatric history half of whom (Career Three) were referred, assessed and diagnosed, had health or social care needs identified and were not referred again; the remainder (Career Four) were not assessed or diagnosed, nor did they have needs identified and consequently all were re-referred repeatedly. Career Five represents neither medicalisation or criminalisation - individuals referred for information and for whom little else is known.

Saturday pm

3

16.00 - 17.00

**Forrest, K., van Teijlingen, E., McKee, L.,  
Simpson, S.A., Wilson, B.J., Haites, N., Matthews,  
E.**

**University of Aberdeen**

### **DISCOVERING AND DISCLOSING THE FAMILY DISEASE: STORIES FROM PEOPLE AT RISK OF HUNTINGTON'S DISEASE, AND THEIR PARTNERS**

#### Background

Our study supports clinical observations that people who have received genetic counselling for risk of a hereditary disease tell some relatives about their potential risk, but not others. This poster presents the findings from in-depth interviews conducted with people who had attended genetic counselling for risk of Huntington's Disease (HD), and some of their partners. Research into HD suggests that some people grow up knowing about the family disease, whilst others do not. Indeed, some only find out after the death of a parent or sibling, or after a relative has been diagnosed.

#### Methods

The interviews explored how participants found out about the disease; whether subsequent relatives had or had not been told; the factors, which influenced disclosure decisions; who should tell; and views of the genetic counselling process.

#### Results

The focus of this poster is upon the relationship between discovering and disclosing the family disease. We explored how and when participants found out about HD and the effect this had on subsequent family relationships and decisions to tell other relatives such as children and partners.

#### Conclusions

The impact of Huntington's disease on family dynamics may result in family secrets and/or living at risk. Overall, the findings suggest that the nature and extent of disclosure is highly dependent on a person's social, cultural and familial context. This study contributes towards a growing body of work exploring family communication about genetic risk and debates about how the 'new genetics' maybe (re)shaping and (re)structuring notions of identity, personhood and kinship.

Saturday pm

4

16.00 - 17.00

**Guassora, A.D.**

**Central Research Unit of General  
Practice, Denmark**

### **SMOKING CESSATION ADVICE TO ALL PATIENTS: CONSEQUENCES ON THE TRUST IN THE PATIENT-PHYSICIAN RELATIONSHIP**

Physicians in general practice as well as in hospital settings are urged by health authorities to give smoking cessation advice to all patients even if their illness or problem is not related to smoking. This mass-strategy for smoking cessation advice is aiming at a public health improvement. Physicians largely confine smoking cessation advice to consultations with patients suffering from smoking related illness, and patients motivated to quit smoking. Thus, smoking cessation advice, which is not a treatment of illness or requested by a patient who wants to stop smoking might possibly violate the established scope of concern in the consultation. Trust is characterized by an expectation that the trusted person behaves in a certain way and is based on shared social understanding and role expectations. Trust is generally given to a confined area and the functional specificity of the patient-physician relationship serves to confine the content of the consultation as to what can be brought up as discussion themes. If smoking cessation advice is brought up unexpectedly in the consultation it might negatively affect the trust in the patient-physician relationship.

The primary focus of this paper is on analysing possible consequences of giving smoking cessation advice to all patients in general practice settings. The analysis draws on role theory (Parsons 1951) and theory of trust (Luhmann 1979).

Saturday pm

5

16.00 - 17.00

Litva, A., Canvin, K., Jacoby, A., Gabbay, M.

University of Liverpool

**PROFESSIONAL PERCEPTIONS OF CLINICAL GOVERNANCE: FROM  
"ACCOUNTABILITY" TO "ZERO" EFFECT ON PUBLIC PERCEPTION OF THE NHS**

Clinical Governance was intended to shift focus onto the quality of healthcare by creating a framework of accountability and an environment of clinical excellence, with the objective of increasing public confidence in the NHS. This study examines PCG board members' (professionals) perceptions of Clinical Governance.

46% of all PCG board members in one Health Authority were interviewed. Interviews were tape recorded and transcribed verbatim. A coding framework was developed by the research team and then applied independently by two of the researchers.

PCG board members described their own and colleagues' difficulties understanding the term, and the detrimental consequences this had on Clinical Governance activities. Whilst these professionals were positive about the purpose of Clinical Governance and the activities they were engaged in, they had reservations about its feasibility. Understanding of the term and involvement in Clinical Governance activity depended to some extent on whether professionals were clinical or non-clinical board members.

PCG board members conceptualised Clinical Governance in a variety of ways and this has consequences for its implementation. The generally positive attitude expressed by these professionals towards Clinical Governance concurs with Government policy and political necessity in light of recent health care scandals. This may be accounted for by the fact that these findings comprise the opinions of PCG board members in particular, and not those of the wider primary care community.

Saturday pm

6

16.00 - 17.00

Payne, S.

University of Bristol

**EXPLAINING SEX AND GENDER DIFFERENCES IN IRRITABLE BOWEL  
SYNDROME: WHAT CAN NEW EPIDEMIOLOGY OFFER?**

Recent years have seen an increasing debate within epidemiology about the conceptual basis of the discipline's approach to the study of health inequality. This debate has opened the discipline itself to the charge of anti-feminist bias (Inhorn & Whittle, 2001).

This presentation draws on a multi-disciplinary literature review to develop a case study of irritable bowel syndrome (IBS). How might these newer conceptual models be applied to this specific condition? Do such approaches help conceptualise differences between women and men in risk of IBS, the experience of IBS, and what do these approaches offer for public health interventions in IBS?

Irritable bowel syndrome is a relatively widespread condition affecting up to 40% of the population. It is reported in both more developed countries and the less developed. It is a condition often described as a diagnosis of exclusion, after tests have ruled out other disease, and it is one with no proven effective treatment. In addition, it is a condition reported more often - throughout the world - by women than by men.

The paper uses two strands of new epidemiology to explore IBS. Critical epidemiology highlights the distinction between biological and gender-linked risk factors, allowing an exploration of the nature of interactions between hormonal factors and social ones. Feminist epidemiology offers a critique of the narrowness and anti-feminist bias of research, highlighting the failure of research to explicitly acknowledge distinct and interwoven aspects of sex and gender in both the risk of IBS and how the disease is experienced and treated.

**Saturday pm**

**7**

**16.00 - 17.00**

**Popay, J., Mallinson, S., Gatrell, A., Thomas, C.,  
Williams, G.**

**University of Lancaster**

### **OUT OF THE PAST: EXPLORING THE ROOTS OF HEALTH INEQUALITIES**

While recent work on social capital has extended our understanding of the role of the 'social' in the genesis of geographical inequalities in health experiences, there remain significant challenges for research in this field. We suggest that part of the problem is the lack of historical perspective in much contemporary research. Research which aims to understand the complexities, uncertainties and apparent contradictions of local people's accounts of 'place' in relation to other 'measures' of area characteristics needs to explore the historical roots of contemporary relationships. It is on this basis that we attempted to find ways of ensuring that our research incorporated a full use of historical resources.

In 2000/1 we conducted a pilot study using historical research methods, which was linked to a larger ESRC funded study of health and place. The pilot research aimed to explore the historical roots of the meanings local people attach to particular places. Using housing as a case study, we identified a wealth of material in local historical archives and generated new data in the form of oral histories from local residents, local politicians and senior/junior local government officers. The pilot research gave us the opportunity to consider the methodological challenges of using historical research methods alongside our existing social research programme and it generated some substantive findings on the history of relationships between local residents and local bureaucracy.

In this presentation we will outline the range of resources we identified, their different contributions to the research process, and our key findings.

**Saturday pm**

**8**

**16.00 - 17.00**

**Toiviainen, H.**

**STAKES, Finland**

### **PATIENTS AS ACTORS IN HEALTH CARE**

Different technologies are increasingly used in health care. Patients' position to technology is in transition. Patients are actively looking for information from different sources and requesting treatments and examinations. New situation provides companies a possibility to influence physicians via patients. This all may be connected to increasing individualism and consumerism in the society as well as healthism.

The aim of the study is to investigate patients as actors in health care. Study questions are: 1. What and why are physicians' opinions, experiences and views about consumer-patients and what influence they have?; 2. What are individual patients' and patient organisations' aims, possibilities and roles in health policy and as health care actors?; 3. From whose conditions and needs and to whose advantage the current diffusion of health technologies occurs?

Two large data are collected: 1. Physicians' opinions, experiences and views of consumer-patients as individuals and of collective patient association perspective are investigated by the physician questionnaire, of which was sent to all Finnish physicians in March 2002 by the Finnish Medical Association. In the future interviews of key informants may be done (e.g. among Finnish Medical Association, Ministry of Social Affairs and Health, The Social Insurance Institution of Finland); 2. Patient organisations' funding, relationship to industry as well as technology's position and marketing in the organisations are investigated by interviews of the chairpersons, leading officials and other key informants of the patient organisations as well as by budget proposals and budgets, action plans and annual reports, official records and newsletters.

**Saturday pm**

**9**

**16.00 - 17.00**

**Traynor, M.**

**London School of Hygiene and  
Tropical medicine**

**HOW NURSES READ RESEARCH: COMMUNICATING AND RECEIVING SCIENTIFIC  
PRODUCTS. RESEARCH IN PROGRESS**

This poster presents work in progress investigating how nurses read and comprehend a research paper. It draws on three theoretical areas: the sociology of scientific knowledge, feminist literary theory, cognitive research into the reading process.

Research suggests that scientific papers are not neutral channels of communication describing pre-existing objects, but persuasive texts originating from networks of scientists who are socially situated, often differently from intended users of research. Similarly, literary theory, particularly feminist theory, proposes that often when women read literature written by men they are positioned to 'identify against themselves' by an implicit or explicit male perspective. This has been said to account for a jarring and possibly undermining reading experience. The findings of cognitive research into reading suggest that understanding is a product of both the text and prior knowledge and viewpoint that the reader brings. This allows the possibility of differences in comprehension between groups due to differences in prior experience.

**Saturday pm**

**10**

**16.00 - 17.00**

**Wilson, A.M., Richards, M.P.M.**

**University of Cambridge**

**A QUALITATIVE STUDY OF CONCEPTS OF KINSHIP, INHERITANCE AND  
GENETICS IN YOUNG ADULTS**

Discussions about the complex interrelations of lay and professional scientific knowledge suggest a wide range of possible interactions between people's existing understanding of particular situations and those they may draw on from scientific work. Lay ideas about inheritance may be developed early in childhood in the context of the family and grounded in concepts of kinship, reinforced by everyday social activities and relationships. Such ideas would be particularly resistant to change and may conflict with Mendelian explanations, making the uptake of these scientific accounts of inheritance difficult. This would have implications for genetic counselling, the teaching of genetics and public knowledge in general. This qualitative study aims to explore connections between concepts of inheritance, genetics, family and kinship in a group of young adults.

The main questions asked in the research are:

- a) What are the participants' concepts of inheritance and of the processes by which inherited characteristics are transmitted by parents to their children?
- b) What are the participants' concepts of kinship and how are these related to concepts of inheritance?

A semi-structured interviewing approach, which encourages participants to provide views in their own terms of the concepts of inheritance, genetics and kinship, has been used. A series of vignettes investigates issues of duty and obligations between family members. Forty social science students and parents of young children have so far been interviewed. Findings from these interviews will be presented.

# WORKSHOPS

Listed in alphabetical order of workshop leader.

**Saturday pm**

**13.00 - 14.00**

**Komaromy, C.**

**Open University**

## **SOCIAL ASPECTS OF DEATH, DYING AND BEREAVEMENT GROUP**

There will be a meeting for members of the 'Social Aspects of Death, Dying and Bereavement' group at which we hope to discuss ideas for the future. At the moment we meet for an annual conference and it would be good to discuss what else we might want to do 'between' conferences that would be supportive, stimulating and fun. The session will be facilitated by Carol Komaromy, who is based at the Open University.

Anyone with an interest in this area is most welcome.

**Saturday pm**

**13.00 - 14.00**

**Letherby, G., Earle, S.**

**Coventry University**

## **THE HUMAN REPRODUCTION STUDY GROUP**

This will be an open meeting - everyone welcome. Please come along prepared to talk about your research, writing and teaching interests and to share ideas about future subject group events and activities.

Gayle Letherby, Coventry University and Sarah Earle, University College Northampton (co-convenors)

**Sunday am**

**11.00 - 11.40**

**Tritter, J., Moynihan, C.,  
Leydon, G.**

**University of Warwick**

## **SOCIOLOGY OF CANCER STUDY GROUP**

This session will provides an annual opportunity to review the work of the Sociology of Cancer Study Group, outline future plans and discuss a key set of issues that relate to research. The topic for discussion, initially broached at the 2nd Annual Conference is the impact on the researcher of studying cancer. We are currently developing resources to act as advice and support which will appear on the website. We will provide an initial presentation of our ideas and discuss how to develop them more fully.

We successfully organized a Sociology of Cancer Stream at the 2001 BSA Annual Meeting in Leicester and our 2nd Annual Study Group Conference. The growing interest in the area has implications for our plans for the 3rd Annual Study Group Conference. We also need to review and evaluate the Study Group Website.

We hope that all those who are currently involved in studying cancer or are interested in exploring this area will feel free to join and contribute their ideas.

**Saturday pm**

**13.00 - 14.00**

**van Teijlingen, E.**

**University of Aberdeen**

## **TEACHING SOCIOLOGY TO HEALTH CARE PROFESSIONALS**

This workshop will focus on assessment.

- What are the best ways of assessing social science learning among medical and nursing students?
- How to fit in sociological questions in a particular type of examination?
- What experience do people have using non-traditional types of examination for assessing sociology.

The medical faculties, for example, use MCQ, MEQ, OSCE, posters, etc. as methods of exam, and the social sciences are expected to slot in their (one or two) questions.

Everyone welcome.

## PAPER SESSIONS

<b>Friday pm</b>	<b>14.00 - 14.20</b>			<b>20 minutes</b>
STREAM	ROOM	PRESENTER	TITLE	
Health inequalities	PX001	Thomson, H.	COMPARING LAY REPORTS OF HEALTH AND PLACE IN TWO AREAS OF GLASGOW WITH CONTRASTING EXPERIENCES OF AREA REGENERATION	
Health/social care	G045	Shelton, P.	CHANGING CARE LABOUR: THE RESTRUCTURING OF NON-PROFESSIONAL HEALTH AND SOCIAL CARE	
Innovative health technologies	G020	Henwood, F.	MEDIA AND RISK: LEARNING FROM THE EXPERIENCES OF PATIENTS	
Primary care	PL005	Shaw, S.	THE DEVOLUTION OF PUBLIC HEALTH TO PRIMARY CARE TRUSTS - A MIXED BLESSING?	
Reproductive health	PL002	Pilnick, A.	"SO WE'RE GOING TO TALK ABOUT SCREENING TESTS": THE PRESENTATION OF NT SCREENING FOR FETAL ABNORMALITY	
Risk/lifecourse	PL001	Eborall, H.	GULLIBLE GUINEA PIG OR GOOD CITIZEN? ATTITUDES TOWARDS PARTICIPATING IN A RANDOMISED CONTROL TRIAL FOR PREVENTIVE MEDICINE	
Young people and health	PL006	McMurray, R.	PARENT PERSPECTIVES ON THE MMR VACCINE AT SECOND DOSE: WHAT INFLUENCES THE DECISION?	

<b>Friday pm</b>	<b>14.25 - 14.45</b>			<b>20 minutes</b>
STREAM	ROOM	PRESENTER	TITLE	
Health inequalities	PX001	Carlisle, S.	(NOT) TALKING ABOUT HEALTH INEQUALITIES IN A SOCIAL INCLUSION PARTNERSHIP	
Health/social care	G045	McColgan, G.	NURSING HOME CULTURE AND ITS IMPACT UPON PEOPLE WHO HAVE DEMENTIA	
Innovative health technologies	G020	Nettleton, S.	THE MANAGEMENT OF CHRONIC ILLNESS IN THE INFORMATION AGE	
Mental health	PT007	Prior, P.M.	MENTAL HEALTH CARE IN SCOTLAND: THE EMERGENCE OF TWO DISTINCT POPULATIONS	
Primary care	PL005	James, V.	BREAKING THROUGH: INNOVATIVE BUREAUCRACY AND PROFESSIONAL MANNERS IN PRIMARY CARE	
Reproductive health	PL002	Saetnan, A.R.	PROFESSIONAL STRATEGY, REALIST ONTOLOGY, MATHEMATICAL NAIVETÉ ...AND THE CONSTRUCTION OF RACE IN FETUSES	

Risk/lifecourse	PL001	Jackson, R.J.	DELIVERING HEALTH: A FOUCAULDIAN ANALYSIS OF THE STRATEGIC DEPLOYMENT OF 'HEALTH' AT THE POST OFFICE
Young people and health	PL006	Robson, K.F.	FOOD AND DRINK: FACTORS INFLUENCING PARENTS IN THE PROVISION OF CHILDREN'S DIET

**Friday pm** **14.50 - 15.30** **40 minutes**

STREAM	ROOM	PRESENTER	TITLE
Reproductive health	PL002	Draper, J.	'IT WAS A REAL GOOD SHOW': THE ULTRASOUND SCAN, FATHERS AND THE POWER OF VISUAL KNOWLEDGE

**Friday pm** **14.50 - 15.10** **20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Health inequalities	PX001	O'Neill, M.	TACKLING HEALTH INEQUALITIES IN THREE DISADVANTAGED POST INDUSTRIAL COMMUNITIES IN SOUTH WALES

Health/social care	G045	Meerabeau, E.	THE VIEWS OF RESIDENTIAL CARE HOME OWNERS ON THE IMPLEMENTATION OF THE CARE STANDARDS ACT
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Innovative health technologies	G020	Tangen, L.M.	SURFING FOR HEALTH: THE INTERNET AS HEALTH INFORMATION PROVIDER
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Mental health	PT007	Wong, L.	CHINESE MADNESS (DIAN KUANG) IN A U.K. METROPOLITAN CITY
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Primary care	PL005	Charles-Jones, H	THE REDISTRIBUTION OF WORK IN GENERAL PRACTICE: AN AID TO PATIENT CENTREDNESS OR A MANAGERIAL TOOL
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Risk/lifecourse	PL001	Owen, C.	GENDER PERFORMATIVITY AND THE CONSTRUCTION OF RISK NARRATIVES IN HEALTH PROMOTERS
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Young people and health	PL006	King, C.	DISCOURSES OF CARE ACROSS THE HEALTH/EDUCATION DIVIDE: CHILDREN WITH CHRONIC MEDICAL CONDITIONS IN SCHOOLS
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**Friday pm** **15.10 - 15.30** **20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Health inequalities	PX001	Huseby, B.M.	REGIONAL DIFFERENCES IN LIVING CONDITIONS AND HOSPITAL USE IN NORWAY

Health/social care	G045	Chesson, R.	HEALTH AND SOCIAL CARE RESEARCH - TIME FOR PARTNERSHIP WORKING?
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Mental health	PT007	Canvin, K.	THE PROFESSIONALISATION OF EXPERIENCE: MAKING EXPERIENCES OF MENTAL ILL HEALTH WORK
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Primary care	PL005	Prosser, H.	FOOLS RUSH IN WHERE ANGELS FEAR TO TREAD: DIFFERENCES IN HIGH AND LOW PRESCRIBING GPS' ATTITUDES AND APPROACH TO NEW DRUG PRESCRIBING
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Risk/lifecourse	PL001	Secker, J.	PROMOTING INDEPENDENCE - BUT PROMOTING WHAT AND HOW?
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**Friday pm** **15.35 - 16.15** **40 minutes**

STREAM	ROOM	PRESENTER	TITLE
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Health inequalities	PX001	Bunton, R.	MODERNISATION AND HEALTH ACTION ZONES
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Health/social care	G045	Bloor, M.	ETHNOGRAPHIC OBSERVATION OF ILLNESS BEHAVIOUR IN TWO CONTRASTING RESIDENTIAL SETTINGS
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Innovative health technologies	G020	Ziebland, S.	THE ROLE OF INTERNET HEALTH INFORMATION FOR MEN AND WOMEN WITH CANCER
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Primary care	PL005	Kelly, M.J.	NEED, COST, AND EVIDENCE: GP PERSPECTIVES ON INVOLVING PATIENTS IN PRESCRIBING DECISIONS
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Reproductive health	PL002	Jonsson, A-C	REPRODUCTIVE HEALTH AND THE RE-FORMATION OF THE NATURAL PROCESS OF CHILDBIRTH
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Risk/lifecourse	PL001	Hyde, M.	LIFECOURSE AND CONTEXTUAL FACTORS THAT INFLUENCE QUALITY OF LIFE IN EARLY OLD AGE
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Young people and health	PL006	Power, R.	'BODYLEARNING': A STUDY OF THREE YEARS OF OSTEOPATHY-IN-ACTION IN A UK 'SPECIAL' PRIMARY SCHOOL FOR CHILDREN WITH 'EMOTIONAL AND BEHAVIOURAL DIFICULTIES'
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**Friday pm** **15.35 - 15.55** **20 minutes**

STREAM	ROOM	PRESENTER	TITLE
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Mental health	PT007	Godin, P.	PSYCHIATRIC IDEOLOGIES IN A MEDIUM SECURE UNIT
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**Friday pm** **15.55 - 16.15** **20 minutes**

STREAM	ROOM	PRESENTER	TITLE
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Mental health	PT007	Speed, E.	MENTAL HEALTH SOCIAL MOVEMENTS AND THE REGULATION OF RATIONALITY: CONTRIBUTORS OR DETRACTORS?
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**Friday pm** **16.20 - 17.00** **40 minutes**

STREAM	ROOM	PRESENTER	TITLE
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Health inequalities	PX001	Kennedy, S.	HEALTH INEQUALITIES AND BARRIERS TO USING HEALTH CARE SERVICES: CONCLUSIONS OF A MIXED METHODS STUDY
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Health/social care	G045	Gabbay, J.	THE PROCESSES OF KNOWLEDGE MANAGEMENT IN MULTI-AGENCY CONSUMER-INFORMED HEALTH SERVICE AND SOCIAL CARE DEVELOPMENT GROUPS
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Mental health	PT007	Stevenson, F.	THE PERSPECTIVE OF USERS OF MOOD MODIFYING MEDICINES: THE DISTINCTION BETWEEN 'NATURAL' AND 'CHEMICAL'
Primary care	PL005	Stokes, T.	BREAKING THE RULES OF CONDUCT: PATIENTS' AND GENERAL PRACTITIONERS' ACCOUNTS OF REMOVAL FROM A GP'S LIST
Risk/lifecourse	PL001	Huby, G.	MANAGING UNCERTAINTY: ELDERLY PATIENTS' PARTICIPATION IN DECISION-MAKING ABOUT HOSPITAL DISCHARGE
Young people and health	PL006	Curtis, K.	'I'VE BEEN LIVING IN THIS BODY FOR 14 YEARS, LISTEN TO ME!' DEVELOPING TECHNIQUES TO EXPLORE CHILDREN AND YOUNG PEOPLE'S EXPERIENCES OF RECEIVING HEALTH SERVICES

**Friday pm** **16.20 - 16.40** **20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Innovative health technologies	G020	Melby, L.	CONTINGENCIES AND STRATEGIES IN MEDICAL INFORMATION SEEKING. MODELLING DOCTOR-COMPUTER RELATIONS
Reproductive health	PL002	Turner, S.	WHAT WOMEN REALLY WANT: DESIGNER BABIES AND WOMEN'S CHOICES

**Friday pm** **16.40 - 17.00** **20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Innovative health technologies	G020	Benjaminsen, S.	JETREK: HOW ORGANISATIONAL IDENTITIES SLOWED DOWN SPEEDY REQUISITIONS
Reproductive health	PL002	Frost, J.	WOMEN'S NARRATIVES OF OPERATIVE DELIVERIES IN THE SECOND STAGE OF LABOUR

**Friday pm** **17.05 - 18.00** **55 minutes**

STREAM	ROOM	PRESENTER	TITLE
Plenary	PX001	Barnard, M.	BREAKING INTO SILENCE: THE RUDE INCURSIONS OF THE SOCIOLOGIST

**Saturday am** **09.00 - 09.20** **20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Health care organisation	G020	Wood, F.	BORNA DISEASE VIRUS: THE SOCIAL ACCOMPLISHMENT OF A SCIENTIFIC PROJECT
Health inequalities	PX001	Maynard, M.	THE HEALTH OF BLACK CARIBBEAN ADOLESCENTS IN LONDON: THE IMPACT OF SOCIO-ECONOMIC CIRCUMSTANCES AND FAMILY LIFE
Men's health	PL006	Dolan, A.	'I AIN'T GOING TO SAY MY BALLS ARE ACHING': PROSTATE HEALTH AWARENESS AMONG MEN IN A WORKPLACE SETTING?
Mental health	PT007	Kendall, K.	CRITICAL INCIDENT REVIEW IN GENERAL PRACTICE AFTER PATIENT SUICIDES: EXTENDING THE CULTURE OF BLAME FOR GPs?

Primary care	PL005	Aranda, K.	TALK OF IN/EQUALITY: THE DISCURSIVE CONSTITUTION OF SELVES IN COMMUNITY NURSING
Risk/health behaviour	PL001	Highet, G.	THE INTERACTION OF GENDER AND PEER GROUP FACTORS ON YOUNG PEOPLE'S CANNABIS USE

**Saturday am** **09.25 - 09.45** **20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Health care organisation	G020	Tourette, M.A.	CONSTRUCTING CLINICAL GUIDELINES: AN ETHNOGRAPHIC CASE STUDY
Health/social care	G045	McDonald, E.	PARENTS' MANAGEMENT OF RISK AND CHILDHOOD VISUAL IMPAIRMENT
Primary care	PL005	Mallinson, S.	WHAT IS PUBLIC HEALTH? THE PERCEPTIONS OF PRIMARY CARE WORKERS

**Saturday am** **09.25 - 10.05** **40 minutes**

STREAM	ROOM	PRESENTER	TITLE
Health inequalities	PX001	Grewal, I.	ETHNIC INEQUALITIES IN THE QUALITY OF LIFE OF OLDER PEOPLE
Men's health	PL006	Kelly, D.	EMBODIMENT AND PROSTATE CANCER
Mental health	PT007	Redley, M.	PSYCHIATRISTS ACCOUNT FOR THE CAUSES OF SELF-HARM AMONGST A DEPRIVED POPULATION
Risk/health behaviour	PL001	Gregory, J.	PROCESSES OF NEGATION AND CHANGE IN THE MEANING OF ORAL HEALTH RELATED QUALITY OF LIFE: A QUALITATIVE STUDY

**Saturday am** **09.45 - 10.05** **20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Health care organisation	G020	Maseide, P.	SOCIAL FACTS AND MEDICAL REALITIES
Health/social care	G045	Clegg, S.	PARENTING A CHILD WITH VISUAL IMPAIRMENT - A 'CHRONIC ILLNESS' PERSPECTIVE
Primary care	PL005	Wirmann, E.	WHAT FACTORS AFFECT THE PUBLIC HEALTH ROLES OF PROFESSIONALS WORKING WITHIN A PRIMARY CARE PRACTICE?
Reproductive health	PL002	Shakespeare, J.	IT'S BABY FRIENDLY, BUT IS IT MOTHER FRIENDLY?

**Saturday am** **10.10 - 10.30** **20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Health care organisation	G020	Underland, G.	INFORMAL MEETINGS, FORMAL DECISIONS: THE INFORMAL CULTURE IN MEDIATING MEDICAL KNOWLEDGE AND INFORMATION AT A HOSPITAL
Health inequalities	PX001	MacFarlane, A.	MULTICULTURALISM IN THE REPUBLIC OF IRELAND: AN EMERGING HEALTH ISSUE

Health/social care	G045	Adamson, J.	BIOGRAPHICAL DISRUPTION/BIOGRAPHICAL REINFORCEMENT - THE EXPERIENCE OF SOUTH ASIAN AND AFRICAN/CARIBBEAN INFORMAL CARERS OF AN OLDER RELATIVE
Men's health	PL006	O'Brien, R.	"STANDING OUT FROM THE HERD": MEN'S EXPERIENCES OF NEGOTIATING MASCULINITY IN LIGHT OF ILLNESS
Mental health	PT007	Owens, C.	"THERE WAS NOTHING MEDICALLY WRONG WITH HIM." LAY UNDERSTANDINGS OF SUICIDE AND ITS RELATION TO MEDICINE
Primary care	PL005	Williams, J.	GENERAL PRACTICE AND THE CONCEPT OF DEPROFESSIONALIZATION
Reproductive health	PL002	Lankshear, G.	'ESTRANGED LABOURERS': MIDWIVES AND DOCTORS APPROACH TO WOMEN'S EMBODIED EXPERIENCE OF CHILDBIRTH
Risk/health behaviour	PL001	Cawley, M.	DOES MY BUM LOOK BIG IN THIS?: OBESITY AND PSYCHOLOGICAL HEALTH

### **Saturday am**

**10.35 - 10.55**

**20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Health care organisation	G020	Boddy, G.	POWER, POLICY, CULTURE AND THE APPLICATION TO NURSING PRACTICE
Health inequalities	PX001	Riley, A.J.	PREVENTING UNINTENTIONAL CHILDHOOD INJURIES THROUGH SURE START: A DEVELOPMENTAL APPROACH
Health/social care	G045	Garcia, C.	'GETTING MYSELF BACK' SOCIAL SUPPORT AND SELF-IDENTITY AMONG CARERS
Men's health	PL006	McGowan, F.	IDEALISED FITNESS: THE ROLE OF THE BODY IN MEN'S BIOGRAPHICAL NARRATIVES
Mental health	PT007	Killingbeck, J.	THE DILEMA OF A 'SELF': NEGOTIATING DEPRESSION AND SELF-IDENTITY
Primary care	PL005	Ehrich, K.	AN INNOVATIVE POLICY ANALYSIS: PRIMARY CARE, HUMAN RESOURCES, AND CONTINUITY OF CARE
Reproductive health	PL002	Denny, E.	"YOU'RE JUST ONE OF THE UNLUCKY ONES": DELAY IN THE DIAGNOSIS OF ENDOMETRIOSIS

### **Saturday am**

**11.00 - 11.40**

**40 minutes**

STREAM	ROOM	PRESENTER	TITLE
Health care organisation	G020	Ormrod, S.	THE TOPIC OF 'CULTURE' IN NHS POLICY AND METHODOLOGICAL IMPLICATIONS FOR THE STUDY OF HEALTHCARE ORGANISATION
Health/social care	G045	Baldwin, C.	ETHICS AND DEMENTIA: THE EXPERIENCE OF FAMILY CAREGIVERS

Men's health	PL006	Robertson, S.	"IF I LET A GOAL IN I'LL GET BEAT UP": CONTRADICTIONS IN MASCULINITY, SPORT AND HEALTH
Mental health	PT007	McNulty, A.	BEREAVEMENT SUPPORT: A COMPARISON STUDY OF BEREAVEMENTS FOLLOWING HOSPICE AND HOME DEATHS FROM CANCER
Primary care	PL005	Elston, M.A.	OUR PROBLEMS ARE CHICKENFEED TO THEM?: GPS' ACCOUNTS OF RELATIONSHIPS WITH THE POLICE
Reproductive health	PL002	Sandall, J.	THE EXOTIC AND THE MUNDANE: TRENDS IN THE SOCIOLOGY OF REPRODUCTION AND CHILDBIRTH

## Saturday am

**11.00 - 11.20 20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Health inequalities	PX001	Shaw, M.	WHAT'S THE BIG (HEALTH) ISSUE? CHARACTERISING AND CONNECTING BUYERS AND SELLERS OF THE BIG ISSUE
Risk/health behaviour	PL001	Wilkinson, K.	HEALTH RISKS, BODY RISKS AND FOOD COVERAGE IN WOMEN'S GENERAL INTEREST MAGAZINES

## Saturday am

**11.20 - 11.40**

**20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Risk/health behaviour	PL001	Barbour, R.S.	LAY AND MEDICAL REPRESENTATIONS OF OBESITY: TALES OF DISEASE, EPIDEMIC, GLUTTONY, SLOTH AND RACING GREYHOUNDS

## Saturday am

**11.45 - 12.30**

**40 minutes**

STREAM	ROOM	PRESENTER	TITLE
Men's health	PL006	Chapple, A.	"I TAKE THE PISS OUT OF LIFE BECAUSE IT'S THE ONLY WAY TO GET THROUGH IT": WHAT JOKES DO FOR MEN WITH TESTICULAR CANCER

## Saturday am

**11.45 - 12.05**

**20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Health care organisation	G020	Philpin, S.	'IF YOU DIDN'T LAUGH YOU'D CRY': THE USE OF HUMOUR TO MANAGE RELATIONSHIPS IN AN INTENSIVE THERAPY UNIT
Health inequalities	PX001	Mitchell, R.	IS GREED GOOD FOR YOU? UNPACKING RELATIONSHIPS BETWEEN ATTITUDE TO INCOME REDISTRIBUTION AND SELF-REPORTED HEALTH
Health/social care	G045	Fincham, L.	SUPPORTIVE CARE: EXPERIENCES OF CANCER PATIENTS AND HEALTH CARE PROFESSIONALS
Mental health	PT007	Lester, H	USER FOCUSED PRIMARY MENTAL HEALTH CARE: SHARING AND CARING OR MISSED OPPORTUNITIES FOR PARTNERSHIP

Primary care	PL005	Guest, C.	DECISIONS TO USE PRIMARY CARE: A QUALITATIVE STUDY IN URBAN AND RURAL GENERAL PRACTICE
Reproductive health	PL002	Panagos, M.	PARENTAL RIGHTS OF MEN AND WOMEN WITH HIV SEROPOSITIVE STATUS

**Saturday pm** **12.10 - 12.30** **20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Health care organisation	G020	Tarr, J.	WEIGHING THE ALTERNATIVES: ALEXANDER TECHNIQUE, ALTERNATIVE HEALTH AND ORTHODOX MEDICINE
Health inequalities	PX001	Barrow, S.	SELF-ASSESSED HEALTH: HOW ITS RELATION WITH SOCIAL FACTORS VARIES FROM OTHER MEASURES OF HEALTH
Health/social care	G045	Cameron, C.	ILLNESS: THE INVISIBLE NARRATIVE TRAJECTORIES OF CARERS AND CLINICIANS
Mental health	PT007	Poole, J.	RE-THINKING RECOVERY: BULIMIA AND BEYOND
Primary care	PL005	Pope, C.	WHY PEOPLE USE WALK-IN CENTRES
Reproductive health	PL002	Hudson, N.A.	INFERTILITY AND ETHNICITY: CONCEPTUAL, METHODOLOGICAL AND ETHICAL ISSUES IN AN APPLIED HEALTH RESEARCH PROJECT

**Saturday pm** **13.00 - 14.00** **60 minutes**

STREAM	ROOM	PRESENTER	TITLE
Workshop 1	PL005	Komaromy, C.	SOCIAL ASPECTS OF DEATH, DYING AND BEREAVEMENT GROUP
Workshop 2	PL006	van Teijlingen, E.	TEACHING SOCIOLOGY TO HEALTH CARE PROFESSIONALS
Workshop 3	PT007	Letherby, G.	THE HUMAN REPRODUCTION STUDY GROUP

**Saturday pm** **14.00 - 14.40** **40 minutes**

STREAM	ROOM	PRESENTER	TITLE
Chronic illness	G045	Nielsen, A.B.S.	HEALTH BEHAVIOUR AND COPING ASSOCIATED WITH CHANGE IN GLOBAL SELF-RATED HEALTH IN PATIENTS WITH TYPE 2-DIABETES
Gender and health	PL002	Hart, G.J.	DR FEELGOOD: THE MEDICALISATION OF SEXUAL BEHAVIOR
Genetics	PX001	Prior, L.	MAKING RISK VISIBLE. THE ROLE OF IMAGES IN THE ASSESSMENT OF (CANCER) GENETIC RISK
Health care organisation	G020	Cooke, H.	THE REGULATION OF EMOTION WORK IN NURSING
Health policy	PT007	Pinder, R.	MAPPING THE PATIENT PATHWAY: TOWARDS A CULTURAL CARTOGRAPHY OF THE NEW NHS

Lay/professional interface	PL005	Tritter, J.	WHO OWNS THE PATIENTS' VIEWS? VARIATION IN PROFESSIONAL RESPONSES TO USER INVOLVEMENT
Theory/ethics	PL001	Abraham, J.	DO WE NEED A POLITICAL SOCIOLOGY OF MEDICINE? A SYNTHESIS OF POLITICAL ECONOMY AND MEDICAL SOCIOLOGY

**Saturday pm** **14.00 - 14.20** **20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Teaching health professionals	PL006	Fenwick, A.	MEDICAL STUDENTS' APPROACHES TO WORKING WITH THE BODY

**Saturday pm** **14.20 - 14.40** **20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Teaching health professionals	PL006	Ragner, A.	GIRLS AND BOYS IN WHITE: MEDICAL STUDENT CULTURE 40 YEARS AFTER

**Saturday pm** **14.45 - 15.05** **20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Chronic illness	G045	Budge, F.	THE NEUROSOCIOLOGY OF STROKE
Gender and health	PL002	Graham, R.	SEXUAL VIOLATION AND MEDICAL DISCOURSE: ETHICS AND THE PELVIC EXAMINATION
Genetics	PX001	Hallowell, N.	BETTER THE DEVIL YOU KNOW: WOMEN'S UNDERSTANDING OF GENETIC RISK FOLLOWING BRCA1/2 MUTATION SEARCHING
Health care organisation	G020	Reed, C.	THE USE OF LIFE HISTORIES TO STUDY RECRUITMENT AND RETENTION OF COMMUNITY NURSES IN MANCHESTER
Health policy	PT007	Greener, I.	PATIENT CHOICE IN THE NHS: THE VIEW FROM ECONOMIC SOCIOLOGY
Lay/professional interface	PL005	Olumide, G.	PARTNERS OR CO-CONSPIRATORS?: PATIENT PARTNERSHIP IN A PAEDIATRIC CLINIC
Teaching health professionals	PL006	Blackburn, C.	MEDICAL STUDENTS' UNDERSTANDINGS OF SOCIAL FACTORS AND HEALTH AND EXPERIENCES OF STUDYING SOCIAL MEDICINE
Theory/ethics	PL001	Hausmann, E.	THE GROWING ACCEPTABILITY OF EUTHANASIA IN CONTEMPORARY SOCIETY: 'KILLING' AND 'LETTING DIE'

**Saturday pm** **15.10 - 15.50** **40 minutes**

STREAM	ROOM	PRESENTER	TITLE
Chronic illness	G045	Bülow, P.H.	"SHADOWS OF TIME" IN ILLNESS NARRATIVES: METHODOLOGICAL CONSIDERATIONS OF TEMPORALISATION IN INTERVIEW NARRATIVES

Gender and health	PL002	Bendelow, G.	'NORMAL' OR PATHOLOGICAL? WOMEN'S EMBODIED EXPERIENCES AND HEALTH-SEEKING BEHAVIOURS AT MID-LIFE
Health care organisation	G020	West, E.	THE EMOTIONAL COSTS OF CARING: HOW MEN AND WOMEN IN CARING JOBS FEEL AT THE END OF THE DAY
Health policy	PT007	Edgley, A.	'CAN'T GET NO SATISFACTION': THEORISING PUBLIC VIEWS ON HEALTHCARE
Lay/professional interface	PL005	Staniszewska, S.	THE MECHANICS OF PATIENT EVALUATION
Teaching health professionals	PL006	van Teijlingen, E.	A QUALITATIVE STUDY OF GP'S EXPERIENCE OF TEACHING A COMMUNITY COURSE (INCLUDING SOCIOLOGY) TO MEDICAL UNDERGRADUATES
Theory/ethics	PL001	Bickley, J.	A COLLAGE OF SPEECH AND SILENCE DISCOURSES: NOT-FOR-RESUSCITATION POWER/KNOWLEDGE

**Saturday pm** **15.10 - 15.30** **20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Genetics	PX001	Polzer, J.	GENETIC RISK AND GENDERED REGULATION: TOWARDS A CRITICAL PHENOMENOLOGY OF INHERITED BREAST CANCER SUSCEPTIBILITY

**Saturday pm** **15.30 - 15.50** **20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Genetics	PX001	Rowley, E.	WHO IS THE PATIENT? A CASE STUDY OF A GENETIC COUNSELLING CONSULTATION

**Saturday pm** **15.55 - 16.15** **20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Chronic illness	G045	Greenfield, S.	ELICITING ETHNIC MINORITY PATIENTS' VIEWS ABOUT CARDIAC REHABILITATION
Gender and health	PL002	Ballard, K.	EXPERIENCES OF THE MENOPAUSE: DOES SOCIAL CLASS MATTER?
Genetics	PX001	Pearce, M.	GENETIC COUNSELLING - MEDICAL TASKS AND A COUNSELLING ROLE
Health care organisation	G020	Timmons, S.	A DISPUTED OCCUPATIONAL BOUNDARY: OPERATING THEATRE NURSES AND OPERATING DEPARTMENT PRACTITIONERS
Health policy	PT007	Flicker, S.	HEALTH AS SOCIAL JUSTICE: A CRITIQUE OF POSTMODERN PERSPECTIVES ON NEOLIBERALISM, 'RISK' AND HEALTH POLICY
Lay/professional interface	PL005	Shaw, A.	FROM SCHISM TO CONTINUUM?: EXPLORING THE RELATIONSHIP BETWEEN LAY & EXPERT KNOWLEDGE: TWO CASE STUDIES

Teaching health professionals	PL006	Kitto, S.	EPISTEMOLOGICAL CHICKEN AND THE TEACHING OF HEALTH SOCIOLOGY IN AN AUSTRALIAN MEDICAL FACULTY: TALES FROM THE ANTIPODES
Theory/ethics	PL001	Dingwall, R.	SHOULD WE EVER ATTEMPT TO RESUSCITATE PEOPLE WITH CARDIAC ARRESTS?

**Saturday pm** **16.20 - 17.00** **40 minutes**

STREAM	ROOM	PRESENTER	TITLE
Chronic illness	G045	Fairhurst, E.	NORMAL, NATURAL LIFETIMES? SYSTEMIC LUPUS AND 'BODY WATCHING'
Gender and health	PL002	Collis, M.	KNOWING THE FEMALE BODY: HOW WOMEN THINK ABOUT AND IMAGINE THEIR 'INSIDES'
Genetics	PX001	Tutton, R.	EXPLORING FORMATIONS OF 'GENETIC SUBJECTHOOD'
Health care organisation	G020	Humphrey, C.	NHS DOCTORS IN PRIVATE PRACTICE: HEROES AND VILLAINS OR ORDINARY MEN?
Lay/professional interface	PL005	Edwards, C.	EXPLORATION OF PATIENTS' NATURALLY OCCURRING EVALUATION, WITHIN THEIR PROCESS OF REFLECTION ON THEIR HEALTHCARE EXPERIENCES
Theory/ethics	PL001	Williams, S.J.	MEDICINE, WARFARE AND THE (NEW) BIOLOGY OF TERROR(ISM): RAISING THE ISSUES FOR MEDICAL SOCIOLOGY

**Saturday pm** **16.20 - 16.40** **20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Health policy	PT007	Thomas, H.	GET WELL SOON: TIME, ILLNESS AND RECOVERY
Teaching health professionals	PL006	Dogra, N.	IDEAL TYPE MODELS FOR EDUCATIONAL PROGRAMMES TO TEACH CULTURAL DIVERSITY TO MEDICAL STUDENTS

**Saturday pm** **16.40 - 17.00** **20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Health policy	PT007	Price, L.	HEALTHY PARTNERSHIP OR FAUSTIAN PACT? THE INFLUENCE OF THE GLOBAL PHARMACEUTICAL INDUSTRY ON THE NATIONAL HEALTH SERVICE
Teaching health professionals	PL006	Iley, K.	TEACHING SOCIOLOGY TO HEALTHCARE PROFESSIONALS: MAKING A DIFFERENCE?

**Saturday pm****17.05 - 17.25 20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Gender and health	PL002	Morrow, R.	CULTURAL ASSUMPTIONS ABOUT SEXUAL DYSFUNCTION IN THE WORK OF WILLIAM MASTERS AND VIRGINIA JOHNSON
Teaching health professionals	PL006	Mowforth, G.	EXPERIENCES OF NURSING STUDENTS ON DIFFERING CURRICULA AND DELIVERY OF BEHAVIOURAL SCIENCES

**Saturday pm****17.05 - 17.25****20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Chronic illness	G045	Mold, F.	AFTER STROKE CARE: EXPLORING THE FACTORS WHICH MAY LEAD TO INEQUALITY
Genetics	PX001	Petersen, A.	BIO-GOVERNANCE: SOME IMPLICATIONS OF RECENT DEVELOPMENTS IN THE NEW GENETICS
Health care organisation	G020	Ellingsen, G.	ACHIEVING INTERDISCIPLINARITY IN HOSPITALS
Theory/ethics	PL001	López, J.	HOW SOCIOLOGY CAN SAVE BIOETHICS. . .MAYBE

**Sunday am****09.00 - 09.20****20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Gender and health	PL002	Walters, V.	GENDERED ACCOUNTS OF HEALTH AND ILLNESS: WOMEN AND MEN IN MID-LIFE
Health care organisation	G020	Brunt, E.	BIOMEDICAL POWER AND THE CHALLENGE OF COMPLEMENTARY MEDICINE
Innovative health technologies	PL001	Tjora, A.H.	THE NEGOTIATED ORDER OF MEDICAL EMERGENCIES
Lay/professional interface	PL005	Dhar, R.	SOCIO-CULTURAL DIMENSIONS OF DOCTOR-PATIENT INTERACTION UNDER DIFFERENT MEDICAL SYSTEMS

**Sunday am****09.25 - 10.10****40 minutes**

STREAM	ROOM	PRESENTER	TITLE
Bioethics/transplantation	G045	Mariados, P.	PUBLIC OPINION ON ORGAN DONATION IN CHENNAI, INDIA

**Sunday am****09.25 - 09.45****20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Gender and health	PL002	Ruston, A.	WOMEN'S BELIEFS ABOUT CORONARY HEART DISEASE: MANAGING PERSONAL RISK
Genetics/disability	PX001	Ellison, G.T.H.	EDITORIAL PERSPECTIVES ON THE USE OF RACE/ETHNICITY IN CONTEMPORARY GENETIC RESEARCH
Health care organisation	G020	Lewin, S.	HOSPITAL-BASED INTERPROFESSIONAL COLLABORATION: MEANINGS AND STRATEGIES
Health policy	PT007	Hobson-West, P.	A BREAKDOWN OF TRUST? ANTI-VACCINATION IN THE UK

Innovative health technologies	PL001	Hanssen, J-I.	THE QUEEN OF DIAGNOSTIC TOOLS; THE SOCIAL MEANING OF MRI
Lay/professional interface	PL005	Marceau, L.D.	BEYOND DOCTOR AND PATIENT: MACRO LEVEL INFLUENCES AFFECTING CLINICAL DECISION MAKING

**Sunday am** **09.50 - 10.10** **20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Health care organisation	G020	Hofseth, C.	THE NURSES' ROLE; OLD PROBLEMS AND NEW CHALLENGES
Innovative health technologies	PL001	Lie, T.A.	BIOTECHNOLOGY AS LEXICALISATION
Reproductive health	PL006	Guthrie, E.	HORROR STORIES AND HEROINES: THE CONSTRUCTION OF RISK BY WOMEN WITH EPILEPSY AND THEIR PROFESSIONAL ADVISORS

**Sunday am** **09.50 - 10.30** **40 minutes**

STREAM	ROOM	PRESENTER	TITLE
Gender and health	PL002	Young, E.	FRIENDS FOR DEATH: CAPTURING WOMEN'S TALK ABOUT FRIENDSHIP IN THE FACE OF IMMINENT DEATH DURING TELECONFERENCE FOCUS GROUPS
Genetics/disability	PX001	Leontowitsch, M.	DYSLEXIA AND DISABILITY - ANTAGONISTS IN A FORCED MARRIAGE?
Health policy	PT007	Gannik, D.	THE PROCESS OF LIBERALISATION: A THREAT TO GENERAL PRACTICE AND THE DOCTOR-PATIENT RELATIONSHIP
Lay/professional interface	PL005	Arber, S.	INEQUALITIES IN HEALTH CARE IN THE UK AND US: HOW PATIENT CHARACTERISTICS INFLUENCE DOCTORS' DECISION-MAKING

**Sunday am** **10.10 - 10.55** **40 minutes**

STREAM	ROOM	PRESENTER	TITLE
Bioethics/transplantation	G045	Chapman, E.	TRANSPLANTATION IN CYSTIC FIBROSIS: DONATION, ACCEPTANCE AND REJECTION
Innovative health technologies	PL001	Jones, A.	ELECTRONIC PATIENT RECORDS AND THE MATERNITY JOURNEY: PATHS OF DESIRE

**Sunday am** **10.10 - 10.30** **20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Health care organisation	G020	Goode, J.	NHS DIRECT - IS IT NURSING?
Reproductive health	PL006	Tsouroufli, M.	ABORTION IN GREECE: PARADOX OR CULTURAL REFLEX?

**Sunday am****10.35 - 10.55 20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Gender and health	PL002	Dhanda, R.K.	KNOWLEDGE, ATTITUDE AND PERCEPTION OF BREAST AND CERVICAL SCREENING AMONGST SOUTH ASIAN WOMEN
Genetics/disability	PX001	Levitt, M.	GENE WEEK: A NOVEL WAY OF CONSULTING THE PUBLIC
Health care organisation	G020	Spilsbury, K.	EXPLORING THE BOUNDARIES OF HEALTH CARE ASSISTANTS' PRACTICE
Health policy	PT007	Waring, J.J.	MEDICAL ERRORS, RISK MANAGEMENT AND THE PRINCIPLE OF "FIRST, DO NO HARM"
Lay/professional interface	PL005	Adams, A.	PRIMARY HEALTH CARE DECISIONS IN LATER LIFE: EXPLORING HOW DOCTORS THINK ABOUT OLDER PATIENTS
Reproductive health	PL006	Thomas, M.	SEXUAL HEALTH OF WOMEN WORKING ABOARD CRUISE SHIPS

**Sunday am****11.00 - 11.20****20 minutes**

STREAM	ROOM	PRESENTER	TITLE
Genetics/disability	PX001	Busby, H.	BLOOD DONATION FOR GENETIC RESEARCH IN THE UK: SOME THOUGHTS ON RISK, TRUST AND FAITH

**Sunday am****11.00 - 11.40****40 minutes**

STREAM	ROOM	PRESENTER	TITLE
Bioethics/transplantation	G045	Sasaki, K.	'GENEALOGY' OF THE NOTION OF DIFFERENCES IN JAPANESE MEDICAL PRACTICES OF ORGAN TRANSPLANTATION
Gender and health	PL002	Hislop, J.	THE AGEING OF SLEEP: THE RELATIONSHIP BETWEEN LIFE EVENTS AND PHYSIOLOGICAL FACTORS IN STRUCTURING OLDER WOMEN'S SLEEP
Lay/professional interface	PL005	Armstrong, D.	RESEARCHING THE SPACE OF THE CONSULTATION
Reproductive health	PL006	Seaman, P.	STRATEGIES FOR NEUTRALISING POTENTIAL STIGMA. UNDERSTANDINGS OF WHAT THE NEED FOR EMERGENCY CONTRACEPTION (EC) COULD MEAN
Workshop 4	G020	Tritter, J.	SOCIOLOGY OF CANCER STUDY GROUP

**Sunday am****11.45 - 12.30****45 minutes**

STREAM	ROOM	PRESENTER	TITLE
Plenary	PX001	McKinlay, J.	MEDICAL SOCIOLOGY: WHERE HAVE WE BEEN AND WHERE ARE WE GOING?

# PAPER ABSTRACTS

Listed in alphabetical order of first author. The abstracts below are not for reproduction without the prior permission of the author.

**Saturday pm**

**14.00 - 14.40**

**Abraham, J.**

**University of Sussex**

## **DO WE NEED A POLITICAL SOCIOLOGY OF MEDICINE? A SYNTHESIS OF POLITICAL ECONOMY AND MEDICAL SOCIOLOGY**

This paper examines how well medical sociology has fared in analysing the institutions of capitalism and the state, particularly in recent years. It is argued that, with the exception of the sub field of health inequalities, medical sociology has developed an unhealthy distance from political economy. This is compounded when institutional analysis is involved. If this trend continues, then political sociology, the sociological analysis of the institutions of capitalism, the state and civil society, may simply develop entirely separately from medical sociology. The consequence of this may be that medical sociology will tell us a great deal about the discourse, promotion, media representations, lay perceptions, professional-patient negotiations and socio-economic determinants, of health and medicine, but very little about institutions of capitalism and the state which impact upon medicine and health (e.g. the pharmaceutical, (petro-) chemical, nuclear and food industries, the government agencies and legislative bodies that regulate them, and the roles of the nation-state, supranational and global governance more generally). As an alternative, this paper argues for a productive theoretical synthesis between the institutional analytical focus of political economy, on the one hand, and medical sociology, on the other, in order to provide the basis for an empirical research programme in political sociology of medicine. One important consequence of this might be that medical sociology could play a much more confident role in public policy debates about the future of capitalism and the state, offsetting the tendency for them to be dominated by economic considerations and/or bureaucratic tradition.

**Sunday am**

**10.35 - 10.55**

**Adams, A., Buckingham, C., Arber, S.,  
McKinlay, J., Marceau, L.**

**University of Warwick**

## **PRIMARY HEALTH CARE DECISIONS IN LATER LIFE: EXPLORING HOW DOCTORS THINK ABOUT OLDER PATIENTS**

Ageism in health care provision is a widely recognised problem. Previous research demonstrates that a patient's age has an effect on the nature of the doctor-patient relationship and the outcomes of clinical decisions beyond its biomedical significance. This paper explores this effect, by providing a detailed analysis of how age influences the process by which UK general practitioners (GPs) and their US counterparts both assimilate and interpret identical clinical information about heart disease and depression in patients aged 55 years and 75 years. Our study's factorial experimental design, using video vignettes of doctor-patient consultations portrayed by actors, permits us to identify differences in how doctors think about these two groups, whilst simultaneously controlling for the effects of gender, race and class.

The study sample comprises randomly selected doctors: 128 in the US and 128 in the UK. This paper draws on their accounts of decision making collected during interviews in which structured information about diagnostic, treatment and patient management decisions was collected, and where doctors were also given a 'free recall' opportunity to describe their decision making processes during the video consultation.

Findings are presented from on-going qualitative analysis of these accounts of decision-making, and related to quantitative data about the outcomes of doctors' decisions. The analysis will help explain the role played by patients' age in clinical decisions and assist in identifying ways of reducing inequalities in primary health care provision for older patients in both the US and UK.

Supported by the National Institute of Health, National Institute On Aging, AG 16747.

**Saturday am**

**10.10 - 10.30**

**Adamson, J.**

**University of Bristol**

**BIOGRAPHICAL DISRUPTION/BIOGRAPHICAL REINFORCEMENT - THE  
EXPERIENCE OF SOUTH ASIAN AND AFRICAN/CARIBBEAN INFORMAL CARERS  
OF AN OLDER RELATIVE**

**Objectives**

Little has been written on informal care among minority ethnic groups in the UK. Using the theoretical framework of biographical disruption, this paper examines the meanings of being an informal carer of an older family member for South Asian and African/Caribbean carers.

**Methods**

The analysis presented here is based on qualitative interviews with 18 African/Caribbean and 12 South Asian carers. The study used maximum variation sampling to capture a range of caring relationships and individuals with diverse ethnic backgrounds. Interviews were carried out for the majority in their own homes, were tape recorded and transcribed. The constant comparison technique was used whereby recurring themes were identified and negative cases scrutinised.

**Results and discussion**

Drawing primarily on the notion of biographical disruption and more recent developments and refinements of this concept, including biographical reinforcement and 'normal crisis', the meanings of caring are examined. Bury's distinction between contingent, moral and core narratives, are used to examine the relationships between the immediate impact of caring and social identity of the carers set within the context of cultural connotations of caring. The implications of the findings, in terms of meeting health and social care needs of carers, is discussed.

**Saturday am**

**09.00 - 09.20**

**Aranda, K.**

**University of Brighton**

**TALK OF IN/EQUALITY: THE DISCURSIVE CONSTITUTION OF SELVES IN  
COMMUNITY NURSING**

One response to the increasing evidence of inequity and disadvantaged in health care has been to demand that practitioners promote equality and develop an 'anti-discriminatory/oppressive practice.' However, continuing inequalities are now argued to be indicative of inherent flaws in such initiatives. Postmodern critiques have challenged the grounds upon which these goals of equality are premised, revealed serious limitations to modern forms of equality and inferred its demise.

In this paper, I argue there are possibilities for re-thinking equality in health care and more specifically, in community nursing. I examine the discursive constitution of 'equal opportunities and anti-discriminatory practice', evident in the talk of twenty-eight community nurse students and practice teachers from two Universities. I show how the resultant narratives reveal the discursive constitution of various selves. I contend this complexity and diversity of selves when talking about in/equality and practice have previously been ignored. I argue that revealing and exploring these selves is critical to an understanding of the possibilities for re-visioning equality within community nursing practice.

**Sunday am**

**09.50 - 10.30**

**Arber, S., McKinlay, J., Adams, A., Marceau,  
L.**

**University of Surrey**

### **INEQUALITIES IN HEALTH CARE IN THE UK AND US: HOW PATIENT CHARACTERISTICS INFLUENCE DOCTORS' DECISION-MAKING**

This paper examines inequalities in health care in relation to clinical decision-making in the UK and the US. Inequalities in doctors' decision-making is considered in relation to two common conditions among mid-life and older people: coronary heart disease and depression. The former has been shown to be diagnosed more frequently among men and the latter among women. However, there is little previous research on how doctors' decisions are influenced by other patient characteristics, namely their age, class and race. This paper uses a factorial experimental design to disentangle the additive and interactive effects of four patient characteristics - gender, age (55 vs. 75), class and race - on doctors' decision-making. A stratified random sample of doctors in the UK and US were shown equivalent, culturally appropriate videos of doctor-patient interactions for each condition, following randomisation of combinations of these four patient characteristics.

We analyse how gender, age, class and race influence the likelihood of

- (1) doctors diagnosing CHD or depression,
- (2) the types of diagnostic tests ordered, and
- (3) the treatments recommended for patients.

The paper shows systematic differences in these areas of doctors' decision-making between the US and the UK, and what underlies these differences. The findings demonstrate the relative influence of patient characteristics, physician attributes and health system factors on doctors' clinical decision-making.

The research was funded by a National Institutes of Health/National Institute of Aging Grant #AG16747.

**Sunday am**

**11.00 - 11.40**

**Armstrong, D.**

**Kings College London**

### **RESEARCHING THE SPACE OF THE CONSULTATION**

This paper explores the methods that have been used over the last 50 years to study the encounter between doctor and patient. First, techniques will be described that have been used to 'stabilise' the consultation so that 'it' can be studied in the sociological laboratory. These techniques have ranged from theoretical fixing, through reports by doctors and/or patients, to audio- and video-taping. Once the consultation has been captured by one of these strategies it has been subjected to further interrogation by researchers in their laboratory'. Overall, these different methods have enabled a multiple and Transient event to be given tangible form and a central place in medico-sociological explanatory frameworks.

**Saturday am**

**11.00 - 11.40**

**Baldwin, C.**

**Institute of Health Sciences, University  
of Oxford**

### **ETHICS AND DEMENTIA: THE EXPERIENCE OF FAMILY CAREGIVERS**

This paper will report on an ongoing research project examining ethical issues in caring for someone with dementia from the perspective of family members who provide such care. While there is a lot written on ethical issues in dementia care this is the first such study that focuses explicitly on the experience of family members.

Approximately 40 family members from a wide range of backgrounds have been interviewed to solicit their accounts of caring and the difficult decisions they have had to make. Unstructured, open-ended questioning elicited long narratives, which were then used as a basis for follow up interviews, focusing on ethical decisions and the decision-making process. Interview transcripts were analysed as individual narratives (narrative analysis) and collectively in terms of themes and issues arising from carers' experiences (the analysis of narratives).

Family members have a unique perspective on the care of people with dementia and the range of ethical issues they face will be presented, together with video footage. The ethical underpinnings of their decision-making will also be examined. As such, we are afforded an insight into the moral lives of family carers.

**Saturday pm**

**15.55 - 16.15**

**Ballard, K.**

**King's College London**

### **EXPERIENCES OF THE MENOPAUSE: DOES SOCIAL CLASS MATTER?**

#### **Objectives**

The experience of the menopause has been found to vary across ethnic groups, with African-American women reporting fewer emotional symptoms than Caucasian-American women. Japanese women have also been found to report fewer hot flushes than Western women. Although in the past, American studies have shown that women from a higher social class are more likely to take hormone replacement therapy (HRT) than their lower social class counterparts, a recent British study of women aged 50 years, revealed the contrary. This paper considers the role of social class on women's experiences of the menopause and their use of HRT.

#### **Methods**

A postal survey sent to a random selection of 650 women registered with general practitioners in South-East England, achieving a 66% response rate. In addition to descriptive statistics, logistic regression analysis is presented.

#### **Results**

When compared to women from a higher social class, women from a lower social class report experiencing more severe menopausal symptoms. Social class differences were also found amongst women having a hysterectomy, with lower social class women having this operation more frequently than their higher social class counterparts. Possibly due to more severe symptoms, a greater proportion of women from a lower social class took HRT, although they took it for a shorter duration than women from a higher social class did.

#### **Conclusion**

Although the menopause is a biological event, social class differences in women's experiences highlights the importance of understanding the social context in which the menopause is experienced.

**Saturday am**

**11.20 - 11.40**

**Barbour, R.S., Guthrie, E., Brown, J.**

**University of Glasgow**

**LAY AND MEDICAL REPRESENTATIONS OF OBESITY: TALES OF DISEASE, EPIDEMIC, GLUTTONY, SLOTH AND RACING GREYHOUNDS**

Obesity is currently high on the public health agenda, with warnings of an unfolding global epidemic, increasing co-morbidity and mortality and concern about rising levels of childhood obesity, which have been accompanied by the production of clinical guidelines and targets. Public awareness is also high, and is reflected in a flourishing and rapidly expanding fitness and diet industry. Recent media coverage relating to the availability of 'obesity drugs' has also further fuelled perennial debates as to the causes and consequences of obesity and appropriate ways of tackling it.

This paper will draw on findings from a qualitative study of patients' perspectives on a range of weight management interventions offered to 'overweight' or 'obese' patients within one general practice in Glasgow. (These included one-to-one sessions with GPs and dieticians, group sessions and involvement in the exercise referral programme.) A purposive sample of 23 patients was selected for interview in order to allow us to compare and contrast the experiences and accounts of men and women living in a variety of domestic and socio-economic situations.

The paper will present patients' views about the acceptability and appropriateness of the various interventions on offer and will describe their experiences and (sometimes creative) responses to information, advice and treatment/management approaches. In particular, it will examine beliefs about the aetiology of and meanings attached to obesity. It will explore lay and discourses around self-control, loss of control, will power and self discipline and will seek to compare these with professional discourses.

**Saturday pm**

**12.10 - 12.30**

**Barrow, S., Bellaby, P.**

**University of Salford**

**SELF-ASSESSED HEALTH: HOW ITS RELATION WITH SOCIAL FACTORS VARIES FROM OTHER MEASURES OF HEALTH**

Self-assessed health (SAH) is widely used as a proxy for other measures of health status when estimating the impact of social factors on health inequalities in populations. We seek to assess the benefits and costs of this practice. The paper is based on analysis of a postal survey in Cheshire that had an unusually high response rate and a large final sample.

We are interested in two relations:

- Between SAH and selected other indicators of health status
- Between SAH and other indicators of individual health status, on the one hand, and a range of social factors that are considered to generate inequalities in health, on the other hand

These are the main issues:

- What are the relative strengths of the empirical associations?
- What is the nature of each relation logically (is it contingent or conceptual)?
- If the relation is contingent, what mechanisms might account for it?
- In summary, to what extent is SAH a reliable proxy for health, and, in so far as it is not so, what are health researchers missing by using it?

The authors conclude that SAH is a valuable tool, but that health researchers should not use it alone or without qualification in trying to estimate the impact of social factors on health inequalities.

**Saturday pm**

**15.10 - 15.50**

**Bendelow, G., Griffiths, F., Green, E.**

**University of Warwick**

**'NORMAL' OR PATHOLOGICAL? WOMEN'S EMBODIED EXPERIENCES AND HEALTH-SEEKING BEHAVIOURS AT MID-LIFE**

Social theorists of embodiment have drawn attention to the usefulness of phenomenologists in understanding illness experience in terms of bodily disruption and body betrayal (Merleau Ponty 1962 Leder 1984). However feminists have expressed discomfort over the assumption that bodies are 'dys' functional only when ill (Battersby 1998), and claim that this cannot be so easily applied to women as their experiences throughout the life course of menstruation, childbirth and menopause mean that bodily disruption is an 'everyday' phenomenon. Furthermore it is claimed that the process of medicalisation has rendered these experiences as illnesses (Martin 1987 Greer 1999) whereas the process of 'being a woman' involves continual negotiation and monitoring of what Shildrick (1997) has so vividly described as 'leaky bodies'. However, debates around medicalisation have continuously highlighted the complexity of women's health-seeking behaviour, especially around reproductive issues and claim that women have both lost and gained from their clinical negotiations (Kohler Reissman 1987). Using data gathered from an ESRC funded project from the Innovatory Health Technology programme, this paper looks at some preliminary findings from women's consultations around mid-life technologies (namely HRT, bone densitometry and breast screening) to consider whether these so-called 'normal' events are indeed experienced as illnesses, and whether women themselves accept that their bodies are medicalised in this way.

**Friday pm**

**16.40 - 17.00**

**Benjaminsen, S., Tjora, A.H.**

**Norwegian University of Science & Technology**

**JETREK: HOW ORGANISATIONAL IDENTITIES SLOWED DOWN SPEEDY REQUISITIONS**

The development in the area of information and communications technologies (ICTs) has had great impact on the use of more advanced instruments for diagnostics and therapy in the hospital sector. However, ICTs have only to some degree been implemented as tools for administrative and communication purposes. Now, when large information systems, for example electronic patient records (EPR), are introduced in most hospitals, the implementation processes are usually experienced as complex and difficult.

This paper reports from a study of the introduction of an electronic requisition system on handheld PCs, "JetRek", in two departments in a large Norwegian hospital. By semi-structured interviews of developers, physicians, nurses and secretaries, the background for developing, and motivation for using, the JetRek system is studied.

The hospital's requisition process is an interesting task from a sociological point of view, since it involves a range of professions (nurses, doctors and administrative personnel) and departments (wards, laboratories, radiology dep., and so on) in the hospital. Accordingly, it is found in this study, that what seemed to be a straightforward implementation task from the developers' point of view, turned out to challenge informally established requisition practices in the wards. The result is that nurses and secretaries would be more willing to use JetRek than doctors.

These findings are discussed using Gouldner's cosmopolitan-local construct (1957), focusing on organisational and professional orientation and loyalty. The analysis implies that an understanding of the distribution of organisational identities may be needed to implement organisation-wide systems successfully.

**Saturday pm**

**15.10 - 15.50**

**Bickley, J.**

**Victoria University of Wellington, New Zealand**

**A COLLAGE OF SPEECH AND SILENCE DISCOURSES: NOT-FOR-RESUSCITATION POWER/KNOWLEDGE**

This paper examines the issue of professional control over death in a New Zealand public hospital. The practice of excluding hospital patients from cardio-pulmonary resuscitation began in the 1970's. Since then, not-for-resuscitation (NFR) policies and practices have been problematic. There have also been major structural and ideological reforms of the public and health sectors. A study investigating the way that medical, nursing and institutional discourses construct knowledge in the specific context of not-for-resuscitation (NFR) was conducted in a general hospital where NFR guidelines are available in the wards and from the Regional Ethics Committee. Critical discourse analysis, a methodology that is primarily concerned with a critical analysis of the use of language, was employed to analyse the talk of twelve holders of different institutional positions; nurses, doctors, managers, policy advisors and the Chairperson of the Regional Ethics Committee.

The study showed that NFR power/knowledge is a collage of silence and speech discourses; concealment, coercion, subversion, collusion, opposition, accommodation and negotiation. This collage is dispersed through the disciplines and shifts to new locations, including nursing, patient and family positions. The result can range from a patient having total control over his or her death to having no control at all. This research is significant on two levels; first, for what it reveals about the way a group of health professionals and policy advisors construct NFR knowledge and secondly, because of the potential impact their construction has on the way patients die.

**Saturday pm**

**14.45 - 15.05**

**Blackburn, C., Read, J., Spenser, N., Hughes, N.**

**University of Warwick**

**MEDICAL STUDENTS' UNDERSTANDINGS OF SOCIAL FACTORS AND HEALTH AND EXPERIENCES OF STUDYING SOCIAL MEDICINE**

A key challenge for those involved in teaching social and behavioural science to medical students is developing teaching and learning programmes that enable students to internalise and integrate learning, transfer it to other situations and use it in clinical practice environments. How students' understandings of key concepts develop, from where they derive and how these understandings are used to shape the delivery of care appear to be important to promoting learning. The recent expansion in medical education has led to a growth in graduate entry programmes, particularly for biological science graduates. This group is likely to come to the programme with different experiences, knowledge bases and learning needs than many students entering traditional five-year programmes.

This paper presents the findings from an exploratory study of graduate entry medical students which set out to explore: students' understandings of the impact of social, biological, psychological and behavioural factors on health and well-being; where students derive their knowledge and beliefs about these factors; the extent to which they are able to integrate social and behavioural science learning with knowledge from the biological sciences; how students' experience studying social and behavioural medicine. The authors will present data from in-depths interviews with students at two points: before they commence their medical training and after they have completed social and behavioural science modules in the first semester of the programme. They will look at how this information can be used to develop teaching programmes.

**Friday pm**

**15.35 - 16.15**

**Bloor, M.**

**Cardiff University**

### **ETHNOGRAPHIC OBSERVATION OF ILLNESS BEHAVIOUR IN TWO CONTRASTING RESIDENTIAL SETTINGS**

Although there are a number of classic ethnographies of illness behaviour in developing societies, ethnographic observation of illness behaviour in developed societies is rarely reported, since much illness behaviour occurs in private and domestic settings. Those developed society studies that have been reported have naturally been conducted in relatively public settings, such as schools (Prout 1986) and factories (Bellaby 1999), but their atypicality in respect of their settings is compensated for by the richness of their data and their prospective importance in theorising illness behaviour.

The paper reports on two small-scale ethnographic studies undertaken by the author nearly twenty years apart: the first in a Scottish common lodging house providing for the needs of 60-70 male lodgers, most of them ex-prisoners, or ex-psychiatric patients, or chronically sick or elderly and infirm, with no access to a family home and limited financial resources; the second on an oil tanker with 34 crew (including 5 cadets) composed of British, Polish and West African seafarers. In both settings the residents had access to 'in-house' medical care - a part-time GP who ran several surgeries per week in the lodging house, and the tanker's 'medicine chest' administered by the mate who had undergone paramedic training. It was therefore possible to ascertain which observed episodes of illness behaviour resulted in a consultation. Schutz's work on 'systems of relevances' is used as a heuristic device in describing the different contingencies shaping illness episodes in both settings.

**Saturday am**

**10.35 - 10.55**

**Boddy, G., Mowforth, G., Richards, J.**

**University of the West of England**

### **POWER, POLICY, CULTURE AND THE APPLICATION TO NURSING PRACTICE**

The concepts of culture and power are vital in enabling nurses to analyse practice placements as cultural and political systems, thus promoting an understanding of their own position within health care.

Our overall aim is to enliven these complex concepts into a workable toolkit for student nurses, who will be operating as registered nurses within a year.

In the context of current government policy, which focuses on patient and public empowerment, nurses themselves need to be confident and knowledgeable about the decision, making process and their ability to influence it. For many years nurses have been criticised as apolitical and this module attempts to offer an applied perspective on policy making as well as on specific health policies.

The NHS Plan (2000) and subsequent policies have discussed changing the culture within the Health care system and nurses need to have time to explore and critique the literature. Culture is also explored by problematising Transcultural Nursing and the gendered nature of health care.

Building on knowledge and skills acquired in previous Sociology modules, many students display enthusiasm and achievement whilst studying the material. Student assignments discuss issues of power, culture and policy affecting practice in a variety of settings which include both the hospital and community environments. Using documentary evidence, we propose to argue that opportunities to critically analyse and evaluate the concepts of power, policy and culture, in relation to practice need to remain essential components of nursing curricula.

**Sunday am**

**09.00 - 09.20**

**Brunt, E.**

**University of Bristol**

### **BIOMEDICAL POWER AND THE CHALLENGE OF COMPLEMENTARY MEDICINE**

In recent years the UK has witnessed a substantial growth in the popularity of complementary and alternative medicine (CAM). Complementary therapists stress the importance of the mind-body-spirit relationship in health and healing and this is often viewed in tension to the discourse of Cartesian dualism, which is the basis of the modern biomedical model. Despite its relatively recent inception, however, biomedicine has achieved hegemonic status in the West, but we are currently witnessing the emergence of a growing disillusionment with scientific medicine, and dissatisfaction with its inability to provide cures for certain degenerative and chronic illness. Public awareness of medical malpractice has also led to a decline in trust and respect for the medical profession. CAM's challenge to medicine's monopolistic control of health care has provoked contradictory responses. CAM therapists have been urged to professionalize and demonstrate the effectiveness of their therapies within the scientific paradigm, preferably via randomised control trials, which are viewed as an unsuitable method for assessing interventions by many CAM therapists. At the same time, however, faced with growing demand, doctors working in the NHS have referred patients to complementary therapists, or even administered therapies themselves - a task for which they may not be qualified. Despite the growing challenge of CAM, the medical profession continues exert considerable power over health care delivery, especially in the context of state provision. This paper charts the changing nature of the response of the medical profession and its representative bodies to the challenge of complementary medicine.

**Saturday pm**

**14.45 - 15.05**

**Budge, F., Harris, C.**

**University of Plymouth**

### **THE NEUROSOCIOLOGY OF STROKE**

Stroke is a socio-medical phenomenon in which an identifiable neurological lesion with an acute onset can lead to non-progressive disruption of higher cognitive functions, which impact on the individual at both the physical and social level. In particular, stroke can damage brain centres responsible for a wide range of recognition deficits (agnosias) including denial of the disorder itself. Traditionally, research on stroke rehabilitation has focussed either on the functional effects of impairments from a medical perspective, or on patients' and/or carers' perceptions from a sociological perspective. We argue that this division is reflected in the rehabilitation process and is suboptimal for maximising patient recovery. We discuss a proposed multi-disciplinary project to investigate a) the nature and degree of perceptual deficits in stroke survivors, and b) assess the social impact of such deficits on survivors' coping strategies, social integration, sense of self, and identity.

This paper explores at a theoretical level the relationship between the neurology and the sociology of stroke. It addresses issues of perception and identity and discusses recent debates within medical sociology on the nature of the body and society.

The overall aim of this presentation and of our research project is to explore ways in which clinicians, carers, neuroscientists and medical sociologists can work together to help improve outcomes for stroke survivors.

**Saturday pm**

**15.10 - 15.50**

**Bülow, P.H., Hydén, L-C.**

**Linköping University, Sweden**

**"SHADOWS OF TIME" IN ILLNESS NARRATIVES: METHODOLOGICAL  
CONSIDERATIONS OF TEMPORALISATION IN INTERVIEW NARRATIVES**

When we are stricken with illness and suffering, the temporal frameworks that we take for granted in our everyday lives are overturned. Thus suffering and illnesses raise questions about temporality; were the past events necessary and unavoidable, could anything else have happened, and what will happen next? With a foothold in the literary scholars Morson's and Bernstein's theories about shadows of time, and Ricoeur's theory of narrative time, we will discuss two intertwined problems that have to do with the organisation of time in narratives about illness: the interviewee's attempt to create an interview narrative and the researcher's need to create a temporal order and coherence in the interview material properly founded in research. We base our argument on an analysis of narratives given in interviews by people affected by Chronic Fatigue Syndrome (CFS). In their narrations about illness and suffering interviewees used different kinds of temporalisations, which have implications for the view of time as being closed or open, and thus raise questions concerning hope, guilt, blame and regret. The various ways of using time include temporalities that frequently go outside linear time perceptions; using "sideshadowings" to tell about what could happen or what could have happened. The methodological question then, is, if we as researchers, in our attempts to create coherent illness narratives - categorising and perspectivising - tend to ignore in our analyses some of the sideshadowings that our interview subjects might express - and how this might effect the view of the function of temporalisation in illness narratives.

**Friday pm**

**15.35 - 16.15**

**Bunton, R., Crawshaw, P., Jackson, P.,  
Gillen, K.**

**University of Teesside**

**MODERNISATION AND HEALTH ACTION ZONES**

Whilst the idea of a 'late' or 'post'-modern medicine has received some academic attention in recent years, 'modernisation' remains a key feature UK policy and has become a central theme of the UK Health Action Zone (HAZ) programme. National policy for the 'The New NHS' frequently links 'modernisation' focus upon priority areas for health improvement such as CHD, Cancers and waiting lists, facilitated by 'improved' and more accessible and responsive services. Typically, it stresses the measurement of outputs and quantitative indicators. 'Modernisation' was added to existing HAZ aims to develop innovation, partnership and to engage communities and, for many working within HAZs its meaning is unclear. This paper draws on findings from an ongoing qualitative, process evaluation of a Northern HAZ programme to examine the meaning and use of the 'modernisation agenda' in context. We describe how, for some, 'modernisation' is associated with confusion and fragmentation and conflicts with other HAZ goals of engaging communities and developing innovative working practices. For others, modernisation is a pragmatic way of achieving realistic targets for health improvement and that programmes such as HAZs have an important role to play in this process. We reflect on the nature of modernisation and its meaning for the development of public and health services.

**Sunday am**

**11.00 - 11.20**

**Busby, H.**

**University of Nottingham**

**BLOOD DONATION FOR GENETIC RESEARCH IN THE UK: SOME THOUGHTS ON RISK, TRUST AND FAITH**

This paper explores the narratives of blood donors for both routine (medical) purposes and for genetic research. By way of introduction I shall briefly outline the scientific and policy background for the development of large scale 'bio banks' of genetic data.

The analytical strategy for the paper is to explore the narratives of blood donors for both routine (medical) purposes and for genetic research and to posit these against some prevailing policy assumptions. I begin with an exploration of the ways that contemporary UK blood donors view this practice. (Data: 50 interviews, with additional shorter interview sketches and observational data from routine blood donor sessions). I also consider the views of volunteers who donate blood for a particular genetic epidemiological research project. (Data: approximately 25 in depth interviews with donors of blood for genetic research project).

Whilst allowing for a consideration of the ways that blood donation for genetic research is distinctive, the paper will explore some interrelated themes across these two groups. These include the ways by which various kinds of risks are actively managed by donors themselves; and the sense in which donors, working at the limits of their expertise, choose to hand over trust, a choice with physical and emotional dimensions as well as the more evident cognitive element.

**Saturday pm**

**12.10 - 12.30**

**Cameron, C., Sparks, G.**

**University of Huddersfield**

**ILLNESS: THE INVISIBLE NARRATIVE TRAJECTORIES OF CARERS AND CLINICIANS**

This paper presents the argument that current medical models of care and thus individual clinicians may fail to take proper account of the experience of those who care for people requiring long term or palliative care. This, in turn, may lead to the provision of a lower standard of care provision and needless distress to carers. It argues that an appropriate method of accommodating such experience is to consider the narrative accounts of carers when planning and implementing treatment regimes. It offers, for discussion, a model of the narrative trajectories of carers and clinicians, based on the personal experience of the authors. This model is utilised to illustrate potential experiential differences between carers and clinicians. Although the model speaks of the clinicians' and carers' experiences in similar terms, it identifies three major areas of difference in narrative accounts of caring. These are; a period of primary adjustment that occurs before initial consultation with the clinician, the establishment of regimes of control by clinicians and carers, and the potentially problematic social and psychological outcomes of what prove to be two very different narrative structures. The paper concludes by asserting the likely advantages of taking account of the narratives of carers to all involved in the planning, implementation and provision of regimes of treatment and care.

**Friday pm**

**15.10 - 15.30**

**Canvin, K., Ford, F.**

**University of Liverpool**

**THE PROFESSIONALISATION OF EXPERIENCE: MAKING EXPERIENCES OF MENTAL ILL HEALTH WORK**

Mental ill health is the most common cause of long-term certified work incapacity, and the reason for sickness absence that causes most concern to work colleagues. Exploratory focus groups and in-depth interviews were conducted with people who successfully returned to work following mental ill health. All interviews were tape-recorded and transcribed verbatim. Data was analysed using grounded theory techniques. A working group comprising people with experience of mental ill health and researchers contributed to all stages of the project.

Participants had commonly successfully returned to work by drawing on their experience of illness and recovery to take on the role of the 'wounded healer'. They 'professionalised' their experiences of mental ill health, leading them into paid and unpaid roles in caring, empowering, representing and campaigning in the field of mental health.

These participants' experiences challenge our notions of 'employment' and as such may have been overlooked in previous considerations of rehabilitation. Furthermore, there is a risk that these success stories do not reflect the increased inclusion of people with mental ill health in society, but are instead both a cause and effect of increased exclusion.

The examples of success uncovered in this study contain valuable clues about job rehabilitation for people with experience of mental ill health. Future strategies for the recruitment and retention of people with mental ill health must address the transferability of skills and increase the accessibility of 'conventional' work.

**Friday pm**

**14.25 - 14.45**

**Carlisle, S.**

**University of Edinburgh**

**(NOT) TALKING ABOUT HEALTH INEQUALITIES IN A SOCIAL INCLUSION PARTNERSHIP**

National and local attempts to reduce inequalities in health are shaped by discourses in which attention is directed 'downward' to the problems of (potentially) sick individuals and (allegedly) sick communities. In this paper I discuss an ethnographic case study of one of the social inclusion partnerships (SIPs) in the west of Scotland. The aim of the Kirklands SIP is to reduce health inequalities in its area. Funded for ten years by the Scottish Executive and led by the local authority, the SIP has faced a number of significant challenges during its first three years. Creating sustainable and meaningful engagement with the community itself is probably the greatest of these. Finding a consensus amongst diverse stakeholders about how best to improve the community's health is also an ongoing challenge, as priorities differ. The gulf between Partnership and community, policy and practice, has sometimes seemed unbridgeable. Unresolved and undiminished tensions between professional prescription and lay empowerment still exist. In a context where public (statutory, voluntary and community) sector organisations are dominated by the constant competition for funds to improve service delivery, it may be that 'tackling health inequalities' at the local level is in danger of becoming a politically expedient label for such activity, rather than a radical departure from existing work. I conclude that the rhetoric of partnership and community involvement as a key strategy in tackling health inequalities is fed by conflicting ideologies and involves deep ambiguities of policy and practice.

**Saturday am**

**10.10 - 10.30**

**Cawley, M., Barbour, R.**

**University of Glasgow**

### **DOES MY BUM LOOK BIG IN THIS?: OBESITY AND PSYCHOLOGICAL HEALTH**

This paper is based upon on-going PhD research investigating the links between obesity, lifestyle and psychological health. Western culture dictates that the "ideal body" should be slender. Likewise, medical discourses construct slender individuals as being a "healthy weight". Depending on the precise measures used, some 50% of the UK adult population are now classified as overweight or obese and therefore do not meet either medical or cultural ideals.

Growing awareness has led to forecasts of a pandemic and the production of clinical guidelines and targets. On an individual level, there is considerable scope for dissatisfaction with weight and body shape and the potential for associated psychological problems. Lay and medical discourses both give credence to overweight and obesity as a problem. However, while the population attempts to "lose weight and look great" the level of obesity nevertheless continues to rise. Public concern is evidenced by the escalation in sales of diet products, gym memberships and fitness equipment. However, failure to achieve the desired goal of slenderness may, in some cases, result in depression, low self-esteem and body dissatisfaction.

Preliminary findings from a community health survey of men and women (aged 30-60 from deprived and affluent areas of Glasgow) will be presented. It will discuss the influence of lifestyle and social circumstances in the aetiology of obesity. The paper will address the possible relationship between weight and psychological health; specifically how weight affects body satisfaction, self-esteem and psychological well-being.

**Sunday am**

**10.10 - 10.55**

**Chapman, E., Landy, A., Srinath, S., Bilton, D., McNeill, K.**

**University of Cambridge**

### **TRANSPLANTATION IN CYSTIC FIBROSIS: DONATION, ACCEPTANCE AND REJECTION**

Transplantation has been available as a procedure for end stage organ failure for a number of years. Survival and quality of life rates are going up as techniques are improving. Rejection by the recipient of the donor organ, which has always been a major problem in transplantation, is gradually being overcome through the use of immunosuppressants. Nevertheless a major problem in transplantation that has not yet yielded is the rejection by society of the concept of transplantation itself, evident in the gap between available organs and those needing transplants.

A primary objective of this paper is to examine some of the key issues that arise in lung transplantation for cystic fibrosis. These issues are reviewed in the light of changing protocols for organ retrieval, varying views of donation and demand in society, and different views of the acceptability of transplant surgery. The paper draws partly on recent literature and partly on data generated in a pilot study of transplant candidates and recipients with cystic fibrosis.

Twelve participants were opportunistically recruited from a regional CF/transplant centre in the UK. The respondents took part in semi-structured interviews. The interviews focused on the process of undergoing organ transplantation, the recovery period, and life after transplant.

Themes arising following analysis of the interviews were: body vulnerability; identity and the mind/body dichotomy; and the donor and the new organ. These themes are discussed here in relation to commodification of the body, society's reluctance to donate organs for transplant, and the gift relationship.

**Saturday am**

**11.45 - 12.30**

**Chapple, A., Herxheimer, A., McPherson, A.,  
Miller, R., Shepperd, S., Ziebland, S.**

**University of Oxford**

**"I TAKE THE PISS OUT OF LIFE BECAUSE IT'S THE ONLY WAY TO GET THROUGH IT": WHAT JOKES DO FOR MEN WITH TESTICULAR CANCER**

Humour may be used to relieve embarrassment, to overcome grim realities of work, express solidarity, or maintain power. But people with a disability or impairment can also use it to protect the self, by identifying a weakness before others do. Alternatively, jokes may be made to show that a disability is not that important, challenging prejudice within our culture.

This paper examines how 45 men with testicular cancer used humour and reacted to jokes. Most had lost one testis. Narrative interviews were collected for the Database of Individual Patients' Experiences ([www.dipex.org](http://www.dipex.org)).

Awareness campaigns to promote testes self-examination, and the fact that prognosis is now excellent, may help explain why we identified less stigma associated with the disease than previous studies. Men we interviewed did experience shock, fear, and anxiety but most said they were happy to talk openly about cancer with colleagues at work. Many made jokes to 'lighten' the situation, to reduce others' embarrassment, or to encourage others to examine themselves. Men's reaction to jokes made by others was usually positive, but depended on context.

There were exceptions. For example, a man, born with one testicle, who had an orchidectomy in 1967, has never discussed his 'guilty secret' and 'lost identity' with colleagues. He fears discrimination, remembering the 'Hitler' jokes of his childhood, and 'public humiliation' when his false testicle rolled down his trouser leg.

However, overall, this apparent reduction in stigma, and ability to joke, may help men to consult their GPs when symptoms arise, thus saving lives.

**Friday pm**

**14.50 - 15.10**

**Charles-Jones, H., Latimer, J.E., May, C.**

**University of Manchester**

**THE REDISTRIBUTION OF WORK IN GENERAL PRACTICE: AN AID TO PATIENT CENTREDNESS OR A MANAGERIAL TOOL**

The paper examines the redistribution of medical work within primary health care teams. It describes the analysis of data recorded during periods of participant observation in three general practices in the north-west of England.

In earlier work, drawn from interview accounts, we showed that through a discourse of redistribution practitioners and managers in primary care are able to constitute classes of work, patient and practitioner. This assists them in organising the patient's journey through the practice and in delivering the requirements of an external policy agenda of efficiency and cost effectiveness. In addition their discursive practices tend to strengthen and develop the professional hierarchies that exist within primary care and create a shift away from the traditional and aspirational discourses of patient-centeredness and biographical medicine to those of managerialism and biomedicine.

Participant observation in this study draws on this earlier work and shows how the structure of the organisation and the processes within it, in particular communication and strategic planning, influence the redistribution of work and the configuration of the nursing and medical roles within primary care. It also examines the role that these factors play in settling the tension between the discourses of managerialism and patient-centeredness in the three different settings.

Given the strong professional and policy drivers behind the redistribution of work in primary care the paper concludes by making tentative suggestions about how the call to the aspirations of patient-centeredness and biographical medicine can be preserved.

**Friday pm**

**15.10 - 15.30**

**Chesson, R.**

**The Robert Gordon University**

### **HEALTH AND SOCIAL CARE RESEARCH - TIME FOR PARTNERSHIP WORKING?**

In this presentation the relationship between health and social care will be explored. It will be argued that a health and social care 'divide' exists within research, mirroring that found in community services delivery. Evidence will be presented that demonstrate different theoretical and conceptual approaches and distinctive research methodologies and procedures, regarding health and social care research. A case will be made that this situation is being perpetuated today by separate funding streams and publication. Yet this is despite an increased emphasis on partnership working between health and social care. Case evidence will be presented, drawn from recent research undertaken by the author. In particular two contrasting projects will be discussed - Patients' Knowledge of Three Scanning Techniques (funded by the Royal College of Radiologists) and Taking a Break (funded by the Community Fund). It will be highlighted how recent government health initiatives such as health improvement programmes and public/patient involvement strategies require underpinning from sociologists. It will be recommended that

- (1) joint programmes of work need to be extended;
- (2) more combined electronic publication databases need to be developed;
- (3) joint meetings and conferences for research dissemination and strategy development need to be organised.

**Saturday am**

**09.45 - 10.05**

**Clegg, S., McDonald, E., Boulton, M.G.,  
Fielder, A.R.**

**Oxford Brookes University**

### **PARENTING A CHILD WITH VISUAL IMPAIRMENT - A 'CHRONIC ILLNESS' PERSPECTIVE**

This paper will use the perspective of the sociology of chronic illness to help to make sense of the experiences of parents of children with visual impairments.

Chronic illness is characterised as having a profound influence on the lives of people experiencing it, including problematising areas such as: maintaining a meaningful role within the work force; social interactions; and family life in general. 'Work' needs to be undertaken in areas such as: managing medical routines; gathering information about the condition; learning the language of the condition; and managing relationships with service providers.

Young children with disabilities may not experience the problems identified in a chronic illness perspective, but the child's parents might. We explored parents' day-to-day experiences in a study carried out in four areas of the UK focusing on families of children with visual impairments. In many cases parents' stories could be best understood through a chronic illness perspective, although they were not themselves chronically ill.

**Saturday pm**

**16.20 - 17.00**

**Collis, M.**

**Monash University, Australia**

**KNOWING THE FEMALE BODY: HOW WOMEN THINK ABOUT AND IMAGINE THEIR  
'INSIDES'**

The focus of this paper is on exploring women's knowledge of their internal reproductive organs and bodily processes. It takes as its starting point Lynda Birke's (1999) critique that recent sociological and feminist theorising on the body has largely failed to go beneath the skin (with the important exception of work related to reproductive technologies). The data for the paper comes from interviews with twenty women from Victoria, Australia who had undergone a hysterectomy for benign conditions. For many of the women, both the problems leading up to the operation and the surgery itself had brought their knowledge - or lack of knowledge - about their bodies into sharp relief. The paper takes a critical look at the kinds of textual representations and popular descriptions of the female body available to the women. It examines both the women's responses to these representations and the impact of the fragmented body of biomedical discourses on the ways in which they talked about and imagined the uterus and other body parts and processes.

**Saturday pm**

**14.00 - 14.40**

**Cooke, H.**

**University of Manchester**

**THE REGULATION OF EMOTION WORK IN NURSING**

In this paper I will discuss the theoretical implications of Hochschild's work on emotional labour and its continuing relevance to 'semi-professions' such as nursing. I will review Hochschild's work in the light of the response to her work from nurses and nurse academics. I will analyse the selective uptake of her work in nursing with particular reference to nurses' reluctance to see their emotion work as alienated and not under their control. Drawing on data from a recent study of the 'problem' nurse I will ask who controls the emotion work of nurses. I consider this question in the light of case material in which the emotional display of nurses had become a subject of conflict.

**Friday pm**

**16.20 - 17.00**

**Curtis, K., Liabo, K.**

**City University**

**'I'VE BEEN LIVING IN THIS BODY FOR 14 YEARS, LISTEN TO ME!' DEVELOPING TECHNIQUES TO EXPLORE CHILDREN AND YOUNG PEOPLE'S EXPERIENCES OF RECEIVING HEALTH SERVICES**

**Background**

Recent years have seen a growing recognition of both children as social agents in their own right and the importance of putting the consumer at the heart of service development. If children's expertise about their own lives is to contribute to improving services we need to bear in mind how children's competencies are different from - though equal to - those of adults, and develop research techniques accordingly.

**Methods**

Researchers at Barnardo's and City University carried out a study in schools, hospitals and community groups to explore with children and young people their experiences of receiving health services. Drawing on both conventional and play-based approaches, and working flexibly with young people, we developed a portfolio of research tools for use in group and one-to-one settings. We also developed resources to introduce the research and explain key research issues. A website was developed both to collect data and provide feedback.

**Results**

Participants were 135 young people aged 4 to 19 years (20% from minority ethnic communities) including some young people with learning difficulties. Young people described positive and negative aspects of their experiences of receiving health care. They raised a range of key issues from resourcing in waiting areas to sensitive communication and recognition of patient expertise.

**Conclusions**

Use of age and context-appropriate techniques facilitated children and young people to comment meaningfully on their experiences of receiving services. Development of appropriate, process orientated resources to explore key research issues contributed to children making informed decisions about their participation in the research process.

**Saturday am**

**10.35 - 10.55**

**Denny, E.**

**UCE, Birmingham**

**"YOU'RE JUST ONE OF THE UNLUCKY ONES": DELAY IN THE DIAGNOSIS OF ENDOMETRIOSIS**

Endometriosis is a chronic condition in women where cells normally found within the lining of the womb are present elsewhere in the abdominal cavity, and respond to cyclical influences on the reproductive system. Although this condition has been the subject of much clinical research, little work has been conducted on the effect of living with endometriosis for the women affected by it. Using empirical research in which semi-focused interviews allow women to tell their stories this paper will focus on one of the issues to emerge from the data. This is the length of time between the experience of symptoms and diagnosis, which can be as long as ten years. For some women this gate keeping role of the medical profession has led to the continuation of pain, and to disruption of many aspects of their life.

The paper will explore this delay in diagnosis by considering the nature of endometriosis, how it is perceived by the women in the study, and the way in which doctors engage in the diagnostic process. It will be argued that in many respects for both the women who experience it, and for the medical profession endometriosis does not conform to conventional expectations of 'illness'.

**Sunday am**

**10.35 - 10.55**

**Dhanda, R.K.**

### **KNOWLEDGE, ATTITUDE AND PERCEPTION OF BREAST AND CERVICAL SCREENING AMONGST SOUTH ASIAN WOMEN**

During the 1980's the UK NHS set up the Breast Screening Programme and Scottish Cervical Screening Programme whose shared aim is to reduce the incidence of, and therefore mortality from, breast and cervical cancer. For both programmes a crucial factor in achieving the aim is the maintenance of a high attendance rate for screening. Investigative studies suggest that the uptake of breast and cervical screening among South Asian women living in the UK is lower than that of non-Asian women.

It was reported that knowledge, perception and attitudes towards cancer will influence uptake of preventive measures at a symposium on 'Cancer and Minority Ethnic Groups' held in London and run jointly by Cancer Research Campaign and the Department of Health in May 1995. Attitudes towards cancer treatment can have implications for rejecting treatment. The aims and objectives of the study are to explore the knowledge levels and attitude towards breast and cervical screening services amongst South Asian women, through a qualitative interpretation of Asian women's practices and experiences.

The research methodology, grounded theory has been chosen as the most appropriate theoretical framework to meet the aims of the research. Additionally, in order to make research culturally responsive a variety of factors have also been considered. It is anticipated this exploratory study will reveal an association with the low uptake levels of the screening services. The presentation will consist of an outline of the proposal and an analysis of interview results.

**Sunday am**

**09.00 - 09.20**

**Dhar, R.**

**Institute of Applied Manpower  
Research, India**

### **SOCIO-CULTURAL DIMENSIONS OF DOCTOR-PATIENT INTERACTION UNDER DIFFERENT MEDICAL SYSTEMS**

Medical Sociologists share a commitment with medical service providers to improve the health care delivery through better understanding of social factors influencing medicine. One such factor is doctor-patient interaction, the therapeutic role of which has even been recognized in Hippocratic corpus. Doctor-Patient interaction is dependent on the social setting in which it takes place, has been well established through research. The need was to find out whether the interaction between doctor and patient remains the same or varies under different medical systems in the same socio-cultural setting.

In order to address this issue a study was conducted to determine the Socio-Cultural Dimensions of Doctor-Patient Interaction in Delhi. The study drew on Parsons (1951) and Szasz and Hollender's (1956) models of Doctor-Patient interaction. Two sets of questionnaires were prepared to gather information from doctors and patients of three major medical systems practised in India Allopathy, Homoeopathy and Ayurveda. In addition, other complementary systems like Naturopathy and Tibetan were covered as case studies. The study also looked into the psychological aspect of medicine through faith healing.

The study revealed that apart from the socio-cultural background of doctors and patients, there are other dominant factors like social networks, physical appearance and nature of ailment that affect the level of interaction between doctors and patients. Significant differences were found in the interaction pattern of doctors and patients under different medical systems with respect to role expectations, communication, patients compliance in different kind of settings i.e. in-patient wards, out-patient departments and private set up.

**Saturday pm**

**15.55 - 16.15**

**Dingwall, R.**

**University of Nottingham**

### **SHOULD WE EVER ATTEMPT TO RESUSCITATE PEOPLE WITH CARDIAC ARRESTS?**

Cardio-pulmonary resuscitation (CPR) is one of the unquestioned practices of modern health care. Most ethical and legal debate centres on the circumstances in which it is appropriate not to attempt resuscitation. It asserts as a default rule that CPR should always be attempted. The issue is then one of when this default can be overridden, either because the intervention is medically futile or because the patient has made an advance directive. This paper will look at the sources of this default rule and their relevance to the actual experience and achievements of CPR. The sources are ethical, legal, professional and cultural.

There are ethical presumptions about the 'right to rescue' regardless of the implications for others; legal presumptions about the prevention of discrimination and the equal treatment of equally placed citizens; professional presumptions about the competence of anyone other than doctors to determine medical futility; and cultural presumptions based on a misleading depiction of CPR in mass media. This system condemns a large number of people to medically futile interventions and denies them dignity in death. These are societal resources that could be put to more effective use in health care. It will be argued that it may be more ethical to invert the 'default rule' and to assume that cardiac arrest victims should not be subjected to resuscitation attempts unless there is a clear and specific clinical justification for doing so. Possible justifications will be outlined.

**Saturday pm**

**16.20 - 16.40**

**Dogra, N.**

**University of Leicester**

### **IDEAL TYPE MODELS FOR EDUCATIONAL PROGRAMMES TO TEACH CULTURAL DIVERSITY TO MEDICAL STUDENTS**

This paper explores educational programmes for teaching cultural diversity and ethnic relations to medical students in the United Kingdom and United States. There are three parts to the presentation. The first part comprises an overview of two contrasting ideal type models of pedagogy and curricula in this area, identified by the author as the 'cultural competence' and 'cultural sensibility' models. Second, the presentation will examine in greater detail specific aspects of the 'cultural competence' and 'cultural sensibility' approaches that warrant further consideration. Although these two perspectives on the educational process for medical students vary in their substance, both are characterised by distinctive positions with respect to educational philosophy and policy, the educational process, educational contents and assessment. The presentation will make comparisons between the two models, in these areas, with respect to their intellectual origins, learning objectives and teaching practices. The historical context with which these models have arisen is also discussed. The third part of the presentation addresses the application of these models in practice and students' experiences of being taught using these models. The presentation draws on literature in the fields of sociology and medical education. It is also based on empirical research with three hundred and ninety medical students (from both the UK and US) using both questionnaire and focus group methodology.

**Saturday am**

**09.00 - 09.20**

**Dolan, A., Thompson, V.**

**University of Warwick**

**'I AIN'T GOING TO SAY MY BALLS ARE ACHING': PROSTATE HEALTH AWARENESS AMONG MEN IN A WORKPLACE SETTING?**

Prostate health has emerged as a key health priority with the Department of Health having recently launched the NHS Prostate Cancer Programme. Despite the widespread prevalence of prostate conditions, however, previous research suggests that many men appear unaware of the symptoms and that men, in general, are more reluctant to use primary health services, which results in delay in seeking medical help. Evidence that men tend to be 'absent' from a variety of traditional health care settings has led to the workplace increasingly being considered as a setting for providing men with health promotion. This paper presents the findings of a small preliminary study that sets out to explore whether: health promotion in the work place is a way to increase men's knowledge and awareness of prostate health; men's reported willingness to access health services if they have health concerns; and men's attitudes towards the workplace as an appropriate setting for promoting men's health. Presenting data from a postal questionnaire, focus groups and in-depth semi-structured interviews, the authors discuss the effectiveness of different health promotion intervention 'packages' upon men's knowledge around the prostate and prostate problems. They suggest reasons as to why knowledge levels found in this study were higher than has been found in other studies. They raise issues for workplace health promotion and further research, concluding that issues of masculinity and potential workplace 'cultures' have to be considered when attempting to achieve men's involvement in health promotion campaigns.

**Friday pm**

**14.50 - 15.30**

**Draper, J.**

**Royal College of Nursing Institute**

**'IT WAS A REAL GOOD SHOW': THE ULTRASOUND SCAN, FATHERS AND THE POWER OF VISUAL KNOWLEDGE**

Drawing on an ethnographic study of the transition to contemporary British fatherhood, this paper discusses men's experiences of the ultrasound scan. Prior to the ultrasound scan, many of the men spoke of the way in which they felt one step removed from the pregnancy experience. In contrast to their partners, who possessed direct embodied experience of the pregnancy, the men described one which was much more distant. Their contact with the baby during pregnancy was mediated therefore by and through their partner's body.

Seeing the baby on the screen seemed to herald an escalation of their awareness of the baby, reinforcing its reality. Visual knowledge, as opposed to other forms of knowledge (such as that generated by touch and feeling), became a primary means of knowing the baby. In this paper I provide a theoretical analysis of men's empirical accounts of seeing the baby during the ultrasound scan. After a description of method, I set up the theoretical foundations for an analysis of these accounts by firstly, examining the development of the primacy of vision within medicine and secondly, discussing the illumination of the body interior, initially by dissection but now via contemporary technologies of vision including ultrasound. The main body of the paper draws upon data from longitudinal qualitative interviews conducted with novice and experienced fathers and discusses how ultrasound can be constructed as simultaneously both a medical and social event with the potential to generate epistemological conflicts. The healthcare and sociological implications of these potential conflicts are examined.

**Friday pm**

**14.00 - 14.20**

**Eborall, H., Cunningham-Burley, S., Fowkes,  
F.G.R.**

**University of Edinburgh**

**GULLIBLE GUINEA PIG OR GOOD CITIZEN? ATTITUDES TOWARDS  
PARTICIPATING IN A RANDOMISED CONTROL TRIAL FOR PREVENTIVE MEDICINE**

**Purpose**

This study aims to understand lay meanings of participation in preventive medicine research trials within the context of a trial for the screening and prevention of heart disease in the healthy population.

**Methods**

Participants were members of the general population invited to participate in screening for a symptomatic atherosclerosis and a subsequent randomised control trial assessing the use of aspirin for preventing cardiovascular events. The study sample included those who had declined to participate in the trial. Semi-structured qualitative interviews and focus groups were conducted with a variety of participants. The interviews were transcribed verbatim and the transcripts analysed for emerging themes.

**Findings**

Participants beliefs varied greatly from those keen to participate in the trial to those declining, but also within these groups. Attitudes towards trial participation related to perceived individual susceptibility to cardiovascular risk, which combined prior health beliefs and interpretations of the screening measure result. Attitudes towards the trial drug were rooted in beliefs about aspirin, medication in general, and preventive health practices. Further salient influences seemed to be altruism, perceived personal benefit, convenience, discontent with randomisation and blinding. There were varied understandings of the selection criteria, screening measure and trial process.

**Conclusion**

Qualitative research can improve our understanding of people's perceptions of participation in preventive medicine research trials, and the context within which the decision to participate is made. This raises important ethical issues about research participation as well as furthering our understanding of lay attitudes towards screening and preventive medication.

**Saturday pm**

**15.10 - 15.50**

**Edgley, A.**

**School of Nursing, University of  
Nottingham**

**'CAN'T GET NO SATISFACTION': THEORISING PUBLIC VIEWS ON HEALTHCARE**

This paper interrogates major studies dealing with patient experiences of, patient satisfaction with and public preferences for healthcare. There are many individual studies available and much policy interest in researching and measuring public/patient views on healthcare. The recent review of much of this research (done on behalf of the Department of Health by Ryan et al) considers the variety of methodological tools and techniques employed to establish findings on these questions. What is not evident, however, is any attempt to theorise about the mass of empirical evidence that now claims to have answers to questions of public opinion on healthcare.

The paper will reveal the frameworks that are employed or implied in these studies. In the process, the sources of these frameworks will be delineated, and the connections between the approaches and the framing taken by the researchers highlighted. The frameworks and patterns of the responses elicited from respondents will also be explored. These frameworks will be analysed and compared, illustrating the relative patterns of theoretical argument and assumptions. Drawing out the wider theoretical assumptions behind the empirical research process leads to a better appreciation of the complexity of the public's views. By exposing the assumptive elements of existing research in this way, inconsistencies between the assumptions underpinning the research process or inputs and the assumptions used by the patients and the public become evident. These findings will have implications for policy and raise questions for future research in this area.

**Saturday pm**

**16.20 - 17.00**

**Edwards, C., Staniszewska, S., Crichton, N.**

**Royal College of Nursing Institute**

**EXPLORATION OF PATIENTS' NATURALLY OCCURRING EVALUATION, WITHIN THEIR PROCESS OF REFLECTION ON THEIR HEALTHCARE EXPERIENCES**

There is currently pressure to demonstrate that users' perspectives have been sought to guide all aspects of health service planning and monitoring, with particular value placed on their assessments of the quality of care. There is, however, no consensus about the most effective way of eliciting patients' evaluations of their care. The methods used tend to be inquirer- not patient-led in both their content and the response options made available, and their most characteristic trait is the uniformly high levels of satisfaction they record.

Little is known about patients' naturally occurring processes of evaluation away from the ubiquitous patient satisfaction survey. We hypothesised that it may be more effective and ethically acceptable to base inquiry on patients' own processes of reflection and evaluation, rather than continuing to impose an inquirer-led structure of inquiry.

Working within the theoretical framework of phenomenological sociology (Schutz 1967), we conducted 45 unstructured interviews with 19 patients undergoing elective orthopaedic surgery. Participants were invited to talk about their experiences, and analysis focused on the investigation of participants' development of opinion. An iterative process of re-assembly of related constructs established main themes, and theoretical development took place within and between themes.

This paper discusses the range of ways in which participants were found to reflect on and evaluate their care; the idiosyncratic nature of their evaluation; and the factors that seemed to impinge on the process. The findings help to explain the ineffectiveness of current methodology in this area. Their potential to underpin new methodology is discussed.

**Saturday am**

**10.35 - 10.55**

**Ehrich, K., Humphrey, C., Kelly, B., Morgan, M.**

**The Tavistock Institute**

**AN INNOVATIVE POLICY ANALYSIS: PRIMARY CARE, HUMAN RESOURCES, AND CONTINUITY OF CARE**

This paper presents some of the findings of an innovative study commissioned by the National Co-ordinating Centre for NHS Service Delivery & Organisation R&D (NCCSDO) to explore the impact on continuity of care of recent and projected policies affecting human resource management in the NHS. The study was part of a national programme of work on continuity of care commissioned by the NCCSDO and was carried out by a multidisciplinary research team from King's College London. This paper focuses on those aspects of the study relating to primary care.

The study was comprised of two parts, beginning with a policy document analysis. This was followed by a series of expert seminars to explore the implications of the policies by looking at the effects of their implementation, including one seminar specifically addressing primary care.

The seminars were audio taped, transcribed and analysed in accord with a six part thematic framework developed in the document analysis. The paper will present some of the views and experiences of primary care seminar participants, focusing on themes such as reconfiguration of services; information technology; and patient centred care.

**Saturday pm**

**17.05 - 17.25**

**Ellingsen, G.**

**University Hospital of Northern Norway**

### **ACHIEVING INTERDISCIPLINARITY IN HOSPITALS**

As today's organisations face increasingly specialisation, work has to be conducted in the context of interdisciplinarity. This has led to many efforts to formalise interdisciplinary work. However, in spite of heavy emphasis of its superiority several of these efforts have failed.

Drawing on semi structured interviews of professionals (physicians, nurses and therapists) and video observations of clinical work at a university hospital in Norway my aim is to identify the conditions for obtaining interdisciplinarity in a complex organisational context. The video observations are conducted at interdisciplinary meetings in which different professionals participate (nurses, ergo-therapists, physiotherapists, physicians, social workers etc).

As professionals generally work in accordance with, and are evaluated in terms of disciplinary guidelines, it is hardly surprising that interdisciplinary work requires negotiations. In order to ease these negotiations it is essential to have mechanisms that promote interdisciplinarity. Firstly, I focus on how artefacts, organisational structure, IT-systems and routines play a role in promoting interdisciplinarity in everyday practice.

Secondly, I illuminate how a strong commitment towards interdisciplinarity shapes the mutual power structure among the professionals. Such devotion might break the traditional division of labour, redistribute power and control and in such a way transform work.

Thirdly, I illuminate how an interdisciplinary department must curb the influence of traditional departments in the hospital. There is no free space where interdisciplinarity is allowed to grow freely. Work is necessary, both to create and maintain it. I pinpoint the problematic conditions for such a constellation.

**Sunday am**

**09.25 - 09.45**

**Ellison, G.T.H.**

**University of London**

### **EDITORIAL PERSPECTIVES ON THE USE OF RACE/ETHNICITY IN CONTEMPORARY GENETIC RESEARCH**

This paper will present thematic analyses of 25 in-depth interviews with editors and editorial staff from 15 genetics journals, selected from the 'genetics and heredity' subject category of the Science Citation Index on the basis that all had regularly published articles using 'race/racial' or 'ethnicity/ethnic'. Given the international distribution of interviewees, all but one were interviewed by telephone. Interviewees adopted two distinct postures when discussing race/ethnicity: a 'popular' or 'public' posture, from which they acknowledged the socio-political sensitivity of racial and ethnic categorisation and rebutted the existence of genetically distinct human races; and a 'scientific' posture, from which 'race' and 'ethnicity' were invoked as pragmatic categories for exploring genotypic variation. There was some evidence that the socio-political sensitivity of racial and ethnic classification and a rejection of sociological critiques considered 'politically correct', had discouraged many geneticists from examining too closely the assumptions underlying the allocation and use of such categories as pragmatic markers of collective genetic affinity. In particular, interviewees overlooked the fact that the genetic affinities of racial/ethnic labels (such as 'European' and 'African') are contingent on a variety of contextual (i.e. environmental and social) factors. Likewise, interviewees seemed unaware that social factors determine the allocation of racial and ethnic identities, and disregarded their potential use in associational studies as markers of collective social experience. These findings suggest that the tenets of racial biology continue to influence the production of genetic knowledge, and that sociological critiques of racialisation and biological determinism need to overcome the disdain of many geneticists.

Supported by the Wellcome Trust's Biomedical Ethics Programme GRANT 057182

**Saturday am**

**11.00 - 11.40**

**Elston, M.A., Gabe, J.P.**

**University of London**

**OUR PROBLEMS ARE CHICKENFEED TO THEM?: GPs' ACCOUNTS OF  
RELATIONSHIPS WITH THE POLICE**

In managing deviance, health care institutions may have to interact with other social control agencies with their own jurisdictional claims. This paper examines how jurisdictional boundaries between GPs and the police are constructed, in the context of research into violence in primary care. Data are from two related projects: an ESRC funded postal survey of GPs with in-depth interviews of those who had been victims of violence; and a Department of Health funded study on the prevention and management of violence, using interviews and focus groups.

Interactions with the police in a range of overlapping roles were described by GPs and their staff: e.g. police as security consultants; police as reactive restorers of order in ongoing incidents; police as gatekeepers to the criminal justice system; police as seekers of information. While some respondents did report good relationships with local police, the predominant picture was of tension between two occupational perspectives, and it could not be assumed that medical authority would prevail. GPs portrayed themselves as 'good citizens' mindful of the importance of 'not wasting police time'. Contrary to official advice, most incidents were not reported to the police, and, when they were, the police were generally the arbiters of whether further action might follow.

Thus our data provide a more complex picture of medicine's role in social control than earlier claims about medical imperialism suggested. At least in the case of violence, GPs have to negotiate the boundaries between 'illness' and 'crime' with the police in a highly contextualised way.

**Saturday pm**

**16.20 - 17.00**

**Fairhurst, E., Brierley, L.**

**Manchester Metropolitan University**

**NORMAL, NATURAL LIFETIMES? SYSTEMIC LUPUS AND 'BODY WATCHING'**

This paper focuses on chronic illness as an embodied phenomenon. The interpretation of bodily matters, their physicality, will be examined with reference to systemic lupus. Systemic lupus alters the immune system and, rather than being organ specific, can damage various parts of the body. The functioning of, for instance, kidneys, lungs and joints may be affected. Since tiredness and joint pains can occur, there are implications for physical stamina. The trajectory of lupus is unpredictable. Not only are there 'good days and 'bad days' but also there may be variations within a day: peaks and troughs of tiredness and/or pain may occur.

Accomplishing everyday activities such as working, cooking, 'going out' and so on, can no longer take for granted the body. At the same time, lupus tends to be diagnosed when individuals are in their twenties and thirties, in the 'prime of their life'.

Sociologically, then, lupus calls into question our ideas of a normal, natural lifetime in which certain events typically occur at certain stages of life and movement from one stage to another rests upon turning points. Audio interviews (shortly after diagnosis and three months later) with newly diagnosed sufferers of lupus are used to explicate how their bodies no longer are taken for granted but are 'watched'. The ways in which 'body watching' is assessed as turning points in the lives of lupus sufferers are explored.

**Saturday pm**

**14.00 - 14.20**

**Fenwick, A.**

**University of Southampton**

### **MEDICAL STUDENTS' APPROACHES TO WORKING WITH THE BODY**

The body's use in medicine has been brought starkly into view with events such as Alder Hay and Bristol and, more sensationally, with the recent Body worlds exhibition. The way in which doctors, anatomists and pathologists engage with bodies has increasingly become the subject of public concern and scrutiny. The role of medical education in contributing to an acceptable and ethical approach to the body in medicine also needs to be examined. My work sets out to explore how medical students learn to negotiate their way through a medical curriculum, which requires them to engage physically with dissected bodies, recently dead bodies and the bodies of both conscious and unconscious patients. To-date I have carried out in-depth interviews with eight medical students over a three year period in order to gain some understanding of how medical practices, which require the body to be objectified, are interpreted and then acted out by students. I found that the students complied and engaged in the process of disciplining or appropriating the body (Frank, 1991), both critically and uncritically. However, when they had more control over what they were learning or practising, they were sometimes able to tailor or disregard what they perceived as curriculum requirements that might contribute to this process. Adopting a more ethical approach to the use of patient's bodies requires a closer inspection of how the medical curriculum operates in practice.

**Saturday am**

**11.45 - 12.05**

**Fincham, L., Copp, G., Caldwell, K., Jones, L., Tookman, A., King, M., Hopkins, C.**

**Middlesex University**

### **SUPPORTIVE CARE: EXPERIENCES OF CANCER PATIENTS AND HEALTH CARE PROFESSIONALS**

With the increasing incidence of cancer, longer survival times and limited resources, cancer care has evolved from focusing on survival to maintaining or improving quality of life (Ferrans 1990). The need to explore the nature and provision of 'supportive care' for patients with cancer has become paramount. To date few studies have investigated patients' experiences of supportive care at different stages of the disease process together with the quality of and patient satisfaction with supportive care services.

This collaborative study involving Middlesex University, The Royal Free Hospital and Edenhall Marie Curie Centre investigates how patients with cancer and the health care professionals caring for them experience supportive care at different stages of the disease trajectory. Qualitative data from two focus groups will be used to develop a survey tool, (the questionnaire). Fifty questionnaires will generate data that will be used to test relationships between variables and allow generalisations to be made to larger populations and show possible significance. The Mental Adjustment to Cancer Scale (Greer Morley and Watson 1989), the GHQ28 for psychiatric screening (Goldberg 1970), EuroQol quality of Life measure (Kind et al 1998), and the MOS Social Support Survey (Sherbourne and Stewart 1991), will be used to provide patient measurement scales. Ten in-depth interviews will facilitate a search for explanations of the relationships found to be statistically significant in the quantitative data. This paper will report the initial findings of the focus groups conducted in the outpatient departments.

**Saturday pm**

**15.55 - 16.15**

**Flicker, S., Nixon, S., Poole, J.**

**University of Toronto, Canada**

**HEALTH AS SOCIAL JUSTICE: A CRITIQUE OF POSTMODERN PERSPECTIVES ON NEOLIBERALISM, 'RISK' AND HEALTH POLICY**

Recent sociological inquiry has been concerned with the ways in which health and health care discourses reflect, serve and are reinforced by prevailing political ideologies. In particular, post-modern and Foucauldian analyses have sought to reveal how discourses on health and health care, and in particular 'risk', may serve to individualize responsibility for health in ways that are consistent with neoliberal rationalities. Critiquing this recent trend, this paper offers both an internalist and externalist critique of post-modern analyses of discourses on health and risk.

Our internalist critique examines how the post-modern project is being embraced by those who want to cut health care spending in line with neoliberal logic. By not explicitly recognizing their own critiques of health discourses as politically co-optable discourse in itself, theorists may be serving the very forces that they are trying to expose. Specific examples are offered of health care cuts in Canada fuelled by such post-modern critiques.

The externalist critique argues that although post-modern analyses reveal illuminating perspectives on how health and health care shape subjectivities, the inaction and impotence born out of this 'view from nowhere' is an inadequate and unethical response to the challenges facing contemporary societies. Rather, we advocate for a theoretical approach that locates the lessons learned from post-modern and Foucauldian analyses within a broader social justice framework. In doing so, we are advocating for a sociology of health and illness that embraces theoretical approaches consistent with 'resistance postmodernism' and 'critical realism'.

**Friday pm**

**16.40 - 17.00**

**Frost, J., Pope, C., Murphy, D., Liebling, R.**

**University of Bristol**

**WOMEN'S NARRATIVES OF OPERATIVE DELIVERIES IN THE SECOND STAGE OF LABOUR**

Since the early qualitative accounts of women's experience of birth; there has been an increasing concern with the emotional impact of childbirth - which has, in part, been associated with the rise in operative interventions during delivery. While sociological research has focused upon the effects of medicalisation and confinement, psychological research has been concerned with the sequelae of postnatal depression. In contrast, medical research has investigated the physical morbidity of such interventions, in terms of physical 'outcomes' for the mother and child. Research concerned with understanding women's experience of childbirth has generally explored the experiences of all women following childbirth (vaginal and operative deliveries), rather than concentrating on the experiences of women who are taken to theatre in the second stage of labour for procedures involving either forceps or ventouse extraction.

This paper reports on the narrative accounts of women who have been sampled from a cohort study, which investigated maternal and neonatal morbidity following delivery in theatre. In-depth interviews with 25 of these women at one year post-delivery have been used to explore their experience of instrumental delivery, in terms of their understanding of this event and their long term reactions to it. This study considers whether these types of operative assistance are seen as a minor intrusion in the experience of childbirth or as a traumatic event with lasting emotional consequences.

Friday pm

16.20 - 17.00

Gabbay, J., le May, A., Webb, D., Jefferson, H., Lathlean, J., Powell, J., Lovelock, R.

University of Southampton

## **THE PROCESSES OF KNOWLEDGE MANAGEMENT IN MULTI-AGENCY CONSUMER-INFORMED HEALTH SERVICE AND SOCIAL CARE DEVELOPMENT GROUPS**

### Background

The confluence of three current trends in NHS policy - knowledge management, consumer involvement and evidence-based practice - led to this R&D project which established two "communities of practice" (CoPs) in an emerging primary care trust. Both groups had representatives of the local community, voluntary agencies, acute and community health services, the private health sector and the local authority social services. Their task was to suggest specific improvements in services for older people in two areas that had been proposed by consumer focus groups. The areas were intermediate care and discharge planning for patients leaving hospital.

### Aims and methods

1. Describe and analyse the formation, development, facilitation, functioning and maintenance of two local CoPs established for this purpose.
2. Determine how each CoP acquires, negotiates, adopts/constructs, uses and shapes knowledge in focused decision-making.

The research design used multiple methods of data collection (participant and non-participant observation, in-depth interviewing of CoP members, and facilitators' diary reflections.) Data were analysed thematically with the aid of NUD\*IST.

### Findings

Each CoP met seven times between November 2000 and July 2001. The groups were dependent on the facilitation which aimed to guide them towards the formulation of credible policy recommendations. A number of inter-related themes emerged:

- Unpredictably contingent knowledge processing
- The predominance of experiential relevance
- Transformation/ experiential internalisation of external knowledge
- Bespoke harnessing/ agenda-structured processing knowledge
- Power-led differential sense making
- The interdependency of roles, knowledge behaviours and knowledge sources

These have implications for similar groups now being established across the NHS

**Sunday am**

**09.50 - 10.30**

**Gannik, D., Bojlèn, S.**

**Central Research Unit of General  
Practice, Denmark**

**THE PROCESS OF LIBERALISATION: A THREAT TO GENERAL PRACTICE AND  
THE DOCTOR-PATIENT RELATIONSHIP**

Many voices urge liberalisation of health care in Denmark today. Until now, health care is largely a public responsibility. 80% of health care costs are financed through personal income taxes. Primary health care services are available for all, however general practitioners function as "gate-keepers" with regard to hospitals and specialised medical treatment. They are paid by regional authorities in a mixed capitation and fee-for-service system. The patient chooses a GP and remains on his/her "list" for a minimum period.

This system builds on a century-long tradition. However, liberalisation is sneaking in by way of changes in administration and in patient and provider behaviour. This development is part of a global liberalisation trend, supported by new economic theory and a growing pressure of demand for services. Liberalisation, at least in Denmark, is seen as a partial solution to rising economic costs due to foreseen increased demand. This pressure of demand is repeatedly emphasized in the political agenda. Surprisingly, nobody debates why demand should increase.

In my presentation I shall analyse what roles increased biomedical knowledge and increased supply of medical services play for the demand for liberalisation, and discuss the possible consequences of the liberalisation trend for general practitioners as gate-keepers in the Danish health care system. The analysis draws on sociological research on the doctor-patient relationship and combines this with health economics and political systems theory.

**Saturday am**

**10.35 - 10.55**

**Garcia, C., Chesson, R.**

**The Robert Gordon University**

**'GETTING MYSELF BACK' SOCIAL SUPPORT AND SELF-IDENTITY AMONG  
CARERS**

MS is the most common neurological disease in adults between 20 and 50 years of age. In the UK approximately 100 in 100,000 persons have MS. In the North East of Scotland the rate is even higher (178 in 100,000). At least two thirds of people with MS have carers. A qualitative study was carried in Scotland in order to determine the nature of social support for MS carers. Semi-structured interviews were held with sixty carers in their own homes. All interviews were audio taped. Two thirds of carers were men, reflecting prevalence rates. The majority lived in the same household as the cared for person. Twenty five percent of carers were living also with children under 16 years of age. Carers mean age was 47 years (range 29 - 73 years) and 50% were not in paid employment. Carers reported a diminishing number of social contacts as the disease course progressed. Increasing caring responsibilities made it very difficult for carers to find time and space for themselves. Overall social isolation was a common problem and many carers had difficulties maintaining another identity alongside that of 'carer'. This study highlights the need for further research on the experience of younger carers, especially ones who take on the role at the height of their earning capacity and family commitments.

**Friday pm**

**15.35 - 15.55**

**Godin, P., Davies, J., Heyman, B.**

**City University**

### **PSYCHIATRIC IDEOLOGIES IN A MEDIUM SECURE UNIT**

Though in recent decades the number of psychiatric beds in England has declined substantially the number of beds within medium secure units, accommodating forensic mental patients, has increased. With an emphasis on security these units epitomise the risk assessment and risk management practices that now pervade contemporary mental health care.

This is a study of the thinking amongst the staff of a medium secure unit about their work. It is informed by Strauss et al's (1964) classic study of psychiatric institutions in the USA. They found that although doctors, nurses, psychologists and other professionals shared the broad common goal of attempting to treat and rehabilitate patients, considerable variability existed between and within professional groups as to how they thought this should be achieved. In part, disagreement and discrepant practices could be explained in terms of the competing ideas staff had about the nature of mental illness and how it should be appropriately treated. These 'psychiatric ideologies' helped shape a negotiated order.

In this paper, we similarly attempt to explain the organisation of a medium secure unit by first considering the varying psychiatric ideologies that different staff expounded in in-depth interviews. Considerable differences were found to exist amongst staff as to their understanding of the relationship between mental illness and offending behaviour. There was disagreement about how each should be appropriately dealt with, and about how treatment and rehabilitation should be understood and practised.

**Sunday am**

**10.10 - 10.30**

**Goode, J., Greatbatch, D., Hanlon, G., Luff, D., O'Cathain, A., Strangleman, T.**

**King's College London**

### **NHS DIRECT - IS IT NURSING?**

NHS Direct now employs roughly 0.5% of nurses within the NHS. Given that it was started in 1998, this is a small but significant percentage. These nurses are important for a number of reasons: one, NHS Direct is envisaged as the gateway to the NHS of the future; two, NHS Direct could be classed as a nurse-led organisation; three, these nurses are necessarily experienced; and four, this form of nursing appears to develop new skills and represents a shift away from nursing as a hands on experience.

The rise of NHS Direct has led to a number of responses - fears that it will drain nurses from other areas of the health system, fears amongst some non-nursing professionals that nurses will move beyond advising patients and, finally, a feeling that NHS Direct does not represent 'real' nursing. This paper tracks these issues with reference to how NHS Direct nurses themselves view what they do. It maps out how these nurses feel their skills are altered, enhanced and debilitated by working in NHS Direct and how being in a nurse-led organisation, that nevertheless resembles a call centre, affects their careers and work identities. Such an analysis is important if the core skills of this new form of nursing are to be understood and enhanced to fit the gateway role the NHS is increasingly wanting nurses to accept.

**Saturday pm**

**14.45 - 15.05**

**Graham, R.**

**University of Newcastle upon Tyne**

**SEXUAL VIOLATION AND MEDICAL DISCOURSE: ETHICS AND THE PELVIC EXAMINATION**

The phenomenon of sexual assault generates voluminous social research, and the concept of sexual violation is central to its construction as an important research problem. However, this use of 'sexual violation' in the research discourse is implicit, and the concept remains neglected theoretically. This neglect may contribute to the problem of adequately defining sexual assault, which correspondingly impacts negatively on the effectiveness of state responses to sexual assault. Exploring the meaning of 'sexual violation' brings greater clarity to defining and responding to the social problem of sexual assault.

The case of pelvic examination is unusual compared with the wider research evidence on sexual assault, because it involves an understanding of consent that is interwoven with notions of ethical medical practice. The (un)ethical pelvic examination draws out contradiction in the more common-sense aspects of defining sexual assault (such as consent and violation). The published research literature on pelvic examination therefore offers opportunities to interrogate the meaning of sexual violation, and to explore theoretically driven, interdisciplinary questions about violation and the sexed body. This body of published research is largely medical, and from this I identify and examine the understandings of violation in researchers' accounts of a commonplace medical practice. The analysis draws on debates within feminist post-structuralist discourse around sexual difference and corporeality. The work therefore contributes to debates within the sociology of health and illness about how conceptualisations of sexed bodies impact on contemporary health care, and offers insight into broader social research perspectives on sexual assault.

**Saturday pm**

**14.45 - 15.05**

**Greener, I.**

**University of the West of England**

**PATIENT CHOICE IN THE NHS: THE VIEW FROM ECONOMIC SOCIOLOGY**

The UK Labour government, having experimented with a centrally-driven, expert-based NHS (Secretary of State, 1997), appear to have now decided that the future of health services in the UK will be driven by patient choice (Department of Health, 2001a, 2001b) and performance measurement. We investigate the economic underpinnings of patient choice, exploring especially the contribution that economic sociology (Callon, 1998a, 1998b, 1999; Granovetter, 1973, 1985) can make to the debate. By taking such an approach, we explore how 'calculative' health markets are, and how, health policy in the UK might be based on an over-reflexive model of human agency (Hoggett, 2001) that is unrealistic, but representative of New Labour's reforms in other welfare areas, and based on a process of passing responsibility for policy failure from the state to the local level. I conclude by considering how we might structure health services more sensibly based upon the critique offered above.

**Saturday pm**

**15.55 - 16.15**

**Greenfield, S., Jolly, K., Hare, R.**

**University of Birmingham**

### **ELICITING ETHNIC MINORITY PATIENTS' VIEWS ABOUT CARDIAC REHABILITATION**

#### **Introduction**

It has been quantitatively documented that patients from minority ethnic groups have a higher rate of non-participation and non-adherence to cardiac rehabilitation (CR) programmes despite a higher prevalence of risk factors. The reasons for this are poorly understood. This study aimed to explore the experience of heart disease and beliefs about CR in patients from ethnic minority groups.

#### **Method**

Patients with a cardiac event within the last 18 months were identified from CR clinic records at 2 hospitals. Patients were either: invited by letter (in English and a minority language with the offer of taped information); telephoned; invited whilst attending CR. 41 in-depth interviews, using a semi-structured interview schedule with topic prompts in a language of the patient's choice, were carried out with; 8 patients who had declined CR; 5 patients who had joined CR but had not adhered; 28 patients who had completed CR. Interviews were audio taped, transcribed into English and analysed using constant comparative analysis.

#### **Results**

29 men and 12 women, age range 34 to 81, representing 6 ethnic minority groups with a range of cardiac conditions were interviewed. The main themes emerging were; beliefs and behaviours about heart disease before, at the time of and after their cardiac event, interactions with healthcare professionals, views about CR. There was evidence of cultural stereotyping by both the managers and the rehabilitation staff.

#### **Conclusion**

There is little qualitative research into the experience of heart attack by ethnic minority patients. This approach can be an effective way of exploring patients' beliefs and behaviours.

**Saturday am**

**09.25 - 10.05**

**Gregory, J., Gibson, B., Robinson, P.G.**

**Guy's, King's and St Thomas' Dental Institute**

### **PROCESSES OF NEGATION AND CHANGE IN THE MEANING OF ORAL HEALTH RELATED QUALITY OF LIFE: A QUALITATIVE STUDY**

Quality of life measures tend to treat quality of life as a stable construct that can be measured externally. They do not take people's differing expectations into account and they assume that what quality of life means to people is stable over time. Luhmann drew on a diverse range of theoretical traditions including systems theory, phenomenology, distinction theory, and autopoiesis. The result is a radical constructivist theory of systems that are self-producing. The aim of this study was to apply Luhmann's theory of social and psychic systems to the study of meaning and quality of life. Data were collected from a series of open-ended interviews with 20 people who had varying degrees of oral health and disease. Data were analysed by asking the following questions: How did the person articulate their relationship between the psyche, the mouth, and their environment? What meanings were made manifest or latent? What processes did people use to maintain or change their expectations? From this analysis a framework was developed to outline how people's meanings of oral health varied. The data demonstrated that people's awareness of the relevance of oral health to their lives were in a continual process of replication or change. Processes included engaging and negating where people acted out and justified, or denigrated and projected observed meanings. The person's awareness was therefore either maintained or changed depending on the relationship between their experiences and expectations. These findings have implications for the application of Luhmann's theory to the observation of psychic systems.

**Saturday am**

**09.25 - 10.05**

**Grewal, I., Nazroo, J.**

**National Centre for Social Research**

## **ETHNIC INEQUALITIES IN THE QUALITY OF LIFE OF OLDER PEOPLE**

This presentation is based on a qualitative study exploring the extent of ethnic inequalities in the quality of life of older people.

The starting point of the study was the concern that little policy or academic research has been carried out into the circumstances of those who migrated to the UK during the post-war period and who are now progressing into early old age and retirement. These people may now be facing substantial inequalities as a result of the 'double jeopardy' of old age and ethnic minority status. The study we describe here aims to contribute towards filling this gap in knowledge, by mapping and explaining ethnic inequalities in quality of life at older ages, while recognising that the concept and components of 'quality of life' might be culturally bound.

Through interviews with respondents from four ethnically homogeneous groups the following dimensions of quality of life were identified:

- having influence and respect which came from having a role through family, friends and community;
- having access to sources of emotional, social and practical support;
- being independent and having control over one's life;
- having/being able to enjoy time;
- having income and wealth;
- and having health.

The presentation will use evidence from the interviews to show that whilst these dimensions of quality of life were consistent across the ethnic groups, it was the ways in which they played out in people's lives that revealed ethnic variations.

**Saturday am**

**11.45 - 12.05**

**Guest, C., Farmer, J., Chesson, R., Campbell,  
N., Deans, G., Iversen, L., MacDonald, J.**

**University of Aberdeen**

## **DECISIONS TO USE PRIMARY CARE: A QUALITATIVE STUDY IN URBAN AND RURAL GENERAL PRACTICE**

### **Background**

Evidence suggests different patterns of primary care consultation for rural and urban patients. While theory exists regarding health behaviour models, further work is required in the area of attitudinal and cultural factors affecting decisions to consult in different types of location.

### **Aim**

To identify factors affecting the initial decision to consult primary care in different types of location.

### **Method**

The study involves participants (aged 45-64) randomly selected from eight general practices (four rural and four urban; four large and four small) in Grampian and Dumfries and Galloway. Four focus groups and 51 interviews were carried out. Discussion was stimulated using audio-taped vignettes. Participants were presented with scenarios describing a range of symptoms and were asked to discuss how they would act in response to such circumstances.

The focus groups and interviews were tape recorded and transcribed.

Analysis was inductive and deductive. NVivo software was used.

### **Initial Findings**

Preliminary analysis of the focus groups has concurred with existing knowledge about health behaviours. Other issues to be considered further include participants perceptions of their GP in terms of a service/relationship perspective and also attitudes and responses to the different scenarios in relation to location and size of practice.

### **Conclusions**

Vignettes were useful in facilitating discussion. Themes emerging confirm aspects of existing knowledge about health behaviours. Further exploration is required of attitudinal and cultural issues related to participants decisions to seek health care.

**Sunday am**

**09.50 - 10.10**

**Guthrie, E., Barbour, R.**

**Glasgow University**

**HORROR STORIES AND HEROINES: THE CONSTRUCTION OF RISK BY WOMEN WITH EPILEPSY AND THEIR PROFESSIONAL ADVISORS**

Women with epilepsy live with a complex range of possible risks. These include 'uncontrolled' seizures, side effects of antiepileptic medication (which can include cognitive impairment, contraceptive failure, fertility problems, and increased rates of foetal abnormality), workplace issues, domestic responsibilities, professionals' incomplete knowledge about epilepsy, as well as societal responses to epilepsy. The label 'epilepsy' can have a major impact on how the women are perceived and how they perceive themselves.

This presentation draws from PhD work in progress that explores the reproductive 'choices' of women with epilepsy. The study includes in-depth interviews of women with epilepsy aged 24 - 58 years accessed from Glasgow general practices and from epilepsy voluntary sector organisations. Purposive sampling aims to include women with a wide range of reproductive experience, living in a variety of family structures with differing educational and occupational backgrounds. Individual and group interviews are being held with health care professionals with both generalist and specialist backgrounds. Generalists will include practice nurses and general practitioners; specialists will include voluntary sector epilepsy fieldworkers, epilepsy specialist nurses, epileptologists, midwives and obstetricians.

The paper will present women stories about risk and professionals' accounts of risk. Comparisons of the different perspectives of risk will be made within and across professional groups, between women, and between professionals and women. The social construction of risk by women with epilepsy and the health care professionals will be compared with literature on risk.

**Saturday pm**

**14.45 - 15.05**

**Hallowell, N., Foster, C., Eeles, R., Ardern  
Jones, A., Murday, V., Houlston R., Watson,  
M.**

**The Institute of Cancer Research**

**BETTER THE DEVIL YOU KNOW: WOMEN'S UNDERSTANDING OF GENETIC RISK FOLLOWING BRCA1/2 MUTATION SEARCHING**

There has been little research that explores the meaning of risks for individuals who are deemed at risk of breast or ovarian cancer because of their family history, and none that has looked at how women who have previously been affected with cancer make sense of their (potentially) increased risks following DNA-testing. This retrospective investigated affected women's perceptions of developing cancer. In-depth interviews were undertaken with 30 women who had undergone BRCA1/2 mutation searching (10 carriers, 8 awaiting a result and 12 who received an inconclusive test result). The interviews explored the impact of genetic testing on their risk perception.

The data suggest that following their initial diagnosis of cancer all women were very aware of their recurrence risk. However, most reported that their anxiety about developing cancer had decreased over time. For some the actual probability of developing cancer was perceived as reducing over time, whilst others described their risk of cancer as constant but their ability to accommodate this risk within their lives changed. Women's understanding of their (potential) inherited risk of cancer involved reconciling their previous experiences of cancer with their expectations of the future. Thus, some women, did not regard genetic risk as a threat, whilst others reported an increase in anxiety on learning they were at risk of developing a second primary cancer. The implications of these findings for our current understanding of risk perception will be discussed.

**Sunday am**

**09.25 - 09.45**

**Hanssen, J-I.**

**National Centre for Comprehensive  
Rehabilitation Research and  
Development, Norway**

### **THE QUEEN OF DIAGNOSTIC TOOLS; THE SOCIAL MEANING OF MRI**

Magnetic Resonance Imaging (MRI) is by far the most important imaging discovery in modern medicine. MRI today is considered the imaging modality of choice for most parts of the body. It is a widely shared belief that MRI has set a new standard in diagnosis and enhances the level of health care in modern medicine. The technique requires however expensive investments and highly skilled personnel and has fuelled the development of the highly technological medicine. The bill is for the public and the patients to pay.

In this paper we question the accuracy of MRI as a diagnostic tool by comparing MRI with surgery reports. Investigating 200 cases we find that in as much as 75 percent of the cases there is hardly any correlation between the MRI findings and the findings reported by surgeons. Thus, MRI is a poor diagnostic tool. Surgeons claim to ignore MRI findings as an instrument for diagnosis and as a basis for decisions of whether surgery procedures should be performed or not. Basically their clinical experience and the symptoms reported by patients are sources of information underpinning their treatment options. They use MRI reports only to support decisions already made and if MRI reports indicate a different diagnosis and a different treatment plan, they would usually ignore them.

The questions are; if MRI does not work, why is it still so important for modern medicine? What is the social meaning of MRI?

**Saturday pm**

**14.00 - 14.40**

**Hart, G.J., Wellings, K.**

**MRC Social and Public Health Sciences  
Unit**

### **DR FEELGOOD: THE MEDICALISATION OF SEXUAL BEHAVIOR**

The exercise of medical authority over sexual behaviour has a long history. Descriptions of sexual behaviour in the 19th century served to define what was normal and what was not. From William Acton's tirades against masturbation in 1857 to the publication of the DSM of Mental Disorders in 1952, behaviours which had previously been morally inadmissible were now considered treatable. The latter half of the 20th century saw major changes in sexual attitudes and mores. Sex that is not for procreation is no longer looked upon as sinful. Medical treatments and interventions have saved thousands of lives. The discovery of the contraceptive pill liberated women from the fear of unwanted pregnancy. Yet the more open discussion of sex has come at a price: mass surveillance establishes norms and standards for sexual behaviour, according to which people can measure themselves and be measured. From the average number of times people have sex every month to articles on how to achieve the ultimate orgasm, the prescriptive boundaries of normality are pushed further. The most recent extension of medicalisation has been into the domain of sexual pleasure. Viagra ranks as one of the greatest success stories in pharmaceutical history. Gynaecological surgery is being harnessed to female sexual pleasure and aesthetics. Relatively recently the imperative was for restraint and moderation in sexual matters; now it is for ever more and better sexual gratification. The irony is that we may be moving away from late 20th century diversity towards greater uniformity in the 21st.

**Saturday pm**

**14.45 - 15.05**

**Hausmann, E.**

**Goldsmiths College**

**THE GROWING ACCEPTABILITY OF EUTHANASIA IN CONTEMPORARY SOCIETY:  
'KILLING' AND 'LETTING DIE'**

This paper investigates the distinction that is often made between 'killing' and 'letting die' and argues that this exercise can point us towards an understanding the dynamics of the growing acceptability of euthanasia in contemporary society. It poses the question whether we should think about 'killing' and 'letting die' as referring to different actions (for example, giving a lethal injection versus switching off a ventilator) and argues that on the contrary 'killing' and 'letting die' are being applied to the same actions, investing them with different meanings. We talk about actions employing the 'institution of responsible action' and the 'institution of causal connection' (Barnes 2000) - it depends on the particular attribution of causal connections where responsibility for an action will be located. An analysis of the language use in newspaper articles of euthanasia over the course of 12 months (1998/99) suggests that 'nature' in the form of terminal illness gets routinely invested with agency, thus diverting responsibility away from human beings as actors. The paper concludes with a reflection on the significance of this for the dynamics of the euthanasia debate.

**Friday pm**

**14.00 - 14.20**

**Henwood, F., Wyatt, S., Hart, A., Smith, J.**

**University of Brighton**

**MEDIA AND RISK: LEARNING FROM THE EXPERIENCES OF PATIENTS**

Central to debates about the emergence of 'risk society' and the associated changes in traditional relationships and sources of authority that are said to characterise late modernity, is an understanding of the role of information and of information and communication technologies such as the Internet. Polarised claims about health information and the Internet are commonplace in popular discourse, as well as some academic texts, and have implications for thinking about risk. Will the greater availability of health information via the Internet lead to the emergence of more informed patients, better able to assess the benefits, dangers and uncertainties of treatment choices? Or, alternatively, will the over-abundance of information available (particularly online), lead to confusion and radical doubt as lay users do not have the expertise to interpret and evaluate the appropriateness of the information?

This presentation provides results from a study, which examines the experiences of health care users as they access and interpret health information about two pharmaceutical interventions - hormone replacement therapy (HRT) and Viagra. We analyse the significance of different media and sources of health information about these treatments in the discursive production of 'risk narratives'. Moreover, we examine the different types of risk negotiated by health care users as well as the different meanings of risk. Types of risk include those associated with treatment, ageing, illness, disclosure of information. Risk can mean not only danger but also uncertainty and pleasure.

**Saturday am**

**09.00 - 09.20**

**Hight, G.**

**University of Edinburgh**

**THE INTERACTION OF GENDER AND PEER GROUP FACTORS ON YOUNG PEOPLE'S CANNABIS USE**

Some of the recent smoking literature has pointed to the importance for health education programmes of more fully understanding the complex interplay between the risk factors associated with smoking, in particular how gender and peer group relationships interact to influence young people's smoking behaviour. Such studies suggest that smoking behaviour is shaped by gender. We know little, however, about how different factors interact with one another to influence young people's cannabis use. Drawing on data from a doctoral study exploring the social context of young people's tobacco and cannabis use, this paper will explore the inter-relationships between gender and peer group factors in relation to young people's use of cannabis. The study comprises thirty interviews with 13-15 year olds from a wide range of backgrounds and with different patterns of use and non-use of cannabis and cigarettes. The data was generated primarily through interviews with pairs of friends.

Data from this study suggest that the psycho-social processes involved in young people's cannabis use, in particular at the early experimentation stage, may be different for boys and girls, with cannabis having a more powerful and enduring significance for boys, related to image, social identity and the nature of boys' friendship groups. Most girls, apart from those trying to gain access to predominantly male peer groups, tend to be more alcohol-orientated and only occasionally use cannabis for recreational purposes. This finding adds to the knowledge base about young people and their lives, particularly in relation to cannabis use and other health-related behaviours.

**Sunday am**

**11.00 - 11.40**

**Hislop, J., Arber, S.**

**University of Surrey**

**THE AGEING OF SLEEP: THE RELATIONSHIP BETWEEN LIFE EVENTS AND PHYSIOLOGICAL FACTORS IN STRUCTURING OLDER WOMEN'S SLEEP**

In proposing his 'disposable soma' theory of ageing, Tom Kirkwood argues that old age results from limited investment in the maintenance of our physical body because of an evolutionary focus on reproduction. We age because of a build up of 'hits' to our physical body over the life course and our failure to repair this damage. This paper reports on empirical research into older women's sleep. It suggests that a similar process of accumulated damage to sleep patterns over the life course may impact significantly on women's sleep from the age of 60. By drawing on data from life grid interviews which explored women's sleep patterns in relation to life events from the age of 40, the paper shows that the expectations, responsibilities, and stress associated with women's roles as wives, mothers, daughters and employees as well as the effects of life crises such as divorce, illness, and bereavement, are responsible for creating a pattern of sleep disruption which accumulates over the life course. The interaction of this pattern of disruption with the biological effects of ageing creates a fertile environment for poor sleep quality in older women. We conclude that sleep disruption may need to be addressed earlier in life as part of health prevention policy to ensure better quality sleep patterns in old age.

This research was supported by the Commission of the European Communities, contract number QLK6-CT-2000-00499.

**Sunday am**

**09.25 - 09.45**

**Hobson-West, P.**

**University of Nottingham**

### **A BREAKDOWN OF TRUST? ANTI-VACCINATION IN THE UK**

This paper will discuss anti-vaccination in the UK and argue that it represents a challenge to the dominant biomedical model and a breakdown of trust in its legitimising institutions.

Protecting citizens from disease is a crucial responsibility of the modern state, both politically and economically. Mass childhood immunisation has become a key tool of preventive health policy. However, in recent years the government has expressed concern that the uptake of certain vaccines (such as MMR) is falling, to the point where 'herd immunity' may be being threatened. In this context, doubts expressed about the safety, need for, or effectiveness of vaccines represent an important challenge to the medical and political orthodoxy.

As well as individual parents refusing vaccination, collective resistance can be observed through the work of vaccination-sceptical groups, such as JABS, and within alternative medicine fields. Empirical research needs to be done to assess the 'ideology' of such groups, and whether competing understandings of health, expertise, responsibility and risk are at play. My assumption is that resistance is more than just a simple response to media scare stories. Rather, a breakdown of trust in vaccination as a technology is a reflection of a breakdown of trust in the modern institutions of biomedicine, science and the state. This research has implications for medical sociology's concern with the construction of lay beliefs, debates about lay versus scientific expertise, postmodernism and risk.

**Sunday am**

**09.50 - 10.10**

**Hofseth, C., Norvoll, R.**

**SINTEF Unimed, Oslo**

### **THE NURSES' ROLE; OLD PROBLEMS AND NEW CHALLENGES**

#### **Objectives**

Based on the results of a study among nurses in Norwegian hospitals the paper presents and discusses empirical findings on persistent problems associated with nurses' professional role, more recent challenges linked to the hospital's organisational structure and development, nurses' strategies to cope with these challenges in hospitals, and alternative strategies on an organisational level.

#### **Methods**

The study comprises three data collection elements, using both quantitative and qualitative methodologies; self-reported time/task study, semi-structured in-depth interviews, and self-administrated questionnaire.

#### **Results**

The results support previous studies that demonstrate the complexity of, and variation in, nurses' duties as well as role stress. Recent changes, such as increasing complexity of hospital organisation and reduction in number of nurse's aides and associated supporting functions, seems to influence the shaping of the nurses' role and contribute to additional pressure. The nurses' central co-ordinating function in the hospital organisation does not seem to be accompanied by a corresponding degree of authority. Their work has become fragmented and consists to large extent of tasks other professional groups have rejected. Strategies used to meet challenges are, for the most part, realised on an individual level.

#### **Conclusion**

Despite previous attention paid to this situation, the nurses' role remains under pressure from a lack of integration of principles of care within the underlying premises of hospital organisation. It is necessary to search for strategies to meet this challenge on an organisational level within hospitals.

Friday pm

16.20 - 17.00

Huby, G., Rogers, W., Stewart, J., Tierney, A.,  
Thompson, A.

The University of Edinburgh

### **MANAGING UNCERTAINTY: ELDERLY PATIENTS' PARTICIPATION IN DECISION-MAKING ABOUT HOSPITAL DISCHARGE**

#### Introduction

'Patient involvement in decision-making about care' is a key, but poorly understood, part of current healthcare policy. Much of the literature concerns decision-making in individual patient-practitioner encounters, but leaves unexplored the organisational context, which shapes these encounters. This paper examines the concept of 'patient participation in decision-making' in the context of discharge planning for elderly patients.

#### Methods

The paper draws on an ethnographic study about elderly patients' participation in decision-making about discharge. It was carried out in a Scottish district general hospital in preparation for a larger study.

20 patients above the age of 60 in 3 different wards in the Medical Directorate were followed out of hospital into their homes. The decision-making around the discharge, and patient's role in this process, were explored from the perspectives of the patients and their professional carers. Through participant observation at wards and in ward meetings the negotiation process in individual cases was linked to the larger organisational context which shaped discharge planning.

#### Findings

Procedures for discharge planning aimed to reduce the unpredictability of discharge of patients whose ability to cope was uncertain. In this process, options for action were excluded, and the opportunity for both patients and staff to participate in decision-making was reduced. Moreover, because discharges are contingent on a range of factors which interact 'chaotically', attempts to contain their complexity often had the opposite effects.

#### Conclusion

The politics and practice of managing uncertainty in discharge planning is discussed with reference to theories about risk, trust and 'the audit culture'.

Saturday pm

12.10 - 12.30

Hudson, N.A., Culley, L.A., Johnson, M.,  
Katbamna, S., Maggs-Rapport, F.

De Montfort University

### **INFERTILITY AND ETHNICITY: CONCEPTUAL, METHODOLOGICAL AND ETHICAL ISSUES IN AN APPLIED HEALTH RESEARCH PROJECT**

There is an extensive literature which presents infertility as a devastating experience, with significant consequences for social and psychological well being. Within the UK, the 'motherhood mandate' is significant, infertility is highly stigmatised, and women in particular bear the burden of reproductive failure. The research literature identifies that the 'infertile' are considered a largely homogenous group and even research in the social sciences has tended to focus on white middle class treatment seekers. Studies have consistently ignored non-treatment seekers, those accessing treatments other than In Vitro Fertilisation (IVF); those in lower socio-economic groups and those from minority ethnic communities. Within the UK, studies of ethnicity and reproduction have tended to concentrate on contraception and childbirth rather than involuntary childlessness with no published work on ethnicity and infertility treatment. This paper discusses some of the conceptual, methodological and ethical issues involved in designing and carrying out an NHS funded research project exploring the relationship between ethnicity, the social meaning of involuntary childlessness and access to infertility services in British South Asian communities. The ways in which the research team has responded to these issues in the design and implementation of research on this highly sensitive topic are discussed.

**Saturday pm**

**16.20 - 17.00**

**Humphrey, C., Russell, J.**

**King's College London**

**NHS DOCTORS IN PRIVATE PRACTICE: HEROES AND VILLAINS OR ORDINARY MEN?**

The conventional assumption is that doctors who work as salaried employees of the NHS are guided in their clinical practice by professional values, which encourage them to put their patients' interests first. A common suspicion is that doctors undertaking fee-for-service practice in the private sector are motivated by self-interest, with commitment to their patients compromised by consideration for their purse. The majority of UK hospital consultants see at least some patients in both sectors, often switching between the two in the course of a single working day. In this paper, we use findings from a recent interview study of 60 surgeons and physicians involved in dual practice of this kind to consider whether and how they reconcile their personal, professional and public sector values and responsibilities with the temptations of the market.

The interviews revealed a complex range of informal principles, tacit and explicit, individual and shared, which these doctors adopt to regulate and justify their activities. A variety of practical strategies, such as keeping NHS and private patients apart in space and time, are also used to avoid confronting ethical conflicts in their work. Paradoxically, the present situation in the UK, where private health care is in high demand and a lot of money can be earned in a very short time, was seen by most of our respondents as enabling them to do the amount of private practice they want to without undue danger of over-treating their private patients or neglecting their work in the NHS.

**Friday pm**

**15.10 - 15.30**

**Huseby, B.M.**

**SINTEF Unimed Health Service  
Research, Norway**

**REGIONAL DIFFERENCES IN LIVING CONDITIONS AND HOSPITAL USE IN NORWAY**

The geographical differences in hospital use in Norway are substantial. In the northern municipalities, the standardised discharge rate is 2,6 times higher than in southern municipalities. Basically, these differences may have two explanations: (i) geographical differences in access to hospital services or (ii) geographical differences in need of hospital services.

The Norwegian health care system is traditionally described as supply-induced. The local governments have been owners and suppliers of public hospitals in Norway. In January 2002, the state undertook the responsibility and the financing of the hospitals. It is expected that this reform will lead to major reforms in the distribution of the economic resources. Accordingly, it has become requisite to analyse the geographical differences in need for hospital services.

The relationship between living conditions and health is well documented in Norway. This relationship implies that geographical patterns of living conditions and health are likely to influence hospital use. Although such studies have been performed in several countries, they have been neglected in Norway.

In this paper, we will present an analysis of the relationship between geographical differences in (i) living conditions (ii) indicators of access and supply of hospital services and (iii) use of hospital services in 435 Norwegian municipalities in 1999 and 2000. The analyses are based on register data on all hospital discharges, rates of mortality, disability, crime, recipients of unemployment and social security benefits, travel distances from each municipality to the nearest local hospital and indicators on hospital level.

**Friday pm**

**15.35 - 16.15**

**Hyde, M., Blane D., Higgs, P., Wiggins R.D.**

**Imperial College of Science**

**LIFECOURSE AND CONTEXTUAL FACTORS THAT INFLUENCE QUALITY OF LIFE  
IN EARLY OLD AGE**

**Aim**

To identify and analyse life course factors that influence quality of life in early age.

**Study**

We conceptualise quality of life as distinct from the factors that influence it. Our model of quality of life is derived from an explicit theory of human need. This 19 item scale comprises four ontologically grounded domains; control, autonomy, self-realisation and pleasure (CASP-19). A postal questionnaire was sent to a representative sample of people aged 65-75 years in the UK. Life course data are held on all sample members and physiological and anthropomorphic measures were taken in 1997-8. The CASP-19 was included in the postal questionnaire along with measures of the contextual influences on quality of life, like social support, health and financial status.

**Method**

We will present a series of conceptual and operational pathways to quality of life in early old age using a combination of regression and latent variable modelling. Finally we examine the relative impact of these pathways in a combined model of quality of life in early old age.

**Results**

We found that there is a range of experiences of quality of life in older age. Preliminary findings suggest the life course influences on quality of life in early old age tend to fade when compared to the impact of present circumstances.

**Saturday pm**

**16.40 - 17.00**

**Iley, K.**

**Southbank University London**

**TEACHING SOCIOLOGY TO HEALTHCARE PROFESSIONALS: MAKING A  
DIFFERENCE?**

The inclusion of sociology applied to health and illness on all healthcare professional courses is well established. With recent governmental policy supporting widening the entry gate and encouraging larger intakes of students on a range of courses such as Nursing, Medicine and Professions Allied to Medicine, the challenge to teach in an effective way has been a concern for many academics in this field.

Is there a challenge to the academic identity of the discipline of sociology of health and illness and its perceived value to healthcare professionals education? Or are sociologists participating in the educational enrichment of a wider and more diverse student population than before?

These questions will be considered firstly, by looking at the author's recent experience of developing a new social sciences course on a pre-registration nursing programme. Secondly, data will be presented from a qualitative study of the first cohort of students to undertake this course. Data obtained from focus groups and questionnaires should provide valuable insights into these students understanding of sociology applied to health and illness and how it informs their clinical practice. Finally, the challenges of delivering inter-professional teaching and learning by sociologists will be examined.

**Friday pm**

**14.25 - 14.45**

**Jackson, R.J.**

**Sheffield Hallam University**

**DELIVERING HEALTH: A FOUCAULDIAN ANALYSIS OF THE STRATEGIC DEPLOYMENT OF 'HEALTH' AT THE POST OFFICE**

Emerging neoliberal rationalities are reshaping the landscape of work, typified by increased flexibility in working practices and decreased job security. These developments have been accompanied by increases in levels of reported stress. This paper uses a Foucauldian inspired framework to explore some of the implications of the rise of neoliberalism for the health practices of the Post Office and its employees. Key questions include: 'How is responsibility for health constructed and where is it located?' and 'What role do constructions of 'risk' play in employee health issues?'

Part of an ongoing Doctoral research programme, the paper attempts to marry the empiricism of sociology with the critical theorising of Michel Foucault. The Post Office comprises one case study where a range of employees and health professionals were interviewed. The significance of the practices of stress and sickness management and the use of screening technologies are examined in order to demonstrate a shift in the construction of responsibility for health, away from the employer and toward the individual employee.

There appears to be a discursive battle going on around the concept of 'health', its contested meanings becoming visible within 'health interventions' such as stress management. Analysis indicates that 'health' is used 'strategically' by both employers and employees. Employees presenting with 'stress' in the context of, for example, arguing for a change in working hours, may encounter an employer response which legitimates otherwise unwarranted incursions into employees' lives.

**Friday pm**

**14.25 - 14.45**

**James, V., Williams, J., Hampshire, M.,  
Nottingham PMS Research Evaluation Team**

**University of Nottingham**

**BREAKING THROUGH: INNOVATIVE BUREAUCRACY AND PROFESSIONAL MANNERS IN PRIMARY CARE**

A central monolith of NHS primary care provision since 1948 has been the dual role of General Practitioners as both clinical lead and overseeing management for the organisation and delivery of services. In 1997 the NHS (Primary Care Act) enabled health professionals to explore new models of service through PMS (Personal Medical Services). Of 567 expressions of interest for the first wave, there were 123 full applications of which 97 were approved, and 88 went live, with one unable to start, leaving 87. Of the 87 pilot proposals, 8 PMS nurse-led projects were implemented and two turned the traditional medical/manager role on its head by initiating nurse-managed practices, one of which is still effective. Drawing on old and new bureaucracy literatures (Du Gay, 2000, Ray and Reed 1994), a case study, of the surviving practice is examined for the interplay of inter and intra-disciplinary manners and the implications for change in bureaucratic and clinical boundaries. Four years into the project, documentation and 30 interviews spanning practitioners within and out with the project; health authority and PCG/T staff, offer themes of risk, scrutiny, sustainability and transferability, along with a central issue of the entrepreneur/charismatic leader who initiated the project. Interviews reveal interpretations of professional manners and bureaucratic processes which centrally affected the viability of the project, and questions of whether 'the mould was broken'.

**Sunday am**

**10.10 - 10.55**

**Jones, A., Henwood, F., Hart, A., Gerhardt, C.**

**University of Brighton**

## **ELECTRONIC PATIENT RECORDS AND THE MATERNITY JOURNEY: PATHS OF DESIRE**

In this paper we will focus on clinical practitioners understanding of, and response to, the introduction of EPRs and related technologies and changing working practices arising from these (Goorman and Berg 2000). Framing our paper in relation to the concepts of 'acceptance' and 'resistance' (Anderson, Aydin et al. 1994), we will explore how EPRs are presented to practitioners, the extent to which they accept them and the factors, which facilitate or inhibit this acceptance. We will also present examples of how practitioners create their own 'desire lines' (term from architectural practice) throughout the journey of the maternity record.

We will draw on data from a national research project entitled 'The use of EPRs in maternity services: professional and public acceptance', funded by the DH under its IC&T Initiative. The project broadly explores the response of practitioners to the government's IT strategy 'Information for Health' and 'Building the Information Core' (NHS Executive 1998; NHS Executive 2001). The research has two parts: a national survey of Heads of Midwifery in England and in depth case studies of four NHS maternity services in England.

**Friday pm**

**15.35 - 16.15**

**Jonsson, A-C**

**University of Linköping, Sweden**

## **REPRODUCTIVE HEALTH AND THE RE-FORMATION OF THE NATURAL PROCESS OF CHILDBIRTH**

Current developments in medical technology clearly offer an unprecedented control over our bodies, yet at the same time the body is rendered as increasingly "uncertain", leading to a growing crisis of identity, concerning what the body is and what it might become. The advances in medical science and technology, from plastic surgery, through genetic engineering, to virtual medicine, have forced us to put our former held beliefs about what the body is in brackets. Within the area of reproduction the consequences of these bodily re-formations achieved by reproductive technologies have been discussed as particularly exceptional, since they may extend the boundaries and possibilities of medical and scientific practice in ways that threaten to outstrip our understanding of morality and control. They radically transform our conception of what it is to be human, parent, child and foetus.

This paper discusses, from differing feminist perspectives, in what sense reproductive health technologies might be said to have changed the natural process of childbirth and our images of the pregnant female body and foetus. I use the case of routine ultrasound to discuss this question further. I will be drawing on examples from an empirical study of midwives and expectant parents uses of the image of the foetus during routine ultrasound, carried out as a part of my PhD project.

**Friday pm**

**15.35 - 16.15**

**Kelly, M.J., Berney, L., Jones, I.R.**

**Barts & The London School of  
Medicine & Dentistry**

**NEED, COST, AND EVIDENCE: GP PERSPECTIVES ON INVOLVING PATIENTS IN  
PRESCRIBING DECISIONS**

There has been relatively little empirical research on how resources affect decision-making in patient-GP consultations. A qualitative study was set up to examine GP and patient experiences and views of how scarce resources affect their decision making about treatment and care. The study involved interviews and focus groups with 24 GPs, and interviews with 18 patients in Greater London. This paper will consider GP perspectives on prescribing and resource availability and how this may affect patient involvement. GPs generally stated that clinical need will always come first in treatment decisions. Cost may come into the decision at times, but it is considered in terms of cost-effectiveness. Decisions are also influenced by the quality of evidence available that the drug is effective. Measures to control practice costs, such as generic prescribing were not in principle considered a problem by most GPs as they were considered to be cost-effective. However, there was support for GP flexibility in prescribing, so that decisions could be made in relation to individual patient need. There are areas where restrictions on prescribing could present a problem, such as when expensive drugs are recommended or requested. This does not happen regularly, but when it does it has a number of implications including concerns about treatment, time, cost, and equity. Prescribing practice is monitored at the level of the individual GP, the practice, and the PCG. The data analysis will be presented and discussed in relation to current models of decision-making and surveillance of practice.

**Saturday am**

**09.25 - 10.05**

**Kelly, D.**

**City University**

**EMBODIMENT AND PROSTATE CANCER**

Prostate cancer is a uniquely problematic male health issue. The biomedical evidence is largely inconclusive about the benefits of screening, or the most effective treatment for this disease. There has also been a lack of focused sociological research on this topic to date.

The presentation reports on a doctoral study which employed an ethnographic approach to examine the experience of prostate cancer in a group of men. Data were obtained from observations of consultations; in-depth interviews with fourteen men diagnosed with prostate cancer; and with five medical professionals. The theoretical basis of the study centered on embodiment. The male body was both objectified and altered in unique ways as a result of prostate cancer. Men's reactions differed in relation to life experiences, cultural backgrounds and personal expectations.

The embodied experience of prostate cancer was observed to begin at the time of diagnosis with penetration of the male body. The focus then shifted to decision making and relinquishing, or seeking to preserve, normative states of male embodiment such as urinary continence and erectile function. During treatment, the body was subjected to a number of interventions which objectified it further, and rendered it both passive and problematic. The final phase was concerned with adapting to compromised states of male embodiment. This trajectory of experience emphasised both the vulnerability of the body, and the impact of cancer on men's embodied lives. Professionals offered support in specific ways during each phase. I will present findings which illustrate each phase of the men's embodied experience.

**Saturday am**

**09.00 - 09.20**

**Kendall, K., Wiles, R., King, L., Rosenvinge, H., Kendrick, T., Gould, C.**

**University of Southampton**

**CRITICAL INCIDENT REVIEW IN GENERAL PRACTICE AFTER PATIENT SUICIDES:  
EXTENDING THE CULTURE OF BLAME FOR GPs?**

Between one-third and one-half of those who commit suicide are in contact with a general practitioner in the four weeks leading up to the act. The Government's 1999 National Service Framework for Mental Health (NSF) recommended that high quality primary mental health care be developed to prevent suicides. Implementing the NSF will require local authorities to review all suicides and take steps to reduce the risk of such an event happening again.

This presentation reports findings from a qualitative study examining the feasibility of critical incident reviews held in general practice after patient suicides. Twelve critical incident reviews were held in practices across South-East England between November 2001 and May 2002. Next-of-kin were interviewed and their views about their relatives' care was fed back at the reviews. All practice-based staff were invited to attend reviews and these were observed by a researcher. Additionally, practice staff were interviewed following the review. This presentation will focus upon interviews held with practice members after the review as well as interviews conducted with family members of the deceased. Findings from this study indicated that the GPs were anxious about holding such reviews fearing that they might entail 'a witch hunt'. They expressed particular anxiety about relatives' views being sought and fed back to the meeting. We argue that such reviews may be seen by GPs as part of a 'culture of blame' which may inhibit the development of improved practice.

**Friday pm**

**16.20 - 17.00**

**Kennedy, S., Goyder, E., Payne, N., Saul, C., Luff, D., McKee, K.**

**University of Sheffield**

**HEALTH INEQUALITIES AND BARRIERS TO USING HEALTH CARE SERVICES:  
CONCLUSIONS OF A MIXED METHODS STUDY**

One way health inequalities can arise is through differential use of health services. This mixed-methods study has identified factors influencing service use generally, quantified their relative importance with the public, and examined variations for different population groups and illnesses. Finally, study findings have been discussed with health professionals, to facilitate the development of 'grounded' recommendations for interventions to reduce barriers.

Following focus group analysis, 36 statements representing factors influencing service use were incorporated into a questionnaire.

Respondents indicated whether the factors stopped/delayed their service use, and personal, socio-economic and health-related information. In 33 interviews, details about influences on use/non-use were explored to explain how, when and why barriers operate.

Survey analysis indicates the major deterrents on service use generally are: only seeing a health professional if illness is thought serious; worry about wasting health professional's time, and worry about drug side-effects. Being female, younger, more materially-deprived and having multiple ill-health are frequently associated with increased deterrent impact for several factors. Interview analysis confirm survey findings, indicating the major impact of past experiences of health care on subsequent service use, and the complex relationships between past and present social and material circumstances, personal attitudes and expectations, and help/health-seeking behaviour. The health professionals conclude that reducing barriers needs action at national, local and individual levels. They highlight the need for better information, education and training of both public and health professionals, the potential for promotional materials to influence perceptions and use of the health service, and recommend various organisational and practical changes.

**Saturday am**

**10.35 - 10.55**

**Killingbeck, J.**

**University of Hull**

**THE DILEMMA OF A 'SELF': NEGOTIATING DEPRESSION AND SELF-IDENTITY**

Depression, as an illness, can directly affect individuals' sense of self-identity. Physical symptoms aside, depression is often characterized by a tangible shift in self-identity that can gradate between 'not feeling oneself', to 'losing oneself'.

The aim of this paper is to discuss the dilemma people may face when experiencing, what is often articulated as a 'loss' of who they subjectively felt they were before the onset of a depressive episode, and the re-conceptualisation of self identity, fostered by the desire to 'return to oneself' after depression. The hope of a 'return to self' may be over-shadowed by a recognition that depression may return. How do individuals seek to negotiate depression as an aspect of self-identity in the face of an increasing awareness that their 'self' may be inherently 'depressive'? The possibilities for, and problems surrounding calls for the 'coming out' of people who suffer from depression will be a central feature of the research.

The paper is based on on-going qualitative interviews, which seek to examine the meaning and experience of depression and the subsequent impact upon self-identity.

**Friday pm**

**14.50 - 15.10**

**King, C., Shucksmith, J.**

**University of Aberdeen**

**DISCOURSES OF CARE ACROSS THE HEALTH/EDUCATION DIVIDE: CHILDREN WITH CHRONIC MEDICAL CONDITIONS IN SCHOOLS**

This paper reports the findings of an interview study with health service providers to explore their views on inter-agency working in relation to the care of children with chronic medical conditions. A total of 27 telephone interviews were undertaken with Child Health Commissioners and representatives of the school health service across the 15 health board areas of Scotland. Six examples of 'good practice' were explored in slightly more depth. It is suggested that fundamental to the health, well-being, and educational experience of children with chronic medical conditions is the provision of appropriate 'care' and support whilst in school settings. An exploration of the data from this study however, suggests that traditional professional and organisational boundaries may prevent health and education personnel from adequately meeting the care needs of these children. A focus on understanding children's perspectives and exploring their ability to participate in their own care may serve as the catalyst necessary to encourage professionals to transcend traditional boundaries of care.

**Saturday pm**

**15.55 - 16.15**

**Kitto, S.**

**Monash University, Australia**

**EPISTEMOLOGICAL CHICKEN AND THE TEACHING OF HEALTH SOCIOLOGY IN AN AUSTRALIAN MEDICAL FACULTY: TALES FROM THE ANTIPODES**

The teaching and practice of medicine in Australia has traditionally been founded upon a monistic modernist and positivistic knowledge base that is diametrically opposed to the epistemological pluralism that characterises contemporary health and medical sociology. As such, the benefits of incorporating a sociological approach to research and teaching into medical faculties within Australian Universities has, in the past, been treated with some scepticism. The Faculty of Medicine, Nursing and Health Sciences at Monash University has broken with tradition and taken a step forward in 2002. Embedded within the Faculty's new five-year MBBS curriculum is an innovative sociological unit entitled: Health, Knowledge and Society. To the knowledge of the author, it is the first course of its type and currently the author is the only full-time health sociologist lecturer to be employed within a medical faculty in Australia. The course utilises aspects of C. Wright Mills' sociological imagination to teach 1st year medical students the importance of analysing the social aspects of health and illness in medical practice. The course contains an innovative teaching methodology consisting of preparatory tutorials that lead to a role-playing scenario. A key aspect of the course is the utilisation of the 'embodied' stakeholder who briefs the students on their lived experiences within the health-care system. This paper outlines the progress of the course to date. The author's experiences of teaching medical students about 'other' (their patients), while being situated in the role of the 'other' (health sociologist) within the medical faculty itself, are also described.

**Saturday am**

**10.10 - 10.30**

**Lankshear, G., Ettore, E., Mason, D.**

**University of Plymouth**

**'ESTRANGED LABOURERS': MIDWIVES AND DOCTORS APPROACH TO WOMEN'S EMBODIED EXPERIENCE OF CHILDBIRTH**

**Introduction**

In Britain, 780,000 women give birth annually with 99% in medical settings. While birthing tends to be a highly medicalised process, the Winterton Report promoted a 'women centred focus'. This paper expands previous ethnographic work and concentrates on approaches to embodiment in delivery suites.

**Methods**

Qualitative research techniques were used in three NHS sites. Data was gathered during set weeks over two years (1998-99) in the first site; during one month (2000) in the second site and for two weeks (2002) in the third site. Field notes and tapes were transcribed and analysed through the use of Atlas.ti.

**Findings**

Analyses focused on how doctors and midwives approach 'the labouring body' and the findings revealed divergent approaches. Doctors followed the medical model, distancing themselves spatially, physically, and psychologically from women's bodies, while midwives were closer but perhaps not as close as 'a naturalistic, women centred' model suggests. Dealing with paperwork, clinical procedures, and bodily maintenance took precedence sometimes over more emotional work.

**Conclusions**

Any deviation from the medical, mechanical model of birth is assumed to indicate potential risks. Therefore, a preoccupation with the body as flesh and as a vehicle for producing a live baby, can lead to the devaluing of the body as a whole. Observational and interview data gathered in three delivery suites is used to update knowledge and current approaches to the body by both doctors and midwives.

**Sunday am**

**09.50 - 10.30**

**Leontowitsch, M.**

**University of London**

### **DYSLEXIA AND DISABILITY - ANTAGONISTS IN A FORCED MARRIAGE?**

#### Objectives

Dyslexia has been a recognised disability since 1970 when it was first mentioned in the Chronically Sick and Disabled Persons Act and since has had this status officially reinforced in the 1995 Disability Discrimination Act. However, the reason for recognising dyslexia as a disability was to classify dyslexic pupils, and later students, as in need of special educational provision. Critics have voiced that this legal recognition has merely been utilised and has inappropriately borrowed from the disability rights movement. This paper will explore the perceptions of students towards their dyslexia, and their somewhat eclectic approach to managing dyslexia at university, and how this relates to disability in terms of medical sociology and social theory of disability.

#### Method

Data were collected through in-depth interviews with fifteen dyslexic students at English universities recruited through dyslexia support officers from the universities.

#### Results and Discussion

Data suggests that the perception of the dyslexic students towards disability depends on whether they decide to apply for a Disability Students Allowance or not. Those who applied felt they were justly receiving compensation for their disability, which was considerably enforced by hindering circumstances within university. However, those students who did not apply feared that a connection to disability could be a further risk of stigmatisation which they counteracted by trying to achieve recognition of normality. Discussion will focus on the perceptions of the students in relation to the sociological and political models of disability, and how this stands relates to the criticism made.

**Saturday am**

**11.45 - 12.05**

**Lester, H., Tritter, J., Sorohan, H.**

**Medical School, University of  
Birmingham**

### **USER FOCUSED PRIMARY MENTAL HEALTH CARE: SHARING AND CARING OR MISSED OPPORTUNITIES FOR PARTNERSHIP**

Drawing on a two-year study of primary care mental health this paper discusses the different conception of GPs, Practice Nurses and people with serious mental illness of the 'patient pathway'. Data is based on six Primary Care Trusts across the West Midlands. In each PCT we conducted a focus groups with people with serious mental illness and, separately, one with health professionals. We highlight the contrast between conceptions of a typical pathway by health professionals with the lived experience of users. Both groups considered ways to develop primary care services for patients with serious mental illness and we explore ways in which they were deemed important by users and were accepted as reasonable or practicable by health professionals.

The results of the study have implications for considering the legal requirement to involve users in the evaluation and development of health care and in decisions about their own treatment as well as the consumerist and clinical governance agendas that shape them. Similarly, the research raises issues about the nature of lay knowledge, the validity or invalidity of the views of users diagnosed with mental illness and the conflict between professional control and legal responsibilities.

The opportunity for development of a user focussed service depends on the identification of common ground between those who provide and those who receive care. Exploration of the ways experience is understood, validated or seen as inappropriate or impossible suggests the limitations of user involvement and the constraints on consumerism in the Modern Dependable NHS.

**Sunday am**

**10.35 - 10.55**

**Levitt, M., Weiner, K.**

**University of Central Lancashire**

### **GENE WEEK: A NOVEL WAY OF CONSULTING THE PUBLIC**

There is consensus in all quarters that the public should be consulted about the new genetics and health. However, there is less consensus about the purpose and content of such consultations. Recently the 'deficit' model of public understanding of science has been challenged by a more constructivist approach, which recognizes that 'the public' can articulate sophisticated ideas about the social and ethical implications of the new genetics regardless of their level of technical knowledge. At the same time, the construction of scientific knowledge is problematised. Studies undertaken within this approach have generally involved small-scale qualitative investigations, such as consensus conferences or focus groups, providing in-depth information. The Gene Week Project, sponsored by the Wellcome Trust, used a novel method of large-scale consultation through a local daily newspaper in Lancashire. An illustrated article was published each day during the Gene Week in both the newspaper and on the associated website, covering aspects of current interest in medicine and genetics. Open-ended questions followed each article and readers were invited to respond with their views. In constructing the articles we were aware that popular media representations of genetics and health tend to be relatively unsophisticated, drawing on a limited repertoire of discourses (hope, fear, tragedy, bravery). In writing the articles for the Gene Week we tried to move away from these formulations, to focus on the social and ethical issues raised by the new genetics. This paper will present some findings and observations from the Gene Week consultation.

**Sunday am**

**09.25 - 09.45**

**Lewin, S., Reeves, S.**

**London School of Hygiene and  
Tropical Medicine**

### **HOSPITAL-BASED INTERPROFESSIONAL COLLABORATION: MEANINGS AND STRATEGIES**

#### Background

Temporal and spatial factors often shape and reflect interprofessional interactions and may enhance or inhibit collaboration. This paper reports qualitative findings from a multi-method evaluation of a new system of organising care within the medical wards of a large teaching hospital. Traditionally, doctors' patients were spread across many wards, severely limiting doctors' interactions with ward-based staff (e.g. nurses, therapists). The new system aimed to promote better interprofessional relations by concentrating each medical team's patients on one or two wards, thereby bringing doctors into closer spatial proximity with ward staff.

#### Methods

Adopting an ethnographic approach, data was generated through participant observation, in-depth interviews and group discussions with different professional staff (e.g. doctors, nurses, therapists) before the introduction of the new system. These data have been analysed to examine the nature of staff interactions and the meanings staff attach to these actions.

#### Findings

Interprofessional interactions tended to be terse and task-oriented in nature, with little social content. In contrast, intra-professional interactions were warmer and more personal. The organisation of work on the wards was seen to limit opportunities for formal collaboration between medical and non-medical staff. To overcome these structural constraints, staff employed a number of informal "backstage" strategies. A contrasting rhetoric of collaboration emerged. While medical staff viewed collaboration primarily as involving work with other medical teams, other professionals constructed collaboration as an interprofessional activity.

#### Concluding comments

Professionals construct "collaboration" in varying ways and often rely on informal strategies of collaboration to overcome the spatio-temporal constraints of hospital work.

**Sunday am**

**09.50 - 10.10**

**Lie, T.A., Tjora, A.H.**

**SINTEF Unimed, Norway**

### **BIOTECHNOLOGY AS LEXICALISATION**

The growing development and use of medical monitoring technologies may be discussed in relation to a medicalisation hypothesis, in which public problems tend to be defined as medical. A large "worried-well" group of patients asks for more and presumably better knowledge about potential diseases. Both medical personnel, patients and their relatives, politicians, and other groups influence use of medical monitoring. Hence, the phenomenon should be studied both in terms of medical efficiency and prestige, technical utilisation, patient satisfaction, as well as economic and political interest.

In this paper, the case of diagnostic ultrasound instruments in primary health care is studied, using a document research design, using evaluations from The Health Technology Assessment Department of SINTEF Unimed in Norway as primary data.

It is found that the availability of the ultrasound technology increases the use of it, for an unnecessary large group of patients. The reason for this is mainly lack of practical and theoretical knowledge about ultrasound among the general practitioners, as well as an illness anxiety and belief in technology among patients. By using ultrasound for a larger population of patients, the potential of false positive findings increases, and so also the need for further examination in secondary health services.

On the basis of these findings, the paper discusses the relevance of critical perspectives within medical sociology and technology studies, as necessary approaches to understand a seemingly limitless demand for medical technology.

**Saturday pm**

**17.05 - 17.25**

**López, J.**

**The University of Nottingham**

### **HOW SOCIOLOGY CAN SAVE BIOETHICS. . .MAYBE**

At present Bioethics is firmly entrenched as a hegemonic discourse and as a fully institutionalised social practice which is central to the development and the governance of biomedical research and medical practice. Sociologists, for their part, have articulated a sustained critical account of the universalistic assumptions underpinning bioethics as well as its apparent lack of sociological imagination. However, it remains far from clear whether sociological practice is providing the tools with which Bioethics might be reconstructed or is instead offering an alternative practice through which the ethical issues associated with biomedical research and medical practice might be addressed. This paper represents an initial attempt to begin to explore this crucial question. It will do so by contrasting the 'theoretical visualities' associated with both Bioethics and Medical Sociology in order to explore points of contact and points of divergence. It will then argue for the need to contextualise the emergence and current vitality of bioethics in the context of the wider 'ethical moment', which is currently evident in wide variety of social processes and in sociology itself.

**Saturday am**

**10.10 - 10.30**

**MacFarlane, A.**

**National University of Ireland, Galway**

### **MULTICULTURALISM IN THE REPUBLIC OF IRELAND: AN EMERGING HEALTH ISSUE**

The Republic of Ireland has witnessed an unprecedented population change with the arrival of refugees and asylum seekers in recent years. The emerging multiculturalism of Ireland has implications for the organisation and delivery of health services. While a body of academic commentary on legal and policy issues is amassing, there is a dearth of Irish health-related research.

The present qualitative project relates to primary health care services in the Western Health Board and Eastern Regional Health Authority (WHB and ERHA respectively) regions of Ireland. It is a three-year study commencing July 2002. The aims are to explore the health care needs of refugees and asylum seekers in Ireland and to gather information about the perceptions and needs of primary health care (PHC) providers to deliver care to this community in a culturally sensitive manner. Specific objectives are to explore lay health beliefs, perceptions and experiences of primary care services among a sample of refugees and asylum seekers. Experiences of delivering services to refugees and asylum seekers as well as perceived abilities/needs to provide a culturally sensitive service will be examined among a sample of PHC providers.

The purpose of the present paper is to review health-related research that has taken place in the Irish context, the UK and elsewhere and to explore appropriate theoretical and methodological approaches to this research.

**Saturday am**

**09.25 - 09.45**

**Mallinson, S., Popay, J., Kowarzik, U.**

**University of Lancaster**

### **WHAT IS PUBLIC HEALTH? THE PERCEPTIONS OF PRIMARY CARE WORKERS**

In a series of recent policy documents and guidelines on the future of public health, the emphasis has been on moving public health 'out of the ghetto' and into the frontline of primary care. The underlying aim of this shift is to make public health more locally responsive, locally managed and inclusive of a whole range of people whose work may contribute to improving health. Successful local governance, via local networks, depends upon shared understandings of what the network is for, how objectives will be achieved and what each member's role is. Our question, in relation to public health, is whether the current conditions in primary care settings are likely to facilitate the development of new 'joined up' working.

This paper will present preliminary findings from interviews with 40 people working in and around primary care in 2 sites in England. The interviewees included people from health care, social services and the voluntary sector backgrounds. The interviews were qualitative and semi-structured. The topic guide covered issues such as the nature of partnerships, the relationship between health policy and practice, the interviewee's perceptions of what constitutes public health work and their views about the future of 'public health'.

Peoples' responses to questions about their understanding of 'public health' reflect some important differences in definition. We argue that these variations point to the different rationalities that individuals bring to any grouping or network, and we suggest that left unaddressed, they could undermine the development of public health networks.

**Sunday am**

**09.25 - 09.45**

**Marceau, L.D., McKinlay, J.B.**

**New England Research Institute**

### **BEYOND DOCTOR AND PATIENT: MACRO LEVEL INFLUENCES AFFECTING CLINICAL DECISION MAKING**

Twentieth century changes in the organization of medical work (bureaucratization), the social position of doctors (corporatization) and the relative power of patients (self care and consumerism) require a new perspective investigating macro level factors influencing affecting the doctor-patient relationship. First generation studies focused on the influence of patient attributes (e.g. age, race socio-economic status, gender and physical attractiveness), second generation studies focussed on influence of physician/provider characteristics (e.g. age, clinical specialty, gender). Third generation studies mark a departure from a closed system model of a doctor and a patient and highlight macro socio-political and organizational influences that now intrude on psychosocial processes at the level of the encounter. This approach recognizes that the doctor-patient encounter does not occur in a sociological vacuum as depicted by prescriptive Bayesians.

We discuss broad contextual factors affecting the doctor-patient relationship including: Corporatization of doctoring; Erosion of professional autonomy; Unintended consequences of practice guidelines; Direct marketing to patients by mainly pharmaceutical interests; Epidemiologic transition and changes in the nature of disease; Changes in the cultural concept of the body; Threat of litigation and defensive medicine; Development of cybermedicine through widespread internet availability; and Erosion of patient trust.

Funding: National Institutes of Health, National Institute on Aging, Grant # AG16747

**Sunday am**

**09.25 - 10.10**

**Mariados, P., Alexander, N.S., Kokilavani,  
A.**

**Madras Medical Mission, Chennai**

### **PUBLIC OPINION ON ORGAN DONATION IN CHENNAI, INDIA**

#### Objective

Evaluate public opinion on organ donation

#### Methods

A sample of 80 adults randomly selected and 85 adolescents in a school, both in a locality near a cardiac hospital were evaluated.

#### Results

Adults ranged from 20 - 60 years (50 males, 30 females) and adolescents 14 - 18 years (33 males, 52 females). All adults but only 89.4% of the adolescents knew about organ donation. More adults (21.2%) than adolescents (7.1%) had excellent knowledge. Regarding attitude to Organ Donation more adolescents (76.4%) than adults (57.5%) strongly agreed to donate organs and this is statistically significant ( $p < 0.05$ ). While gender is significantly associated ( $p = .045$ ) with attitude, education is significantly associated with level of knowledge ( $p = 0.03$ ).

Adolescents who disagreed to donate organs even after death is less (2.4%) in comparison with adults (11.3%). But more adults (73%) than adolescents (62.4%) were willing to donate kidneys while living.

The Indian strong religious and caste sentiments are reflected with 16% of adults revealing that religion does not permit donation of organs and with 31.3% of adults willing to donate organs only to their own family/community. It is noteworthy that 68% and 48.2% of adults and adolescents respectively, agreed to donate organs for monetary benefits.

#### Conclusion

Knowledge among adolescents and attitudes of adults require foci in interventional programs for successful transplant programs.

**Saturday am**

**09.45 - 10.05**

**Maseide, P.**

**Bodø Regional University, Norway**

### **SOCIAL FACTS AND MEDICAL REALITIES**

The paper reports from field work in a thoracic ward in a Norwegian hospital. The purpose was to study collaborative medical problem solving in a hospital setting. Metaphorically the hospital is seen as a system of distributed cognition. It is composed of subsystems, such as for instance wards. Within these subsystems, there are other cognitive systems important to problem solving. One of them, the thoracic meeting, is given special attention here. In this meeting various kinds of medical experts meet to generate diagnoses or make plans for treatment or further examinations. Physically the patient in question is never there. Instead the participants relate to various forms of representations. Many of these are also physical, such as x-rays or other material images. They represent physical facts about the patient. A major and essential part of the representations, however, are verbal formulations. They refer to physical as well as social or moral facts. All kinds of representations are to some extent flexible and transformable, and the verbal representations particularly so. The transformation of material representations and the processes of making them practically useful also require verbal formulations. In this paper problems related to constructivism are discussed. The verbal representations are seen as social facts generated through interactive processes. As such they should not be confused with medical realities. Instead they are practical and flexible tools, situationally produced to deal with complicated ontological and epistemological medical problems.

**Saturday am**

**09.00 - 09.20**

**Maynard, M., Harding, S., Williams, R.**

**MRC Social and Public Health Sciences  
Unit**

### **THE HEALTH OF BLACK CARIBBEAN ADOLESCENTS IN LONDON: THE IMPACT OF SOCIO-ECONOMIC CIRCUMSTANCES AND FAMILY LIFE**

Little is known about the health of young UK-born Black Caribbean's. The adaptation model of migrant health predicts a shift in disease patterns towards that of the host population and progressive narrowing of socio-economic and educational differentials. However, Black Caribbean morbidity remains high, partly because mortality from hypertensive disorders, diabetes and certain cancers is high, though overall mortality of Caribbean-born migrants is low primarily because of low coronary heart disease mortality. Similarly first generation Black Caribbean's are among the most economically disadvantaged people in the UK, and a recent report showed that significantly less Black children achieve 5 GCSEs compared to their White and Indian counterparts. Our project relates to predisposing factors for these long-term conditions: we hypothesise that socio-economic background, family and school life are independently related to the health of these children, but that these factors may interact to compound the effect on risk profiles and physical and mental health status. Children with poor lone parents may not be well equipped to face difficulties at school such as racism and bullying, may suffer from low self-esteem and be more likely to engage in negative risk behaviour. This could trigger internal responses that result in higher than expected blood pressure, for example. Conversely, a secure family environment, whether lone- or two-parent, may 'buffer' these negative effects. This paper will summarise some of the possible pathways that could link these underlying factors to health outcomes and present preliminary findings from a pilot survey examining the health of Black Caribbean adolescents.

**Friday pm**

**14.25 - 14.45**

**McColgan, G.**

**University of Stirling**

### **NURSING HOME CULTURE AND ITS IMPACT UPON PEOPLE WHO HAVE DEMENTIA**

A key element of ethnography is to conduct research in the natural setting. When this setting is an environment operating within a medical model it can be very far from natural. This proved to be the case for a group of people in a nursing home in central Scotland. There was a culture of surveillance, punctuated by routine, group activity, and bed and bodywork, in which power and control were prevalent. Maintaining independence and individuality within this culture presented challenges. Those at the centre of this investigation additionally had dementia, which was easily blamed for impairments and disability that might equally be attributable to the environment.

Using a theoretical perspective that might be used to study any group situation, ensured that in this study residents were on equal terms with others rather than dependent dementia 'sufferers'. By addressing the nursing home culture an unwrapping occurred, from which residents emerged as competent and active social participants. By showing respect and recognising dignity the personhood of those with dementia revealed itself. Residents were no longer the passive recipients of care.

This paper examines the impact of the setting upon those within. It also suggests that the culture reflects, projects and perpetuates negative stereotypes and images commonly associated with dementia.

**Saturday am**

**09.25 - 09.45**

**McDonald, E., Clegg, S., Boulton, M.G.,  
Fielder, A.R.**

**Oxford Brookes University**

### **PARENTS' MANAGEMENT OF RISK AND CHILDHOOD VISUAL IMPAIRMENT**

While all parents manage risk on behalf of their children serious visual impairment increases risk to young children, and this has an effect on parents in terms of day-to-day care and decision-making. This paper investigates parents' constructions of childhood disability and of risk, and how those constructions affect their management of their children.

Qualitative data is used from semi-structured interviews with parents of children aged 3-8 from 60 households. The children have serious visual impairments and some have additional impairments or conditions; they all live at home with their families in one of 4 areas in England.

Parents' management of their children's VI includes a balance between protecting the child against physical, social and emotional risks and promoting her/his independence. It also includes management of service provision where there is often limited health treatment available and limited education and social services resources.

Conclusions: Parents' perceptions of risk to their child with VI are linked to their constructions of disability, and how they see their child's ability to function in an environment created by and for sighted people. Parents' management of risk is therefore a difficult balance between protecting their child in that environment and into the future, and promoting their effective functioning and developing their independence.

**Saturday am**

**10.35 - 10.55**

**McGowan, F.**

**University College London**

### **IDEALISED FITNESS: THE ROLE OF THE BODY IN MEN'S BIOGRAPHICAL NARRATIVES**

This article presents findings taken from a larger qualitative study which explores perspectives of health and experiences of embodiment among men pertinent to their perceived stages of the life course. Twenty men were interviewed aged between 20 and 40 years - a time span specifically selected as it is marked by significant life course transitions including those occurring between adolescence and youth to adulthood and the subsequent progression into middle age. In focusing on men meeting this age range, the accounts of the respondents reflect how different aspects of the life course provide both a framework and meaning for behaviour and actions concerning the body and health. While concepts of physiological ageing were included, aspects such as demographic status, work and career and social and family obligations were routinely mentioned as important indicators through which masculine identity is established and expressed. These various aspects were found to be associated with and characterised by changes in experiences of embodiment and physicality. Whilst being aware of the impact of these physical changes, the majority of the respondents chose to describe and refer to a time when they regarded their bodies to be in peak condition - "at their best", frequently upholding this self image in terms reflecting and portraying good health. Further issues relating to health and bodily experiences of men are shown to be understood not primarily in relation to age but rather to circumstances and social associations which are perceived to contribute to a distinct 'time and space' in the life course.

**Friday pm**

**14.00 - 14.20**

**McMurray, R., Weighall, A., Cheater, F.M.**

**School of Health Care Studies,  
University of Leeds**

### **PARENT PERSPECTIVES ON THE MMR VACCINE AT SECOND DOSE: WHAT INFLUENCES THE DECISION?**

#### **Background**

The MMR vaccine has been shown to be effective and has a good safety record. However, adverse publicity in the UK regarding MMR threatens to derail the vaccination programme. Evidence suggests that reluctance to vaccinate is the result of parental and health professional concerns about the safety and efficacy of the MMR vaccine. Yet, there is limited understanding of either the processes involved in parental decision making about MMR, or the effectiveness of the information provision. This paper presents initial findings of a 14 month study, funded by Northern and Yorkshire NHSE, examining parental experience of MMR information transfer across health care agencies, and in-depth exploration of the decision making process at second dose.

#### **Methods**

Semi-structured interviews were undertaken with parents (N~80) and health professionals (N~16) across four general practices, two in areas of high deprivation, and two in areas of low deprivation. Three parent groups participated: those who did not vaccinate with MMR, those who vaccinated with only one dose, and those who vaccinated at both first and second dose. This allowed comparisons of received information, contact with health professional and the decision-making process within and between groups. Data were analysed using a framework approach.

#### **Results**

Preliminary results from parent interviews will be presented. Emerging themes and their implications will be outlined.

#### **Conclusions**

The contribution of the study to existing knowledge is explored, including the impact of information transfer & decision making support on vaccination intention, and the implications for service delivery, child welfare and immunisation policy.

**Saturday am**

**11.00 - 11.40**

**McNulty, A.**

**University of Hull**

**BEREAVEMENT SUPPORT: A COMPARISON STUDY OF BEREAVEMENTS  
FOLLOWING HOSPICE AND HOME DEATHS FROM CANCER**

Hospice and home care services (e.g. Macmillan) share a commitment to provide palliative care for the patient and family during the patient's illness and bereavement. Bereavement support is an essential feature of palliative care and yet its definition is lacking. Furthermore attempts to assess its provision have not addressed whether differences exist between service providers. Underpinning any definition is the understanding of provision and what concepts providers attach to the meaning of bereavement support.

In a mix-method study, 12 older bereaved persons were interviewed, using a phenomenological approach, to explore their experiences of bereavement following a hospice or home death from cancer. In addition 12 hospices and 10 home care services were asked to complete a two-part questionnaire. The first part comprised questions relating to their own definitions of bereavement support and protocols adhered to. The second part, aimed at measuring provision and ascertaining demographic data, was completed by the provider each time a death occurred during a three-month period.

Thematic analysis of the interviews showed little difference between the experience of bereavement in both settings. Furthermore their experiences followed a staged path, as regularly reported in bereavement literature; i.e. shock, anger. However the survey revealed that bereavement support significantly differs depending on place of death both in its provision and what is provided. Qualitative data from the survey allowed a conceptual framework of bereavement support to be developed.

The study raises two questions; why the disparity exists and how to overcome this within the services limited capacity.

**Friday pm**

**14.50 - 15.10**

**Meerabeau, E., Antoncino, J.**

**University of Greenwich**

**THE VIEWS OF RESIDENTIAL CARE HOME OWNERS ON THE IMPLEMENTATION  
OF THE CARE STANDARDS ACT**

The residential care of elderly people is in Le Grand and Bartlett's terms a quasi-market which has a considerable impact on another quasi-market, that of health care. There are several big players such as BUPA, and many smaller players; it was estimated in 1998 that there were 13,800 residential homes housing 300,000 people in the UK. Local authorities have until recently been both providers, commissioners, and also (under the Registered Homes Act 1984) regulators. Public expenditure on residential care mushroomed in the 1980s but was curtailed by the NHS and Community Care Act 1990; due to downward pressure on costs it is currently estimated that 18 homes per week close. Pressures on owners/managers, particularly in the south east, include difficulty recruiting staff and the low monetary value of businesses, often less than the value of the land on which they are built. This paper examines the views of 201 care home owners in Kent on the possible effects of the national standards published in March 2001. Data were gathered by postal questionnaire by the second author.

Although generally positive about the proposal to have a more consistent inspectorate, there were mixed views on whether the new regulatory body would lead to improvements in standards of care, and further exits from the market were predicted.

**Friday pm**

**16.20 - 16.40**

**Melby, L.**

**Norwegian University of Science &  
Technology**

**CONTINGENCIES AND STRATEGIES IN MEDICAL INFORMATION SEEKING.  
MODELLING DOCTOR-COMPUTER RELATIONS**

The use of computerized tools in healthcare is becoming increasingly common, and may simplify several aspects of healthcare work. Even though the number of success stories of technology implementation in the health service has increased, there also are some "horror stories" of failed implementation. Why is it that several computer systems in healthcare do not succeed, in terms of not fulfilling what they promise?

As member of an interdisciplinary research group (MOBEL), working with system development for hospitals, the question is of vital importance. System design literature may give us a hint: Traditional system design paid little attention to the contingent nature of health care work, when specifying the functions of systems. Today's system design is far more sophisticated and systems may be flexible, in terms of being context sensitive, and providing information and guiding action, rather than commanding action. This of course requires detailed knowledge about the working environment.

As sociologist, my task has been to provide system designers with descriptions of "real life" in the hospital. This was achieved through 4 months of participant observation in a hospital ward at St. Olav's hospital, Trondheim, particularly following doctors through their working day.

The empirical findings support the view that health care work in general, and seeking information in specific, is an extremely contingent activity. There exist an almost infinite numbers of contingencies, which may cause difficulties for systems aimed at giving decision support in the traditional sense. Hence contingencies must somehow be taken into account in system design.

**Saturday am**

**11.45 - 12.05**

**Mitchell, R.**

**University of Edinburgh**

**IS GREED GOOD FOR YOU? UNPACKING RELATIONSHIPS BETWEEN ATTITUDE  
TO INCOME REDISTRIBUTION AND SELF-REPORTED HEALTH**

This study asks whether variation in attitudes towards income redistribution amongst the British population is associated with variation in wealth and self-reported health status. Are poorer folk more likely to hold positive attitudes towards redistribute policies? Are richer folk more likely to hold negative attitudes towards redistribution? Are the relatively sick population also those who desire redistribution to ease the material and psycho-social pressures they are under?

Using items from the 1999 British Social Attitudes survey (n=607) an index of attitude towards redistribution was derived. Individual respondent score on this index was found to be related to individual age, household income level, individual social class, smoking status and self-reported health. Ordinary regression demonstrated that association with self reported health was substantial, even after controlling for age, sex, smoking status, household income and social class. In fact, the index of attitude to redistribution was the strongest predictor of self-reported health of all these variables. Closer analysis reveals a clear gradient between health status and attitude to redistribution across all social classes and income groups.

Finally, the paper discusses how to interpret the direction of causality in this relationship. Does holding 'greedy' attitudes somehow benefit health or not being 'greedy' somehow raise the chances of poor health? Or are sicker folk more likely to desire redistribution, regardless of their individual social, economic and demographic characteristics.

**Saturday pm**

**17.05 - 17.25**

**Mold, F., McKevitt, C., Wolfe, C.D.A.**

**Kings College London**

**AFTER STROKE CARE: EXPLORING THE FACTORS WHICH MAY LEAD TO  
INEQUALITY**

Provision of care to stroke patients is known to vary geographically and by socio-demographic and clinical characteristics. Data from the population based South London Stroke Register suggest that older and more disabled people receive less care, including contacts with health professionals, access to rehabilitation and risk factor management after stroke. Individual characteristics such as age and clinical status may predict such inequalities but what drives them? We are currently investigating the processes, which may give rise to inequity in the provision of stroke care in an interview-based study involving stroke patients and professionals. In this paper we will report preliminary findings from interviews with health and social care providers (medical, nursing, therapy staff and social care managers/workers) in three areas of inner city London, focusing on their perceptions of the causes of inequity. The issues identified from work to date include: the existence of structural barriers such as eligibility criteria for hospital and community based rehabilitation services and for community care services which tend to exclude complex care needs; geographical factors in the form of organisational differences between boroughs; language and cultural representation issues; assumptions about the rehabilitation 'potential' of older and more severely disabled stroke patients. By understanding the processes, which lead to inequity in the provision and uptake of stroke care, we hope to identify strategies to address such inequalities.

**Saturday pm**

**17.05 - 17.25**

**Morrow, R.**

**University of Newcastle, Australia**

**CULTURAL ASSUMPTIONS ABOUT SEXUAL DYSFUNCTION IN THE WORK OF  
WILLIAM MASTERS AND VIRGINIA JOHNSON**

This paper explores certain aspects of the relationship between culture and sexual dysfunction in the work of William Masters and Virginia Johnson: two of the twentieth century's most influential sex researchers and therapists. The paper examines their concept of sexual dysfunction, their model of the human sexual response cycle and their 'ground breaking' classification of sexual dysfunction. It is argued that their concept of sexual dysfunction is narrowly grounded in a mechanistic view of the human body; that their model of the human sexual response cycle has a number of important flaws; and that it is inappropriate as a basis for constructing general norms of sexual health and illness. Finally, it is argued that their nosology of sexual dysfunction has been constructed, in part, on the basis of implicit and questionable cultural assumptions which the researchers seem largely unaware of or else do not adequately explain. The paper concludes by briefly noting some of the wider implications of the problems with their nosology.

**Saturday pm**

**17.05 - 17.25**

**Mowforth, G., Morris, M., Harrison, J.**

**University of the West of England**

### **EXPERIENCES OF NURSING STUDENTS ON DIFFERING CURRICULA AND DELIVERY OF BEHAVIOURAL SCIENCES**

This paper is a work in progress as part of a research project exploring and comparing experiences of student nurses on the Adult Pathway. The authors are investigating the student's experience of the relevance and the application of the behavioural sciences to their nursing care. The nursing education curricula have been thoroughly overhauled and debated since 1990 and most recently was heavily influenced by the 'Making a difference' document published by the Department of Health, which concentrated on a competency based curriculum. Students who are participating in this study have either undertaken a curriculum that has discrete science modules or one that has adopted an integrated approach.

The methodology chosen for the study is qualitative, using focus groups and the results have undergone thematic analysis. The initial findings that have emerged have implications for staff development, curriculum development and teaching and learning strategies, and would suggest that students on the integrated curriculum are less articulate about the value and the relevance of all subjects within the sciences. However the notion of integration is complex and also requires closer examination.

It is too early to state with any confidence and certainty that there are obvious differences, because we have yet to target students in their third year on the integrated programme.

**Friday pm**

**14.25 - 14.45**

**Nettleton, S., O'Malley, L., Burrows, R.,  
Pleace, N.**

**University of York**

### **THE MANAGEMENT OF CHRONIC ILLNESS IN THE INFORMATION AGE**

Since the 1950s sociologists have made a significant contribution to understanding the experience of chronic illness. Two key issues examined within the literature are: how people seek out information about their conditions ('information work' Corbin and Strauss, 1985) and how they manage their disease. It is likely that experience and management of chronic illnesses will be influenced by the proliferation of information (re)sources associated with the development of information and communication technologies. The aim of this paper is to report on an on going research project which is exploring how the growth of e-based health resources have impacted upon the experiences of both parents and children who suffer from three highly prevalent conditions - eczema, asthma and diabetes. In exploring this question the study is undertaking an audit of e-based resources that are available on these illnesses. This audit provides contextual material for the interview data generated by way of interviews, which are being carried out with parents and children to explore ways in which they have accessed and acted upon information from the internet. The empirical material in the paper will be used to critically engage with the idea of agency inherent in the notion of reflexivity espoused by Beck and Giddens. Drawing on the work of (Lash 2002) and others, the paper will use recent theorisations on the 'critique of information' to rethink the relationship between reflexivity and welfare in the information age.

**Saturday pm**

**14.00 - 14.40**

**Nielsen, A.B.S., Gannik, D., de fine Olivarius, N., Hindsberger, C., Siersma, V.**

**Central Research Unit of General Practice, Denmark**

### **HEALTH BEHAVIOUR AND COPING ASSOCIATED WITH CHANGE IN GLOBAL SELF-RATED HEALTH IN PATIENTS WITH TYPE 2-DIABETES**

Few studies have examined changes in global self-rated health (SRH) and never in persons with type 2-diabetes (T2DM).

This paper examines changes in SRH from T2DM-diagnosis until one year later in 599 middle-aged persons receiving structured care in Danish general practice settings (Olivarius, BMJ 2001; 323:1-9). Treatment focus was glycaemic control improvement to prevent/postpone diabetic complications.

In general, the first year with T2DM is emotionally and practically turbulent because people have to learn sticking to diet and medication, and adjusting to social situations. This demands self-regulation, support by others, and coping with the situation. If lifestyle sacrifices are not followed by perceived health-improvements, non-adherence to treatment is more likely to occur.

In our analyses of change in SRH we included confounders known to affect SRH, e.g. co-morbidities; changes in glycaemic control indicators; illness-acceptance; patients' evaluation of support, lifestyle-changes, medication, and patient-doctor relationship.

The result revealed that changes in SRH were not associated with change in glycaemic control. However, illness-acceptance, the ability to manage and implement treatment regimen in everyday life combined with being understood by other people, and perceived physical consequences owing to altered life-style were related to change.

Consequently, this study raises a broader question: to what extent is SRH-change a matter of change in glycaemic control versus illness-adaptation or shifts in standards/priorities owing to emotional coping? This issue will be discussed in connection with the treatment-implications arising from the findings of this study relating to the theoretical issues from Michael Bury and Anselm Strauss.

**Friday pm**

**14.50 - 15.10**

**O'Neill, M., Williams, G.**

**Cardiff University**

### **TACKLING HEALTH INEQUALITIES IN THREE DISADVANTAGED POST INDUSTRIAL COMMUNITIES IN SOUTH WALES**

The 'Triangle Project' is one of seven action research projects funded under the Welsh Assembly Government's Sustainable Health Action Research Programme. The aim of the project is to work with local stakeholders in three different communities in order to document and understand the determinants of the health problems in these areas, and identify strategies for dealing with them. Although each area is distinctive in terms of history, culture, environment and population, all three are designated as 'deprived' in the Welsh Index of Multiple Deprivation. During the past eighteen months the project has been utilising a participative action research (PAR) strategy. Inherent in the in the PAR approach is the development of a distinctive relationship between researchers and the researched and between research and action. However, establishing such relationships is never straightforward and needs continual negotiation throughout the research period. This paper will consider some of the issues that have been encountered in utilizing a PAR strategy in local communities, present some of the initial findings of phase one of the initiative and discuss the implications of this work for re-thinking 'community studies'.

**Saturday am**

**10.10 - 10.30**

**O'Brien, R., Hunt, K., Hart, G.**

**University of Glasgow**

**"STANDING OUT FROM THE HERD": MEN'S EXPERIENCES OF NEGOTIATING  
MASCULINITY IN LIGHT OF ILLNESS**

The view that chronic illness results in a loss of self or a 'disrupted biography' has been well documented. This paper considers how serious illness affects men's gender identity. Men's verbatim accounts will be presented, exploring loss of masculinity and disruption to their gender biographies resulting from illness.

The research examined the accounts of health and illness offered by fifty-nine Scottish men (who took part in fifteen focus group discussions) between the ages of fifteen and seventy-two. Accounts given by 'healthy' men were compared to group discussions examining men's experiences of particular illnesses (prostate cancer, coronary heart disease, M.E, and mental illness). The latter groups proved effective at encouraging men to reflect on, and articulate, links between masculinity and health. Discussions also enabled men to consider the process of re-evaluating themselves as men when diagnosed with serious illness.

Men suffering health problems felt the presence and pressures of hegemonic masculinity, whether or not they were involved in its practice. Men described feelings of isolation from their masculine culture when seriously ill (e.g. as workers, providers, sexual beings, peer group members). Participants also described how conventional practices of masculinity were usually flouted to enable them to deal effectively with their illness (e.g. asking for help, actively monitoring their bodies) in conjunction with a loss of physical strength, signalling an end to their prior conception of masculinity. While many believed that their condition necessitated a rejection of hegemonic masculinity, some attempted to normalise their symptoms to maintain aspects of their identity.

**Saturday pm**

**14.45 - 15.05**

**Olumide, G., Bury, M., Gabe, J.**

**University of London**

**PARTNERS OR CO-CONSPIRATORS?: PATIENT PARTNERSHIP IN A PAEDIATRIC  
CLINIC**

The notion of 'partnership' between health service users and their doctors is employed with increasing confidence in UK Government and Department of Health communications and here we take it to mean some sharing of information and decision-making about illness and treatment. Using video and audio data from clinic consultations, and interviews with children in their homes, we are investigating ways in which 'partnership' is played out in a busy London paediatric clinic.

The medical team who service the clinic articulate a strong version of partnership in which child participation in decision-making and self care form part of a professional narrative of illness, treatment and recovery. Within this context children and their parents interact with medical information, with one another and with clinic staff.

Paediatric consultations involve at least doctor, child and parent and partnership in these triads becomes a complex encounter in which different priorities, knowledge's and desires compete. A settlement is achieved when information is exchanged, treatments mooted and decisions made or postponed.

The term 'coalition' - defined by Coe and Prendergast as 'interaction between two members of a triad who adopt a common strategy in contention with the third member' - is a valuable analytic tool for studying three way clinic interaction.

We focus here on sequences of coalition-formation - attempted, failed or realised - between any of the three parties in the clinical paediatric encounter. In studying coalitions it becomes possible to identify factors that help or impede decision making processes in the clinic.

**Saturday am**

**11.00 - 11.40**

**Ormrod, S.**

**St George's Hospital Medical School**

**THE TOPIC OF 'CULTURE' IN NHS POLICY AND METHODOLOGICAL IMPLICATIONS FOR THE STUDY OF HEALTHCARE ORGANISATION**

In health service policy the term 'culture' is gaining prominence. Some of this policy literature indicates that culture can be managed. Yet this view is controversial within organisational studies. Much of the latest policy literature seems unaware of such debates. Does the new-found topicality of organisational culture indicate political fad or policy development? If the latter, what are the methodological implications for health service research? There is a substantive literature that addresses organisational culture, located within sociology and organisational studies, including classic ethnographic studies in medical sociology, that need to be accessed by policy-makers. Some ideas from these areas of study have been operationalised through an organisational ethnography of a NHS innovation in the treatment of severe personality disorder.

**Friday pm**

**14.50 - 15.10**

**Owen, C.**

**University of Derby**

**GENDER PERFORMATIVITY AND THE CONSTRUCTION OF RISK NARRATIVES IN HEALTH PROMOTERS**

This paper explores the ways in which those who reproduce health promotion discourse and who are also produced by it, construct narratives of risk which underpin the construction of self and identity. These narratives are a fundamental resource in the reflexive project of the self and reflect the ways in which dominant health risk discourse is negotiated, taken up or resisted in order to maintain self-concept or to initiate and enable change. This empirical study uses a Focus Group and in-depth semi-structured interviews to explore how discourses around the concept and management of risk are taken up, internalised and interpreted by a sample of health professionals, particularly at the individual, micro-level. It is suggested that, amongst other strategies and techniques, gender performativity is a powerful tool in the construction of personal risk narratives.

**Saturday am**

**10.10 - 10.30**

**Owens, C., Lambert, H., Donovan, J., Lloyd, K.**

**University of Exeter**

**"THERE WAS NOTHING MEDICALLY WRONG WITH HIM." LAY UNDERSTANDINGS OF SUICIDE AND ITS RELATION TO MEDICINE**

Concern has been expressed by sociologists among others about the increasing medicalisation of normal human conditions. This paper will explore the notion of medicalisation in relation to suicide and its aetiology.

The study draws on data collected as part of an earlier case-control study of 100 suicides. Semi-structured interviews were conducted with close relatives, with the aim of building up a comprehensive picture of those who killed themselves, their lives and the circumstances leading up to their deaths.

The original quantitative analysis supports the dominant medical model, according to which suicide is attributable to mental illness and is therefore theoretically preventable through timely medical intervention. Subsequent analysis of the interview transcripts using qualitative methods fails to support this model, however. Informants put forward a range of explanatory models of suicide in which mental illness does not always feature.

This paper offers some reflections on the way in which the same body of data can tell different stories depending on the mode of analysis and research agenda; on the reasons why lay individuals may favour non-pathologising models of human distress over those that render it pathological, and on the implications of this for suicide prevention strategies.

**Saturday am**

**11.45 - 12.05**

**Panagos, M.**

**University of Newcastle**

### **PARENTAL RIGHTS OF MEN AND WOMEN WITH HIV SEROPOSITIVE STATUS**

This paper draws on empirical research undertaken on women affected and infected by HIV/Aids in relation to their social understanding and perception of people's reproductive rights when acknowledging a positive status to HIV infection. The primary objective of this paper is to address how decision-making is constructed, to report some findings of the study undertaken in Britain and to conclude with a discussion of implications raised on a social policy level, that of relating the 'principle of finitude' while living in a 'risk' society to male and female reproductive rights, such as parenting when tested HIV positive. Due to the sensitive nature but to also capture heterogeneity the sample was drawn from a variety of settings, including the University of Newcastle upon Tyne, self-help groups and organisations based both upon a governmental and a non-governmental level in different parts of the country. Data was drawn from a questionnaire evaluated by SPSS and twenty-four in-depth semi-structured qualitative interviews in the UK among women of an unknown or a known positive or negative HIV serostatus. The method of membership categorization device {MCD} was employed to analyse women's responses and to examine the way in which they make sense of daily phenomena and interpretations of notions of 'reproduction', 'rights' and 'HIV testing' by attaching to categories assumptions about their characteristics. The language used by the interviewees revealed that there is a hierarchy of acceptance to parenting among HIV positive individuals depending on timing acknowledging a positive status, gender and whether having previously children.

**Saturday pm**

**15.55 - 16.15**

**Pearce, M.**

**University of Nottingham**

### **GENETIC COUNSELLING - MEDICAL TASKS AND A COUNSELLING ROLE**

Genetic counsellors and the genetic counselling profession profess a strong adherence to the ethos of non-directiveness and to the philosophy of Roger's person-centred counselling. Clarke (1997) suggests this is largely attributable to the dominance of the ethic of autonomy and the need for human genetics to dissociate itself from the abuses perpetuated by the eugenics movement earlier this century. By accounting themselves as "counsellors" and part of the "therapeutic culture" (Rose 1999), however, the genetic counsellors are also committing themselves to a philosophical framework often at odds with the traditional medical role. Strong's (1979) seminal work on the 'ceremonial order of the clinic' found that "the bureaucratic format" was overwhelmingly dominant in medical consultations and was collaboratively created by doctor and patient - a co-construction confirmed more recently by the work of conversation analysts such as ten Have (1991) and Pilnick (1999). Doctors were assumed to be competent experts and responsible for setting the agenda. This provides a marked contrast to person-centred counselling's rejection of the role of "expert" and emphasis on the importance of allowing clients to set the agenda. Using the sociological approach of conversation analysis I illustrate how this tension is manifested in the genetic counselling consultation. Sections of transcript are used to demonstrate how non-directiveness or agenda-setting become interactionally problematic to sustain. As the genetic counsellors struggle to fulfil both non-directiveness and their person-centred counselling role I raise the question is the combination of medical tasks and a counselling ethos setting them impossible goals?

**Saturday pm**

**14.00 - 14.40**

**Pinder, R., Petchey, R., Shaw, S.**

**City University**

**MAPPING THE PATIENT PATHWAY: TOWARDS A CULTURAL CARTOGRAPHY OF THE NEW NHS**

Rather than reading them as representations of reality, cultural cartographers read maps as cultural and political constructs. They view them as powerful rhetorical tools that systematically impose their own order on events, and are shot through with interests. We present a critical analysis of a specific instance of map-making in health policy, namely, the growing use of (patient) pathways in care planning and service delivery. Pathways seem to be becoming the tool of choice for ensuring quality of care, equity of treatment, optimal allocation of resources, and a rational division of labour between healthcare professionals. Hitherto, researchers have treated them simply as helpful (and perfectly neutral) tools for routing patients through the system.

This paper is based on in-depth interviews with twenty-four health workers from a range of professions and occupations in three areas. Following a brief account of their development, we show how pathways configure the patient, highlighting some aspects of their experiences, while others are silenced and stripped of context and meaning. We also consider the role of pathways in the carving up and surveillance of social space that is implicated in the emergence of the 'hybrid professional', particularly the new specialists such as GP specialists, specialist nurses, extended scope physiotherapists and others. Finally we draw out some of the wider implications of ICPs, in particular the push and pull between joining and splitting in service development, standardisation and variation in the pursuit of the quality of care, and between patient-centeredness and efficient professional disposal.

**Saturday pm**

**17.05 - 17.25**

**Petersen, A., Davies, D.**

**University of Plymouth**

**BIO-GOVERNANCE: SOME IMPLICATIONS OF RECENT DEVELOPMENTS IN THE NEW GENETICS**

Recent developments in the field of human genetics are radically transforming notions of the body, the self, and society. Increasingly, genetic knowledge is offering a new means of classifying bodies and treating and preventing disease, as well as providing the foundation for identity and sociality. This so-called new genetics draws heavily on the rhetoric of empowerment and consumer choice: 'the public' is 'empowered' through better understanding of the basis of their health and illness, and the provision of new 'personalised' medicines and preventive interventions. As such, it can be seen as an instance of governance through 'freedom'. This paper asks, what has been the impact of these developments on those who are the subjects of, and are subject to, new genetic knowledge, and more specifically those who currently have a genetic disorder, or are carriers, or are deemed to be 'at risk' of developing genetic disease? It will draw on the findings of recent empirical research, involving interviews with members of genetic support groups in Western Australia, who are suffering a range of genetic conditions, and who are faced with making important decisions based on genetic information. The paper will explore the implications of the research for assessing the impact of the new genetics on identity and subjectivity, for the field of genetic medicine, and for the sociology of health and illness.

**Saturday am**

**11.45 - 12.05**

**Philpin, S.**

**University of Wales Swansea**

**'IF YOU DIDN'T LAUGH YOU'D CRY': THE USE OF HUMOUR TO MANAGE  
RELATIONSHIPS IN AN INTENSIVE THERAPY UNIT**

**Background:**

There is much in the literature to suggest that use of humour to manage relationships in health care settings serves a number of purposes, with the emphasis on maintaining social cohesion. Writers have noted humour's utility in managing relationships where power differentials exist, avoiding open conflict, dealing with uncertainty and ambiguity and coping with extremely stressful events.

**Objective:**

To examine the ways in which jokes are used to manage relationships between nurses and other health care professionals, between nurses themselves and also between nurses and patients in a critical care environment.

**Method:**

This paper draws on early findings from doctoral research into nursing culture, which took the form of a participant observation study of nursing work in an intensive therapy unit.

**Findings:**

The data suggest that the intensive care unit nurses' use of humour to manage the inherent tensions of their work is complex and multi-faceted. This paper will focus on the following three broad areas concerning the use of humour. First, the way humour is used to veil challenges to more powerful professional groups; second, the ways in which nurses skilfully deploy humour in a therapeutic relationship with patients who are extremely dependant; and third, the use of humour to manage distressing situations, including the careful judgements required to avoid breaching delicate social norms.

**Friday pm**

**14.00 - 14.20**

**Pilnick, A.**

**University of Nottingham**

**"SO WE'RE GOING TO TALK ABOUT SCREENING TESTS": THE PRESENTATION  
OF NT SCREENING FOR FETAL ABNORMALITY**

Much of the sociological research that has been carried out into antenatal screening has been highly critical of the practical implementation of these programmes, particularly around issues of choice, routinization and the status of information that is gained as a result. However, for the most part this research is based on interviews conducted with participants after screening has taken place. This paper presents a preliminary exploration, based on ongoing research, of the interactional presentation of a particular antenatal screening procedure, known as nuchal translucency, or NT screening. This is a relatively new form of antenatal screening which is offered at some specialist centres within the UK in place of maternal blood serum screening, and which results in a risk factor for Down's Syndrome. The data are analysed from a conversation analytic perspective, with a focus on the ways in which screening is introduced, explained and discussed by those involved. The issue of choice, and of the need to actively make a decision, are explicitly topicalised by midwives in these consultations. However, it is argued that the choice that is presented in this setting is one that reflects the documented failings of previous screening practice, rather than a straightforward choice between screening and not screening.

**Saturday pm**

**15.10 - 15.30**

**Polzer, J.**

**University of Toronto, Canada**

**GENETIC RISK AND GENDERED REGULATION: TOWARDS A CRITICAL PHENOMENOLOGY OF INHERITED BREAST CANCER SUSCEPTIBILITY**

With the identification of mutations in the BRCA1 and 2 genes, "genetic risk" has emerged as a new way of conceptualising breast cancer etiology, and screening for susceptibility to breast cancer through family history assessment and genetic testing. Critical social theories of risk suggest that, by situating women as "carriers" of mutated genes, and by constructing their breasts as potentially diseased and dangerous, BRCA1/2 testing has serious implications for how women experience their bodies, and how they relate to themselves and their families in everyday life.

Based on in-depth interviews with women undergoing BRCA1/2 testing, this paper will present women's experiences of their susceptibility to breast cancer before genetic counselling, after counselling, and after they receive their test results. Combining the theoretical concerns of phenomenology and Foucauldian studies in governmentality, this "critical phenomenology" of genetic risk conceives of women's lived experiences as bounded, but not determined, by discursive forces. From this perspective, data will be presented to show how women's experiences of breast cancer susceptibility are governed, and made governable, through their participation in genetic testing. Interview data will also be presented to illustrate how women's experiences transform and challenge genetic testing as a practice of governance.

**Saturday pm**

**12.10 - 12.30**

**Poole, J.**

**University of Toronto, Canada**

**RE-THINKING RECOVERY: BULIMIA AND BEYOND**

Bulimia has been a major concern of health practitioners, researchers and theorists for over twenty years. For researchers and practitioners working within a biomedical paradigm, bulimia is an abnormal state in which eating practices are 'out of control'. The goal is recovery, a health end that many argue is possible to achieve, despite 'evidence' that points to high rates of relapse. Policy makers tend to follow suit, and in Ontario, Canada, many are calling for the province's network of mental health care services to be renamed 'the recovery system'. Although theorists interested in the sociology of the body have taken up the task of thinking through bulimia and anorexia, like practitioners and policy makers, many have not yet interrogated the notion of recovery. With a view to the individual and social effects of this neglect, this paper aims to rectify this lacuna, taking initial theoretical steps towards a sociology of recovery.

Drawing on a number of theorists such as Foucault, Gallop, Kristeva, Bataille and Deleuze and Guattari, the paper begins to unpack 'recovery', offering readings of it as transcendence, transgression and a plane of immanence. The readings move us away from binary conceptions of disorder/order and recovery/relapse and towards practical possibilities for re-thinking recovery. In short, dislodged from its biomedical moorings, the readings move the notion of recovery into a more critical space, a necessary step for future practice, policy and theoretical work in this area.

**Saturday pm**

**12.10 - 12.30**

**Pope, C., Chalder, M., Salisbury, C.**

**Bristol University**

### **WHY PEOPLE USE WALK-IN CENTRES**

What people do in response to symptoms, how and why they seek help, has been an enduring theme in medical sociology, from classic papers on 'triggers' to consultation through to recent work unravelling the complex pathways which underpin service use. Various health policies have sought to encourage help seeking and improve access, yet at the same time, health professionals, notably GPs, have highlighted the problem of inappropriate attendances about self-limiting illness.

This paper reports on the qualitative component of the national evaluation of forty NHS walk-in centres established to provide nurse-led, 'drop in', primary care services. It is based on case studies conducted at ten sites between May and July 2001. Brief interviews with centre users (n=50) explored reasons for consultation and interviews with staff looked at issues such as the appropriateness of care, the lack of continuity of care, and the impact of the service. This was supplemented with observation of waiting room, reception and consultation areas. The analysis was conducted by systematic comparison of themes in these data and used a charting procedure loosely based on the framework approach.

This analysis provides an opportunity to re-examine the tensions between the problem of trivia as specified by health care providers, and the consumerist policies which gave rise to walk-in centres. We also look at disempowerment in the age of mass health information by exploring how walk-in centre users account for their consultation behaviour and the medicalisation of minor symptoms.

**Friday pm**

**15.35 - 16.15**

**Power, R.**

**British School of Osteopathy**

### **'BODYLEARNING': A STUDY OF THREE YEARS OF OSTEOPATHY-IN-ACTION IN A UK 'SPECIAL' PRIMARY SCHOOL FOR CHILDREN WITH 'EMOTIONAL AND BEHAVIOURAL DIFFICULTIES'**

The head teacher of a school in London invited the British School of Osteopathy teaching clinic to establish osteopathic provision for the children in the school, as he thought 'osteopathy could help'. This collaborative venture started in October 1998, established and run by Averille Morgan and Richenda Power. Children reach an EBD school after a process of 'statementing', resulting in exclusion from mainstream education. Unusually, for osteopathic intervention, these children are not 'ill' or in pain in a conventional sense, but their personal development is disrupted to the extent that they have become ineducable by the age of 5 or 6.

The research questions addressed were:

1. Can osteopathy enable a secure experience of 'true self' so a child is able to start using 'the territory covered by the words "teaching" and "learning"' (Winnicott 1986: 69)?
2. How can osteopathy achieve this?

The setting was suitable for 'action research', which involved a combination of ethnographic style methods of observation of behaviour, body movement, verbalisation, non-verbal communication and interaction as well as osteopathic clinical methods of observation and palpation. The evolution of a method of working is outlined: osteopathic interventions that 'worked' and 'didn't work' were recorded and developed for future application.

The theoretical framework of analysis is drawn from sociology of childhood (e.g. Berry Mayall), osteopathy and child psychoanalysis (e.g. Winnicott). It is suggested that this small scale study makes a contribution to the theorising of the socialisation of subjectivities.

**Saturday pm**

**16.40 - 17.00**

**Price, L.**

**University of Plymouth**

**HEALTHY PARTNERSHIP OR FAUSTIAN PACT? THE INFLUENCE OF THE GLOBAL PHARMACEUTICAL INDUSTRY ON THE NATIONAL HEALTH SERVICE**

The government is committed to partnership with the pharmaceutical industry ("Industry") for explicitly economic reasons. As a result, Industry has been invited to participate in the development of health policy at every level of the NHS, including areas with direct implications for patient safety, such as procedures for drug regulation and ethical review, and for clinical practice, such as national service frameworks.

This paper will examine this partnership from a critical perspective, arguing that it is one of inherent conflict of interest. The NHS ethos is to provide needs-based, evidence-based health care and to promote health in a context of accountability, transparency and economic rationality. The Industry's guiding ethos is profit maximisation. It needs to create and sustain markets for drugs, and so has an interest in generating health needs, but not in promoting health. It operates in secrecy ("commercial confidentiality"), controls knowledge production and dissemination and manipulates prices to enhance profits.

The extent of the incursion of the pharmaceutical model of health into the NHS at every level, including domination of the research agenda will be described. It will be argued that much Industry conduct is unaccountable, unethical and antithetical to health and well-being, both nationally and globally, and that the government/Industry symbiosis is a cause for concern.

**Friday pm**

**14.25 - 14.45**

**Prior, P.M., Hayes, B.C.**

**Queen's University Belfast**

**MENTAL HEALTH CARE IN SCOTLAND: THE EMERGENCE OF TWO DISTINCT POPULATIONS**

Based on census materials collected from 1921 to 1991, this study focuses on gender differences in occupancy rates in mental health beds (hospitals and other residential facilities) in Scotland. The main finding is that the pattern of gender equivalence, which prevailed for most of the twentieth century, was negated in 1991. There is now a notably higher proportion of females than males in residential mental health facilities in Scotland. There is also some evidence to suggest that there are currently two distinct populations in these facilities - a male group, which is predominantly of working age, and a female group, which is predominantly of retirement age. This is not to deny, however, the substantial increase in retired men. Although women are in the majority, the proportion of retired men within the male population in mental health beds has almost doubled since 1971, with the single/never married clearly predominating.

**Saturday pm**

**14.00 - 14.40**

**Prior, L., Wood, F., Gray, J., Pill, R.**

**Cardiff University**

**MAKING RISK VISIBLE. THE ROLE OF IMAGES IN THE ASSESSMENT OF  
(CANCER) GENETIC RISK**

Whilst analysis of 'risk' (in its many conceptual shapes) has loomed large in both medicine and social sciences over the past 25 years, detailed investigations as to how risk assessments are actually put together (in either lay or professional contexts) are few in number. The studies that are available usually focus on the use of words or everyday conversation in assembling risk.

Talking about risk is, of course, important, but what tends to be ignored is the fact that risk can be and is often made visible. For example, it can be made visible through the use of tables, charts diagrams and various kinds of sophisticated laboratory images. This paper concentrates on the role of such images in the context of a cancer genetics clinic and its associated laboratory. Precisely how these images are tied into the production of risk estimates, how professionals discuss and use such images in clinical work, and how professionals reference them to display facts about risk is the focus of the paper.

The paper concludes by highlighting the significance of different kinds of visibility for an understanding of genetic abnormalities and how such differences might impact on the attempts of lay people to get to grips with risk.

The data on which the paper depends are gathered from an ethnographic study of a cancer genetics clinic funded under by the ESRC Innovative Health Technology Programme.

**Friday pm**

**15.10 - 15.30**

**Prosser, H., Walley, T.**

**University of Liverpool**

**FOOLS RUSH IN WHERE ANGELS FEAR TO TREAD: DIFFERENCES IN HIGH AND  
LOW PRESCRIBING GPs' ATTITUDES AND APPROACH TO NEW DRUG  
PRESCRIBING**

**Background**

Prescribing varies considerably between GPs and a minority account for a large proportion of new drug prescribing. Variation is not explained by morbidity or socio-demographic factors, whilst qualitative methods have shown a range of influential psychosocial factors.

**Aim**

The aim of this study was to explore the differences between high and low GP prescribers of new drugs in their approach and attitudes towards new drug prescribing.

**Method**

Qualitative interviews using the critical incident technique were undertaken with 107 general practitioners from a range of high, medium and low new drug prescribing practices in two health authorities in the North West of England. Interview topics included reasons for prescribing new drugs; use of information sources; attitudes and approach to drug innovation; consideration of the balance of risk and therapeutic benefit.

**Results**

Differences in appraisal of new drugs enabled the development of a classification of attitudes and approaches that apply to high and low prescribers. Differences in the behaviours of each group a matter of degree of attitude or influence rather than (usually) its absence. Key dimensions in the classification are attitudes towards new drug prescribing, perception of risk and benefits, strategies adopted for risk management, information seeking behaviour; contact with and use of the pharmaceutical industry as a significant information source.

**Conclusion**

Variability in GP's prescribing of new drugs relates not only to levels of objective knowledge, but also to differences in subjective and ideological beliefs.

**Saturday pm**

**14.20 - 14.40**

**Ragner, A., Tjora, A.H.**

**Norwegian University of Science and  
Technology**

### **GIRLS AND BOYS IN WHITE: MEDICAL STUDENT CULTURE 40 YEARS AFTER**

In 1961 Becker, Geer, Strauss and Hughes published "Boys in White", a study of student culture in the medical faculty at Kansas University, USA. Instead of a traditional "reading to the exams" strategy as reported by Becker et al., the Medical Faculty at the Norwegian University of Science and Technology, has now applied a "problem based learning" (PBL) model. In this model students are given medical problems and the responsibility for solving these and decide for themselves where to put their efforts in performing these tasks.

By ethnographic observation of students attending lectures, meeting with patients, performing dissections, and participating in PBL work teams, and by using interviews, the study seeks to identify study strategies, for example what the students consider important medical knowledge, what kind of attitudes they develop towards patients and diseases and how they perceive their future roles as medical practitioners, to name a few.

Although in a preliminary stage, the study shows that the students tend to emphasise learning "new medicine" such as clinical chemistry and imaging techniques as opposed to "old medicine" such as anatomy and Latin. Further, the students change opinion on what is important to learn during their education, as they move towards an increasingly clinically oriented education.

The study implies that the socialisation into a role as physician is a complex, partly unconscious, process, where the role of the faculty is only partly understood. Sociological analyses of these processes may inform development of medical study programs.

**Saturday am**

**09.25 - 10.05**

**Redley, M.**

**The University of Edinburgh**

### **PSYCHIATRISTS ACCOUNT FOR THE CAUSES OF SELF-HARM AMONGST A DEPRIVED POPULATION**

This paper is based upon 31 qualitative interviews with psychiatrically trained medical personnel. The respondents have all recently assessed a non-psychotic self-harm patient (by overdose) from an area of multiple deprivation area. In the interviews the respondents are asked to give their assessment of, the patient, the possible causes/reasons for their overdose and whether the fact that the patient lives in a deprived area is significant.

The analysis notes that these psychiatrically trained respondents have a preference for explaining these acts of self-harm in terms of deprivation factors (social geography) past life events (biographical particularities) and lowered inhibitions due to intoxication by either alcohol or drugs (biochemistry). The patients' psyche - as feelings or dispositions of character that transcend geography, biography or biochemistry - are not a routine feature of their accounts. And to the extent that the psyche does feature in these interview accounts it functions to gloss an, 'explanatory-deficiency': none of the preferred explanatory factors - deprivation, life events and intoxication - has a conclusive causal significance.

The paper concludes by suggesting that the way these psychiatrically trained respondents accounting for self-harm, by minimising the significance of the patients psyche is

- (a) embedded in clinical routines
- (b) functional in terms of maintaining professional distance and
- (c) perpetuates treatment regimens that are not particularly successful.

**Saturday pm**

**14.45 - 15.05**

**Reed, C.**

**University of Manchester**

### **THE USE OF LIFE HISTORIES TO STUDY RECRUITMENT AND RETENTION OF COMMUNITY NURSES IN MANCHESTER**

The Practice and District Nurse workforces are unusual in their ability to retain older nurses and the Practice Nurse workforce more so in its ability to also recruit older nurses. Understanding the reasons for this may enable NHS employers to enhance nurse recruitment and retention in other sectors. Life Histories were chosen as a suitable methodology to enable the study of the span of up to 40 working years in some cases. The technique has been used to develop approximately 30 case studies, 15 of each District and Practice nurses, of varying ages and length of service in their speciality.

These case studies have been able to illustrate and explore known themes for example the different age of entry of the two groups into their respective specialties, District Nurses classically entering at a younger age. The case studies are also being used to develop new theories, for example concerning the ability of Practice Nursing to absorb and 'satisfy' a very diverse workforce. The Life history approach has been invaluable in exploring the impact of major policy changes for example the Community Care Act and the 1990 GP contract, as perceived by individual nurses working at the time.

Life histories have been shown to be a flexible and pragmatic tool in this health service setting, enabling the development of new theory as well as providing descriptive materials to compliment existing 'workforce' data.

**Saturday am**

**10.35 - 10.55**

**Riley, A.J., Bestall, J.C., Carter, Y.H.**

**University of London**

### **PREVENTING UNINTENTIONAL CHILDHOOD INJURIES THROUGH SURE START: A DEVELOPMENTAL APPROACH**

#### **Introduction**

This project involved local stakeholders in the development of guidance notes incorporating priorities and recommendations for the prevention of childhood accidental injuries.

#### **Methods**

An 'expert panel' identified recommendations on health promotion interventions for childhood accidental injuries. Semi-structured telephone and face-to-face interviews with local community stakeholders were followed by a parental focus group. Professionals were asked to assess their roles, relationships and level of involvement relating to injury prevention. Interviews were tape recorded and transcribed. The data was inductively analysed through charting emergent conceptual themes. An interpretative analysis of themes was developed drawing on the social theoretical models of profession identity, relationships in primary care and decision-making.

#### **Results**

The review and expert panel revealed that there were three main areas of risk for children: roads, the home and leisure environment. Priority areas in childhood accidental injuries included: the implementation of a multi-agency work group; involvement of the local community; the identification of those at risk and the provision of fitted and maintained safety equipment. Synthesised focus group and interview analysis revealed positive responses despite certain perceived barriers and the identification of additions to the recommendations. Issues of socio-economic deprivation were also uncovered and practices adopting social models of healthcare took accidental injury prevention seriously when compared to those adopting a medical model.

#### **Conclusion**

Results of this project will be employed to modify the guidance notes, which could then be used by health professionals and communities to implement throughout the Sure Start scheme.

**Saturday am**

**11.00 - 11.40**

**Robertson, S.**

**Institute for Health Research**

**"IF I LET A GOAL IN I'LL GET BEAT UP": CONTRADICTIONS IN MASCULINITY,  
SPORT AND HEALTH**

This paper presents a critical exploration of the triadic relationship between masculinity, sport and health by reporting findings from a wider qualitative study on lay men's and health professionals' beliefs about masculinity and preventative health care.

Recent years have seen a surge of interest and activity in relation to 'men's health'. In particular, the Department of Health has highlighted sport as a successful way of engaging men in discussions about health and has identified and funded initiatives to this end. In such projects, men's connection with sport, teamwork and competitiveness are used to introduce facets of health. In contrast, work in the sociological literature on gender and sport, influenced by feminist research, has raised issues of concern about the relationship between men, masculinity and sport. Such work demonstrates how nurturing attributes such as competitiveness and aggression in sport helps create and sustain a culture of misogyny and homophobia that contributes to violence both within and beyond sport and can ultimately be damaging to men themselves. It would appear then that a straightforward "men + sport = health" relationship cannot be assumed.

A series of focus groups and interviews with health professionals and men, including gay and disabled men, were undertaken to facilitate examination, through narrative analysis, of the socially integrative meanings of sport and masculinity, and their relationship to health. Socialising, 'macho' culture, and the body, emerged as three main themes and the implications of these empirical findings for health promotion are discussed.

**Friday pm**

**14.25 - 14.45**

**Robson, K.F., Murdoch, C., Chestnutt, I.G. University of Wales College of Medicine**

**FOOD AND DRINK: FACTORS INFLUENCING PARENTS IN THE PROVISION OF  
CHILDREN'S DIET**

This paper is drawn from research investigating parents' knowledge of feeding practices potentially detrimental to oral health, and will offer an overview of the factors considered by parents in the provision of both food and drink for younger children. 33 semi-structured interviews were conducted in 2 areas of Cardiff with high caries prevalence, with parents or carers of children under 3 years old. The research found that drinks and foodstuffs were considered in distinctive ways, and this paper will examine these distinctions with particular reference to issues relating to:

- Offering variety in diets;
- Persisting with different foodstuffs or drinks;
- The place of 'treats'
- The neutrality of drinks in nutritional considerations;
- Barriers to offering water;
- The ambiguity of milk as both a food and a drink;
- The importance of what are viewed as 'children's' brands.

The findings offer valuable insights into the dynamics of effectively communicating health related messages about children's diet, and in particular the barriers to adopting the traditional oral health education message that only milk and water are safe for teeth. The project was funded by Sure Start Cardiff and the authors acknowledge their support and assistance.

**Saturday pm**

**15.30 - 15.50**

**Rowley, E.**

**University of Nottingham**

**WHO IS THE PATIENT? A CASE STUDY OF A GENETIC COUNSELLING CONSULTATION**

Since the mid 1990s, regional NHS trusts have been able to offer genetic testing to individuals considered to be at high risk of inheriting BRCA1 and BRCA2, mutated genes linked to breast and ovarian cancer. Genetic testing, whilst possibly empowering, is also perceived to be potentially harmful. Hence, as a matter of course, individuals are offered genetic counselling where they can meet a trained counsellor. In such a consultation it is possible to address any questions that individuals may have, and discuss any matter related to being genetically at-risk of breast and ovarian cancer.

The aim of this paper is to investigate who is the patient in the genetic counselling consultation - the individual referred to the clinic by their GP, their immediate family who may, or may not, be present at the consultation, or their wider/extended family? In turn, what consequences may decisions such as finding out if one does carry the mutated genes or opting to undergo prophylactic surgery, have? Using a case study of a genetic counselling interaction, the difficulty of extrapolating 'who is the patient' is illustrated and discussed in relation to the notion that the genetic 'dimension' of medicine deals with families rather than individuals. The debate is approached from a conversation analytic stance.

**Sunday am**

**09.25 - 09.45**

**Ruston, A.**

**University of Greenwich**

**WOMEN'S BELIEFS ABOUT CORONARY HEART DISEASE: MANAGING PERSONAL RISK**

Coronary Heart Disease (CHD) accounts for approximately one in four deaths in men and one in five deaths in women each year. Although mortality rates for women lag approximately ten years behind those for men once the disease has developed women have no survival advantage. Very few studies have explored women's beliefs about CHD and the underlying premise of this study was that women might not assess themselves as at risk because CHD is often perceived both by the public and by most health professionals to be predominantly a male disease - an image reinforced by the media, health educators and the medical press. In depth interviews were conducted with 50 women who had been admitted to hospital following a cardiac event and 33 women without manifest CHD who had been admitted to hospital for routine elective surgery. Their views on the causes of CHD, their perceptions of risk and the possibilities for prevention were sought. Hayes (1991) suggests that critical to the success of any risk assessment strategy is: the identification of risk markers that can accurately predict specific adverse health outcomes and the ability of the strategy users to measure risk factors and calibrate them appropriately. This paper examines the way in which women's beliefs and interpretation of health information acted as barriers to the accurate calibration of the risk associated with specific lifestyle behaviours. Women's beliefs about the potential dangers of physical activity and their beliefs about what constituted a healthy diet prevented them adopting health promoting behaviours.

**Friday pm**

**14.25 - 14.45**

**Saetnan, A.R.**

**Norwegian University of Science and  
Technology**

**PROFESSIONAL STRATEGY, REALIST ONTOLOGY, MATHEMATICAL NAIVETÉ  
...AND THE CONSTRUCTION OF RACE IN FETUSES**

One of the arguments for routine ultrasound scanning in pregnancy has been that ultrasound gives a more accurate estimation of gestational age than do women's reports on menstrual history and sexual activity. This argument can be seen as related to strategies of professional autonomy and to scientific assumptions/realist ontology within medical culture. The mathematical models and social practices used to date pregnancies with ultrasound implies that (up to the time of a dating ultrasound: from 10 to 20 weeks depending on local practices) all fetuses the same age are the same size - a logic not born out by the published data. In a recent (Feb 2001) Medline and Science Citation Index search to bring myself up to date on this field, I found a number of titles, abstracts, and full texts proposing specific fetal biometry statistics for racially, nationally, geographically, or ethnically identified populations. This paper is a study of those titles and texts, raising questions of what role they play in the construction of gender, profession, and race and in the (de-?)construction of a singular biometrics of the fetus. The same mix of professional strategy, scientific assumptions, and weak mathematical knowledge seems to be playing a continued role, now in constructing fetuses to be of different sizes between racial groups but of uniform size within groups. The paper raises concerns regarding the possible social, political, and health consequences of establishing either of these truth claims, either one standard for all foetuses or different standards for specified population groups.

**Saturday am**

**11.00 - 11.40**

**Sandall, J.**

**King's College**

**THE EXOTIC AND THE MUNDANE: TRENDS IN THE SOCIOLOGY OF  
REPRODUCTION AND CHILDBIRTH**

This paper will review some of the key theoretical and empirical concerns within the sociology of childbirth and reproduction over the last twenty years. It will provide an outline of trends and issues within both the sociology of childbirth and reproduction, and the arena of reproductive politics. It will examine the reflexive nature of the production of knowledge in this field and the dynamic relationship between academic writers, activists in reproductive politics, and mainstream policy and practice. Many writers in this area have made explicit statements about linking research and academia to the reality of women's lives and this paper discusses the 'audience' for sociological work and examines the relationship between issues raised as sociological concerns and those raised by women grounded in their experiences of reproductive health care technologies and systems. Current theoretical linkages, both within, and external to sociology are highlighted, gaps in current work in the field, and promising possibilities for future areas of work suggested.

**Sunday am**

**11.00 - 11.40**

**Sasaki, K.**

**Lancaster University**

### **'GENEALOGY' OF THE NOTION OF DIFFERENCES IN JAPANESE MEDICAL PRACTICES OF ORGAN TRANSPLANTATION**

This study examines the way in which organ transplantation and the definition of brain death have been described differently in Japan than in the UK and USA.

Japanese organ transplant specialists waited 31 years to perform the second cardiac transplantation since their first case in 1968; during which time Anglo-American societies established a positive public attitude and system for organ transplant from brain dead donors. During the moratorium in Japan (1968-1999) and even afterwards, Japanese society has experienced a series of public debates regarding:

- 1) Whether or not the definition of death should be changed,
- 2) Whether or not organ transplants from brain dead donors should be allowed,
- 3) If the above two agenda were to be approved, in what way and on what terms the Japanese society should authorise them.

Earlier researches pursued religious and cultural reasons for Japan's contrasting attitude towards medical practices; it could rather be argued that different perceptions of the above issues were moulded through the process of consideration during these public debates.

Therefore, I wish to analyse the way in which certain cognitive frameworks and 'discursive genres' have been established in Japan, contrasting with those of Anglo-American societies and particularly, how certain Japanese notions of foreign technologies and the concepts of life and death, in relation to public concerns and perceptions about clinical medicine and its practice, have been 'articulated' throughout the course of this public debate.

**Sunday am**

**11.00 - 11.40**

**Seaman, P., Fairhurst, K., Wyke, S.,  
Zielbald, S., Glasier, A.**

**University of Edinburgh**

### **STRATEGIES FOR NEUTRALISING POTENTIAL STIGMA. UNDERSTANDINGS OF WHAT THE NEED FOR EMERGENCY CONTRACEPTION (EC) COULD MEAN**

This study is based on in-depth interviews with 25 women who were given 5 packs of EC to keep at home as part of an intervention study (the Lothian Emergency Contraception Project) in Scotland. It explores reasons for the low uptake rates of the intervention in General Practice and why the intended 'patient-led' strategy was not effective.

The processes by which stigma acts as a barrier to individuals accessing healthcare services has been well documented. The management of identity to avoid belonging to a stigmatised group can be threatened by the decision to take up services such as screening for sexually transmitted infection or, as argued in this paper, requesting multiple packs of EC. The possibility of stigma can be more sharply felt in the context of General Practice where a patient can understand the relationship between themselves and the health professional as one based upon personal knowledge.

The availability of medicalised long-term options in family planning has created the possibility of the stigmatisation of unplanned, unprotected sexual intercourse (UPSI) within a discourse of "responsibility". It is argued here that patients saw within the offer of EC to keep at home a possible threat to their moral identity if uptake suggested intended future UPSI. Womens' strategies to neutralise potential stigma included not requesting EC to keep at home or highlighting one's own suitability in contrast to other potential users such as those not using 'regular' contraception and younger, more chaotic users.

**Friday pm**

**15.10 - 15.30**

**Secker, J., Hill, R.**

**King's College London**

### **PROMOTING INDEPENDENCE - BUT PROMOTING WHAT AND HOW?**

Promoting the independence of all patient and client groups is a central theme of recent UK health and social care policy. However, 'independence' is rarely defined. Instead we use the term in a taken for granted way, assuming intuitively that we know what it means.

Based on a review of the literature relating to independence in older age, this paper first examines the ways in which independence is conceptualised. While the most common conceptualisation equates independence with the absence of dependence on others, for older people themselves independence is a far broader concept, encompassing not only self-reliance, the value of which is in any case culturally determined, but also self-esteem, self-determination, purpose in life, personal growth and continuity of self.

Drawing on previous work in the field of health promotion, we put forward a model that takes older people's perspective into account by reconceptualising independence in terms of two intersecting axes representing levels of dependence and levels of independence. While dependence equates to reliance on others, independence can be seen as subjectively assessed lived experience. Thus it becomes possible to combine high levels of dependence with high levels of experienced independence, a particularly pertinent combination for service provision.

Finally we examine the ways in which independence as lived experience can be promoted at the individual, institutional, community and societal levels. We conclude that supporting the growth of social movements within which older people can embrace and reconstruct their own identity may be the most potent means to that end.

**Saturday am**

**09.45 - 10.05**

**Shakespeare, J.**

**Summertown Health Centre**

### **IT'S BABY FRIENDLY, BUT IS IT MOTHER FRIENDLY?**

"Baby Friendly" is a WHO/Unicef initiative to encourage breast-feeding. It underpins current "good practice" in midwifery and health visiting services throughout the UK by promoting the advantages of breastfeeding over artificial feeding. Psychosocial factors, including postnatal depression (PND), are associated with the early cessation of breast-feeding with depression preceding cessation of breastfeeding, but "Baby Friendly" makes no mention of this.

This paper discusses a qualitative interview study, designed to evaluate a PND service in Oxford City. A purposeful sample of 39 postnatal women were chosen to represent both different general practices and a spectrum of emotional distress after childbirth. The interviews were analysed using the constant comparative method. For this sample breastfeeding unexpectedly emerged as the commonest cause of postnatal distress. The dataset was explored by asking "What were women's experiences of breastfeeding and support for it by health care professionals?"

Women had high expectations of their ability to breastfeed, strong cultural beliefs that "good mothers" breastfed, and they were surprised, guilty and distressed when the reality of breastfeeding was exhausting and difficult. Health professionals were frequently consulted about breastfeeding difficulties, but they often lacked credibility because they had not personally breastfed, insisted on "doing things by the book" and would not discuss other feeding options with distressed women.

Health care professionals should help and support women's informed decisions about feeding their infants. "Baby Friendly" should reflect this, rather than censoring it. New mothers need reassurance that the quality of their mothering is not linked solely to their chosen feeding method.

**Friday pm**

**14.00 - 14.20**

**Shaw, S., Abbott, S., Bryar, R., Carter, Y.H.,  
Petchey, R., Taylor, S.**

**Queen Mary's School of Medicine &  
Dentistry**

## **THE DEVOLUTION OF PUBLIC HEALTH TO PRIMARY CARE TRUSTS - A MIXED BLESSING?**

### Background

The organisation of the NHS has changed considerably. The continued development of primary care trusts (PCTs) and the formation of strategic health authorities (SHAs) has implications for the organisation and management of the public health function, now largely devolved to PCTs. This project investigates the effect of these changes.

### Methods

Case studies with a purposive maximum variety sample of five London PCTs. Semi-structured interviews with Chief Executives, DsPH and health visiting leads. Key concepts and themes were extracted and charted, forming the basis of analytical interpretation.

### Results

There was strong support for bringing public health expertise closer to local populations. However, there were grave concerns over capacity to deliver public health through PCTs in London. This was heightened by historical inequities in the distribution of resources and devolvement of public health from health authorities. In addition, there was confusion around the public health role of SHAs. PCTs need an 'enabling' environment but there was a lack of clarity over the SHA process of performance management. The reorganisation of roles and responsibilities may increase capacity and encourage cross-boundary working, particularly through the effective development of public health networks. Directors of Public Health (DsPH) were being appointed within all PCT Boards. Their strategic leadership skills were a key force in driving forward such a challenging agenda.

### Conclusions

The devolution of public health responsibilities to PCTs is a mixed blessing. Whilst there is support for recent changes, effective implementation is reliant on factors over which PCTs feel they have little direct control.

**Saturday pm**

**15.55 - 16.15**

**Shaw, A., McClean, S.**

**University of Bristol**

## **FROM SCHISM TO CONTINUUM?: EXPLORING THE RELATIONSHIP BETWEEN LAY & EXPERT KNOWLEDGE: TWO CASE STUDIES**

Debates about the differences between lay and expert knowledge have characterised developments in a range of sociological fields over the last decade and have had particular resonance within medical sociology. These are a reflection of wider discussions surrounding the status of 'professional' knowledge in Western societies. The authors seek to contribute to emerging debates that problematise the lay-expert knowledge relationship by exploring the fluid boundaries between them. Illustrative examples of recent qualitative fieldwork exploring food risks (Shaw) and alternative medicine (McClean) are used to illuminate key issues concerning this boundary.

Shaw's work suggests that diverse 'lay publics' are differentially engaged in the questioning and critique of 'scientific expertise' relating to various food risk issues. The lay-expert knowledge divide becomes particularly blurred in the case of genetically modified (GM) food, where both 'expert uncertainty' and 'lay expertise' characterise individuals' understandings and narratives. Drawing on research on the use and practice of alternative medicine at a healing centre, McClean discusses how healers encourage 'patients' to see the healing potential in themselves, both as experts of their own bodies and as co-producers of healing knowledge. This also has implications for the kind of knowledge they produce, where individuated (lay) and systematised (expert) explanations for health and illness jostle for recognition. The authors' findings suggest that the relationship between lay and expert knowledge is characterised by a continuum rather than a schism. This continuum incorporates different forms of knowledge(s), reflecting how individuals' position themselves in relation to scientific or biomedical discourses.

**Saturday am**

**11.00 - 11.20**

**Shaw, M., Cookson, R., Mitchell, R.**

**University of Bristol**

**WHAT'S THE BIG (HEALTH) ISSUE? CHARACTERISING AND CONNECTING BUYERS AND SELLERS OF THE BIG ISSUE**

This paper will present results from a survey of Big Issue vendors in the South West region of England. In January 2002, 164 vendors completed a self-completion questionnaire on a range of health and social issues. This survey found that vendors experience a range of health problems, from minor ailments to chronic illness. Mental health problems were particularly stark: one in five vendors report attempting suicide in the past 6 months and two in five report suicidal thoughts in the past few weeks. However, this 'excluded' group have a range of characteristics and connectedness with services and 'mainstream' society.

Data from the British Social Attitudes Survey (1999) will be used to provide information on some of the key demographic characteristics of people who buy the Big Issue. How do their health and social circumstances differ from those of vendors? Specifically, attitudes towards Big Issue vendors and towards beggars will be explored.

By introducing comparisons of these two 'groups' of people – those who sell and those who buy the Big Issue – who live and work in the same society but whose lives only occasionally fleetingly overlap, this paper seeks to raise questions about relations between the disadvantaged and the advantaged, particularly concerning issues of difference, inequality and redistribution.

**Friday pm**

**14.00 - 14.20**

**Shelton, P.**

**University of Central England**

**CHANGING CARE LABOUR: THE RESTRUCTURING OF NON-PROFESSIONAL HEALTH AND SOCIAL CARE**

The restructuring of welfare in Britain has established a radical template for the delivery of welfare services particularly in the field of health and social care. The structural and processual changes set in motion by the National Health Service and Community Care Act (1990) including the creation of internal markets, various policies of privatisation (including compulsory competitive tendering (CCT) and market testing) have seen far reaching effects on the organisation and delivery of health and social care. While much of the literature has focused on outcomes and efficiency, an important current has also been concerned with the impact of the reforms on patterns of work and occupational organisation. This discussion has tended to centre on the public dilemmas experienced by the dominant professional groups in the NHS and social services. However, relatively little attention has been paid to formal non-professional support work in either health or social care. Yet it is in this area that the effects of policy change have particularly been felt, and where there have been varied and rapid developments taking place in the organisation of both the labour market and labour process.

There are few publications providing qualitative accounts of the experience of the changes for managers. Through the use of qualitative methods including contrasting case studies, semi-structured interviews, and observations, this paper seeks to examine the extent to which NHS and community care reforms have altered the way in which contemporary formal non-professional health and social care work is organised, managed and carried out.

**Friday pm**

**15.55 - 16.15**

**Speed, E.**

**University of Dublin**

**MENTAL HEALTH SOCIAL MOVEMENTS AND THE REGULATION OF RATIONALITY:  
CONTRIBUTORS OR DETRACTORS?**

This paper takes as a point of departure the notion that mental health service users are often regarded as being irrational. Drawing upon theories of agency and rationality, this paper will consider the role of psychiatry and society in regulating rationality, and the consequences this regulation can have upon an 'irrational' persons' agency. If a basic notion of agency is of actions performed by rational voluntaristic agents, this notion functions to exclude those deemed irrational. Additionally service users may be deemed unable to act voluntaristically. This exclusion and its consequences can be evidenced, in extremis, in procedures for involuntary committal. The effect of this regulation is that any sense of agency can be seriously undermined and any or all action may become pathologised and regarded as symptomatic.

Mental health social movements may function as alternative collectives within which 'irrational' agents can assess their own rationality. They may offer a way out of this perpetual cycle for the service user. Within mental health social movements, the components of human agency which are often withdrawn from service users in regulated mainstream society, such as notions of responsibility, accountability and voluntarism may be more readily available for them to draw upon. This paper will consider whether the regulation of rationality/ies is looser in mental health social movements and will address the role that these movements might play in terms of engendering a greater sense of personal agency amongst service users. This analysis will be based on data collected from Irish Mental Health Movements.

**Sunday am**

**10.35 - 10.55**

**Spilsbury, K., Meyer, J., Godin, P.**

**City University**

**EXPLORING THE BOUNDARIES OF HEALTH CARE ASSISTANTS' PRACTICE**

Throughout the NHS the boundaries between different professional groups are changing. Registered nurses have extended their clinical activities and responsibilities due to demographic changes (an ageing population), concerns about a crisis in availability of nurses, economic constraints and political and professional imperatives. However, registered nurses do not work alone. They are supported in their work by health care assistants (HCAs) - some 20-40% of the nursing workforce across specialities. As HCAs fill the gaps in care left as a result of altered patterns of working within nursing, the roles of these workers have also been changing. Whilst research generally suggests that changes to the roles of registered nurses (particularly in relation to the development of specialist and advanced practice) have a positive impact on patient care and multidisciplinary teamwork, there is little research examining the shifting boundaries of the work of HCAs.

This paper will present the preliminary findings of a mixed methods case study exploring the boundaries of HCAs practice in a UK NHS Trust. In particular, it describes HCAs' perceptions of their work alongside the researcher's observations of role negotiations in practice. The paper highlights the strengths and weaknesses of being a nurse working alongside HCAs as a route to understanding their role and the unique data gathered by virtue of wearing a HCAs uniform. In illustrating these changing boundaries the author will draw on the theoretical literature of power, professionalisation and organisational change.

**Saturday pm**

**15.10 - 15.50**

**Staniszewska, S., Henderson, L.**

**RCN Institute**

### **THE MECHANICS OF PATIENT EVALUATION**

#### **Objectives**

The exploration or measurement of patient experiences has become an integral element of health care evaluation. However, we still have a poor theoretical basis to underpin the methods used to access patient experience and concepts such as satisfaction are now acknowledged as being flawed. The objective of this study was to push forward thinking in the field by identifying the mechanisms or processes patients use when evaluating care, with the aim of informing future tool development.

#### **Methods**

41 out patients were interviewed at 3 points during their health care experience in their own homes (before and after their experience and then a few weeks later). Interviews were tape-recorded and transcribed. Data was managed using QSR NUD\*IST. Analysis was informed by McCracken's (1988) approach.

#### **Results**

A number of mechanisms and processes of evaluation were identified. Patients were found to be natural describers and evaluators of their care, often using varying forms of comparison. They evaluated at specific and global levels using a range of descriptors. The provision of a rationale for their evaluations was important in justifying their feelings. Negative evaluations differed from positive ones and tended to be more personal and detailed. Some patients used proxy evaluation, such as expression of preferences. Patient satisfaction as an evaluative concept was not present.

#### **Conclusion**

Patient evaluation is more complex than has been acknowledged and is not adequately captured by current methods of accessing patients' experiences, which need to become more sensitive to the phenomena they are trying to capture.

**Friday pm**

**16.20 - 17.00**

**Stevenson, F.**

**Royal Free and University College  
London**

### **THE PERSPECTIVE OF USERS OF MOOD MODIFYING MEDICINES: THE DISTINCTION BETWEEN 'NATURAL' AND 'CHEMICAL'**

The meaning of the term natural is not self-evident, however people share a common-sense understanding that if something is natural then it must be beneficial. In relation to medicines, being labelled as natural marks a medicine as different from orthodox medicines, which in turn are perceived to be artificially produced chemical compounds. This paper explores the way nature is evoked in relation to mood modifying medicines.

Data are drawn from 24 interviews with people who were taking, had been offered, or had taken, either or both prescribed and herbal mood modifying medicines. The interviews explored respondents' perceptions of medicines and the ways in which they treated their symptoms.

The use of mood modifying medicines was characterised by a general avoidance of taking prescribed remedies that were referred to as chemicals and thought to produce artificial effects. Preferences were expressed for taking remedies that were perceived to be closer to nature. There was not, however, an uncritical acceptance that natural was better, or of St John's Wort as natural. Decisions regarding medicine taking were further complicated by the influence of general beliefs about medicine, the experience of symptoms and more general beliefs about treatment for mental health problems, thus supporting the notion of the complexity of lay thinking about medicines.

**Friday pm**

**16.20 - 17.00**

**Stokes, T., Dixon-Woods, M., McKinley, R.K.**

**University of Leicester**

### **BREAKING THE RULES OF CONDUCT: PATIENTS' AND GENERAL PRACTITIONERS' ACCOUNTS OF REMOVAL FROM A GP'S LIST**

#### **Objectives**

Doctors categorize patients as 'good' or 'bad' depending on whether or not they conform to the rules of the doctor - patient relationship. Patients may also typify doctors as 'good' or 'bad' using the lay rules of the relationship. It is unknown, however, if both doctor and patient invoke the same rules of the relationship in accounting for specific doctor-patient encounters. This paper will explore this question using retrospective accounts of the removal of a patient from a GP's list.

#### **Methods**

In a study exploring GPs' and patients' accounts of removal twelve interviews were 'paired': each party gave their version of the same removal event. Three of these 'pairs' were treated as case studies.

#### **Results**

Both GP and patient typify the other party as 'good' or 'bad' depending on whether they conform to or break the informal rules of conduct which govern the doctor-patient relationship. The case study dealing with 'breaking the rules of conduct' will be presented in detail. It will be shown that each party invokes the same rules of conduct 'politeness/rudeness' and 'uncomplaining/complaining'. This strategic use of the narrative of removal allows each party to assert their identity as a 'good' GP and a 'good' patient.

#### **Conclusion**

Analysing each party's account of removal offers valuable insight into the nature of the doctor-patient relationship. Each party draws upon the same rules of conduct to explain 'what is happening'. The study findings offer empirical support for Goffman's (1967) claim that the rules of conduct are interactionally accomplished.

**Friday pm**

**14.50 - 15.10**

**Tangen, L.M., Tjora, A.H.**

**Norwegian University of Science and Technology**

### **SURFING FOR HEALTH: THE INTERNET AS HEALTH INFORMATION PROVIDER**

The increased use of the internet as a health information provider has made several questions sociologically relevant and interesting; questions about people's need for health information, about the role of physicians on the net, about the lay-professional interface in these services, and so on.

In a study of the use of four well-established Norwegian "web doctor" services, it is questioned how users perceive and use doctor-on-the-net services and in what way the use of services may contribute to a changed understanding of health. By observing dialogues on the net services and by semi-structured interviews of web doctor users, both the actual interaction between users and professionals on the net and the users' interpretation of, and action on the basis of, this interaction is addressed. Also web doctor physicians themselves have been interviewed.

The study shows (preliminarily) that users of web doctor services do not necessarily accept the answers they get from the doctor, but seem to appreciate contributions of others users. Hence, the illness stories and experiences of other people, who might have been in the same situation, are considered more useful than the doctor's answers. On the other hand, the web services distribute "expert knowledge" more broadly than before, which may give the doctors greater influence on a large audience. On the basis of these findings, the paper discusses how web doctor services may promote significant changes in lay-professional interactions within health and medicine.

**Saturday pm**

**12.10 - 12.30**

**Tarr, J.**

**University of London**

**WEIGHING THE ALTERNATIVES: ALEXANDER TECHNIQUE, ALTERNATIVE HEALTH AND ORTHODOX MEDICINE**

Alexander Technique is a method of movement re-education used by athletes, performing artists, and those with stress injuries and back pain. It aims to improve bodily alignment and promote ease of body use through simple exercises involving standing, sitting, and walking. Alexander Technique is frequently categorised as a form of alternative health or alternative therapy, yet this sits uncomfortably with many Alexander practitioners, who see it not as therapy but as health education.

This paper will look at how Alexander Technique practitioners mediate its role in relation to the fields of alternative health and orthodox (allopathic) medicine. I will examine data from 25-30 qualitative, semi-structured interviews with Alexander Technique teachers and pupils about how they interpret the technique and its relation to other disciplines. I have also undertaken participant observation in Alexander Technique and will draw on my field notes from this as another source of data. In analysing the themes that emerge from the data one of the key issues has been the degree to which people are responsible for their health.

Drawing on Coward's (1989) claim that personal responsibility for health is a major issue in alternative health practices generally, I will show how Alexander Technique practitioners go further to simultaneously reject both alternative therapy and orthodox medicine as undermining patients' responsibility and ability to affect their own cures. The Technique's growth in popularity therefore has important implications for sociology of health in terms of the goals of health practice and patient health education.

**Saturday pm**

**16.20 - 16.40**

**Thomas, H.**

**University of Surrey**

**GET WELL SOON: TIME, ILLNESS AND RECOVERY**

Despite an extensive medical sociological literature concerned with illness behaviour and the experience of illness and sickness, remarkably little attention has been paid to the experiential and social process involved in the restoration of health. The identification and recognition of illness has outscored the business of 'getting better'.

This paper considers the fate and place of recovery and convalescence both within the social world and within the sociology of health and illness. It argues that the processes of restoration are themselves casualties of an increasing pace of life. Increasing use of day surgery, early discharge, and minimally invasive techniques have speeded up the process of sickness in institutional settings. The demise of convalescence, as an arena appropriate for continuous professional care, has given way to self- and family care delivered within domestic settings intermittently attended by professionals. The shift of sickness from public space and time to private space and domestic time represents disruption to the rhythms of recovery and to the restoration of relationships between body, self and society. In addition, the paper argues, a binary division between 'health' and 'illness' has further served to eclipse these processes.

**Sunday am**

**10.35 - 10.55**

**Thomas, M.**

**Cardiff University**

## **SEXUAL HEALTH OF WOMEN WORKING ABOARD CRUISE SHIPS**

### Background and method

This paper reports on a global study of women seafarers in both the cargo and cruise sectors of the shipping industry. The research involved qualitative and quantitative interviews with women seafarers, human resource managers of shipping companies, union officials, international regulatory bodies and trade unions in over 30 countries worldwide. The findings presented are based on data collected on the cruise sector of the industry, in particular on the accounts of women crew.

### Findings

Sexual relationships among crewmembers are a common feature of shipboard life. Sexual relationships, which are close, confiding and provide emotional support can be very beneficial for women working in the harsh environment of the cruise ship. Use of contraception is limited by the non-confidential and restricted access to the ship's doctor and the public location of condom supplies. Company policies that dictate immediate dismissal and repatriation for pregnant crew, along with the lack of confidentiality regarding consultations with shipboard medics, may result in non-disclosure of pregnancy and, in some cases, 'back-street' abortions.

### Conclusion

Women working aboard cruise ships are at risk of unwanted pregnancy, sexually transmitted disease (STI) and the potential health problems associated with abortion performed by individuals outside the medical profession. Confidential access to the ship's doctor and opportunities to obtain condoms discretely are vital to the consistent use of contraception and the prevention and diagnosis of STI contraction. Pre-boarding induction courses for crewmembers should include education on sexual health and sexual risk.

**Friday pm**

**14.00 - 14.20**

**Thomson, H., Kearns, A., Petticrew, M.**

**MRC Social & Public Health Sciences  
Unit**

## **COMPARING LAY REPORTS OF HEALTH AND PLACE IN TWO AREAS OF GLASGOW WITH CONTRASTING EXPERIENCES OF AREA REGENERATION**

Assessing the health impacts of area changes and interventions has been widely recommended, yet there is little research describing the health effects of area change. It has been recommended that lay reports should inform future public health policy.

We studied two similar residential areas in Glasgow which have had contrasting experiences of regeneration: Gorbals and Pollokshaws. Using focus groups, we studied lay perceptions of health and place. Based on the reported definitions of health and place we examined the data for accounts of how area based change had impacted on health. In particular, we looked at the place of local amenities, such as leisure facilities, clubs and shops. Data from Gorbals and Pollokshaws were compared. Emerging themes within lay narratives of area changes included power issues, people, choice, social contact and mental health. Experiences of regeneration were both positive and negative.

Using the example of a pool closure in Pollokshaws and a pool opening in Gorbals, we were able to examine and compare the data for health effects attributed to a specific intervention in both areas. The place of the swimming pool was reported in the context of the other area changes. Parents of young children and elderly people were reported to be particularly vulnerable to the closure of local amenities.

Analysis of residents' accounts of health and place identify possible pathways by which area change may impact on health. Themes which emerged in both areas included, sense of belonging, location, people, services, area reputation and power.

**Saturday pm**

**15.55 - 16.15**

**Timmons, S., Tanner, J.**

**University of Nottingham**

**A DISPUTED OCCUPATIONAL BOUNDARY: OPERATING THEATRE NURSES AND  
OPERATING DEPARTMENT PRACTITIONERS**

Traditionally, surgeons (and to a lesser extent anaesthetists) have been assisted primarily by nurses. Operating theatre nursing is the oldest specialism within nursing. This role has been threatened in recent years, in the UK NHS (and elsewhere) by a relatively new profession, that of the Operating Department Practitioner (ODP). The ODP profession is still in the process of establishing itself as a 'full' profession within UK health care. While occupational boundary disputes between professions are common in health care, it is unusual for them to become as overt as the dispute we will analyse in this paper. Drawing on the history of the two professions involved, as well as fieldwork observations and interviews conducted in operating theatres, we will show how this dispute arose, how it is manifested at both the micro and the macro level, and how both groups involved justify their positions, drawing on surprisingly similar rhetorical strategies. We will consider the implications that this dispute has for patient care, and set it in the wider context of managerial efforts to change working practice within the operating theatre. A further unusual feature of this dispute is the fact that, unlike many attempts by managers to substitute one type of labour for another, issues of cost are relatively unimportant, as both theatre nurses and ODPs earn similar salaries.

**Sunday am**

**09.00 - 09.20**

**Tjora, A.H.**

**Norwegian University of Science and  
Technology**

**THE NEGOTIATED ORDER OF MEDICAL EMERGENCIES**

Effective communication is accepted as a prerequisite for successful handling of medical emergencies. Various organisational solutions have been implemented to get information and patients as fast as possible between relevant services. In Norway, a decentralised system of 43 so-called acute-medical communication (AMK) centres, which is manned by nurses and ambulance personnel, covers medical emergencies across the country.

By the use of qualitative/quantitative questionnaires to all 43 AMK centres and ethnographic observation and video recording of work in a limited number of centres, this study questions how information and communication technologies (ICT) are applied to support coordination of medical emergency actions.

The study shows that the large amount of disintegrated technologies in the Norwegian AMK centres leaves coordinating activities to human actors rather than a possible integrated technical system. The technologies in the centres are operated as a flexible set of tools, leaving space for improvisation, negotiation and locally developed strategies on how to handle patients, other callers, and other health professionals.

An important aspect of the findings in this study is that it may prove sociological perspectives relevant within health informatics by challenging the quest for large-scale integration within systems development. Within health care policy, the study implies that the further development of a decentralised medical emergency system (rather than a centralisation strategy) may increase security in the service.

**Saturday am**

**09.25 - 09.45**

**Tourette, M.A., Moore, R.G., Feder, G.S.**

**Queen Mary University of London**

### **CONSTRUCTING CLINICAL GUIDELINES: AN ETHNOGRAPHIC CASE STUDY**

The role of scientific evidence and technology in rationalising medical work is well established. Clinical guidelines are one example of this. Guideline development has evolved, with an increasing concern for transparent methods and explicit links between research evidence and recommendations. The focus is on the use of systematic reviews and meta-analysis in identifying and appraising research. To date, there is substantial literature explaining how clinical guidelines should be developed.

However, this field of inquiry has narrowly focused on technical attributes of guideline methodology, with relatively little analysis of the social context of guideline development work. Studies of laboratory work have provided evidence that scientific knowledge is shaped by complex and continuous negotiations between scientists, and their interactions with the methods and tools that enable them to produce 'scientific facts'. In guideline development, the production of scientific knowledge is substituted with a process aimed at informing clinical practice, and is shaped by negotiations between guideline developers who use meetings, discussions and documents to produce recommendations. In this paper I will examine how insights into the social production of scientific knowledge can help address important questions in the field of policy development. To what extent can the process of developing guidelines, and translating research evidence into recommendations, be interpreted as one mediated by social processes?

**Saturday pm**

**14.00 - 14.40**

**Tritter, J., Evans, S., Sanidas, M., Daykin, N.**

**University of Warwick**

### **WHO OWNS THE PATIENTS' VIEWS? VARIATION IN PROFESSIONAL RESPONSES TO USER INVOLVEMENT**

Based on a three-year study of user involvement in cancer services, we present findings on the response to involving patients in evaluating and developing services by different types of health professional. The Health and Social Care Act (2001) requires that all NHS organizations involve users in the development, planning and provision of services. There is clear evidence, however, that user involvement is neither systematic nor consistent.

Drawing on case studies of five different Multi-Disciplinary Cancer Teams in each of three NHS Trusts and data from Nominal Groups with different categories of health care professionals across one Cancer Network, we explore the understanding of and response to user involvement. Variations in doctors' responses to user involvement appear, in part, to be related to their speciality while nurses and some allied health professionals were, overall, more resistant.

Our findings relate to issues of power, control and forms of knowledge at the heart of the relationship between patients, carers and the health professionals who treat them. Drawing on theories of consumerism, professionalization, proletarianization, and concepts of altruism and entrepreneurialism, we also consider ways in which discussions of user involvement highlight the contested nature of health professional's roles as patients' proxies and how their responses help promote a certain vision of their profession. A clearer understanding of the differentiation in responses to user involvement and variations in the perceived threat of users' 'speaking for themselves' has implications for patient empowerment, the training of health professionals and the nature and working of multi-disciplinary groups.

**Sunday am**

**10.10 - 10.30**

**Tsouroufli, M.**

**University of Warwick**

### **ABORTION IN GREECE: PARADOX OR CULTURAL REFLEX?**

Abortion on demand has been a common, relatively safe medical procedure in Greece, well before its legalisation in 1986. Abortion is documented, by previous research, to be used as a contraceptive method in Greece and also responsible for a decline in the Greek birth rate since the Second World War. Abortion has been constructed mainly by male public discourses as a threat to the preservation of the Greek nation and of its 'distinct' Greek-Orthodox identity.

Women have clearly been rendered responsible for the situation. Strangely enough the role of the medical profession in subtly promoting abortion and in establishing it as profitable business, has been overlooked. Women's voices have also been neglected and only few female researchers have explored the interplay of perceptions of health, motherhood, womanhood, family and religion in abortion-decision-making.

Social change and technological development have transformed women's reproductive choices in many countries. This does not seem to be a concern for the Greek State, nor are women's views. Abortion should be approached holistically as a complex phenomenon in a rich culture characterised by a public-private dichotomy in most affairs. Future research should look at how women negotiate their identity and power in the new era and how cultural and medical discourses influence this process. This will increase understanding of women's reproductive choices and will hopefully improve policy-making.

**Friday pm**

**16.20 - 16.40**

**Turner, S.**

**University of Nottingham**

### **WHAT WOMEN REALLY WANT: DESIGNER BABIES AND WOMEN'S CHOICES**

As genetic understanding increases and human genetic technologies advance, the possibility of the genetic modification of human beings approaches reality. While this reality may well be some years into the future, since the cloning of Dolly the sheep in 1997, and the completion of the Human Genome Project in 2000, speculation has grown exponentially with regard to the application of genetic technologies to human beings. The increased use, and high levels of publicity, surrounding the use of pre-implantation genetic diagnosis has led to increased concern about the possibility of 'designing babies'.

The question, however, remains: if the technology was available, would women want to change the genetic characteristics of their children?

As part of my doctoral studies, I am conducting a study to evaluate the attitudes and potential response of pregnant women to germ-line gene therapy. By drawing on questionnaires and qualitative interviews with a sample of women in the early stages of pregnancy, this paper aims to answer the question of what conditions and characteristics women would want to change. The initial data suggest that women would want to change the genetic characteristics of their children, at least in some respects. Based on these preliminary findings this paper will also attempt to offer explanations for these choices.

**Saturday pm**

**16.20 - 17.00**

**Tutton, R., Kerr, A., Cunningham-Burley, S.**

**University of York**

### **EXPLORING FORMATIONS OF 'GENETIC SUBJECTHOOD'**

This paper explores contemporary 'genetic subject hood' in terms of how people relate to themselves and to others as citizens or consumers in the context of genetics research. Through the notion of 'genetic subject hood' we are seeking to address both questions of personhood in relation to risk, heredity, identity, family and social position, and forms of governance that emerge from the complex relations between biomedicine, government, markets and individual subjects. Focusing on the ownership, control and use of genetic information in light of developments in diagnostics and databases, such as the Bio bank UK initiative, we are interested in delineating how people either construct themselves or are constructed by others as consumers or citizens in different contexts such as genetic testing or tissue donation. In this paper we discuss research that has contributed to an understanding of 'genetic subject hood' from the perspectives of citizenship and consumption, including work undertaken in sociology, public understanding of science, public health, disability studies and anthropology. We pay particular critical attention to claims that there has been a transformation in notions of self-related to theories of 'late' or 'high' modernity. We conclude by outlining our own empirical investigation into 'genetic subject hood' that will assess the analytic value of this notion in terms of when, where and how genetics becomes meaningful in people's personal, professional and political lives.

**Saturday am**

**10.10 - 10.30**

**Underland, G.**

**Norwegian University of Science &  
Technology**

### **INFORMAL MEETINGS, FORMAL DECISIONS: THE INFORMAL CULTURE IN MEDIATING MEDICAL KNOWLEDGE AND INFORMATION AT A HOSPITAL**

The developing and mediation of medical knowledge and information at hospitals are mostly concerned with the patients; about their diseases, treatment, medication and caring. The patients trust that vital decisions are made from the health professions best ability. There are both formal and informal meetings during the day where signs and symptoms, results of examinations and surgery are closely discussed.

The research on which this paper is based is from an ethnographic study at a surgical ward at a Norwegian hospital. The study is a combination of observation, documented by photographs and video recording, and interviews. This paper reports findings from the "pre-round" meetings and the ad hoc discussions at the ward, which seems to be most relevant arenas for clinical decision-making.

This study indicates that medical work and knowledge is more often than not discussed and mediated in informal settings. The contents of these discussions and the decisions made are complex and formal. Also formal meetings are accomplished in an informal way. The written documentation, like the patient record, is often not used when the physicians' refer the patients' disease history. Clinical decision-making is based on negotiations and discussions with colleagues-not only in formal meetings, but also ad hoc, in any time and place. This implicates a broader discussion on the mediation of medical knowledge. A sociological analysis of phenomena, as the lack of written documentation and the reliance of trust in complex decisions, may lead to development of effective documenting procedures in hospitals.

**Saturday pm**

**15.10 - 15.50**

**van Teijlingen, E., Lammie, S., Sinclair, H.,  
Smith, B., French, F., Taylor, R.**

**University of Aberdeen**

**A QUALITATIVE STUDY OF GP'S EXPERIENCE OF TEACHING A COMMUNITY  
COURSE (INCLUDING SOCIOLOGY) TO MEDICAL UNDERGRADUATES**

**Background**

The General Medical Council recommended changes in the medical curricula of UK universities in 1993. Consequently, the University of Aberdeen designed a new course to introduce 'health and normality' through group work, community-based teaching, and early patient contact. This Community Course includes elements of social and behavioural sciences. A large share of this teaching is provided by community-based general practitioners (GPs). The authors designed this qualitative study to ascertain the views of GPs on their experience of tutoring on, their attitudes towards and perceptions of the new course.

**Methods**

Small-scale questionnaire study followed by semi-structured interviews.

**Results**

General practitioners generally enjoyed tutoring and appreciated the students' opportunity for early patient contact and the emphasis on group work. However, constraints on teaching accommodation in the community and general practitioners' time need to be borne in mind when designing a community-based curriculum.

**Conclusion**

This study raises a number of issues, which anyone involved in designing a community-based curriculum should consider in order to maintain overall quality and tutors' motivation and enthusiasm. There are also issues related to competency and expertise when teachers from a wide range of academic disciplines are involved in teaching topics in which they are not experts.

**Sunday am**

**09.00 - 09.20**

**Walters, V., Charles, N.**

**University of Wales Swansea**

**GENDERED ACCOUNTS OF HEALTH AND ILLNESS: WOMEN AND MEN IN  
MID-LIFE**

In this paper we report on interviews with 26 women and 25 men in their 40s, 50s and 60s. The semi-structured interviews were conducted in south Wales between summer 1999 and spring 2000. Drawing on the accounts of respondents we examine gender differences in the health problems they report and the ways in which they understand their health. We explore the effects of health problems on their lives and how these influence their sense of uncertainty about their future. We conclude with a discussion of gender differences in the ways women and men talk about their health, including the absence of a language of health among men.

**Sunday am**

**10.35 - 10.55**

**Waring, J.J.**

**University of Nottingham**

**MEDICAL ERRORS, RISK MANAGEMENT AND THE PRINCIPLE OF "FIRST, DO NO HARM"**

In the British National Health Service it is reported that ten percent of admissions experience an "adverse event" to the cost of £2 billion of extra care and litigation. Moreover, high profile cases such as the Bristol Inquiry have shown many of the social processes that underlie this problem, including ineffective organisational systems, ineffective regulatory systems and the "club culture" of medicine. The policy response to this problem has been to promote the human factor approach to mistakes; drawing attention to the individual actions but also the unsafe systems that enable, promote and exacerbate mistakes. Within this framework a National System for Learning from Adverse Events and Near Misses has been introduced, which involves the compulsory reporting of adverse events and near misses, their analysis in line with the human factors approach and the develop of service changes. Research into this and similar schemes has revealed a number of seminal yet important social and organisational processes that are of relevance to the desired success of the policy and also the sociology of medical professional regulation. In particular, the social construction of medical errors, the notion of normal and abnormal mistakes, the conflict between professional regulation and management, the divergent domains of risk management, and the impact of the media. These emergent themes resonate with the findings of the Bristol Inquiry, but are also discussed with regards to the principle of "first, do no harm" that symbolically underpins many of the cultural features of medical errors.

**Saturday pm**

**15.10 - 15.50**

**West, E., Barron, D.N.**

**Royal College of Nursing Institute**

**THE EMOTIONAL COSTS OF CARING: HOW MEN AND WOMEN IN CARING JOBS FEEL AT THE END OF THE DAY**

This paper explores whether employees whose jobs are predominantly designed to serve the needs of others, such as nursing, teaching or social work, report higher levels of negative job related feelings at the end of the working day than do workers whose jobs demand physical or intellectual labour. We also ask whether gender plays a role in shaping negative feelings that arise as a consequence of work. The theoretical framework for the paper is derived from the literature on gender, occupations and health. The data are from Wave Nine of the British Household Panel Survey (1999) when respondents were asked whether, at the end of the working day, they tended to worry, have trouble unwinding, feel exhausted or "used up". Responses to these four questions were used to develop categorical dependent variables, which we analyse using ordinal regression. Control variables in the models include: number of children, age, hours worked per week, managerial responsibilities and job satisfaction, all of which have been shown in previous research to be significantly related to "burnout". Our findings support the hypothesis that women pay a high emotional cost for working in caring occupations. Men do not emerge unscathed but report significantly lower levels of worry and exhaustion at the end of the day than do women. The findings are relevant to developing a sociology of caring behaviour and should be of interest to policy makers, particularly in the area of health and education, where workforce issues are a major concern.

**Saturday am**

**11.00 - 11.20**

**Wilkinson, K.**

**University of Nottingham**

### **HEALTH RISKS, BODY RISKS AND FOOD COVERAGE IN WOMEN'S GENERAL INTEREST MAGAZINES**

My current research area is the media's portrayal of health, food and nutrition in women's magazines. These themes will be examined with regard to any editorial and commercial influence over time and across this media sector. The research is likely to involve both a textual analysis and interviews with magazine editors. This will enable an empirical investigation of the making of editorial policy in relation to magazine content. I am currently working on the initial stages of this research project which involve a review of secondary sources and an examination of the development of women's magazines and editorial styles. This stage will help to determine selection of documents for analysis and the identification of suitable candidates for interview. The actual data collection stage will involve the examination of archived material at the British Newspaper Library at Collingdale. This stage will provide supporting data on any significant variations in content, editorial selection and practice over a selected time period. Interviews will then take place with editorial staff, the topic areas covered will reflect issues of selection and presentation within editorial policy and hopefully illuminate any 'relationship' between editorial decision and the perceived popular readership. The overall aim of this project is to enable empirical comment on associations between changing social health priorities and contemporary commercial cultures.

**Saturday am**

**10.10 - 10.30**

**Williams, J., Petchey, R.**

**School of Nursing, Nottingham University**

### **GENERAL PRACTICE AND THE CONCEPT OF DEPROFESSIONALIZATION**

Government policy over the last 15 years has placed primary care at the forefront of the National Health Service, and subjected it to rapid and radical re-organisation. Specifically, the 1997 Primary Care Act allowed for employment of salaried general practitioners (GPs) within Personal Medical Services (PMS) Pilots. Traditionally general practitioners have been self-employed, independent contractors.

Salaried employment combined with increasing demands from the public (active consumerism) and the expansion of nurse roles (skill mix), has been perceived as threatening to the professional status of general practitioners. Deprofessionalization is related to the loss of autonomy, status and control a profession has over its knowledge base and working conditions.

This paper is based on 50 in depth interviews with salaried doctors, and a wider sample of 162 key stakeholder colleagues, within 12 PMS pilots, as part of a three-year national evaluation. The concept of deprofessionalization is applied to the understanding of emergent themes.

Findings demonstrate that most doctors were satisfied with the flexibility salaried posts had to offer. Positive factors included: i) the ability to concentrate on practising medicine; ii) effective team-working and iii) the lack of administrative responsibility. However, a number of doctors felt professionally under-valued, isolated and inappropriately managed by non-clinicians. Hostility towards salaried doctors from GP colleagues was widespread initially, but abated over time.

Policy and cultural change within primary care may result in the deprofessionalization of general practice as a medical specialism, whilst at the same time many general practitioners prefer a less vocational work-life.

**Saturday pm**

**16.20 - 17.00**

**Williams, S.J.**

**University of Warwick**

**MEDICINE, WARFARE AND THE (NEW) BIOLOGY OF TERROR(ISM): RAISING THE ISSUES FOR MEDICAL SOCIOLOGY**

This paper explores two inter-related sets of issues, themselves underplayed in medical sociology to date, concerning: (i) relations between medicine and the military, health and warfare in general, and; (ii) the health aspects of chemical and biological weapons/the (post-September 11th) public health threat of bio-terrorism in particular. These topics, it is argued, raise important health-related issues for medical sociology, from militarisation to medicalisation, and from epidemics of fear if not (intentional) disease, to the spectre of genetically spliced super bugs in the back to the future scenarios of the new millennium. Medical sociology, it is concluded, has much to contribute to these debates, and the broader agendas of surveillance and diplomacy, defence and disaster management, within which they are located in the 'global age'.

**Saturday am**

**09.45 - 10.05**

**Wirrmann, E.**

**Oxford Brookes University**

**WHAT FACTORS AFFECT THE PUBLIC HEALTH ROLES OF PROFESSIONALS WORKING WITHIN A PRIMARY CARE PRACTICE?**

The 'public health function' within an increasingly Primary care-Led NHS has received much attention in recent years. This sits within the increasingly global recognition that primary care practitioners are key agents in the drive to strengthen the public health function. Despite this heightened interest and clearer policy, there remains much variation in the type and quality of public health activity engaged in at primary care practice level.

It has been recognised that much activity at this level does not sit within the formal professional roles of practitioners, or indeed within the normal rules of the organisation. There remains little understanding of why public health activity is confined to 'pockets' of good practice and innovation. In order to strengthen the public health function within primary care, there must be a greater comprehension and appreciation of why some practitioners engage in the broader public health agenda, and why some do not.

This paper discusses some of the factors that might influence the type and quality of the public health activities carried out by primary care practitioners, suggesting that they are many and complex. It proposes a framework within which such 'influencing factors' might be further explored and better understood. Role theory is used as a conceptual bridge between the practitioner and the social and organisational structure within which s/he works. The paper concludes that all these layers of 'influencing factors' must be taken into consideration if the public health activity of primary care practitioners is to be progressed and better supported.

**Friday pm**

**14.50 - 15.10**

**Wong, L., Richman, J.**

**Wai Yin Chinese Women Society,  
Manchester**

### **CHINESE MADNESS (DIAN KUANG) IN A U.K. METROPOLITAN CITY**

Although globalisation is a multiplex concept - one of increasing elasticity - it permeates most aspects of social life. Not least, concerns of medical anthropology and transcultural psychiatry, asking the question of whether there is a 'culture bound syndrome'. The bio-scientific medical model, rooted in the rationality of the enlightenment, has wide transference and currency dominating traditional medicine. The thrust of the paper concerns Hong Kong Chinese in a northern UK city and their knowledge of Dian Kuang (as part of a wider study).

Traditional Chinese medicine, with its essential paradigm relatively undisturbed for 5,000 years, makes no body mind distinction of Cartesian hue, yet recognises, a category of 'madness'. The first western mental health conditions, neurasthenia (1869) 'reached' China last century. During the Maoist period mental illness (incorrect thoughts) was considered a capitalist product.

This study is based on case studies of 16 Chinese families. Methodological difficulties of researching the U.K. Chinese is also highlighted. All respondents had an understanding of Dian Kuang (even those born in the U.K.). Mental illness is regarded as a 'lower' form of Dian Kuang. However, those with Dian Kuang are regarded as extremely dangerous to others.

The logical explanatory 'fame' of Dian Kuang is a case example of how a traditional, 'externalising health belief' can still survive the powerful thrust of modernism. Dian Kuang has implications for psychiatry.

Chinese medicine has no medical hegemony hand is understandable via the health/cooking. The paper explores respondents' practical reasoning of Dian Kuang; its aetiology and prognosis.

**Saturday am**

**09.00 - 09.20**

**Wood, F.**

**Cardiff School of Social Sciences**

### **BORNA DISEASE VIRUS: THE SOCIAL ACCOMPLISHMENT OF A SCIENTIFIC PROJECT**

#### **Background and Aims**

Borna disease virus is thought to cause neurological disease in a range of animals and in recent years there has been speculation of its contribution to human psychiatric illness. World-wide research into the virus has been beset by a number of methodological and scientific problems which continue to be debated by virologists, epidemiologists and psychiatrists. Applying theories and techniques developed within both Medical Sociology and the Sociology of Scientific Knowledge, the paper examines how Borna disease virus has become a topic worthy of scientific investigation and funding and how that scientific research is operationally accomplished in a multi-disciplinary scientific team.

#### **Methods**

Drawing on an ethnographic approach, the paper is based on a detailed qualitative case study of a group of UK scientists and policy makers who are researching the significance of Borna disease virus in human populations in the UK, most notably in farming populations. Research methods include in-depth interviews and observations of scientific team meetings.

#### **Discussion**

By analysing the importance of professional role, expertise, practicality, rhetorical devices and decision making the paper shows how scientific knowledge and opinion are constructed through discourse. Whilst displaying many characteristics of clinical multi-disciplinary teams, it is suggested that one feature of scientific multi-disciplinary teams is a lack of occupational rivalry. The paper concludes that scientific knowledge can be considered to be socially constructed as it is dependent on the organised consensus of a scientific community.

**Sunday am**

**09.50 - 10.30**

**Young, E.**

**Ipswich Hospital NHS Trust**

**FRIENDS FOR DEATH: CAPTURING WOMEN'S TALK ABOUT FRIENDSHIP IN THE FACE OF IMMINENT DEATH DURING TELECONFERENCED FOCUS GROUPS**

Does an understanding of the symmetry of friendship dyad processes contribute to an understanding of dying for individuals, and vice versa, does the imminence of death reveal fundamental formal characteristics of friendship dyads? The paper will consider this question by drawing on the formal sociology of Simmel's appreciation of the dyad and Glaser and Strauss' awareness contexts.

Data from two series of teleconferenced focus groups: one series of four groups of friends of women who were dying, and another series of six focus groups with women in general will be presented. Visual data displays of the whole focus group interaction and coding schemes for the forms of interaction will be used to highlight the patterns of interaction across a whole focus group.

The particular interactional forms of 'confession' and 'absolution' revealed an underlying estrangement of the survivors from the dying friends and their behavioural strategies to manage and/or conceal their estrangement. It will be argued that open, aware dying of one within a dyad has implications for the surviving other. The data are uncomfortable and sensitive, not only because of the absolute nature of dying for the dyad, but also because estrangement from a dying friend is in contention with the normative ideology of friendship continuity. This normative view of friendship continuity was captured in the interactions of women who did not have a friend who was dying.

**Friday pm**

**15.35 - 16.15**

**Ziebland, S., Chapple, A., Rozmovits, L.,  
Prinjha, S., Evans, J.**

**University of Oxford**

**THE ROLE OF INTERNET HEALTH INFORMATION FOR MEN AND WOMEN WITH  
CANCER**

Health Information on the Internet can be used for many purposes: facts and figures can be gathered, answers sought to questions that are difficult or embarrassing to raise in person, comparisons can be made with other people's experiences, and information about innovative treatments can be sought. Sociologists have discussed how increasing access to health information may contribute to the de-professionalisation of medicine, while medical journals have focussed on concerns about the quality of health information on the web. To date there has been little research on how information gained from the Internet is used by those who have been diagnosed with a serious illness. In this paper we explore how people who have been diagnosed with cancer describe using information from different sources.

Since September 2000 over 150 in-depth interviews with people treated for cancer of the prostate, breast, bowel, cervix or testes have been collected for the DIPEX ([www.dipex.org](http://www.dipex.org)) database of illness narratives. Participants are invited to talk about everything that has happened since they first suspected a health problem and the interviews are all recorded and transcribed for analysis.

In this paper we use narrative analysis to explore the ways that respondents with access to the Internet sought and used information about their cancer at four different stages - investigations, treatment decisions, initial follow up and aftermath. We discuss how information gained from the Internet is combined with other forms of information and advice and explore the effect that this access has on relationships with health professionals.