Understanding
Health

A SOCIOLOGICAL INTRODUCTION

ANNE-MARIE BARRY & CHRIS YUILL

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CONTENTS

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INTRODUCTION

Aims

The aim of this book is to provide an introduction to the sociology of health to both health science and social science students. Throughout this text we argue that sociology provides not only essential information about the context of health and illness but, crucially, that sociology can equip us with the relevant tools to enquire into and explore the world around us. An enduring characteristic of the discipline of sociology is its radical, critical edge, that allows us to question what is taken for granted. To this end, this book is often concerned with uncovering and questioning the very basis of our understanding of health, medicine and illness. It would be easy, for example, to accept medical knowledge as a 'given' and as a true and objective representation of the body and of our experiences of disease and illness. What this text seeks to do is to deconstruct medical knowledge by examining its origins and by considering the assumptions on which the medical model is based, and to explore alternative models of health.

Organisation

This text does not assume prior knowledge of sociology. For this reason it is essential to begin with an overview of sociology itself. Chapter 1 seeks to provide readers with a basic understanding of three areas. First we consider what is distinctive about sociology as a discipline in terms of what is or is not its subject matter. Second, we examine the methods of enquiry and evidence that underpin the discipline. Particular attention is paid to the 'sociological imagination' (the requirement to think outside our own experiences and to evidence any statements made). Finally, we provide an overview of different theoretical approaches within the discipline.

Chapters 2–4 are principally concerned with medical knowledge and medical practice, rather than with health and illness *per se*. It is essential, we believe, for students of the sociology of health to have a detailed knowledge of the body of knowledge that has dominated our thinking about health and disease for hundreds of years. Chapters 2 and 3 seek a sociological understanding of the history, development and practice of biomedicine in the western world. Here you will find a critical evaluation of the strengths and weaknesses of the medical model, using both historical and contemporary examples. Chapter 4 explores alternatives to the practice of biomedicine and to its knowledge base through a discussion of critiques offered by feminist sociologists and practitioners of alternative medicine.

Chapters 5 and 6 seek to explore the social context of health and disease in terms of the influence of our social and physical environments on our health. Chapter 5 is concerned with an often neglected aspect of health, namely mental health. It is surprising that mental health has a relatively neglected status within existing texts on the sociology of health, given that depression is the main reason given for people attending their GP. Both chapters examine how socio-economic factors, gender and race impact upon health, and how sociology can explain inequalities in health.

Chapters 7–9 are also concerned with the social context of health and disease but this time in terms of the thoughts, ideas and beliefs that influence our health and the delivery of healthcare. In Chapter 7, the human body itself is the focus in terms of examining what the body is and how changing beliefs have influenced ideas about what the body 'should' be. Our expectations about the 'perfect' and the healthy body are then considered in relation to the 'failed' body, that is, the body that is chronically ill. Chapter 8 explores the health of older people in the context of what we 'expect' to be the experience of ageing. Here we consider whether poor health is an inevitable part of the ageing process or whether there are assumptions made about old age that lead us to expect this part of our lives to be characterised by physical and mental decline. The final chapter considers the social context in which healthcare takes, looking at issues relating to institutions, the community and provision of care.

Using this book

This book provides readers with the opportunity to make links between related topics, making it possible to read the book as whole or in selected parts. At the beginning of each chapter, a text box will guide you through the content of that chapter. Each section of the book is 'signposted' to point out related discussions elsewhere in the text. Key concepts and terms are clearly defined at relevant parts of the text. You will also find that selected chapters have attached 'case studies' which will allow you to revise what you have learnt from the chapter by applying the relevant theories and concepts.

THE SOCIOLOGY OF HEALTH AND ILLNESS

Explaining and Theorising

1.1 **Sociology: a method of enquiry and explanation.** An introduction to the discipline of sociology. The relationship between society and individuals. The historical origins of sociology. Sociological methods of enquiry. Can sociology be 'scientific'? The 'sociological imagination'.

1.2 **An introduction to sociological theory**. Sociological theory and common sense theory. Functionalism. Symbolic interactionism. Marxism. Feminism. Post-modernism

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Key concepts

The sociological imagination, structure, agency, theory, discourse functionalism, symbolic interactionism, Marxism, feminism, discourse and post-modernism.

The aim of this chapter is to introduce the discipline of sociology and to focus, in particular, on the significance of the sociological study of health, illness and medicine for health-related professions. In order to do so it is necessary to begin by establishing the scope and remit of sociology as a subject area *and* as an explanatory method.

Sociology is concerned with the study of society and specifically with key issues such as explaining change and the distribution of power between different social groups. The discipline of sociology also offers its students specific methods of investigation and explanation. For example, this chapter introduces you to the concept of the 'sociological imagination', asking you to adopt a critical and questioning approach to even the most mundane aspects of social life. Sociological knowledge is based on 'a scientific' approach built upon evidence to support theoretical perspectives. This chapter offers an introduction to a range of sociological perspectives.

1.1 Sociology: a method of enquiry and explanation

The raw material of sociology is human society, the development of groups, and the ways in which social groups are organised and change over time. Sociology is, therefore, the study of society. Such a statement, however, tells us very little about sociology and does nothing to draw out what is distinctive about the discipline in relation, for example, to psychology or simply to our own observations of society and social groups. Sociology is concerned with the study of human society (Giddens 1994: 7) in terms of the interaction between individuals and groups and the interaction between groups. It is not individuals, *per se*, who draw our attention, but how they interact with the social environment. Giddens uses the term society to refer to 'a cluster, or system of institutionalised modes of conduct' (Giddens 1997: 7). Sociologists refer to society as a 'system' and our own behaviour as 'institutionalised' to draw attention to what is external to the individual, that is 'society' itself. 'Society' refers to the structural or external factors that influence our beliefs and behaviour and that establish some predictability and regularity to our lives.

What troubles many new students of sociology is the suggestion that something referred to as 'society' shapes or determines our behaviour. Such an explanation seems to take away what is individual about us and suggests that our behaviour and our beliefs are not unique but may be determined by an external force and replicated by many other individuals. On reflection, however, this process of shaping and influencing is evident in all that we do. Socialisation into the norms and values of a particular society enables us to predict and make sense of the behaviour of others and ourselves. 'Society' provides us with the cultural resources to live in the social world because patterns of behaviour, responses and ways of behaving are not invented anew each day but exist outside any one individual. In most human encounters within a specific society, there are roles to be played out, responses that can be predicted and cues that are acted upon.

> Sociology is the study of the interaction between groups and individuals in human society

> The term 'society' refers to a range of external factors that influence our beliefs and behaviours.

> Socialisation refers to the process whereby we become aware of the values and beliefs of society.
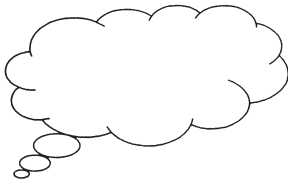
> *Pause for a moment and consider how many of our own actions and responses are automatic in the sense that you 'know' how to act in that given situation.*

Rosenhan's study, 'On being sane in insane places' (1973), is an excellent illustration of the potential for our identities to be imposed on us by others. Rosenhan's experiment involved eight researchers posing as 'insane' who presented themselves to mental health professionals, claiming to hear voices. Apart from the supposed symptoms, the researchers told the truth about their circumstances and background. All eight researchers were admitted to hospital. Except for the initial alleged symptoms, the researchers acted normally and upon admittance stated that they no longer had any symptoms. According to Rosenhan, it is therefore problematic to say that we 'know' what insanity is. The medical professionals in this case

responded to certain cues (alleged symptoms) and interpreted the researchers' behaviour and histories in the light of their assumed insanity. This experiment is important in so far as it illustrates the way in which others can impose identities upon us. The behaviour of the researchers was interpreted in the light of a set of shared symbols and meanings. In this case, the shared symbols and meanings referred to the diagnostic categories developed and used by the medical profession. The diagnosis of insanity only had meaning in the light of the diagnostic categories. This particular experience begs the question of whether patients actually present 'real' symptoms or whether the symptoms are in the minds of the people carrying out the diagnosis.

A further example of the way and extent to which the group influences individual behaviour can be illustrated with reference to the work of Festinger et al. (1956). In this case, the group was a cult who were prophesying the end of the world by a very specific date and time. When the prophecy was proven false, the beliefs of the group members were *not* fundamentally altered. A message from God, relayed by the group leader, indicated that the end of the world was not to happen at this point after all, since the group manifested such goodness that the world would be saved from destruction. Festinger then asks why beliefs persist even in the light of contradictory evidence. The explanation lies within the group itself and its ability to reinforce the original belief. The power to do so is greater when the group consists of a close network without any dissenters. Festinger notes that, in this case, people who had been part of the group but who had not gathered in one place prior to the alleged catastrophe did not show the same adherence to the original prophecy.

The relationship between society and individuals

Thus far this discussion has been concerned to demonstrate what sociology 'is' by examining the subject matter or what has been referred to as the 'raw material' of study, namely society. However, the discussion has developed further in terms of suggesting a specific and distinct relationship between individuals and the society or 'structure' in which they live. A helpful example of the way in which structure (society) influences the actions and experiences of individuals is provided by Giddens. He uses the analogy of language to illustrate the relationship that individuals have with the wider social structure. None of us has invented the language that we use but without it social activity would be impossible because it is our shared meanings that sustain 'society'. However, as Giddens (1994) also points out, each of us is capable of using that language in a creative, distinct and individual way, and yet no one person creates language. In the same way human behaviour is not determined in a mechanical way by the structure we call society. Later chapters discuss the significance of social class in determining levels of morbidity and mortality and yet not every person in each social class category will have identical experiences. There will, however, be enough similarities in patterns of health within each

Chapter 6 provides an example of the complex relationship between structural factors and personal choice in relation to health inequalities.

social class for us to justifiably place people in these specific groupings. Similarities in people's experiences can be seen in terms of income levels, of availability of local resources such as GPs, of geographical location, and of their physical environment and patterns of expenditure. The relationship and interplay between society and the individual is explained in terms of *structure* and *agency*. The latter is a concept used to refer to a cluster of ideas about the potential for individuals to determine their lives, to change their environment and, ultimately, to influence the wider structure. The concept of agency, therefore, allows us to appreciate the way in which we are shaped by society, and in turn shape society.
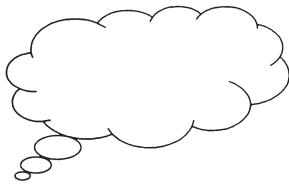
Gender is a good example of how structures shape our lives and how we make individual choices about how we live. In your experience as a man or woman, what experiences do you share in common with your gender? In what do you consider yourself 'unique' and different from all other women or men?

The term 'structure' is similar to that of 'society' in so far as it draws our attention to those factors that help determine our experiences through the establishment of expected ways of behaving. In contrast, the concept of 'agency' reminds us that individuals do not simply act out pre-determined roles but 'interpret' those roles in a way unique to them.

If the subject matter of sociology is human society, and behaviour is explained primarily in terms of 'structure', then this logically denotes specific factors in the explanatory framework of the discipline. Sociological explanations of what determines our state of health will necessarily differ from, for example, biological explanations. Clearly disease is a biological and physical entity experienced through the medium of the body. The causes of disease, while biological, can also be considered in terms of social and structural factors. The immediate cause of a disease may be infection but the factors that lead to this may be many and varied. If we reflect upon patterns of morbidity and mortality over the last two centuries, then it is possible to observe a significant shift away from infectious diseases to chronic conditions. Commentators such as Doyal (1979) argue that improved standards of living, better hygiene and the availability of medicine via the NHS have caused this change. In other words, when we consider the factors that influence a person's state of health, the risk of infection, an ability to fight infection and genetic predisposition are greatly important but, within sociology, these are not our main focus. Social and environmental factors such as age, social class and gender are as, if not more, important.

A sociological understanding of health considers structural and social factors, rather than simply biological explanations of health and disease.

It is possible to define what we mean by 'sociology' by sketching out the discipline's remit in terms of the study of human society. From this it is logical to conclude that the study of sociology is relevant to understanding and explaining health in so far as health and its determinants need to be explained within a social context. Within nurse education, for example, the emphasis placed on 'holistic' care can also be used to justify the study of sociology in that it provides information that places an individual within a social context. To conclude that this is all that the discipline of sociology can offer in terms of studying health, illness and medicine is mistaken and unnecessarily limiting. What sociology offers is a questioning and critical way of thinking and a distinct method of explanation. To fully appreciate

this element of sociology it is helpful to understand, how, why and when the discipline came into being.

The historical origins of sociology

In historical terms, 'modern' is a term used to refer to the time period from the late nineteenth century to the mid-twentieth century.

The discipline of sociology is fundamentally a 'modern' one, bound up with attempts to explain, anticipate and alter a rapidly changing world. According to Giddens (1997: 5), the focus of sociology at its inception was the structures and relationships that derived from industrialisation (Giddens 1997: 7). An examination of the works of the founding fathers of sociology (Comte, Durkheim, Weber and Marx) suggests a preoccupation with attempts to understand a rapidly changing world and to do so in a way that was 'scientific', objective and rational. Auguste Comte, for example, believed that the development of any society was ultimately positive and progressive, and identified three different phases: the religious, the metaphysical and the scientific. Each of these phases represented a mode of thought and explanation: the religious period represented a supernatural interpretation of the world, the metaphysical one replaced religion with a belief in forces such as nature, and the final, scientific stage, represented the most positive and rational phase of human development (Craib 1997: 23). Understanding this new and complex society meant adherence to rational, scientific and empirical methods. The underlying motivation of the discipline was to reveal the reality of social relationships. For Karl Marx, this was in terms of making plain the 'real' relationships of power and exploitation behind social class. For Emile Durkheim, getting to the heart of the reality meant the observation and recording of 'facts' to provide a picture of the world as it is, rather than to anticipate how the world should be.

Can sociology be 'scientific'?

Sociology strives to be 'scientific' in the sense that it seeks to evidence its findings and to ensure that explanations are consistent. However, a fundamental difference between the social and natural sciences is that the subject matter of the social sciences, unlike that of the natural sciences, is human beings and their behaviour.

In as far as sociological explanations attempt to be rational and empirical they share certain features with scientific disciplines. According to Bruce (1999) scientific explanations are consistent (that is to say they cannot contradict themselves), they must accord with the evidence, and when evidence is found to refute the explanation, the explanation itself must be changed (Bruce 1999: 3). A fundamental issue for sociologists is whether sociology is a science in the same sense as the physical sciences. Bruce suggests that one crucial difference is in the methods employed to uncover evidence. Natural sciences are able to make full use of the experimental method because of the relative simplicity of their subject matter. As Bruce points out, we can explain why, how and when water boils but because the water 'has not *decided* to boil we do not need to refer to the consciousness of the water' (Bruce 1999: 12). However, any explanation of human society and human behaviour has to take into account the consciousness of the subject, because actions have meanings, which derive from consciousness. For these reasons the experimental method is impractical for sociologists.

This does not mean, however, that evidence need not be sought when sociologists generate and test theories. Despite apparent difficulties in establishing the 'truth', Bruce (1999: 17) argues, it is still possible to arrive at an accurate account of people's lives. He draws an analogy between sociological evidence and evidence in a court of law: in both cases, he suggests, it is possible to establish the truth from what appear to be contradictory accounts.
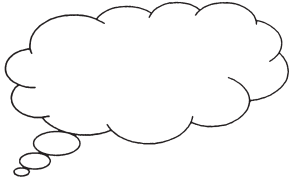
> *Summarise the main differences between sociological methods of enquiry and those associated with the natural sciences.*

The 'sociological imagination'

There is little doubt that sociology is among one of the most controversial of all academic subjects, often giving rise to hostile reactions. Sociology has been associated with a radical and left-wing perspective, and despite the fact that sociologists such as Comte and Durkheim conceived of the subject in terms of describing and analysing what actually exists as opposed to speculating on what ought to exist, sociology has always been strongly associated with critiques of existing societies and speculation about the possibility of change. Zygmunt Bauman recognises that this questioning approach can invoke hostility: 'In an encounter with that familiar world ruled by habits . . . sociology acts as a meddlesome and often irritating stranger . . .' (cited in Kirby et al. 1997: 3).

What critics might see as most questionable about the discipline of sociology, its practitioners see as its main strength. Anthony Giddens, for example, writes that the study of sociology is essentially liberating because 'it teaches appreciation of cultural variety and allows us an insight into the workings of social institutions' (cited in Kirby et al. 1997: 3). To 'do' sociology requires one to think in a specific way; fundamentally, it requires what C. Wright Mills describes as the *sociological imagination*. C. Wright Mills urges us to think outside our own experiences and look at what appears to us as 'mundane' in a new light. Using the sociological imagination means departing from what are referred to as common-sense explanations, implying an explanation of phenomena which are based on limited observations of human behaviour and our own, again limited, experiences of the social world. C. Wright Mills (1970) states that the sociological imagination enables three fundamental questions to be asked: (i) What is the structure of this particular society? (ii) Where does this society stand in human history? (iii) What varieties of men and women now prevail in this society and this period? What is important here is a questioning attitude to what is given, what is seen. Asking and answering all three questions ensures that no assumptions are made about what is being studied and that the context, both cultural

The concept of the 'sociological imagination' refers to a specific way of thinking about the world, characterised by a willingness to think beyond our own experiences and to challenge common-sense or obvious explanations of human society and human behaviour.

and historical, is taken into account when considering any explanation of what is observed.

We seek to argue that without this critical and questioning edge, 'doing' sociology ceases to have any real purpose other than to describe, to provide background detail and a social context. Such an approach does not require one to ask the critical questions posed by C. Wright Mills, and neither, crucially, does it ask us to think about why social situations are as they are. One of the fundamental concerns of sociology is the distribution of power in society and its consequences. When, later in this book, you analyse inequalities in health you will see that social class is one of the main factors influencing levels of morbidity and mortality. What Chapter 6 will describe and analyse for you are not simply differences but inequalities in chances of good health and longevity. Inequality in terms of health is, literally, a matter of life and death. Social classes don't exist in isolation from one another, they form part of a social relationship; social disadvantage has another side and that is advantage. An understanding of theories of power is therefore essential to 'doing' sociology successfully.

Thus far this chapter has drawn out what is unique about the discipline of sociology in terms of its subject matter, the nature of sociological evidence, methods of explanation and the mind-set described as the sociological imagination. The next section seeks to expand upon these themes by presenting an explanation of how sociologists explain social phenomena in terms of different theoretical perspectives.

> The sociological imagination is crucial to 'doing' sociology as it provides a critical and questioning edge, without which the discipline would be limited to simply describing social phenomena.

1.2 An introduction to sociological theory

In this section we seek to explain and illustrate how sociologists explain the social world. To do this we will examine various competing theoretical approaches. To begin, however, it is necessary to think in terms of what is meant by the term '*theory*' as a method of explanation. In common-sense terms a theory refers to a set of ideas or propositions used to explain and predict social phenomena. Our explanations derive ultimately from a particular perspective or worldview. Comte, for example, as we have already seen, divided human history into three phases, each characterised by a particular mode of thought (religious, metaphysical and scientific). Each of these modes of thought permits only certain kinds of explanations. The rational and scientific phase does not tolerate explanations that cannot be evidenced. Similarly, Seale and Pattison, in their study of the history of medicine identify 'paradigms' or worldviews that characterised different stages in the development of medicine. Scientific medical knowledge is just one example of a medical paradigm (Seale and Pattison 1994: 28) and is based on what Seale and Pattison refer to as 'systematic investigation of all aspects of human biology . . . and includes experimental manipulation of body functions and testing of treatments under scientifically controlled conditions'.

> Within the discipline of sociology, 'theory' refers to attempts to provide systematic and consistent explanations of social phenomena.

> The term 'paradigm' refers to a systematic way of thinking.

Sociological theory and common-sense theory

Bruce argues that sociological explanations should share characteristics with scientific explanations in so far as they should be consistent, must accord with the evidence and must change if evidence can be found to refute them (Bruce 1999: 3). In so far as this is true, it seems that sociological explanations differ from more common-sense explanations. It is possible to argue that the latter do not have to be supported by evidence and when evidence *is* produced there is little or no attempt to scrutinise its validity. Common-sense theories tend to be more in the nature of opinion than of fact. So far, then, this discussion has succeeded in establishing that sociological theory is characterised by the need to be consistent and evidenced. What also distinguishes sociological theory from common-sense theories is its ability to provide an 'account of the world which goes beyond what we see and measure' (Marshall 1998: 666). 'Doing' and using sociological theory, therefore, enables us to explain phenomena of which we have no direct experience. Such a definition highlights what is unique and exciting about the discipline of sociology in terms of its ability to inform us of differences and to think beyond our own experiences. In this way, understanding the nature of sociological theory is a reminder of the importance of using the 'sociological imagination' as described by C. Wright Mills.

Sociology is characterised by a range of different theoretical approaches, each providing a very different way of understanding social phenomena. The purpose of what follows is to provide you with an overview and introduction to these differing perspectives.

> 'Doing' and using sociological theory, therefore, enables us to explain phenomena of which we do not have direct experience.
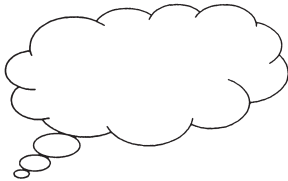
> *What would be the main elements of a 'common-sense' theory about gender differences? How might this kind of explanation differ from a sociological explanation?*

Functionalism

> Functionalism offers an explanation of human society as a collection of inter-related sub-structures, the purpose of which is to sustain the over-arching structure of society. As such, functionalism provides a 'consensual' representation of society, based on, first, an agreement to sustain society as it is and, second, on shared norms and beliefs.

The first approach to be examined is *functionalism*. This theoretical approach is based on an analogy between society and a biological organism. Just as the body is made up of different but inter-related and interdependent parts, so society is made up of a number of different systems and sub-systems. These different parts achieve a unity in so far as they function to sustain the whole, in this example the wider social structure. Therefore, functionalism is less concerned with the individual and his or her aims, beliefs and consciousness, than with how our actions and beliefs function to maintain the system as a whole. An essential element in ensuring that the system is maintained is the cultural sub-system which ensures that individual motivations are in line with the values of the

system as a whole. Without this central value system society would cease to function, because its cohesiveness could not be ensured. Each person has a certain role or function to fulfil, bounded by a certain set of expectations about how they will behave and how others should respond. These social expectations are referred to as role relationships, each of which carries with it a specific set of rights and obligations. The fulfilment of these roles and relationships ensures order and continuity in society.

In relation to the study of health and illness is, for example, the functionalist perspective illuminated by Talcott Parsons' concept of the 'sick role'. First, the concept is used to analyse sickness as a social role, not merely as a biological entity and physical experience. For any society to function smoothly, 'sickness' needs to be managed in such a way that the majority of people maintain their normal social roles and obligations. This perspective is based on the assumption that if too many people were to describe themselves as 'sick' and in need of being excused from their normal range of social obligations, this would be 'dysfunctional' in the sense of being disruptive for society as a whole. Those individuals who are judged by the medical profession as genuinely ill are only temporarily excused from normal obligations and then only if they comply with the rules of the sick role. Those people taking on the sick role do so only if they agree to comply with the regime given by the medical practitioner and if they are committed to getting well as soon as possible.

The functionalist perspective is a consensual approach to understanding society, which also assumes that the latent or hidden functions of everyday activities have significance for maintaining the system as a whole. In relation to something as simple as eating, Lupton (1996) argues that the 'function' of food can be seen in broader terms than just as nutritional intake. A functionalist perspective serves to highlight the way in which 'food practices serve to support co-operative behaviour or structures of kinship in small groups' (Lupton 1996: 8). Lupton has also argued that the meal is a way of illustrating the culture of a specific society in terms of the order in which food is served (savoury then sweet) and the mixing of food types and temperatures.

However, the functionalist perspective has been subject to much criticism. In relation to the sick role, for example, it has been suggested that Parsons overlooked the potential for conflict between the patient and the practitioner and that he misguidedly assumed that the practitioner would always act in the best interests of the patient. However, the main criticism levelled is that it is an unproven assumption that situations have a fixed, obvious and shared meaning.

Symbolic interactionism

In contrast, *symbolic interactionism* is based on the premise that there is a fundamental difference between the subject matter of sociology and that of the natural sciences. While the study of the natural world deals with physical, inanimate objects, the subject matter of sociology consists of people

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When a person takes on the 'sick role', they are excused from their normal roles and responsibilities. The medical profession determines who is legitimately 'sick'. This regulatory role ensures that not too many people are unable to fulfil their normal roles – otherwise illness would have a detrimental effect on the society as a whole.

Symbolic interactionism explains social phenomena from the perspective of its participants. An essential element of this theoretical perspective is the unique nature of the social world as made up of the actions of participants motivated by human consciousness. The meaning of human action cannot, therefore, be observed or assumed, but 'interpreted' by studying the meanings that people attach to their behaviour.

There is a clear link between symbolic interactionism and the concept of the sociological imagination in terms of stressing the necessity of questioning the taken-for-granted.

In the context of this discussion, 'micro' refers to the small-scale aspects of human behaviour, for example why individuals embark on criminal activities. 'Macro' refers to the larger, structural aspects of society. In terms of criminal activities, this might involve an analysis of the economic circumstances of criminals, an analysis of law makinng and law enforcement, as well as of the role of the state in regulating such behaviour.

whose actions are motivated by human consciousness. Symbolic interactionism is, therefore, concerned with how people see and understand the social world. This theoretical approach is concerned less with the larger social system or structure than with interpreting human behaviour. As with the 'sociological imagination', the emphasis here is on looking again at the most common-sense and commonplace aspects of our culture and questioning what we assume to be 'natural' and 'normal'.

The significance of this approach can be seen in relation to understanding health behaviour that appears to be irrational. Graham (1993) examined patterns of cigarette smoking among mothers on low incomes. What is revealed is relatively high levels of spending on cigarettes in low-income households. In terms of what can be observed or assumed, this behaviour might well indicate a degree of irrationality in that it contradicts dominant health messages about the dangers of smoking, and diverts limited financial resources away from the family. Graham, however, favours a theoretical approach dependent upon the symbolic interactionism tradition of interpreting human behaviour in the context of peoples' own beliefs and meanings. This alternative interpretation associates cigarette smoking with the maintenance of normal, caring routines in so far as smoking creates a 'space' between the mothers and their children, providing 'time out' from the demanding routines of caring. 'Viewed within the context of mothers' daily lives, cigarette smoking appears to be a way of coping with the constant and unremitting demands of caring: a way of temporarily escaping without leaving the room' (Graham 1993: 93)

What the interactionist tradition presents us with is insight into two important aspects of social phenomena; first, in terms of the emphasis placed on the disputed nature of meaning we are clearly reminded of what is central to the discipline itself, namely the questioning of the taken-for-granted. Second, the focus is on what are referred to as the 'micro' elements of society, that is, the small-scale interactions between individuals and between individuals and groups. An overview of the research based on this approach is indicative of both the strengths and weaknesses of symbolic interactionism. Becker's (1974) analysis of deviance is an excellent illustration of the symbolic interactionist perspective. The definition of deviance that Becker offers does not assume that what is described as deviant is fixed for all time, or that different cultures have the same definition of what counts as deviant. Becker's analysis focuses instead on the understanding of the meaning of deviance and the way in which that definition may be considered fluid rather than static. Becker defines deviance as any act that is perceived as such. Deviance is a label attached to the behaviour of an individual, rather than a quality of their behaviour. His own research tended to concentrate on certain types of 'deviant' behaviour such as illicit drug use and prostitution, the process that led to an individual taking on a deviant career, the factors that sustained him or her in that deviant career, and the processes whereby deviant behaviour became labelled as such. Becker's research concentrated less on the structural factors that might help explain crime and deviance, such as poverty, with little emphasis on the source of power of those agencies, such as criminal

justice agencies, who label some people deviant. Becker talked of 'moral entrepreneurs' as influential shapers of public morals but there was little or no attempt to place these individuals and groups within the social context of society. In other words, the 'macro' elements of the social structure were given much less emphasis.

Marxism

Marxist theory takes us back to the concern with the structure of society, suggesting that it is the economic structure of any society that determines the social relations contained within that structure. It is the distribution of the ownership of the means of production that gives rise to specific patterns of class relations which, crucially, in all societies are characterised by inequalities of power. Marx described modern societies in the west as capitalist, that is to say divided between those who privately own the means of production (a minority) and those who are dependent on selling their labour power to make a living (the majority). This classic division provides a description of the two main classes, the bourgeoisie and the proletariat. The relationship between the two is unequal, primarily in that the relations of production result in the exploitation of the latter in a way that is systematic and oppressive.

Marxist theory is used to question the 'naturalness' of capitalist relations and to unmask the reality of what is fundamentally an exploitative relationship. This theoretical approach is representative of a structural analysis of society, less concerned with the 'micro' elements and more concerned with the larger picture, the underlying factors that explain social, economic and political relationships. Marxist theory, therefore, represents a distinct sociological perspective, a tool for our analysis of the social structure. It would be a mistake to assume that all that this theoretical perspective can offer us is an appreciation of the significance of economic factors on, for example, health chances. Such an approach would lose sight of what Marxist theory can provide us with in terms of a critique of existing social, economic and political relationships. Vicente Navarro's analysis (Moon and Gillespie 1995: 73) of the causes of ill health and the relationship between the state and the medical profession is based on such insights. What Navarro provides us with is an explanation both of the causes of inequalities of health between different social classes and of why this situation continues and is, as he argues, maintained by the medical profession.

The key to this situation is, Navarro suggests, to be found in the alliance of interests between the ruling classes and the medical profession; each, for different reasons, derives power from the continuation of these conditions of inequality. For the ruling classes, health inequalities are an indication of the difference in life chances that exist between themselves and the working classes in particular. The provision of health care through a system such as the National Health Service is largely about maintaining a reasonable level of health among the working classes, sufficient to ensure that

Marxism explains social phenomena as primarily determined by the economic structure of society. Social change, it is argued, is the product of changes in economic relationships. In the context of the modern period the advent of capitalism and industrialisation produced social divisions based on the ownership or non-ownership of property.

The economic inequalities that result from ownership or non-ownership of property are the starting point for understanding why there are inequalities in health between the middle and the working classes.

people are able to work and be returned to work following illness. Navarro in part explains the medical profession's alliance with the ruling classes in terms of their shared willingness to perpetuate the belief that the principal causes of ill health are personal and physical rather than social. Such a situation in turn strengthens the position of the medical profession in explaining illness to the lay population but also, significantly, fosters a dependency on the medicine to cure illness and disease. To admit that patterns of disease and illness are largely determined by economic and social factors would be to rob the medical profession of ideological dominance in terms of claiming that it is medical advances and medical technology that have produced the most startling improvements in the health of the nation. Therefore, the alliance between the ruling classes and the medical profession serves the interests of both by maintaining the professional dominance of the latter and by sustaining a reasonably healthy working population for the former.

Feminism

Marxist theory has been criticised in particular for its almost exclusive emphasis on the economic determinants of social relationships and for the resulting primacy of social class in any analysis of inequality. *Feminist theory* sought to challenge what was seen as the invisibility of gender in sociological theory. Giddens suggests that sociology has as its main focus 'the study of the social institutions brought into being by the industrial transformations of the past two or three centuries' (Giddens 1997: 8). Feminist critics argued that the founding fathers of sociology were concerned with a narrow range of topics such as social class, the division of labour in industrial society and the role of the state.

> 'Feminism' is a broad concept that explains social structures as fundamentally based on inequalities between women and men. In general, feminist sociologists have challenged the traditional preoccupation of the discipline with the effects of industrialisation and the world of paid work and institutional politics. Such an approach, it is argued, has ignored the significant elements of society such as the family and gender relationships.

   It is possible to argue that two essential elements of this social transformation were largely overlooked. The first relates to the way in which industrialisation impacted specifically upon women, compared to men. According to Ramazanaglu (1989) one of the most significant changes for women related to the shift of work for remuneration from the home (or near the home) to a separate and distinct space, such as the factory. Such a split set up for the first time the dilemma of how to combine 'work' and childcare. The second element illuminates the practical changes in women's lives as well as to conceptual shifts in explanations of social phenomena. The modern era is associated with a perceived split between the 'public' and the 'private' spheres. It was assumed that the natural area of study for sociology was the 'public' world of paid work, politics and the state. Since these were also the areas where men were dominant, it was this aspect of the social world that came to be associated with them. Women, on the other hand, remained within the 'private' sphere of the home, family and unpaid work. The former sphere was clearly seen as open to change, while the latter was assumed unchanging and 'natural'. The result of this conceptual split was an unquestioning acceptance of women and men as fundamentally different from one another and an assumption that these 'natural' differences could not be altered.

As a challenge to these assumptions, Feminist theory can make a substantial contribution to our understanding of the social world in general and to the study of health and illness in particular. Feminist theory provides, for example, an analysis of gender relations on the basis of the way in which female inequality has been structured and maintained in society. One rather controversial concept used to explain this inequality is that of 'patriarchy', literally meaning the rule of men over women and of older men over younger men. In terms of uncovering what is distinct about women's lives as compared to men's, the concept of patriarchy provides a unique insight into many aspects of women's lives. Writers such as Oakley (1984) have argued that women's lives have been subject to far greater control and regulation by the medical profession than have men's. Particular examples can be seen in relation to pregnancy and childbirth, where what was previously seen as a 'natural' event attended by women, rapidly became the focus of medical intervention, and now principally takes place in hospital, with the profession of obstetrics being dominated by men.

> Chapter 4 includes a discussion of the male dominance of medicine in relation to reproductive technology.

Post-modernism

The final theoretical approach to be discussed in this chapter is less a school of thought than part of a recent critical and challenging questioning of traditional sociological theory. *Post-modernism* refers to the present historical period characterised by the globalisation of the economy and culture, and by a fragmentation of individual identity such that old certainties of class, national and gender identity are called into question. The term 'post-modern' also refers to a particular paradigm or worldview. In this case, what is being challenged is the certainty of our knowledge about the world, the ability of sociological theory to uncover the 'truth' about the social world, and the desirability of this. Thus, the emphasis within this particular approach is less on producing an all-embracing theory which explains all aspects of the social structure, and more on inquiring into the nature of knowledge itself.

> Post-modernist theories veer away from all-embracing theories such as those described above that attempt to explain all social phenomena. Instead, the emphasis is on the impossibility of uncovering the 'truth' about society. Post-modernism draws our attention to how our knowledge of the social world is constructed, and offers a critical and questioning approach to understanding the world around us.

Foucault argued that in order to understand science and medicine we have to think about them as 'discourses' about the body, health and the natural world, rather than accepting these disciplines as objective descriptions of reality. The concept of discourse is an important one within contemporary sociology and represents a distinct way of thinking, seeing and conversing about a particular phenomena, all of which create a virtual 'arena', ruling some ways of thinking as legitimate and others as not. Medicine is often described as a dominant *discourse* in relation to the study of health, disease and the body because western biomedicine has become the accepted, and therefore legitimate, way of thinking, talking about and seeing these aspects of human experience. Medicine represents one discourse on health, disease and the body and Foucault draws our attention to previous, non-scientific explanations of disease and perceptions of the body. Post-modernist theory makes two main contributions to the study of

> Medical knowledge is an example of an established body of thought that is challenged by post-modernism as just one interpretation of reality. In other words, the 'truth' of medical knowledge is challenged.

> Discourse refers to a specific way of thinking about, conceptualising a particular subject. The essence of a discourse is the language used to express thoughts. Science is an example of a discourse that rules out some kinds of explanations (for example spiritual) and only allows for others (for example, rational and evidenced 'facts').

health and disease: first, we are offered a way of challenging the dominance of medicine and questioning what appears to be scientific, true and objective. Second, we can appreciate the way in which knowledge discourses can be used to discipline us. According to Bilton et al. (1996), medicine cannot be seen, then, as merely and actively associated with clinical healing; 'the medicalisation of the body . . . has to be understood as a process of social control' (Bilton et al. 1996: 424). We have seen from the earlier example of feminist theory and the critique of the regulation of pregnancy and childbirth that the application of medical techniques and knowledge often results in the control and regulation of patients.

This chapter has sought to establish the nature of the discipline of sociology by detailing what is distinctive about its subject matter and method of enquiry. You have also been introduced to various theoretical explanations of social phenomena.

Summary

- Sociology is concerned with the study of society and specifically with key issues such as inequalities in life chances.
- Sociology offers what Bruce (1999) terms a 'scientific' method of enquiry characterised by the search for valid evidence.
- The study of sociology requires us to think outside our own experiences and to employ the 'sociological imagination'.
- Sociological theory can be distinguished from 'everyday theory' by its requirement to resort to reasoned, evidenced and coherent explanations of social phenomena.

Recommended reading

Bruce, S. (1999) *Sociology: A Very Short Introduction*. Oxford: Oxford University Press. **Provides an excellent introduction to the discipline of sociology**.

Craib, I. (1997) *Classical Social Theory*. Oxford: Polity. **For a detailed and more advanced consideration of sociological theory.**

THE DEVELOPMENT OF MODERN MEDICINE

Delusions of Adequacy

2.1 The development of modern medicine: science, rationality and the legacy of the Enlightenment. A historical account of the ideas that influenced the development of medicine. The significance of the post mortem for the development of medicine.

2.2 Medical perspectives on the body, health and illness. The medical and social models of health.

2.3 Medical paradigms: the social construction of medical knowledge. Jewson's three paradigms of medical knowledge. Paradigm shifts in medical thought.

2.4 Foucault and the clinical gaze. The body as an object. The normal and abnormal functioning of the body.

Key concepts

The Enlightenment, science, rationality, paradigm, social model, medical model, bedside medicine, clinical medicine, laboratory medicine, and the clinical gaze.

The sociological imagination is crucial to 'doing' sociology as it provides a critical and questioning edge, without which the discipline would be limited to simply describing social phenomena.

The aims of this chapter are twofold: to provide a historical account of the development of modern medicine and to examine the social construction of medical knowledge. We employ the concept of the sociological imagination to stress the necessity of a historical and questioning approach to the study of medicine and the development of the medical profession.

Medicine represents a specific type of knowledge about the human body that is applied to either care for or cure the recipient of medical treatment. In order to understand the practice of medicine at the present time, it is necessary to know how it developed historically. This chapter, therefore, seeks to explain two main elements of medical knowledge; first, its historical origins and, second, the type of knowledge underpinning the practice of medicine.

2.1 The development of modern medicine: science, rationality and the legacy of the Enlightenment

The Enlightenment refers to a body of thought, first developed in the eighteenth century, which challenged explanations of the world based on religions or superstitious explanations. Enlightenment thought, on the other hand, was based on a commitment to rational, secular and scientific explanations.

The concept of 'science' is associated with the study of the natural and physical world, characterised by observation, measurement, experimentation and objectivity.

Secularisation refers to the acceptance of non-religious explanations of the world.

Before we begin to examine medical perspectives on the body, it would be helpful to ascertain the origins of these ideas. According to Stacey (1988) various cultural, social and economic factors, all of which have their origins in the eighteenth-century Enlightenment help explain the development of modern medicine. The term 'the Enlightenment' refers to a body of thought rather than to a specific period in European history. Underpinning this intellectual movement was a strong emphasis on reason rather than belief, superstition or even religious thought. The Enlightenment is traditionally associated with rationality and the search for evidence. It was anticipated that on the basis of rational, reasoned and evidenced thought traditional institutions and ideas could be replaced with 'modern' practices. This element of the Enlightenment movement paved the way for a secular rather than a religious understanding of society and of people's place within it. The application of reason to human life, it was argued, opened up the possibility of the advancement of the human race by uncovering the massive potential of *science* and reason. Stacey (1988: 47) argues that the developments that took place laid the basis from which biomedicine developed, led to its domination over all alternative healing systems and established a division of health labour that its practitioners also dominated.

In the first instance, the growing *secularisation* of society opened the way for alternative, scientific explanations for disease. 'Medical' labels and 'scientific' explanations could be used to understand the origins of disease and their potential cures. Chapter 5, which examines mental health, will illustrate these arguments in detail. Explanations of 'madness' in spiritual terms or in terms of 'possession' gave way to explanations drawn from the examination of the body and brain based on empirical observation and the recording of the underlying physical, organic cause. This drive to uncover the specific aetiology of a disease by examining the human body finds its exemplification in the desire to explore the bodies of the dead as well as the living. The search for knowledge about the body encouraged early medical practitioners to act unlawfully by taking possession of cadavers procured illicitly. This illegal trade thrived despite the fact that practitioners already enjoyed access to the bodies of the poor and destitute who had died in workhouses and other institutions.
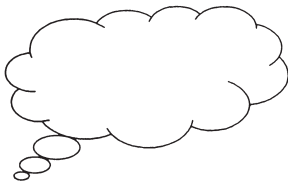
How important for the medical profession is the continuing use of bodies for research and teaching? What is the connection between the decline in religious belief and the greater use of bodies for research and teaching?

Edinburgh was notorious for its 'body snatchers' or 'resurrectionists', principally because of its strong tradition of medical education. The best known practitioners of this trade were Burke and Hare who, in the early

part of the nineteenth century, also murdered to provide corpses. When captured the latter turned king's evidence, while Burke was hanged in front of a crowd of 20,000 and his own body later dissected in the same way as those he had procured. A wallet made from Burke's skin still resides within the Medical School at Edinburgh University.

> Visitors to older Edinburgh graveyards must have noticed their strange resemblance to zoological gardens, the rows of iron cages suggesting rather the dens of wild animals than the quiet resting places of the dead. And, in fact, these barred and grated cells were designed as a protection against human wolves who nightly prowled about such places in quest of prey, and furnish very real testimony to the fears by which our forbears were beset respecting the security of the sepulchres. . . . It is obvious that the lawful supply of subjects was wholly inadequate to meet the growing needs of the new [medical] school . . . the surgeons and barbers' apprentices has been in use diligently to till the soil and reap the harvest of what has been finely called 'Death's mailing'. . . . At first zealous apprentices were the only body snatchers, but owing to the popularity of the Edinburgh medical school and the great increase of students, there arose a class of men who, adopting as a business the raising of the dead, became known as the Resurrection's. (Roughhead 1921: 152)

The Enlightenment underpinned the development of specific *methods* of investigation in relation to medicine, namely scientific methods. The superiority of scientific thought was said to lie in the fact that evidence and theories were derived not from belief but from observation, and confirmed through a process of experimentation. Evidence developed in this way was seen as unbiased, *rational* and purely descriptive of the natural world. Scientific facts could not be disputed except by employing the same methods to question or disprove an assertion. In Chapter 4 we will examine alternative medicine and see that, still, the same assumed superiority of scientific methods is used to question the validity of practices such as homoeopathy.

> Science's ability to provide rational explanations continues to be one of its main strengths. 'Rational' refers to adherence to a logical and tenable process of explanation.

2.2 Medical perspectives on the body, health and illness

Biomedicine is the principal way of understanding health and illness in western culture, being widely accepted not just by the medical profession but also by the lay (non-professional) population. There is general agreement among contributors to debates in medical sociology that the *medical model* of explanation has a number of defining characteristics. Nettleton, for example, describes five features. (Nettleton 1995: 5).

> The medical model is a specific way of thinking about and explaining disease based on biological factors.

1   *Mind–body dualism*. This refers to an acceptance that when treating disease the mind and the body can be treated as two separate entities. The physical body rather than the more problematic 'mind' is *the* subject of medicine. Medicine's appropriation of the body is such that, until recently, there was very little written by sociologists about the body; this was the domain of the medical profession.

2   *Mechanical metaphor*. Nettleton uses this concept to draw our attention to the way in which medicine is said to view the body as a machine, the functioning of which is determined by biological and scientific laws. Having knowledge of how the body functions allows medical practitioners to 'repair' any dysfunction.

3   *Technological imperative*. This refers to the significance attached to medical methods of intervention, whether pharmacological or surgical, in treating the body. As we shall see, there is often a tendency to over-emphasise the curative element of biomedicine and underplay the beneficial contributions made by, for example, changes in diet or environment. While the development of medical technology brings with it considerable benefits, these developments also have a cost, which may be understood in terms of, for instance, the harmful consequences either of medicines or of medical intervention.

4   Biomedicine is described by Nettleton as 'reductionist' in that there is a tendency to reduce all explanations to the physical workings of the body. There is an echo of this reductionist tendency in the dualistic nature of medicine as well as in the significance attached to the 'technological imperative' in the primary role attached to all things physical. One of the major criticisms of the medical model stems from its apparent unwillingness to acknowledge that both social and psychological factors influence health.

5   The *doctrine of specific aetiology* refers to the belief that all disease originates from a specific and knowable causes.

Such a description of the medical model may well strike you as rather rigid, and as a far more accurate account of medicine and medical practice in the past rather than today. We would argue, however, that central elements of medical knowledge remain but that medicine is a dynamic body of thought, capable of changing and adapting in the light of new discoveries. The fluid nature of medical knowledge means that some elements of the medical model may be more or less important than they were in the past.

It is perhaps easier to see the relevance of such a model in the past, when infectious diseases were the main cause of morbidity and mortality. However, the major killers of the twentieth and twenty-first centuries are long-term, chronic illnesses. What distinguishes these conditions from diseases of the past is that their causes are 'social'. Heart disease is the main cause of death in Scotland and some cities like Glasgow, for example, have particularly high rates of heart disease. While some causes of heart disease can be traced back to a specific dysfunction of the organ, the principal cause of heart disease is an unhealthy lifestyle. It may be difficult to defend the medical model as outlined by Nettleton when public awareness campaigns attach such a degree of significance to individuals changing their lifestyles rather than to the medical profession repairing what appears simply to be a faulty machine. Pharmaceuticals such as lipids may be able to reduce the harmful effects of heart disease and hypertension but they cannot eradicate the disease.

A more detailed discussion of the body and chronic illness is provided in Chapter 7, section 7.1.

Authors such as Lupton (1995) have urged us to consider the way in which the medical model has developed and reinvented itself to the point where it can embrace social as well as psychological factors. It is, therefore, not always appropriate to contrast the medical model of medicine with the *social model* of medicine. The earlier example of the social dimensions of heart disease is a topical example of this as is the recent acknowledgement by the British Medical Association that diseases such as ME have both a physical and a psychological dimension. It would be a mistake, therefore, to accept the medical model as a static representation of medical thought and practice. Medicine and medical practice are no longer solely concerned with the biological and the physical but, because of the changing nature of disease, are able to place disease and the diseased body in a social context. Medicine goes beyond simply treating disease and is now actively engaged in a moral crusade to change the way in which people live, and to influence the choices that they make. Turner (1994) suggests that the growth in the influence of medicine over our lives, coupled with the demise of religious influence has resulted in a new moral order: 'the doctor has replaced the priest as the custodian of social values' (1994: 37). This 'moralistic' element of medicine cannot be adequately accounted for in terms of the five characteristics identified above. In order to embrace the modern dimensions of medicine and medical practice we have to be prepared to extend the traditional medical model to a more complex body of thought that can and does embrace social and psychological aspects of health and disease.

> The social model of medicine suggests that medical intervention is only a partial explanation for patterns of morbidity and mortality. More significant, it is argued, in explaining these patterns are social factors such as improvements in hygiene and nutrition.

2.3 'Medical paradigms': the social construction of medical knowledge

Thus far, this chapter has explored the intellectual and cultural origins of medicine and provided an account of the main characteristics of the medical model. The significance of this discussion, and that of other chapters that follow, is that it allows the student of sociology to place the development of medicine within a historical context, and thus fulfils one of the essential criteria of the request to employ the 'sociological imagination'. The second objective of this chapter is to explain the social construction of medical knowledge.

Social constructionism is characterised by an emphasis on the extent to which 'society' is actively and creatively produced by human beings. The world is portrayed as made or invented – rather than as given or taken for granted. 'Social worlds are interpretive nets woven by individuals and groups.' (Marshall 1998: 609). The extent to which medical knowledge can also be said to be socially constructed, that is, the degree to which medical knowledge is a product of those engaged in its practice can be illustrated by Jewson's concept of *paradigms* of medical knowledge. The term 'paradigm' refers to a model or mode of thought, a particular way of seeing the world, that sets boundaries to *what* we see, *how* we might measure and record that information and *which* factors are significant and which are not.

Paradigms of knowledge shift and change over time, as illustrated by the earlier discussion of the medical model, and, therefore, offer us a way of conceptualising the fluid and dynamic nature of medical knowledge.

Figure 2.1 *Jewson's three paradigms of medical knowledge*

Bedside medicine	**Clinical medicine**	**Laboratory medicine**
• disease as a total 'psychosomatic' experience	• specific aetiology of diseases	• disease as a 'biochemical disturbance'
• lay and 'medical' practitioners	• specialist practitioners in possession of specialist knowledge about the body	• specialist practitioners, knowledge of cellular construction of the body
• place of treatment: home	• place of treatment: hospital	• place of treatment: laboratory

Source: Seale and Pattison (1994)
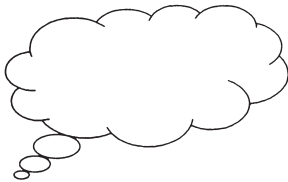
> *What are the main differences between the three models in terms of (a) the relationship between the practitioner and patient? (b) the opportunities for lay people to administer medical treatment? and (c) the location of care?*

Figure 2.1 represents a simplification of the three paradigms but is a useful starting point in the analysis of the social construction of medical knowledge and raises the following significant points:

- Medical knowledge has changed and developed over time. What was once held as a reasonable explanation may later be disputed and cast aside. Early medical theories of hysteria, for example, maintained that the womb of 'hysterical' women moved around the body.
- Medical knowledge and, more generally, knowledge about health and disease has become increasingly specialised, focusing first on the 'whole' person, then on specific parts of the body and finally, analysing the construction of cells. Theoretical knowledge of the body, learnt knowledge, has taken precedence over experiential knowledge. Medicine and medical practice has increasingly become the preserve of those educated and trained by current practitioners and registered with their professional bodies. Lay practitioners, such as lay midwives, were systematically excluded from the practice of medicine.
- Each paradigm shift in thought has entailed a shift in the nature of the relationship between the practitioner and the patient. The 'bedside manner' paradigm suggests that, at least in the case of the wealthy, practitioners were 'patronised' by clients. Clients paid directly for the service and those providing it were often considered their social inferiors; power lay with the patient. If you compare and contrast this with the quality of, and the balance of power in, the contemporary relationship between practitioner and patient, a very different picture emerges. Despite the clear benefits which derive from the provision of

a National Health Service, the position of general practitioners as 'independent contractors' within the service means that payment is not gained directly from the patient but via the Health Service itself. It could be argued that because of this the service provided is organised around the needs of the practitioners rather than of the patients. Appointment times might be one example. Most appointments are offered within the confines of the working day and, with the exception of emergencies, only on Monday to Friday. Given this, for many people in work it is hard to find a suitable time to see a GP without taking time off paid work.

The paradigm that accords most with our experiences of medicine in contemporary terms is that of clinical or hospital medicine. The following discussion provides a more detailed consideration of this aspect of medical knowledge and practice.

2.4 Foucault and the clinical gaze

The concept of the 'clinical gaze' is part of a specific discourse on the body in which the body is perceived as a physical object capable of being observed, measured and treated with little or no reference to the person.

Chapter 7, section 7.1 explains the central role of medicine in interpreting the human body.

The contested nature of knowledge is explored in Chapter 1, section 1.3 in a general discussion of post-modernism.

The concept of the 'clinical gaze' is associated with Foucault and refers to a specific way of conceptualising the body, rather than simply describing the physical location of the examination. This new conceptualisation of the body stemmed from a number of developments, some of which have been mentioned in the discussion above. As you have already seen, for example, the Enlightenment gave rise to the dominance of scientific and rational thought, an essential element of which was the opportunity to see the physical body as part of the 'natural' world. Part of this way of conceptualising the body is based on the idea of the mind/body split, enabling us to perceive the body as a physical object outside, external and separate to us as represented by the mind.

The ability to conceive of the body as an object in part stemmed from the increasing trend towards its physical dissection. The corpse became the source of knowledge about the body and that knowledge was the domain of medical science. The concept of the clinical gaze was used by Foucault (1973) to describe a specific and distinct method of examination and understanding, made possible by the physical examination of the internal workings of the body. Foucault's analysis contains the possibility of extending our knowledge of the socially constructed nature of reality. What may appear to us as real – for example, the physical make-up of the body – is actually the outcome of a specific kind of knowledge. To interpret the body and its workings requires a 'guide' because the body and its functions are not self-evident. Our representations of the body, whether through models or through diagrams, are the product of how we understand it. Without some training in what to look for and some general acceptance of the functions of the different parts of the anatomy, it is argued, we would not be able to interpret what we see. A map of a geographical area is a representation of it, full of complex signs and symbols that help us interpret what we see. The map is not an accurate representa-

To be able to interpret the body we require a guide. How we represent the body, the type of models or diagrams we use, are in turn, products of how we understand the human body.

tion of what we actually see as we walk about a city, but it is a guide that helps us interpret what we see. In the same way, medical knowledge provides a guide by which to read the body.

That medical science does not represent 'reality' can be illustrated with reference to explanations once held as 'true' but since revised in the light of new knowledge. The example of medical understanding of the blood is a useful illustration. As late as 1750 the nature and function of blood was interpreted in a very different way from today. It is also worth remembering that this belief dominated despite the discovery of the circulation of the blood by the English physician William Harvey in 1628.

> Working with the understanding that there are two independent systems of blood vessels, the arteries and the veins, Galen (Greek physician, second century AD) believed that some almost immaterial vivifying substance (that is to say a substance endowing life), *pneuma*, was brought in from the air when we breathe, taken to the lung and from there to the left chamber of the heart, where it was mixed with ordinary blood and was then drawn into the arteries. Its life possessing and life giving properties were evident to the senses when it was compared with the blood in the veins; arterial blood was bright, frothy, it spurted when the artery was cut, it needed the strong walls of the arteries to contain its natural tendency to expansion, and it had the pulse of life. Venous blood, by contrast was slow moving, and the thinner walls of its vessels showed no pulse. (Cunningham 1994: 62)

The physical examination of the body provided the opportunity to distinguish between normal and abnormal functions. On this basis, it is hardly surprising that the dominant definition of 'health' is as the absence of disease, and that medicine is so closely associated with the treatment of dysfunction rather than the promotion of health. The physical setting of the clinic or the hospital provided practitioners with the opportunity to examine bodies in large numbers and establish concepts of normality and abnormality. The benefits of such a distinction are clear. Practitioners are able to distinguish between a working kidney and one that is malfunctioning. We know that it is normal for babies to be born with a fontanelle, but in cases where this gap has prematurely closed surgery is necessary to allow the brain to develop normally. The question of normality and abnormality seems unproblematic in cases such as these. Sociologists of health and illness are concerned, however, that such judgements extend further to embrace human behaviour and lifestyles, for example in relation to mental health and well-being. What begins to emerge from this analysis is a picture of medicine and medical practice as both caring and potentially controlling, suggesting as it does what is normal and abnormal. The next chapter examines these issues in detail.

This chapter has explored the development of modern medicine by providing a historical account of the belief systems that gave rise to the practices that are still with us today.

Summary

- This chapter has explained the development of modern medicine as a specific form of knowledge about the human body.
- The development of medical knowledge is strongly associated with science, rationality and the Enlightenment.
- Scientific medical knowledge represents a specific way of seeing and understanding the functions of the body. One example of this is the traditional idea of the mind/body split.
- Medical knowledge is dynamic and evolving, as evidenced by Jewson's models of the patient/practitioner relationship.
- The possession of specialist medical knowledge leads to an increasing tendency to engage with the disease rather than with the patient.
- Medical knowledge is a form of power, with the potential to control and influence the lives of its recipients.

Case study

Imagine that you were being asked to publicly debate the use of embryos in medical research. Embryonic materials can be used to grow stem cells that in turn can be used to develop replacement organs for those that have failed and thus, ultimately, to save and prolong human lives. You are encountering strong resistance from the opposing side, made up of religious groups who oppose the use of embryos in medical research.

1 On what grounds might religious groups protest about the use of embryos to grow stem cells?
2 What arguments could you produce to allow this kind of research to continue?
3 On a personal level, reflect upon your own feelings about this kind of research.

Recommended reading

Lupton, D. (1995) *The Imperative of Health: Public Health and the Regulated Body.* London: Sage. **A detailed and more advanced account of the concepts underpinning medicine in western culture.**

Stacey, M. (1988) *The Sociology of Health and Healing.* London: Routledge**. An excellent historical account of the development of medicine.**

CHAPTER 3

MEDICAL CARE OR MEDICAL CONTROL?

> **3.1 'Clinical autonomy': Doctor knows best.** Medicine as a distinct body of knowledge. The clinical method. Attempts to curb the autonomy of clinicians. The case of hysteria: diagnosis without proof.
>
> **3.2 Public health: the morality of everyday life.** What is the 'public health' movement? The control and regulation of disease. Surveillance of the population: the example of women's sexual health.
>
> **3.3 The latter-day 'resurrectionists': the continuing power of the medical profession.** The power of clinicians: the 'sick role'. The ability to diagnose as a form of power. The making of life-and-death decisions as a form of power.

> **Key concepts and terms**
>
> Power, clinical autonomy, the clinical method, surveillance.

The meaning of the concept of power is the subject of much debate within sociology. In the context of this discussion, however, the concept refers to (a) the ability to ensure that a particular point of view prevails in a disputed situation, (b) the capacity to ensure that someone acts in a certain way, and (c) the ability to stifle opposition to a particular perspective.

The purpose of this chapter is to consider the implications of the *power* of the medical profession. The nature and extent of this power can be understood in a positive sense (caring for) in terms of improving our quality of life and extending our span of life. However, a sociological analysis of medical power must take cognisance of the way in which this same ability can also be used as a means of controlling and regulating human lives. Like Bob the Builder, the medical profession, in most cases, can answer the question 'Can we fix it?' with an emphatic 'Yes we can!' The power of medicine is beyond doubt, but simply saying we can do something does not imply that we should. To say, for example, we can clone animals is not the same thing as saying that we should. Developments within modern medicine have meant that what in the past may have been purely clinical decisions are now ethical decisions. For example, the age at which premature babies can survive has steadily decreased, raising the question of at what stage of pregnancy terminations should be permitted. Medical staff

have increasingly found themselves trying, on the one hand, to maintain the life of one child and on the other, aborting a foetus of the same age.

3.1 'Clinical autonomy': Doctor knows best

The concept of *clinical autonomy* is best understood in terms of the freedom of clinicians to make decisions on the basis of their professional judgement and specialist knowledge. Doctors are not unique in claiming this level of autonomy; most professions make similar claims on the basis of the possession of an exclusive body of knowledge and a specialist education. Doctors, dentists, lawyers, nurses and even dieticians have their claim to specialist knowledge and judgement supported by the state in the form of state registration. Only those having fulfilled the necessary requirements in terms of training and experience are allowed to practise.

Clinical autonomy therefore suggests freedom to both diagnose and treat patients with appropriate means. As Seale and Pattison (1994: 100) comment, the clinical method itself is premised on 'an overriding orientation towards action.'

> The concept of clinical autonomy refers to the freedom of clinicians to make decisions on the basis of their professional judgement and specialist knowledge. This definition implies the downgrading of other assessments of the same situation.

Figure 3.1 *The clinical method*

Diagnosis – take a history – define symptoms – examination – signs – prognosis

Source: Seale and Pattison (1994: 101)

Challenges to this degree of clinical freedom have come from a variety of sources. Patients are generally better informed about their conditions than in the past, and those with chronic long-term conditions can accumulate an impressive level of knowledge and understanding of their illness. Cultural and political developments have encouraged us to see ourselves as consumers of health care with resulting rights to adequate treatment and recourse if we feel that the treatment has not been appropriate. A second challenge has come from alternative practitioners who have raised serious questions about the effectiveness of conventional treatments and their potentially damaging long-term effects.

Health managers' attempts to curb the power of clinicians

A third challenge to clinical autonomy has come from within the National Health Service itself in terms of various reforms that have sought to enhance the power of managers to control the activities of clinicians. Proposals made in the 1989 White Paper 'Working for Patients', and later enacted in the 1990 NHS and Community Care Act, aimed at curtailing the power of clinicians. Any attempt to control and regulate expenditure in the NHS, it was argued, must encompass the activities of clinicians. Decisions made by virtue of clinical autonomy can also be translated into

expenditure figures, so in effect clinicians make not just medical decisions but also financial ones. Hunter comments: 'Getting a grip on the freedom enjoyed by clinicians and holding them to account for the expenditure they incur is seen as the last unmanaged frontier of the NHS.' (Hunter 1994: 6). Significantly, Hunter adds that attempts to manage doctors' activities may not be successful unless time and effort is devoted to 'developing a managerial consciousness' among doctors, and unless there is 'an understanding of the doctor's world and culture' (ibid.: 12).

Essential elements of 'the doctor's world and culture' can be gleaned from the previous chapter in terms of the ideas, influences and conditions that gave rise to modern medicine. As Chapter 2 makes clear, a significant part of the medical model is the technological imperative, the ability and the requirement to intervene to produce a positive change in the body. The development of modern medicine is also crucially linked to ideas that emerged during the Enlightenment and this commitment to the principle of improving human welfare, combined with the Hippocratic oath, has meant that a doctor's first commitment has always been to the patient, or so it is argued. It is hardly surprising, then, that attempts to influence the behaviour of clinicians have been resisted. An analysis of the response of doctors to the introduction of the NHS in 1948 is evidence of this resistance. Doctors were willing to become employees of the NHS and wanted to retain their right to carry out work in the private sector. To this day general practitioners remain independent contractors who do work on behalf of the NHS but do not formally work *for* the NHS. Some attempts are being made to introduce salaried general practitioners – partly to ensure the availability of services in particularly deprived areas, but also to gain some influence over the activities of doctors.

It is important to note that restrictions on the activities of doctors have largely been in order to get to grips with the cost implications of their decision making, rather than placing restrictions on their professional autonomy. However, two regulatory bodies have been established in the UK in recent years – the National Institute for Clinical Excellence (NICE) in England and Wales, and the Health Technology Board Scotland (HTBS) – both of which will rule on which drugs should be prescribed by the NHS. The roles of these organisations are principally to end what has been described as 'post code prescribing', where local Health Boards (Health Authorities in England and Wales) make independent decisions about whether or not a specific drug can be prescribed within their area. NICE, for example, recommended the prescribing of Arecipt, a drug for the treatment of Alzheimer's disease. The decision was made on the basis of clinical effectiveness rather than purely on cost effectiveness. The prescribing practices, however, of Health Authorities and Health Boards vary to such a degree that some patients will not have access to Arecipt.

The *clinical method*, the process that takes us from diagnosis to prognosis and treatment, remains very much intact. This should neither surprise nor, for the most part, alarm us, for the vast majority of clinical judgements are reasonable and bring about positive changes in the patient.

> The clinical method refers to the process that begins with diagnosis and leads to a prognosis and subsequent treatment.

However, it is equally clear that some decisions can lead to negative effects on the patient, that some are based on assumptions rather than on medical 'fact', while others are made without clear evidence to support them.

Medical harm: iatrogenesis

Iatrogenesis literally means harm caused by doctors. In its most literal sense it refers to the harmful consequences of medical intervention. Illich also uses the concept to draw our attention to our cultural dependence on medicine and medical practitioners, such that we do not seek alternative explanations or alternative remedies for ill health.

The first basis on which we can question the power of clinical freedom is in terms of its iatrogenic effects. The concept of iatrogenesis, associated with Illich, means 'doctor-caused illness', that is to say, harm would not have been caused *without* the medical intervention. Illich argues that the 'damage done by medicine to the health of the individuals and populations is very significant.' (Illich, 1993) This aspect of iatrogenesis is referred to as 'clinical' iatrogenesis and Illich cites drug therapies, doctors or hospitals as the cause of harm. A second aspect is that of 'cultural' iatrogenesis, which denotes a dependence on medicine to cure and to care for. Illich argues that cultural iatrogenesis means that people no longer take responsibility for their own health problems and the diagnosis of their symptoms. Illich asserts that 'medical practice sponsors sickness . . . reinforcing a morbid society that encourages people to become consumers of curative, preventative, industrial and environmental medicine' (1993: 158). The result of this dependency is a situation of 'medical nemesis', where the harm caused by medicine is difficult to eliminate except by recourse to further medical intervention, which in itself results in further harm. Illich paints a picture of an inevitable decline into an increasingly unhealthy world, where the provision of health care ultimately has a negative effect on our well-being.
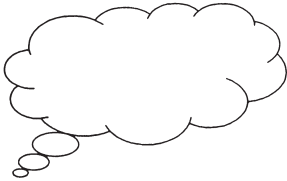
Think of your own examples of instances where medical intervention has had negative effects.

A balanced account of the harm resulting from health care would also, clearly, have to take into account positive developments in medicine. Hardey (1998) characterised the 1950s and 1960s as a period of great optimism about the potential of medicine to cure and care for people, and evidences this with reference to mass vaccination programmes that eradicated diseases such as polio and smallpox. At one end of the spectrum medicine can save and prolong life through radical interventions such as organ transplants, while at the more mundane end of the spectrum the symptoms of minor ailments such as headaches and menstrual pain can be eliminated through readily available pain relief. It is hardly surprising, therefore, that lay people may have a sense of dependency on medicine. Compared to people's experiences of health in the past, our own ill health may well seem trivial. Giddens comments that a glance at those experiences 'provides graphic evidence of the level to which illness and the prospect of an early death haunted the lives of individuals in the

eighteenth century. Infectious diseases were rampant and the ordinary person suffered from a range of chronic complaints which many of us in modern social conditions would find intolerable' (Giddens 1997: 47–8).
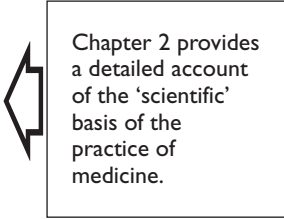
> In the eighteenth century in particular, deadly fevers – contemporaries called them 'spotted', miliary', 'hectic', 'malignant', etc. – struck down hundreds of thousands, young and old alike, while the so called 'new' diseases gained ground – some crippling such as rickets; some fatal, such as tuberculosis. Today's minor nuisance, like flu, was yesterday's killer. 'The Hooping Cough is yet with us', wrote George Crabbe in 1829, 'and many children die of it'. And all this against a backdrop of endemic maladies, such as malaria and infantile diarrhoea, and a Pandora's box of other infections (dysentery, scarlatina, measles, etc.) that commonly proved fatal, above all to infants, to say nothing of the 101 other pains, eruptions, swellings, ulcers, scrofula and wasting conditions, not least the agonizing stone and the proverbial gout, which threatened livings and the livelihoods, and all too often life itself.
> (Taken from L. Porter and L. Porter, 'Sickness and health in pre-modern England', reprinted in Giddens 1997: 55)

The above discussion illustrates one strand of thinking which is critical of clinical autonomy on the basis of the harm resulting from medical intervention. The second level on which one can question the dominance of clinical autonomy is that clinical decisions are sometimes made on the basis of assumptions and beliefs rather than on scientific, objective grounds.
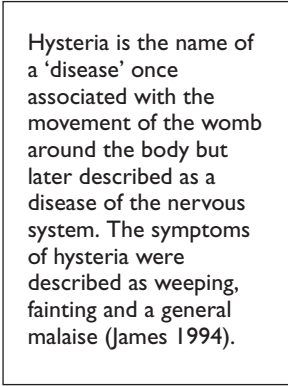
Fact or fiction? The making of medical decisions

> Chapter 2 provides a detailed account of the 'scientific' basis of the practice of medicine.

The previous chapter highlighted the extent to which the medical model is based on a commitment to scientific methods and empirical evidence, both of which suggest a high degree of objectivity. Critics of the medical model, however, have suggested that medicine is also the product of its social and cultural environments and, as such, is bound to reflect values dominant in society. Historically, the treatment of female patients provides a useful illustration of the extent to which medical categories reflect broader social and cultural values. Medicine does more than simply describe sets of symptoms; it may also create certain types of behaviour by applying a label to describe and categorise. According to Lupton (1996: 57) medicine can be seen as a 'moral exercise . . . used to define normality, punish deviance and maintain social order'. A historical example of such a 'moral exercise' is hysteria.

> Hysteria is the name of a 'disease' once associated with the movement of the womb around the body but later described as a disease of the nervous system. The symptoms of hysteria were described as weeping, fainting and a general malaise (James 1994).

   James (1994) provides a detailed account of hysteria, its symptoms and remedies, from Greek theories of the womb's tendency to move around the body, to eighteenth-century theories of hysteria as a demonstration of the greater delicacy of women, particularly celibate women. Such ideas clearly resonated with ideas dominant at the time about women's essential differences from men. According to Turner (1994), descriptions of hysteria were linked to ideas about the subordination of women in so far as women

were seen as 'naturally' frail and emotional. It had frequently been noted that women who were most likely to experience hysteria (James 1994: 80) were unmarried and, therefore, seen as either sexually inactive or as sexually active but in an inappropriate manner. Neither celibacy nor unlicensed sexual activity was seen as conducive to physical or good mental health. The remedy for hysterical behaviour was, therefore, marriage and reproduction. It is important to remember that the eighteenth and nineteenth centuries are associated with the beginnings of the modern women's movement, with its demands, for example, for equal access to education. Coincidentally, hysteria just happened to be diagnosed among women whose sexuality was not expressed 'normally', according to the prevailing values of the time, through marriage and child-bearing, and among women who attempted to pursue their education and careers. Turner writes that it was 'the absence of normal sexual activity designed to bring about reproduction which was associated in medical discourse with the prominence of hysteria' (Turner 1994: 84). The diagnosis of hysteria was linked not just with maintaining women's health but also with maintaining a specific pattern of gendered social relationships.

This chapter has established the ways in which medical power and knowledge can be used in positive and negative ways. The concept of clinical autonomy suggests that 'doctor knows best'. The preceding discussion has sought to highlight the specific nature of this professional dominance with examples such as the NHS reforms of the late 1980s and early 1990s when government attempted to rein in the power of the clinician. Two further examples, the concept of iatrogenesis and hysteria, were discussed to illustrate that clinical autonomy can be used to further ends other than to enhance the well-being of the patient. However, it might be argued that these are rather extreme examples, and that for the most part medicine does enhance health and well-being. Underpinning this line of argument is a strong belief that medicine is essentially a benign practice and that its ultimate function is to care for rather than to control. The following discussion challenges this idea by examining further the degree to which medicine is a disciplinary practice as much as a caring one.

3.2 Public health: the morality of everyday life

The moralistic
element of
medicine was
introduced in
Chapter 2,
section 2.2.

The previous discussion of the medical model of health draws our attention to the ways in which that model embraces issues relating to lifestyles and choice. 'Public health' refers to those areas of health and disease shared by the population in general and which are seen to be amenable to preventative intervention. Strategies to tackle public health cover more than simply medical techniques and have included measures to address housing problems, for example, and to ensure the supply of clean water and adequate sanitation. Contemporary definitions of public health have tended to take as their object the environment, including social, psychological and physical elements (Peterson 1997: 192–3).

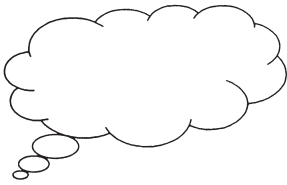There are four significant points that arise from these public health

initiatives. First, the at-risk category embraces most people. Health and the practice of medicine, therefore, no longer embrace only those who are diseased but now encompass even those who are well. Second, public health appears to be concerned with the regulation and control of individual bodies. Lupton (1995: 30) argues that controlling and preventing the spread of disease has largely involved confining bodies and controlling their movements. Third, over and above the control and regulation of individuals is the regulation of the social body. Many of the facts and figures presented throughout this book are themselves a product of the public health movement and, in particular, of attempts to 'map' the spread of disease and its distribution within the population. Epidemiology involves the recording of information, 'constant record-taking, measuring and reporting back to a system of government agencies' (Lupton 1995: 31). Increasingly our risk of disease becomes understood in terms of statistical probability calculated for us by experts. Finally, what emerges from an analysis of public health initiatives is a sense of what is pathological (diseased) and what is normal in terms of health and behaviour. The latter is often understood in terms of what is statistically average. Seale points to this tendency and highlights its implications in terms of the association of normality with what *ought* to be the case (Seale 1998: 105).

The control and regulation of disease

The act of collecting information, analysing that information and calculating 'risk' suggests that knowledge is being used as a form of power and influence. At one end of the spectrum, this form of power could be described as 'disciplinary' (for example, confining infected bodies to their homes), or at the very least as 'directional' (for example, directing us towards healthy eating practices). The work of Foucault leads us to the conclusion that the modern period is associated with subtle forms of power, control and regulation. The best illustration of this form of power is the panopticon – a construction containing a central observation tower around which other buildings are placed and into which the occupant of the central tower can see. The occupants of the outlying buildings are not afforded the same opportunity and do not know when or if they are being watched. The aim of this system of *surveillance* is to ensure that this state of uncertainty is transformed into self-surveillance. Such a system is in stark contrast to sovereign forms of power, exemplified by sixteenth- and seventeenth-century monarchs. Under their regimes, Seale argues, power was manifest in rather more obvious and brutal forms, principally through 'physical coercion and public punishment for wrongdoing' (Seale 1998: 105). Public acts of punishment were a reminder of the power of the monarch and it was the act of punishment that marked an individual as an 'out law'. In contrast, disciplinary power 'operated by constructing and promoting, with the aid of statistical information, particular definitions of normality. From being coerced to follow the will of the king, citizens learned to survey themselves as bearers of normality' (ibid.: 105).

Chapter 7, sections 7.2 and 7.3, provides a discussion of the body as a site of control and regulation, not only for health professionals but for individuals as well.

'Surveillance' refers to a form of scrutiny and observation but one that does not necessarily depend directly on the physical proximity of the watcher and the watched. Instead, subtle forms of surveillance are said to characterise modern society, typified by the tendency of individuals to act in ways that they think they 'ought' to.

Can you identify any incidents in your own life where you have been assessed for 'normal functioning'?

A specific example of surveillance and self-surveillance can be found in the case of screening for cervical cancer. Research carried out by McKie suggests that in this instance 'screening is both creating and reinforcing a surveillance of women's sexual lives and health' (McKie 1995: 441). As the above discussion describes, screening involves not only uncovering infection but also identifying groups at risk. In the case of cervical cancer, treatment is not confined to women with cervical cancer but includes those women identified as having pre-cancerous cells that might develop into cervical cancer at a later stage. An additional complication with this form of screening is that there are difficulties in establishing the causes of cervical cancer and thus there is a further difficulty in differentiating between those women who might consider themselves normal and those who might be most at risk. For this reason the at-risk category essentially embraces all women. Failure to recognise your own at-risk status is viewed in negative terms. 'Women are encouraged to attend on a regular basis and those who do not are often considered by health care workers to be irresponsible, feckless and non-compliers' (McKie 1995: 445).

McKie highlights the extent to which much of the surveillance carried out by the medical profession on behalf of the state is around behaviours that are believed to lead to the spread of the disease. Despite the causes of cervical cancer being unclear, many researchers maintain that the human papilloam virus HPV, which can be transmitted through sexual intercourse, is to be found in the majority of cancers. As McKie points out, this in itself raises the question about the causes of HPV and a number of factors are said to place women at greater risk. These include age, heterosexual intercourse, lower age at first intercourse and smoking status. It is, therefore, not just the cervix itself that is subject to surveillance but types of behaviour, many of which – such as sexual intercourse at an early age and sexual promiscuity – have negative connotations. To receive a positive result for a cervical cancer may stigmatise the woman as someone who 'sleeps around' (McKie 1995: 449). In this instance it is possible to argue that screening does not simply describe what is the case (the number of women with cervical cancer) but has implications for what ought to be in terms of suggesting a link between stigmatised behaviours and the causes of the disease. Screening for cervical cancer, therefore, carries with it certain normative assumptions about how women ought to behave, and this extends to the assumption that all women are heterosexual. This assumption is especially significant since many practitioners use the 'smear' as an opportunity to talk to women about other health issues, principally contraception and sexual health, again based on the same assumption of exclusively heterosexual experiences.

The preceding discussion raises the issue of medicine as a moral discourse regulating various aspects of our lives. An important aspect of this

regulation is self-surveillance of our own behaviour, convinced as we are of the morality of what we are required to do when, for example, submitting ourselves to screening for diseases. Surveillance is a form of power that does not physically constrain or persecute people but one that apparently gives people the freedom of taking responsibility for their own health and well-being. As Seale comments, concepts of normality become internalised 'so that under disciplinary power, people constantly monitor themselves for signs of pathology. Thus people draw upon a widespread knowledge of what it is to be sane, healthy and good, and of their opposites, madness, disease and criminality' (Seale 1998: 106).

One conclusion that can be drawn from the discussion so far is that the power of clinicians does not so much reside in the person as in the profession. Such conclusions are well recorded within the sociology of health. Parsons' concept of the sick role is a clear example of a model that not only accepts that there is inequality in the clinician/patient relationship, but that this actually benefits both parties. The following discussion examines the continuing power of the medical profession.

3.2 'The latter-day 'resurrectionists': the continuing power of the medical profession

Parsons' functionalist account of the sick role lays out the roles, responsibilities and rights of patients and practitioners based on an assumption of a consensus between the two parties, ultimately beneficial to both.

A description of the functionalist approach is available in Chapter 1.

Figure 3.2 *Parsons' concept of the sick role*

1. LEGITIMISES WITHDRAWAL FROM A RANGE OF 'NORMAL' OBLIGATIONS, SUCH AS PAID WORK.
2. A PERSON CANNOT GET WELL WITHOUT THE INTERVENTION OF A MEDICAL PROFESSIONAL.
3. PEOPLE HAVE A SOCIAL OBLIGATION TO GET WELL AS SOON AS POSSIBLE. THIS IS THE ONLY BASIS UPON WHICH LEGITIMATE ACCESS TO THE 'SICK ROLE' IS GRANTED.
4. CARE HAS TO BE PROVIDED BY A COMPETENT MEDICAL PRACTITIONER.
5. THE DOCTOR/PATIENT RELATIONSHIP IS CHARACTERISED BY NEUTRALITY.
6. IN RETURN FOR COMPLIANCE WITH THE 'SICK ROLE' THE PATIENT IS PROVIDED WITH MEDICAL CARE.
7. DOCTORS HAVE THE RIGHT TO DIAGNOSE, EXAMINE AND TREAT PATIENTS.

Source: adapted from B.S. Turner 1994: 46.

A number of criticisms made of the concept of the sick role are particularly relevant to this discussion about the power of the medical profession. According to Turner, one major area of criticism has been Parsons' assumption that the doctor/patient relationship is 'complementary and functional' (Turner 1994: 46). Not only does sociological research suggest that patients may be well-informed and, therefore, questioning of the treatment

provided, but it suggests that the power of the practitioner is not always used for the benefit of the patient. Certainly, arguments such as these have been used to justify the practice of clinical autonomy. The NHS reforms of the 1980s and 1990s challenged the undisputed power of clinicians with the introduction of the principle of general management. It was not difficult for critics of the reforms to argue that it could only be practitioners who had the best interests of the patients at heart since it was practitioners, not managers, who had direct contact with them. Counter-arguments centred on questioning whether practitioners could also use clinical autonomy to safeguard their own professional interests. Resources might be used to research a particular disease, for example, with ultimate benefit to the patient. However, resources for research might also further an individual clinician's career in so far as it enabled someone to pursue a particular interest and add to their reputation and knowledge.

To fully understand the nature of the relationship between the practitioner and the patient it is necessary to employ the sociological imagination to uncover what lies behind the obvious. Within sociology, there is a long tradition of acknowledging that the possession of knowledge is a form of power. Such an approach is evident in the work of Foucault and the concept of the clinical gaze. The 'gaze' not only reveals a specific way of 'seeing' the body (or the insides of the body), but with it comes a whole vocabulary by which to know and interpret the body. This specialist knowledge has the effect of excluding other, alternative explanations of the body and disease. The work of Becker (1974) and the labelling tradition also allows us to explore how knowledge is used as a form of social control. A central tenet of labelling theory is the acceptance of the social construction of knowledge. In other words, meanings are not fixed but are the outcome of a process of definition, a process in which some groups and individuals have considerably more say than others. Within the labelling tradition, deviance has 'no consistent unitary content or essence' (Turner 1994: 73). It is possible to interpret medical knowledge as a form of labelling in so far as diagnostic categories are ways of describing and categorising behaviour. It is useful to reflect on an example of research used in the opening chapter. There we outlined Rosenhan's (1973) work, 'On being sane in insane places', which concluded that diagnostic categories were social constructs with which it was possible to both describe and create 'madness'.

The making of life-and-death decisions

The ability to diagnose, recommend and carry out treatment, therefore, represents a distinctive form of power. Simple examples of this power are evident in relation to pregnancy and death. Pregnancy may be evident to the mother-to-be and those around here, but it awaits 'official' confirmation by the medical profession. Again, it may be clear to others that death has taken place but it is not for them to confirm that. Illich argues that the degree of control exercised by the medical professional is extensive: it 'starts with the monthly prenatal check-up when he decides if and how the

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A contemporary example of the tendency of the population to contest the power of the medical profession is the current resistance to the MMR triple vaccine. Despite reassurances by the medical profession that the triple vaccine is safe, large sections of the general public remain sceptical.

foetus shall be born; it ends with his decision to abandon further resuscitation' (Illich, cited in Harvey 1997: 719).

Reproductive technology involves new techniques of surveillance and examination, such as ultrasound and foetal monitoring, that make the woman and the unborn child 'visible' in a way that turns them both into objects and subjects of medical, legal and state intervention. Doyal (1994) calls the foetus the 'newly discovered second patient' and describes situations where doctors seek court orders to protect the best interests of their 'new' patients.

The legal and medical professions, it is argued, are the 'managers' of death. Harvey asserts that the medical dominance of death is reflected in the mirroring of medical images of death in the popular consciousness. She argues that 'the "straight green line" on the oscilloscope has become a compelling late twentieth-century image of death, while the electronic alarm signal has replaced the (organic) death rattle in popular consciousness' (1997: 725). Harvey suggests that in situations where therapeutic intervention has reached its limits and there is no improvement in the patient's condition, clinicians may consider 'withdrawal of active support' (ibid.: 724). Such support is reduced on a gradual basis, Harvey's research suggests, in order to mimic a natural, gradual death. There are said to be specific benefits to this approach. In the first instance, it allows relatives of the patient to come to terms with the imminent death of a loved one. Second, death is less dramatic, less like pointing a gun at someone, as one of the interviewed consultants, suggested.
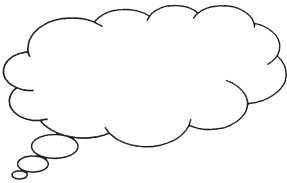
Prior to the rise of the medical profession who would have been actively involved in the diagnosis of death?

The making of 'end-of-life decisions' is clearly fraught with medical, technological, legal and ethical considerations. With the power to save and prolong life comes the onerous power to end it. Wade, a consultant and professor in neurological disability, explores the specific example of patients in a permanent vegetative state. (Wade 2001). Permanent vegetative state is characterised by Wade in the following manner (2001: 352).

1   The patient shows no behavioural evidence of awareness of self or environment.
2   There is brain damage, usually of known cause, consistent with the diagnosis.
3   There are no reversible causes present, and
4   At least six (usually 12) months have passed since the onset of PVS

A number of ethical issues are raised not just by the decision to end a life but, Wade suggests, by the diagnosis itself. He suggests that the diagnosis is not certain and there is no standard test to assess levels of awareness. The actual decision to withdraw feeding is fraught with legal and ethical

issues. For example, treating a patient who may be regarded as 'non-sentient' raises questions about how to maintain that person's dignity and privacy. Committing resources to the care of people in a permanent vegetative state raises issues about the rationing of scarce health resources. 'is it equitable to allocate substantial scarce resources to someone who is unaware of their situation and will not recover awareness?'(Wade 2001: 352). Wade recognises that the issue raises questions outside the remit of individual clinicians, and argues that one solution might be to take into consideration the interests of other parties, 'and to use a full ethical accounting procedure' (ibid.: 352). The suggestions made are interesting if only because they seek to share out the responsibility for decision making in relation to the ending of life.

Figure 3.3 *Permanent vegetative state: interested parties and their interests*

Patient
May have pre-existing statement of wishes.
May have wished to donate organs.
May have had strong beliefs (religious or
  otherwise).
May or may not be experiencing emotions.
  May have strong beliefs.

Relatives (and friends)
May have a financial interest (will or settlement).
May have other legal interests.
May have emotional or other stressful
  experiences.
May be ignoring children or others.

Ward staff
May have emotional interests in patient
  or family.
May have strong beliefs.

Organisation giving care
May have financial interests
  (positive or negative).
May have political or public relationship interests.

Organisation funding care
May wish to allocate resources differently.

Society
May wish to preserve sanctity of life.
May wish to avoid 'slippery slope'.
May support different allocation of resources.

Source: Wade 2001

> Chapter 2, section 2.1, provides an overview of the significance of the post-mortem for the development of medical knowledge.

Decision making relating to the ending of life is complex and demonstrates both the actual and potential power that clinicians have, in terms of making decisions. In the light of technological advancement they are increasingly being faced with decisions that might appear to be purely clinical but are also ethical and legal. While the death of a patient might be seen as a failure in terms of the medical profession's ability to maintain life, death itself provides important information and 'resources' that can save other lives and advance medical knowledge. One of the key factors that allowed the development of clinical medicine was the ability to examine the corpse and to learn from this. Thus pathology plays an important part in developing medical knowledge. Clinicians no longer have to rely upon 'resurrectionists' to supply them with bodies, since social and cultural taboos about the use of dead bodies have largely been eroded. It is a legal requirement in the case of sudden or violent death for a post-mortem to take place and for tissue to be retained as evidence. Many thousands of people carry organ donor cards and the medical profession talks openly about the 'harvesting' of organs for the purpose of transplants.

Despite a general acceptance of the use of dead bodies for teaching and research purposes and the desirability of 'harvesting' organs in order to prolong the life of others, revelations about the extent and nature of the retention of such material has caused a national outrage. When it emerged in 1999 that various organs from children treated at the Alder Hey Hospital in Liverpool had been removed and retained without the knowledge or consent of parents, there were calls to government to ensure that this would not happen again. While there was widespread condemnation of these practices by other clinicians, the case, nevertheless, represented a dilemma for the medical profession. It was important to be seen to act ethically and with the consent of relatives, but at the same time there was a necessity to secure an adequate supply of human tissue to continue research.

> Professor Gordon McVie, director general of the Cancer Research Campaign, told the *BMJ (British Medical Journal)* that, although researchers remained 'extremely sensitive to the issue of patient consent', it was unreasonable to expect scientists to list every use a tissue sample might be put to.
>
> 'It's impossible to predict everything you are going to do. There are 3,000 genes linked to breast cancer. Are you going to list then all on a consent form.'
>
> Professor McVie expressed concern that plans to create banks of excised tumour tissue to aid cancer research could be put at risk if all collection of tissue was restricted. (Hunter 2001: 322)

Liam Donaldson, Chief Medical Officer in England and Wales, advised that informed consent should be sought rather than simple 'lack of objection' and that consent forms should contain 'details of the tissue and organs to be retained, the uses to which they might be put, and the agreed length of time for retention' (Hunter 2001: 322). Confusion had arisen in particular about the ambiguous use of the word 'tissue', which to lay people suggested small, insignificant parts of organs or blood vessels. In contrast, clinicians used the term as a catch-all category to include substantial body parts such as the heart. The characteristics of the medical model outlined in the first chapter are a reminder of the 'mechanical' metaphor for the workings and parts which make up the human body. It is possible to argue on the basis of the Alder Hey scandal that the medical model, the clinical gaze, has the effect of dehumanising the body and obscuring the ability of those involved to appreciate the significance of the 'whole' body for family and friends.

This chapter has outlined the nature of medical power in terms of both negative and positive aspects. The conclusion that can be drawn is that medicine as a profession has considerable power in diagnosing disease and in making life-or-death decisions. The following chapter explores the challenges that are made to this power.

Summary

This chapter has examined the extent and nature of the power of the medical profession in relation to clinical autonomy, public health and

contemporary examples of decisions made about ending life and retaining human organs for research.

- Much of the apparent power of clinicians rests on the possession of a specialist body of knowledge that provides a justification for the exclusion of others from the process of decision making. This conclusion does not deny the obvious benefits of medical intervention but seeks to draw your attention to the implications of the use of power.
- Support for the concept of clinical autonomy may well lead to a quality service for patients, but may also lead to direct and indirect benefits for clinicians.
- Public health programmes such as mass screening have played a central role in the elimination of diseases such as polio, but it is also clear from the examples discussed above that such programmes are underpinned by a strong sense of what people 'ought' to do.
- It is possible, therefore, to conclude that public health is at least directional, if not a form of disciplinary power. Contemporary examples of the practice of medicine, such as the Alder Hey scandal, underline the fact that medicine is ripe for criticism.

The following chapter considers the basis upon which such criticisms have been made and looks at possible alternatives to current orthodox medical knowledge and practice.

Case Study

Calum has been in a permanent vegative state for three months, following a car crash. There are no signs to indicate that he will ever gain consciousness again, leaving his parents in a state of confusion and misery. His body appears unmarked, undamaged but with no hope of recovery. At age 18 he was a fit and healthy young man, but now it appears that his life is over. His parents are reluctant to do anything that will end his life. As long as he stays this way he is at least not lost to them, and yet there can be no more engagement with him.

Using the series of questions set by Wade in his 'Interested Parties' concept (p. 37 above), analyse this situation and reflect upon how ending this life would impact on all the people involved, both family and care providers.

Recommended reading

Harvey, J. (1997) 'The technological regulation of death: with reference to the technological regulation of birth', *Sociology*, 31(4): 719–35. **For a detailed discussion of the medicalisation of death and dying.**

Hunter, D.J. (1994) 'From tribalism to corporatism: the managerial challenge to medical dominance, in J. Gabe, D. Kelleher and G. Williams (eds) *Challenging Medicine*. London: Routledge. **An account of how various NHS reforms have attempted to curb the power of clinicians.**
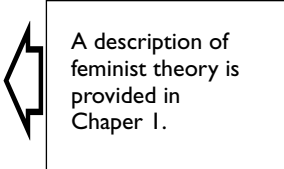
CHAPTER 4

CHALLENGING MEDICAL DOMINANCE

> **4.1 'The miracle of life': the medical colonisation of reproduction.** The regulation of reproductive technology. The medicalisation of pregnancy and birth. Assisted conception.
> **4.2 Challenging the dominance of the biomedical model: alternative therapies.** Defining 'alternative' therapies. Homoeopathy and acupuncture: two examples of alternative medicine. The professional marginalisation of alternative practices. Concepts of health: alternative practices. Why do people use alternative therapies? A critique of alternative practices.

> **Key concepts**
>
> Complementary medicine, alternative medicine, reproductive technology and medicalisation.

A description of feminist theory is provided in Chaper 1.

The previous chapter gave specific examples of medical power by exploring the concept of clinical autonomy, the morality implicit in public health messages, and medicine's continuing access to and control over the body. This chapter seeks to analyse the basis upon which critics have challenged that dominance. There are two major themes to be explored here. The first is that of the medical control and regulation of women's lives in the context of reproduction and reproductive technology. Feminist critiques of medicine are concerned not only with the numerical dominance of men in the profession in general as well as in specific areas such as acute services, but with challenging the values, beliefs and ideology associated with the theory and practice of medicine. The second theme to be examined is that of alternative or complementary therapies. Like the feminist critique of medicine, alternative perspectives represent a radical challenge to the most basic concepts and practices of western biomedicine.

4.1 'The miracle of life': the medical colonisation of reproduction

Reproductive technology embraces a range of medical interventions (pharmaceutical and invasive), the purpose of which is either to promote or to prevent pregnancy.

The concept of medicalisation is used to describe a tendency to explain behaviour and experiences in medical terms.

See Chapter 3, section 3.1 for a related discussion of the concept of clinical autonomy.

The medicalisation of death is dealt with in Chapter 3, section 3.3.

Feminist critiques of medicine challenge the way in which women's lives, principally in relation to reproduction, have been subject to the control of the medical profession, with women themselves seen as passive objects. The phrase *reproductive technology* refers not only to pregnancy and birth but also to the use of contraception and to assisted conception in the form of IVF, for example. Oakley suggests that reproduction embraces both the 'promotion of pregnancy' and the 'preventing of pregnancy'. (Oakley 1987: 40). This type of control and regulation is representative of the degree to which women's lives are subject to *medicalisation*. Previous chapters have already made reference to the manner in which medical knowledge can be used as a form of power, and the extent to which the practice of medicine can be based on moral judgements rather than on scientific evidence. In relation to this discussion of reproduction it is particularly helpful to think about medicalisation as the way in which specific 'behaviours or conditions are given medical meanings and thus medical practice becomes the appropriate vehicle for their elimination or control' (Levinson 1998: 75). In this way, the apparently 'natural' process of reproduction is defined as a medical condition requiring 'expert' knowledge, treatment and intervention.

A significant aspect of the concept of medicalisation is the extent to which natural experiences are transformed into medical ones. Oakley provides historical evidence of how the experiences of pregnancy and childbirth were significantly changed because of medical intervention. Prior to the widespread dominance of biomedicine, Oakley argues, the main healers in society were lay women. 'Childbirth occurred at home. There was no systematic medical care during pregnancy. Institutions grouping pregnant and labouring women as 'patients' along with the sick did not exist' (Oakley 1987: 37). It was not until the eighteenth century that childbirth became increasingly technical and appropriated by male medical practitioners. The opportunity to study pregnancy and childbirth was facilitated by the use of hospitals to care for women.

Similar themes emerge from Reissman's account of the medicalisation of childbirth in mid-nineteenth-century America. Like Oakley, Reissman argues that childbirth increasingly came to be seen as a technical problem, thus requiring the expert intervention of the medical profession within a suitable physical location, namely the hospital rather than the home. She suggests that this process of medicalisation resulted in a fundamental change to the nature of childbirth: 'the meaning of childbirth for women was transformed from a human experience to a medical technical problem' (Reissman 1992: 127). The emerging profession of obstetrics reached a position of dominance for a variety of social and medical reasons. Obstetricians were male, mainly white and middle-class, enjoying social and class dominance over the female, lower-class, and mainly immigrant midwives. Of particular importance, argues Reissman, was the ability of the emerging profession to convince both colleagues and the public that pregnancy

required medical and technical intervention in order to reach a successful conclusion. Most significantly of all, mothers were seen as passive objects, knowing less about their own pregnancy than the medical expert.

Oakley suggests that this shift towards the definition of women as 'mindless mothers' emerged at the same time as the technological dominance of pregnancy (1987: 39). The notion of women as 'walking wombs' is clearly illustrated by the following conversation recorded by Oakley.

> *Patient:* It's the tightening I worry about.
> *Doctor:* It's normal in pregnancy. Your womb is supposed to tighten.
> *Patient:* I didn't have it with the other three.
> *Doctor:* Every pregnancy is different. Let's see you in one week.
> [Reading notes] You do seem to have put on a bit of weight.
> *Patient:* What does that mean?
> *Doctor:* It doesn't necessarily mean anything but you must take things easy.
> *Patient:* That's what my husband says. It's easy for men to say that.
> *Doctor:* You shouldn't blame us.
> *Patient:* I'm not blaming you. It's not your fault.
> *Doctor:* It's your set-up at home. You should have organised things better.
> *Patient:* Well, I've got three kids to look after.
> *Doctor:* Yes.
> (Taken from Oakley 1987: 46)

Oakley's analysis of the conversation is intended to illustrate the power dynamics implicit in the doctor–patient relationship. She argues that firstly the doctor dismisses the patient's understanding of her condition and the authority of his own knowledge is reaffirmed. Secondly, the conversation reveals the power the doctor possesses in terms of withholding information. The patient's weight is commented upon but the doctor does not reveal the significance of this fact. The conversation also reveals a general acceptance on the part of both the patient and the doctor of women's responsibility for childcare and housework. The patient herself is seen as being responsible for not taking things easy. Oakley concludes that the doctor is concerned primarily with the technical management of the pregnancy rather than with the real person coping with both her pregnancy and domestic responsibilities. 'The problem of pregnancy management as he has defined it discounts the importance of the whole person' (Oakley 1987: 47).

Feminist critics have questioned the reasoning behind the accepted ways of treating pregnancy and delivering babies. Doyal (1994) talks about the potentially demeaning practices such as the shaving of pubic hair and the giving of enemas. Other commentators have questioned the need for the majority of births to take place within hospitals, suggesting that most labours are 'uneventful' and as such could take place within the woman's own home (Lupton 1995: 148). Removing pregnant women to the hospital environment suggests that pregnancy is an illness, and has the added disadvantage of placing women in an environment unknown to them at a time when they are particularly vulnerable (ibid.: 148). Responses to such criticisms have come in two main forms; the development of a natural

childbirth movement, and a change in the attitudes and practices of the medical profession itself. Natural childbirth is defined in terms of childbirth with 'as little drug intervention as possible' (ibid.: 148). The degree to which the medical profession has embraced a more 'natural' model of childbirth is subject to debate, but there is a growing recognition of the need to allow women to make informed choices about how and where they deliver.

Feminist critique can suggest that medicine and medical practitioners see women as objects and mindless mothers who play no part in deciding what kind of medical care they receive. However, what is perhaps lacking from this analysis is an appreciation that women have at times welcomed technological interventions and even benefited from them. Reissman argues that women 'participated in the medicalisation of childbirth for a complex set of reasons' (Reissman 1992: 128). The principal reason was a desire to find relief from the pain and frequency of childbirth. The desire for pain relief was, Reissman comments, part of a change in social attitudes towards pregnancy, with childbirth no longer seen as 'a condition to be endured with fatalism and passivity' (ibid.: 129). An overall reduction in fertility rates, especially marked among the middle and upper classes, meant that the experience of birth was changing. The fact that women had fewer children resulted in increased anxiety about childbirth and a greater desire for the delivery to take place safely. In the broader context of medicalisation generally, Lupton reminds us that patients and doctors might well collude, effectively enhancing the medical dominance of the latter (Lupton 1995: 98). While medical power can be appreciated in terms of 'disciplining' and controlling people's lives, it may well be true that people give themselves over to medical power voluntarily because of the apparent benefits that accrue.
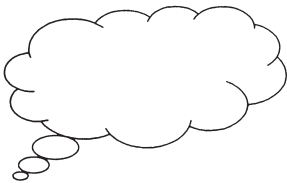
> *In terms of pregnancy and childbirth, what are the benefits of medical intervention?*

Part of Oakley's critique of the medicalisation of pregnancy and childbirth is the failure of the medical profession to take into consideration the whole person. Instead, she argues, women are seen as 'mindless mothers' whose own experiences and knowledge of pregnancy are often ignored. An essential element of the concept of medicalisation can be thus understood as the transformation of human experiences into medical and technical ones. According to Oakley, the personal and social implications of medical treatment are rarely considered:

> It took some twenty years for the practitioners of obstetric ultrasound to wake up to the fact that seeing her foetus on the screen might change the way a women felt about it. This elementary piece of wisdom has translated into technical paediatric language and the notion of prenatal mother–child bonding was born. (Oakley 1987: 52)

> Chapter 3 examines the ability of the medical profession to place the body, even in its inner workings, under surveillance.

In a similar vein, Lupton has considered how the procedure of genetic testing involves a new discourse of the body. It is impossible, Lupton suggests, to separate the technical aspects of genetic screening from its social and emotional implications. Part of the basis upon which people are persuaded of the necessity of undergoing such tests is an appeal to their emotions and anxieties about being a 'good' and responsible parent. Genetic screening provides a very different way of understanding the body; it becomes a collection of codes, like a machine-based system, that can only be interpreted by 'experts' (Lupton 1995). Lupton suggests that this particular discourse on the body has little meaning to lay people. Being told of your risk of passing on a genetically inherited disease in purely statistical terms can appear as overly abstract and difficult to translate into decisions to carry on with or terminate the pregnancy. Lupton contrasts the 'abstract language of biomedicine' with the 'individualised narratives' provided by the parents themselves (ibid.: 152).

Assisted conception

The medicalisation of pregnancy and childbirth has a relatively long history but medical dominance is increasingly interpreted in terms of the ability to create life in the various forms of assisted conception. The following discussion has two main strands; first, an examination of the social, ethical and cultural implications of assisted conception and, second, a consideration of the implications of the medical dominance of women's lives. The preceding chapter outlined the scope and power of medicine in terms of its ability to prolong and enhance life. It was noted that while science provides the means to transform our lives, it does not answer the question of whether or not such interventions should take place. Ethical debates about the use of biomedicine are nowhere more acute than around the use and potential of assisted conception. Debates about assisted conception necessarily go beyond helping those people who are unable to conceive naturally, and embrace complex arguments about its use (and potential misuse), such as the storing of human embryos.
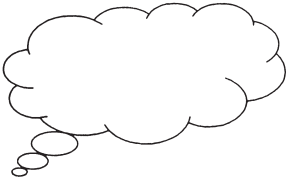
   The use of assisted conception brings into sharp relief the question of who, and under what circumstance, a person is the parent of the child. Under normal circumstances, the parentage of a child seems a simple matter. This is true in the case of the mother (there can be little dispute about who has given birth) but slightly more problematic in the case of the father who, it can be argued, does not know beyond doubt that he is the father of the child, without the aid of blood tests. Parentage, however, is more than simply providing the genetic material to produce a child, as it also involves the social roles and responsibilities associated with raising that child. As Smart (1996) has commented, 'motherhood' is more than a biological relationship; simply giving birth does not result in 'motherhood' or 'mothering'. However, with assisted conception it is possible to extend the notion of 'mother'. Lupton comments that we can refer to someone as an 'egg mother', 'birth mother', 'surrogate mother', 'legal mother' and

'adoptive mother'. Similarly, sperm donation raises the question of whether the donor could enjoy the status of 'father' (Lupton 1995: 156). The Human Fertilisation and Embryology Act of 1990 attempts to circumvent this complex debate by providing what Franklin describes as a technical definition of mother. The Act describes a mother as 'the woman who is carrying or has carried a child as a result of the placing in her of an embryo or of sperm and eggs' (Franklin 1997: 226).

The use of assisted conception raises a further complex question about who should have access to those techniques and enjoy the experience and status of a parent. Debates about access to assisted conception are only partly about the resources to fund such techniques; perhaps more importantly these debates also centre upon a person's (usually a couple's) desire and suitability to parent. According to Franklin, (1997) the desire to parent is seen as a 'natural' impulse. The Warnock Report (1985), set up to debate ethical issues arising from techniques of assisted conception, argued that for many childless couples the social pressures to parent were very significant. Being childless is often seen as a 'failure' to fulfil convention (Franklin 1997: 91). Franklin cites the authors of *The Infertility Handbook* who argue that there is a biological impulse to reproduce: 'Call it a cosmic spark or spiritual fulfilment, biological need or human destiny – the desire for a family rises unbidden from our genetic souls' (Bellina and Wilson 1986: xv – cited in Franklin 1997: 91). It is equally clear, however, that this desire to have a child has to be understood within a social and cultural context and in the case of many western countries this is within the framework of the family, most commonly understood as a heterosexual (married) couple. Such a definition excludes both single women and lesbians who, presumably, are not thought to possess the same biological desire to reproduce. Patrick Steptoe, one of the pioneers of assisted conception techniques, argued that such women should be excluded on the basis that for them to have children would be unnatural and morally wrong (Franklin 1997: 92).

There are many restrictions placed on who may parent via assisted conception. What would your reaction be if similar restrictions were placed on parents who can conceive without medical intervention.

Access to techniques of assisted conception is, therefore, restricted on social and moral grounds. Doyal argues that access to reproductive technology is thus only possible with what she refers to as the tacit or explicit agreement of the medical profession.

For Castells, as for many commentators, the advent of reproductive technologies such as assisted conception represents women's 'growing control over the timing and frequency of child bearing' (Castells 1997: 135). For others, such as Porter (1990), this optimism is misguided, as access to such techniques, she argues, is only achieved via the gatekeepers of services, namely the medical profession. Porter highlights the extent to

which developments in assisted conception have meant the medicalisation of conception as well as of contraception and childbirth. The end result is the exercise of control over 'means of reproduction – access to procedures, technology, information and so on – and thereby controls over women's bodies and ultimately their lives' (Porter 1990: 185).

Porter's research indicated that medical professionals worked with 'ideal types' in relation to the provision of specific methods of contraception. The ideal patient for sterilization was 'a woman in her early thirties, happily married with two or three children. The ideal type depo provera patient was a woman in her early thirties with a large number of unwanted pregnancies, not in a stable relationship and living in local authority housing in a poor part of the city' (Porter 1990: 195). The significance of these ideal types lies in the way in which doctors were reluctant to offer alternative forms of contraception to women who did not fit their ideal type.

Oakley (1987) has noted that in relation to pregnancy and childbirth women largely appear as passive objects and recipients of care. A similar tendency to describe women in passive terms as recipients of embryos is noticeable in relation to assisted conception. Lupton contrasts how 'male scientists and doctors are commonly portrayed as active, expert and rational, the "producers" and "fathers" of "test-tube babies", while women are represented as desperate for children, passive, reacting emotionally to their chance to experience the joys of desired motherhood' (Lupton 1995: 157). According to Franklin, descriptions of IVF treatment tend to underplay the role of would-be parents, in particular that of the mother, and to emphasise the creative power of medical technology. (Franklin 1997: 103). An unquestioning commitment on the part of the hopeful parents to the technological processes involved is ensured by seeking to portray the medical profession as simply lending a helping hand in an otherwise completely 'natural' process (Franklin 1997: 103). Franklin describes initial accounts of IVF as over-simplified – omitting, for example, to provide an accurate representation of the failure rate. The only agency referred to is that of the 'invisible hand of technology' which facilitates conception (ibid.: 104). Medicine itself has brought forth the 'miracle of life'.

The preceding discussion has sought to illustrate both the dominance of the medical profession and the challenges made to this position by feminist critics. In the following discussion, a further dimension of the challenge to biomedicine is introduced in the form of alternative therapies.

4.2 Challenging the dominance of the biomedical model: alternative therapies

Alternative, or complementary, therapies embrace many philosophies and methods but collectively represent a challenge to the concepts of health and disease articulated in the medical model. This part of the discussion begins by defining what is meant by 'alternative' practices and provides specific examples.

Alternative medicine embraces any medical practice that falls outside the boundaries of conventional medicine. Some commentators use the term 'complementary medicine' to imply that non-conventional medicine can be used in conjunction with western biomedicine rather than as a radical alternative.

In their broadest sense, the terms *alternative medicine* or *complementary medicine* can be used to describe any practices that fall outside the boundaries of conventional medicine. West (1993) acknowledges that it is problematic to try and define such a diverse body of practices but offers the possibility of categorising different types of practices. The main categories are identified as physical, psychological and paranormal. She suggests a further distinction between practices that demand a high level of training and those she describes as virtually 'do-it-yourself'. For others the principal distinction between 'alternative' and biomedicine is the former's 'holistic' emphasis. Saks suggests that in 'orthodox' medicine, the overwhelming emphasis is on the physical, with the mind and the spirit 'still typically regarded as relatively peripheral to health care' (Saks 1998: 198) In contrast and despite their apparent diversity, most alternative therapies deal 'with the unity of the mind, body and spirit'. (ibid.: 198) The following are examples of two alternative approaches to understanding health and illness.

Two examples of alternative practices

Homoeopathy is an effective and scientific system of healing which assists the natural tendency of the body to heal itself. It assumes that all symptoms of ill health are expressions of disharmony within the whole person and that it is the patient who needs treatment not the disease.
Source: www.apothecary.co.uk

Acupuncture is medical treatment that can relieve symptoms of some physical and psychological conditions and may encourage the patient's body to heal and repair itself, if it is able to do so.
Acupuncture stimulates the nerves in skin and muscle, and can produce a variety of effects. We know that it increases the body's release of natural painkillers – endorphin and serotonin – in the pain pathways of both the spinal cord and the brain. This modifies the way pain signals are received.
But acupuncture does much more than reduce pain, and has a beneficial effect on health. Patients often notice an improved sense of well being after treatment.
Modern research shows that acupuncture can affect most of the body's systems – the nervous system, muscle tone, hormone outputs, circulation, antibody production and allergic responses, as well as the respiratory, digestive, urinary and reproductive systems.
Source: www.medical-acupuncture.co.uk

The professional marginalisation of alternative medicine

An important element of alternative medicine's status as 'other' and different from orthodox medicine rests on the different conceptualisations of the relationship between the mind, body and spirit. A second and equally important element of the status of alternative practices is their institutional and professional marginalisation in relation to orthodox medicine. Chapter 3 examined the extent of the professional dominance of biomedicine, a dominance powerfully signalled by the illegality of other occupational

groups carrying out tasks for which medical practitioners alone are state registered. Surgical procedures, for example, are the exclusive province of doctors. Other professionals, such as nurses, may observe and assist but not carry out the procedure itself. Saks (1994) argues that this professional dominance was further enhanced by the establishment of the NHS in 1948 because the only form of health care accessible, 'free at the point of delivery', and available to all was orthodox medicine. He describes the state-sponsored NHS as being dominated by 'the drug treatment and surgical interventions of orthodox medicine', thus relegating alternative therapies to the private health care market (Saks 1994: 86).

Orthodox medicine occupies a position of power and dominance over alternative medicine, as illustrated by the definitions of alternative practices offered by professional organisations such as the British Medical Association. The BMA draws a distinction between complementary therapies and alternative practices: the former are defined as treating patients while they are receiving drug therapy from a *registered* doctor, and the latter as treating patients *in place of* a *registered* doctor. The BMA offers a definition of orthodox medicine based principally on *who* delivers the treatment, in this case a 'registered medical practitioner' (BMA 1993: 7). In a similar vein the definition of 'non-conventional' medicine centres around *what it is not*, that is orthodox, rather than considering of *what it is* in terms of the concepts of health and disease underpinning alternative practices. Non-conventional medicine is defined as 'those forms of treatment which are not widely used by orthodox health care professions, and the skills of which are not taught as part of the undergraduate curriculum of orthodox medical and paramedical health care courses' (BMA 1993: 7). Saks (1994) argues that orthodox medicine has conducted a 'strong campaign' against its alternative competitors and draws on evidence from a report by the BMA first published in 1986. This report, he suggests, 'extolled the scientific aspects of modern biomedicine, whilst at the same time generally depicting alternative medicine as superstitious dogma' (Saks 1994: 88). Supporters of orthodox medicine are keen to point out the importance of the patient having 'faith' in alternative practitioners and argue that this reinforces the message that the therapy will work. In contrast, it is suggested that orthodox medicine does not depend on this element of faith but on its proven ability to eradicate disease.

Alternative concepts of health

The following discussion requires you to draw on the examples of specific practices outlined above. The central elements of alternative medicine are detailed below:
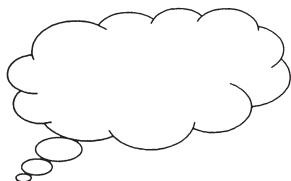
> *Go back to the descriptions of homoeopathy and acupuncture. Can you recognise these concepts of health in the descriptions offered?*

Figure 4.1 *Alternative medicine: concepts of health*

Alternative medicine	Biomedicine
Health as a balance of opposing forces within the body.	Health as the absence of disease.
Disease understood as indicating the presence of negative, disruptive forces within the body. Symptoms are the product of the body's attempts to rid it of toxic substances.	Disease as defined in relation to a specific part of the body. Essentially, disease is understood as a deviation from normal functioning.
'Reading' the body, examining dietary habits, lifestyles and constitution types to achieve diagnosis.	Diagnosis achieved by examining the form and structure of specific organisms and the degree to which the presence of a disease indicates a deviation from normal functioning.
Therapy is based on an attempt to strengthen vitalising, positive forces within the body.	Therapy consists of attempts to destroy or suppress disease.

Source: C.W. Aakster in A. Beattie, M. Grott, L. Jones and M. Sidell, *Health and Well-being: A Reader* (1993). Macmillan/Open University. Reproduced with permission of Palgrave Macmillan.

> The association between science, objectivity and rationality is explained in Chapter 2, section 2.1.

Attempts to describe particular alternative practices and to detail what is specific about the concepts of health underpinning this approach reveal the essential differences between this approach and the biomedical model. The discussion has sought to draw your attention to differing conceptions of health, disease and the relationship between mind, body and spirit. Biomedicine has sought to emphasise a further distinction between itself and alternative practices by asserting the supremacy of science over superstition. Previous discussions of biomedicine have dealt with its commitment to scientific methods free from social or political bias (BMA, cited in Saks 1992). The scientific observation of natural phenomena allows for the development of laws governing such phenomena and, perhaps most significantly, such laws and the resulting 'facts' can be said to be valid because the results can be reproduced repeatedly, proving their validity. This reproducibility of results, it is argued, cannot be matched by alternative medicine.

> See Chapter 2 for a detailed discussion of medicine as a dominant discourse.

The juxtaposition of 'scientific' medicine and 'unscientific' alternative practices leaves little scope for debate, as both sides appear to base their arguments on criteria not accepted by the other. It is biomedicine, however, that enjoys the dominant position in terms of being *the* established form of medicine. An essential element of this dominance can be traced back to a wide acceptance of the validity of science and scientific methods during the Enlightenment. The practice and philosophy of alternative medicine is, arguably, at a distinct disadvantage because science has reached the status of 'truth'. In the opening chapter, you were introduced to some of the basic elements of a post-modern critique of society and knowledge. Post-modernism is critical and sceptical of attempts to offer single, monolithic explanations of any phenomenon and so the whole basis of rational

scientific knowledge has been questioned. Saks (1998: 204) argues that this critique of 'science, reason and enlightenment' provides a useful tool with which to reappraise the philosophical basis of alternative medical practices. Since post-modernism is characterised by 'the acceptance of multiple realities and coexisting narratives' (Saks 1998: 204) it is possible to appraise the relative merits of alternative medicine and biomedicine in such a way that both are accepted as different but equally valid conceptions of the body, health and disease. Interestingly, the British Holistic Medical Association also draws attention to changes in modes of thinking and in particular to an acceptance of the non-scientific in terms of recognising the significance of human spirit and conscience. The British Holistic Medical Association argues that medicine in the twenty-first century will increasingly come to recognise the significance of the relationships between the mind, body and spirit and the human capacity to alter both the internal and the external environment (www.bhma.org).

Choosing to use alternative medicine

Alternative medicine clearly demonstrates the possibility of a philosophical challenge to the dominance of orthodox medicine. It should also be evident from the critique of medicine presented in the preceding chapter, that the practice of orthodox medicine is also ripe for criticism. Coward (1993) argues that biomedicine has not only medicalised many aspects of human existence but has done so in an inhumane way. The examples of iatrogenic practices discussed in Chapter 3 included a consideration of the harmful side-effects of drugs as well as examples of medical interventions, such as surgery, that have resulted in harm to the patient. The later discussion of mental health will also illustrate that the practice of medicine, as well as specific forms of treatment, have been uncaring and inhumane. The supposed neutrality of biomedicine, its ability to see disease as a purely biological entity, may not always be perceived as beneficial. As Coward comments, a purely rational explanation of disease as arbitrary does not, perhaps, satisfy a more fundamental need to understand why our own life has been affected in this way.

Many of the more abstract points made by Coward are echoed in the empirical research carried out to ascertain why people use alternative medicine. Sharma (1992) found that in general people used alternative medicine because they placed a high value on what they found to be the more equal and informed relationship between practitioners and patients and because of the importance attached to the consideration of the personal circumstances of their illness. A more detailed attempt to understand the use of alternative medicine is offered below. Three elements are highlighted: the extent to which its use reflects a rejection of biomedicine; the extent to which its use represents a recognition of the positive benefits; and the extent to which its use is part of a wider cultural change in which choice and self-determination are seen as paramount.

We have highlighted the assumed advantages of alternative practices

Figure 4.2 *Explaining why people use alternative medicine*

- **The limits of biomedicine**
  Biomedicine is unable to 'cure' certain conditions.
  Biomedicine does not place enough emphasis on the causes of illness and is preoccupied
     with relieving symptoms.
  The side-effects of biomedical treatment are potentially harmful.
  Biomedical treatment is often too drastic and too invasive.

- **The benefits of alternative medicine**
  Provides an explanation of the causes of ill health and disease in the context of a person's
     individual lifestyle.
  Provides a more egalitarian relationship between patient and practitioner.
  Offers an alternative to 'high-tech' medicine.
  Alternative medicine treats the whole person.
  Alternative medicine encourages individuals to take greater responsibility for their health.
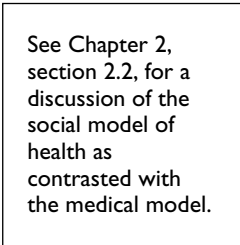
- **The use of alternative medicine as an expression of post-modern society**
  The use of alternative medicine expresses a greater desire for self-determination and
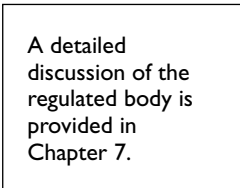   choice.
  The use of alternative medicine challenges the cultural dominance of biomedicine.
  The use of alternative medicine reflects a more general trend for maintaining the body
     through the purchase of consumer goods and services.

Sources: Sharma (1992), Coward (1993) and Lupton (1995)

See Chapter 2, section 2.2, for a discussion of the social model of health as contrasted with the medical model.

over orthodox medicine. However, these practices themselves have been subject to critical scrutiny. Commentators such as Coward have emphasised the individualistic assessment of health underpinning many alternative practices. Such an approach can be contrasted with the social model of health which draws our attention to the social, economic and cultural determinants of health. Chapter 6, examining inequalities in health, seeks to place patterns of morbidity and mortality within a social context. There is widespread acceptance within the discipline of sociology that economic and social factors have a significant impact upon health outcomes. Sociologists of health do not deny the importance of agency (that is to say the capacity of individuals to act rather than be acted upon) but also accept that agency has its limitations. In contrast, Coward argues, alternative medicine stresses the extent to which individuals can determine their health status and that their explanation leads almost inevitably to the conclusion that individuals are responsible for their own health regardless of their social circumstances.

A detailed discussion of the regulated body is provided in Chapter 7.

This appeal to the individual is, Coward suggests, part of a cultural obsession with the performance and appearance the body. It is important to note, however, that a central theme in the world of the 'worried well' is an obsession with appearance in terms of the body as a project, something owned by the individual and open to change and development by them. The widespread popularity, for example, of diets to lose weight, fitness to tone the body, and cosmetic surgery to alter it, are evidence of the new significance attached to the body. Working on the body to alter or enhance its

appearance is represented as a matter of choice and self-determination. Good health and poor health, therefore, become matters of personal responsibility and, as Lupton reminds us, contain strong moral overtones of how we ought to care for the body.

Coward argues that part of the attraction of alternative medicine is its association with the natural world and the healing power of nature (cited in Lupton 1995: 126). Like the concept of 'science' with its association with the values of rationality, objectivity and progress, 'nature' is closely linked to ideas of virtue, goodness and purity (Lupton 1995: 127). Such an association suggests that nature and natural remedies are implicitly good for you and inevitably preferable to artificial substances such as pharmacological drugs. Lupton argues that it is impossible to support such a clear-cut distinction between natural and artificial substances since 'many naturally occurring substances can be toxic, and many chemicals are derived from naturally occurring substances' (1995: 126). Many freely available herbal remedies carry the potential to be harmful when not taken in an appropriate manner. One such example, for the treatment of depression, would be the use of St John's wort, available over the counter and capable of being used even when a diagnosis of depression has not been made. It is perhaps ironic to note that, at a time when the use and efficacy of drugs are subject to more stringent regulation (through, for example, the Health Technology Board Scotland and the National Institute for Clinical Excellence in England and Wales) and when there is a requirement for pharmaceutical manufacturers to provide detailed patient information, natural remedies are not subject to the same degree of regulation. Most herbal remedies are in fact not classified as medicine and, therefore, are not subject to the same requirement for testing and regulation as artificial substances.

This chapter has described and analysed two challenges to the dominance of biomedicine by feminist critiques and by alternative medicine.

Summary

- The process of medicalisation has transformed natural experiences into medical ones. This is particularly true of pregnancy and childbirth.
- Medicine acts as a gatekeeper to reproductive technology. Decisions about access to reproductive technology are made not on the basis of medical and objective evidence but on the basis of prevailing social and cultural values.
- Authors such as Oakley argue that medicalisation has resulted in women patients being seen as passive recipients of care.
- Alternative medicine represents a fundamental challenge to the belief system underpinning biomedicine, as illustrated by two specific examples, homoeopathy and acupuncture.
- For an increasing number of people, alternative medicine represents a positive alternative to biomedicine.

Case Study

Kathy was recently treated in hospital for a grade 'A' streptococcal infection that lead to cellulitis, septicaemia and pneumonia. During her period of illness, she was given large doses of antibiotics and strong painkillers. The former placed a huge strain on her kidneys, while the latter made her drowsy and 'spaced out'. Kathy never questioned the treatment she received even though she did not fully understand everything that she was told by the doctors and nurses.

Kathy is also a regular user of alternative medicine for the treatment of migraine. She has taken on board what she has been told by her homeopathic practitioner and altered her diet and tried to deal positively with stressful situations.

1 How can Kathy be a user of orthodox medicine and alternative medicine?
2 For someone who has actively sought out a second opinion on her migraine and who has attempted to address the underlying causes of the condition through non-medical means, do you find it odd that she simply accepted what happened to her in hospital?
3 Talk to friends and colleagues and try and find out who uses or has used alternative medicine. Have they visited a practitioner or have they treated themselves by purchasing herbal medicines? For which conditions were people more likely to use alternative medicine?

Recommended reading

Aakster, C.W. (1993) 'Concepts in alternative medicine' in A. Beattie, M. Gott, L. Jones and M. Sidell (eds) *Health and Well-being: A Reader.* London: Macmillan/Open University. **This article provides a good starting point for any further reading on alternative medicine.**

Franklin, S. (1997) *Embodied Progress: A Cultural Account of Assisted Conception.* London: Routledge. **A very detailed and in-depth cultural account of assisted conception and a very useful starting point for further research into this subject area.**

Saks, M. (1992) (ed.) *Alternative Medicine in Britain.* Oxford: Clarendon Press. **An in-depth and questioning account of alternative medicine.**

GENDER, ETHNICITY, 'RACE' AND MENTAL HEALTH

5.1 Introduction. Outlines the role and profile of mental health within society.

5.2 Perspectives on mental health. Discusses different and competing ways of explaining and perceiving mental health.

5.3 Patterns of mental health/illness. Identifies trends and statistics relating to mental health.

5.4 Ethnicity and mental health. Examines the inequalities in care and treatment for Black and Asian people.

5.5 Gender and mental health. A discussion of why men and women have different experiences of mental health.

5.6 Suicide. Identifies an increasing trend among young men, as well as discussing major theories.

Key concepts

Mental illness, lay-health narratives, stigma, ethnicity, race, racism, sexism, gender roles, social constructions and suicide.

One theme that has been developed throughout this book is that health is never value-free nor free of the influences of a variety of attitudes and prejudices that exist in the wider society. Much sociological research over the last few decades has drawn attention to how health, whether physical or mental, is affected by factors such as class, race and gender. Class, or socio-economic status, will be more fully discussed in Chapter 6. This chapter will look at how gender and race affect and influence health by concentrating on the field of mental health. It must be noted that it is not only mental health where such inequalities are evident and other chapters have discussed and highlighted gender and race issues. The discussion will begin with a general overview of mental illness and then will turn to aspects of mental health and race, specifically focusing on the problems of defining race, how people from ethnic groups encounter care, and the

relationship between racism and mental health. The focus will then turn to gender issues, initially looking at how women are over-represented in mental illness statistics, before turning to the increasing trend of young men attempting suicide.

5.1 Introduction

> I start to get the feeling that something is really wrong. Like all the drugs put together – the lithium, the Prozac, the desipramine, and Deysrel that I take to sleep at night can no longer combat whatever it was that was wrong with me in the first place. I feel like a defective model, like I came off the assembly line flat-out fucked and my parents should have taken me back for repairs before the warranty ran out. But that was long ago. (Wurtzel 1996: 1)

There exists an illness that lies hidden beneath the skin with very few physical symptoms, an illness that is difficult to detect, or for the people who have it to realise that they are ill. This is mental illness in all its varieties, from depression to schizophrenia to bi-polar affective disorder. In previous centuries mental illness was seen as possession by demons, a curse by God. Even in more enlightened times it was the ultimate transgression against reason and rationality. As a result mental illness became stigmatised, the badge of the outsider and the deviant, associated with danger and violence.
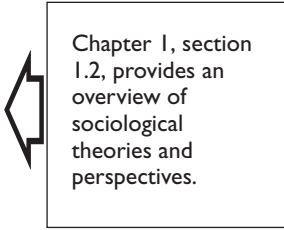
The quotation above from the American author Elizabeth Wurtzel reflects her experiences of long-term depression and the debilitating effects it had on her life until the salvation offered by Prozac, which provided a stability that she had never experienced before. There are many other examples of reflections on mental illness in the arts. English singer-songwriter Nick Drake, whose depressive introspection and withdrawal from the world eventually led him to end his short life by taking an overdose, conveyed his experiences of depression in his song 'Black-eyed dog'. The song borrows Winston Churchill's famous metaphor of depression as a faithful, ever-present black dog who is both part of you yet separate. The names of a writer, a musician and a politician have been mentioned in relation to mental illness. This list could be considerably extended to include notable people from all walks of life, including scientists, sports people, artists, academics, etc. This suggests that mental illness is a very common condition, with depression the most common form of it. Nevertheless, mental illness still attracts much stigma and fear.
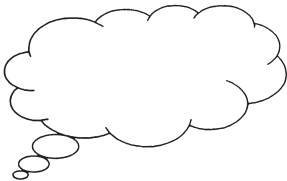
Try to identify and discuss the way in which mental illness is portrayed or represented in society – think about films, soaps, plays, newspapers.

5.2 Perspectives on mental health

As mentioned elsewhere in this book, we usually accept medical terminology and classifications as given, that is, as being fact, value-free and scientific. These notions have been challenged by various sociologists and other writers. Their arguments were summarised earlier.

When looking at mental illness we see the coming together of social, cultural, historical and medical discourses mainly concerned with the functioning and dysfunctioning of the mind. Mental illness operates at the interface of the mind and the social body, its many forms being classified in the light of how someone perceives actions and verbal communications of someone else. Here we see how useful sociology can be in attempting to understand mental illness.

The mind is a very complex entity to analyse and understand, especially when it is judged to be acting in an unusual and problematic manner, for those judgements are based not on purely neutral 'scientific' criteria but, rather, on social values and cultural norms (Foster 1995).

One good example of this is the way in which psychiatry and society have changed their perception of homosexuality. Until relatively recently, being gay was considered a form of mental illness and gay men could find themselves on the receiving end of some quite invasive interventions such as incarceration. During the 1960s, however, social attitudes towards homosexuality changed, partly due to the activities of campaign groups such as the Gay Liberation Front and events such as Stonewall when gay people fought back against police harassment. As the stigma and stereotyping diminished, so did the view that homosexuality was an illness rather than just another form of human sexuality.

As has been said, many myths and pejorative images surround people who have mental illness. One common misconception is that people with schizophrenia have a Jekyll and Hyde personality, whereby they are sane and rational at one moment and violent and deranged the next. Unfortunately these negative images appear to be widespread and persistent. Early research by Star (1955) identified negative stereotypes in the US, while similar work by Hall et al. (1993) in England found people possessing similar attitudes nearly 40 years later and on a different continent. Wider representations of mental illness also conflate mental illness and danger. Some form of 'mental imbalance' often characterises many a movie or soap series villain. However, these are not just neutral images that are contained within the safety of the cinema or the TV screen, but form beliefs and constructs held by people in everyday contexts. In turn these social stigmas increase the stress of those with mental illness and exacerbate feelings of social exclusion and social distance.

The 'Counting the cost' survey by Baker and MacPherson (2000) for MIND highlighted the extent of stigmatising images and the effects they had had on people with mental illness. For many respondents to the survey the social stigma was harder to deal with than the symptoms of their particular condition. Some key results from this survey are summarised below:

- 73 per cent of respondents felt that the media had been unfair, unbalanced or very negative over the previous three years.
- 12 per cent felt that the media had been fair, balanced or very positive.
- 50 per cent claimed that poor media coverage had a negative impact on their mental health.
- 24 per cent experienced some hostility from neighbours and their local communities as a result of media reports.
(Baker and MacPherson, 2000: 5)
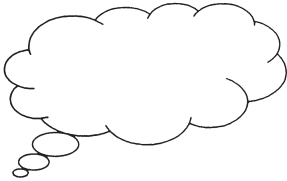
> *Discuss why mental illness attracts such negative imagery.*

Negative views of mental illness and mentally ill people are also evident among young people. The 'Tomorrow's minds' (Baker and MacPherson, 2000) survey reached similar findings on stereotyping and prejudice. Sixty per cent of young people in the survey admitted to using abusive terms such as 'psycho', 'schizo', 'nutter' or 'loony' to describe mentally ill people.

Historically, these images of mental illness have their roots in ideas of demon possession (Scheff 1966) or the loss of rationality (Foucault 1967). Currently, negative images of mental illness are presented in newspaper articles, films, documentaries and popular dramas. Again we see a dominance of stereotypes and misleading images. Philo (1996) noted that the majority of images were associated with violence, particularly violence towards other people, though also to self. The reasons that so many negative images dominate is not necessarily to do with the prejudiced attitudes of programme makers but rather with the restraints imposed by the format of television shows, especially soaps. Programmes are restricted to half-hour slots with multiple plot-lines and a need to provide dramatic entertainment unfolding over a relatively short period of time. Thus, realistic portrayals of mental illness with all the various subtleties and intricacies that people with mental illness experience are ignored or glossed over. In addition, the need for storylines to develop, peak and pass quite quickly can often present a very unrealistic portrayal of an illness, how it develops and how it affects someone's life.
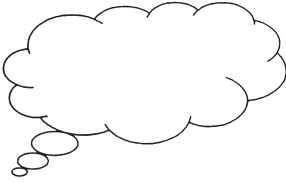
Stigma

Stigma refers to an attribute that discredits someone full acceptance in a particular situation.

Goffman is probably one of the best-known sociologists who has studied and analysed how certain groups of people attract a stigma. His humanistic and sympathetic work focuses on why certain attributes of an individual or group deny them full acceptance in given situations and lead them either to be excluded or to be left with a feeling of not 'fitting in'. He classifies stigma into three broad groups:

- **physical stigma** – for example facial scarring, a physical impairment or an amputation

- **personal/character stigma** – for example drug use, sexuality or mental health
- **social stigma** – belonging to a particular group or ethnic minority (Goffman, 1968)

Can you identify conditions, mental or physical, that could be potentially stigmatising? Try to figure out why they could be stigmatising.

Like other interactionists he seeks to explore the subtleties and intricacies of how people present themselves to the outside world, especially if their identity is in some way 'spoiled' or stigmatised. How that identity can be spoiled or stigmatised may vary greatly. Sometimes it is highly visible, in the case of facial scarring for example, or it can be highly invisible, such as a history of depressive episodes. Whatever it is, it carries the possibility of completely altering social identity. In some respects we may all have something in our lives that we wish to keep hidden, or pieces of personal information that we manage in certain ways so as to maintain a particular 'face' to those about us. Another aspect of Goffman's notion of stigma is that it is highly relational, depending on the situation in which we find ourselves. The previous section outlined how people with mental health problems are portrayed in a negative light, and, if their status is known, in certain situations, the effects could be quite damaging. However, if that same person was with others who shared similar mental health problems then the stigma would be reduced or non-existent. Notions of what is normal or what stigma is, in this way are highly contextual with each of these labels being socially constructed with no inherent or natural basis.

People can respond in a variety of ways to a potentially stigmatising condition or situation though, as Goffman argues, this can depend on how concealed or 'displayed' the stigma is. For those with a concealed or concealable stigma, an attribute that Goffman terms 'a discreditable stigma', there is the possibility of managing, manipulating or presenting information so as to avoid revealing the stigma. This is termed 'passing' and entails devising a routine. This routine may involve being careful about what one talks about, where one goes, what one wears and so on – basically managing your daily life so as to keep potentially stigmatising information secret (see box opposite).

> 'Passing' refers to attempts to conceal a potential stigma and prevent its disclosure.

Goffman points out that trying to maintain this round of secrecy can come at a terrible cost and be quite emotionally draining and demanding. There is always the chance of letting information slip or being discovered, and the consequences, real or imagined, having to be endured.

> Chapter 6, sections 4 and 5 discusses issues of physical chronic illness, identity and stigma.

As persuasive and elaborate as Goffman's ideas are, he has been criticised for not acknowledging the material basis of stigmas and on overly reflecting on the individual (Goffman 1968). His ideas however, do provide a challenge to health professionals as he stresses the importance of constructing identity. For some people, as the work by Baker and MacPherson

Example of stigma and passing

David encountered severe mental health problems shortly after leaving university with a degree in plant science. Feeling very depressed he found himself unable to leave his flat and even to attend to his personal hygiene. After several years of drug therapy and counselling he became more socially confident and able to deal with aspects of his mental health. He soon reached the point where he wanted to start working and perhaps catch up with old friends again. However, he did not want them to find out about his mental health problems and was worried that they might find him strange or dangerous. The potential problem was made worse by having a gap of several years in his life when he was ill and did not start a career like so many of his old university friends. Fortunately, he managed to find a job working in the greenhouses of the local botanical gardens. His job involved routine repair and cleaning activities, even though he was qualified to take on more complex and demanding work. The job, though, gave him the cover of saying that he was working in the Botanical Gardens, making it sound that he was currently in work that was of an appropriate level for a graduate with several years' work experience, even though it was not. This made it easier for him to catch up with old friends as he could pass himself as 'normal' and hide aspects of his biography that he did not want revealed.

(2000) illustrates, sometimes the social stigma of a condition can be more of an issue than the condition itself.

Patterns of mental health/illness

As mentioned in the introduction, mental illness is a common form of illness in society and affects a wide cross-section of people of different ages, sexes and ethnicity. Though certain conditions tend to be found in some groups more than in others, certain people, for a variety of reasons, are more at risk of developing a mental illness. Overall, mental illnesses are fairly common, the most common being depression. A summary of the statistics would indicate that:

- Around 300 people out of 1,000 will experience mental health problems every year in Britain
- 230 of these will visit a GP
- 102 will be diagnosed as having a mental health problem
- 24 will be referred to a specialist psychiatric service
- 6 will become in-patients in psychiatric services
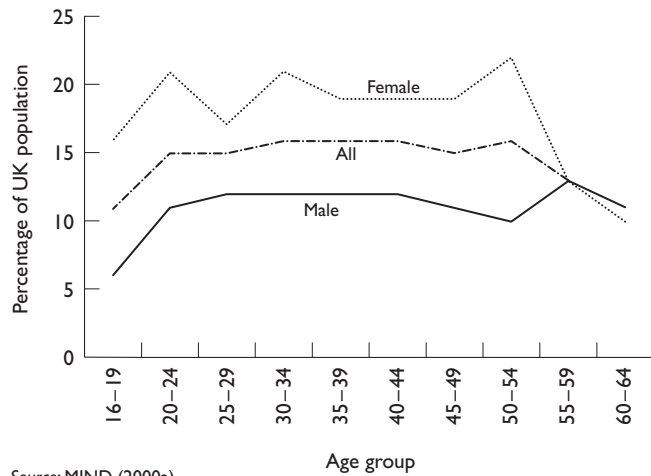 (MIND 2000a)

As Figure 5.1 indicates there are more women with diagnosed mental illness than men at most ages.

It is quite apparent from Figure 5.2 that there is a tendency for mental illness to be distributed unevenly across the class scale, particularly for women. In the research this association between social class and mental illness has long been noticeable. Early researchers such as Faris and Dunham (1939) from the Chicago School of Sociology, in their study of the various
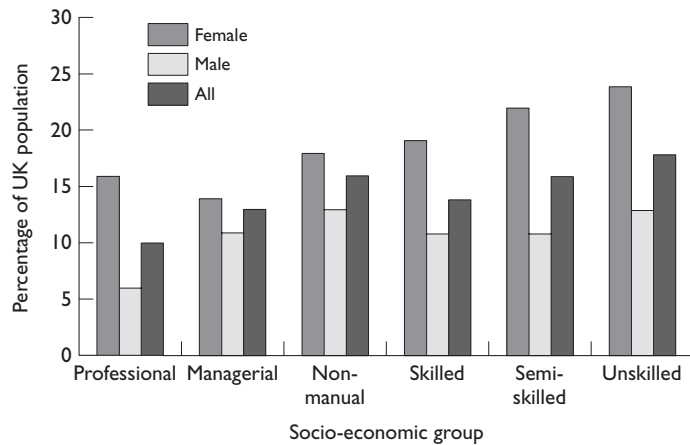
Figure 5.1 *Mental illness by age and sex*

Source: MIND (2000a)

Figure 5.2 *Adults by socio-economic group with significant mental health problems in Britain*

Source: MIND (2000a)

residential zones of Chicago observed that schizophrenia was more frequent among working-class people. Slightly later American work by Hollingshead and Redlich (1953) also identified class factors in relation to mental disorder. The now classic work by Brown and Harris (1978) also noted class differences when they came across higher rates of depression among working-class women with children than their middle-class counterparts.

5.4 Ethnicity and mental health

As mentioned before, mental illness is bound in with social and cultural discourses both in terms of identification, patterns and causes. This is especially so when ethnicity and race are considered. There are distinct patterns and issues that relate to how people from a variety of ethnic backgrounds are diagnosed with mental illnesses and their interactions with mental health services.

Before we carry on this discussion there is a need to proceed with care and caution when using terms such as race and ethnicity. The term race is highly problematic both in its conceptual basis and in its scientific validity. Again, it is a term that is often used uncritically in daily lay discourse and accepts the idea that there are distinct and different types of human with certain characteristics and patterns of behaviour. However, this whole assumption is riddled with historical prejudice and racist attitudes. If we look first at the scientific basis of categorising humans into different races we find that there is no evidence that this can be done. No credible contemporary scientist would argue for the different races case. Genetically humans are too similar to each other to attempt to do this:

> Of all genetic variation known for enzymes and other proteins, where it has been possible to actually count up the frequencies of different forms of genes and so get an objective estimate of genetic variation, 85% turns out to be between individuals within the same local population, tribe or nation; a further 8% is between tribes or nations within a major 'race'; and the remaining 7% is between major 'races'. This means that the genetic variation between one Spaniard and another, or between one Masai and another, is 85% of all human genetic variation, while only 15% is accounted for by breaking people up into groups . . . Any use of racial categories must take its justifications from some source other than biology. The remarkable feature of human evolution and history has been the very small degree of divergence between geographical populations as compared with genetic variation among individuals. (Rose et al. (1984: 126–7)

Concepts and discourses of classifying by skin colour are historically quite recent. At other times in history the colour of someone's skin was almost an irrelevance. In ancient Rome, for example, distinctions between people were made according to their status as free citizens or as slaves, with both groups of people being a heterogeneous mix of skin colours. In the Middle Ages religion acted as a way of distinguishing people, with diverse populations classified as belonging to Islam, Christianity or Judaism. It was not until the introduction of slavery in the early days of capitalism, from the late 1700s onwards, that we start to see racism as we would understand it today, emerging as a way of justifying the mass exploitation of millions of people enslaved in plantations throughout the Americas (Callinicos 1992).

Similar qualifications must be made when using the seemingly more neutral term of ethnicity. It too is overlaid with certain assumptions and images. The phrase 'ethnic minority' often acts as a coded term for Black or Asian people. Rarely is it used in a context where it represents white

'Race' is a problematic term within sociology. It is often used to imply distinct characteristics between humans on the basis of skin colour, but lacks any real scientific validity.

Often appearing more neutral than the problematic term of race, ethnicity too can be contentious as it acts as a coded term for Black and Asian people.

people – how often, after all, does one hear the term 'ethnic majority' (Davidson 1999)? We must also be wary when using terms such as 'Black' and 'Asian'. Even though these are highly useful when refering to certain groups of people, they also run the risk of implying that everyone who is Black or Asian forms a homogeneous group, where ideas, cultures and experiences are similar. If one thinks of the diversity of cultures that exists among people who might be described as being white European, then we can alert ourselves to potential problems.

Racist ideas and cultural superiority have long influenced western ideas about the mental health of Black people. During the American Civil War Black slaves who ran away from plantations were said to be suffering from a condition called 'drapetomania', the assumption being that they must be 'mad' to want to leave the security of plantation life! Unfortunately, these instances of racist health beliefs are not just curious oddities located in history. Current literature and research finds that Black and Asian people experience considerable problems when being diagnosed, on being admitted to psychiatric hospitals, and during treatment (see Figure 5.3 for a summary of findings).

Figure 5.3 *Black people and care – summary of findings*

Summarising hospital studies and anecdotal evidence, MIND (2000a) found that Black and African-Caribbean people are more likely:

- To be diagnosed with schizophrenia. Studies point to rates between ten to eighteen times higher.
- To receive 'physical' treatments when in care.
- Not to receive counselling or psychotherapy or to see Black counsellors.
- To be regarded as violent, located in locked wards, and have longer stays in medium-secure care.
- To receive higher doses of medication.
- To find their way to hospital via the police, or compulsory admission under the Mental Health Act or from prison.
- Overall, Black people will have poorer outcomes after care.

Source: MIND (2000a)

Figure 5.3 shows how Black people are over-represented in mental illness statistics, more likely to be placed in secure wards and to receive different, if not poorer, treatment and care than whites. As ever, statistics and research findings beg the question of why is this so. Delving a little deeper we can see a picture of intentional and unintentional prejudice, racism of various kinds and a general lack of cultural sensitivity. To answer the question in more detail we shall look at why there is an over-representation of black people in the statistics, how black people come into contact with services and the treatment that is offered.

Pathways to care: ethnic minorities' initial contact with psychiatric services

As we have indicated, one of the most common pathways for African-Caribbean people to come into contact with psychiatric services is via the police. From the research, Pilgrim and Rogers (1993) identified multiple interconnecting reasons. Black people, especially young Black men, are more likely to be regarded as potentially threatening and/or dangerous than white people. These attitudes exist not only among the public, for the Stephen Lawrence Inquiry found examples of institutionalised racism within the Metropolitan Police Force. Here we see the police, an important part of the 'control culture' in British society, reflecting and acting on the wider racist attitudes that exist in society. Therefore, when the police come into contact with young Black men they are more likely to react and interpret their behaviour in a negative manner. This negativity can extend to the judiciary as well. Pilgrim and Rogers also noted that Black people have a different perception of services from white users, whether one of mistrust or a cynicism about the quality of treatment they might receive.

Treatment

When people from Black or Asian communities are offered treatment, the form and quality of the services on offer can again be different from those offered to white service users. Reviewing the literature on treatment of ethnic minorities, Pilgrim and Rogers (1993: 57) noted that 'black people are treated in a more coercive and punitive way within the psychiatric system'. They cited various examples of research which indicated that Black people, even when they were non-violent, tended to receive more medication over the period of their treatment and that medication was more likely to include major tranquillisers. In addition, African-Caribbean patients were more often seen as potentially threatening or aggressive.

Problems exist for Black and Asian people in aftercare and in living in the community. The ever present problem of racism emerged clearly in Radia's (1996) study of Asians with mental health problems living in the four London boroughs of Brent, Harrow, Ealing and Tower Hamlets. Respondents here reported that they feared racial assault and abuse on the streets. Service provision was also noted to be poor and lacking in cultural sensitivity, with Asian people in this study often being subject to stereotyping by service providers. Common myths were that Asian people would be looked after 'by their own' and that services were not wanted because no one came forward. The lack of cultural sensitivity came through when conceptualising mental illness. Western notions of the mind and body being separate entities are not shared by Asian people, who see both existing as a whole. Fenton and Sadiq-Sangster (1996) have also noted this point. They found that south Asian women conceptualised mental

distress using metaphors that shared images and expressions of mind and body. In their study feelings of being stressed and of low mood were expressed as 'thinking-too-much-in-the-heart'.

Other research has also noted a lack of cultural sensitivity within service provision. Examining counselling providers in Glasgow, Leeds, Bristol and London, Netto et al. (2001) reported that a lack of awareness of cultural and religious factors could have a negative impact on the uptake and success of counselling services for Asian and Black people. They suggested that services could be improved by increasing access to counselling for Black people; by increasing the number of trained counsellors with appropriate experience and/or training in cultural sensitivity; by reviewing service provision in order to obtain feedback from Black service-users; and by encouraging the Black community to question their own attitudes to mental health to make it easier for Black people to come forward with mental health problems.

Irish people and mental health

So far we have concentrated on the experiences of Black and Asian people but there exists another ethnic minority in the UK that also experiences difficulties. This minority has a distinct problem, namely invisibility, because they are classified as part of the indigenous white population. Here we are referring to Irish-born people living in Britain. Even though Irish-born people may outwardly appear to share the characteristics of native-born white people in terms of skin colour and language there are many cultural subtleties that are overlooked by service providers and by society as a whole.
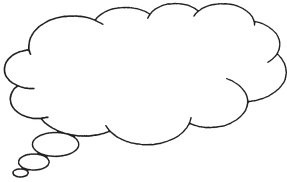
Figure 5.4 *Irish-born people and mental health*
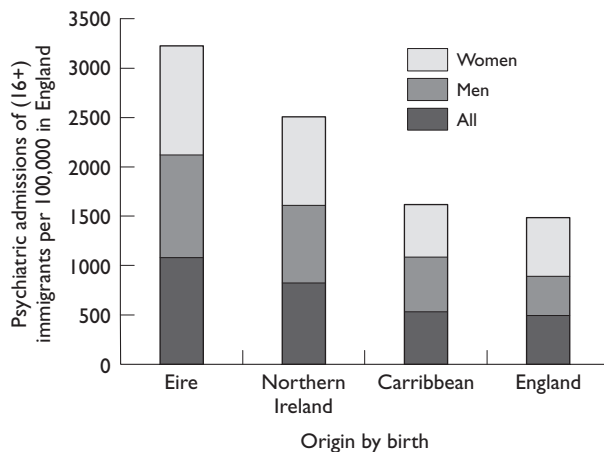
Source: Pilgrim and Rogers 1993: 59

Irish-born people face the following problems:

* lack of services designed for Irish-born people
* high unemployment
* high levels of mental and physical health problems
* reduction in life expectancy on immigration to England
  (MIND 2000b)

Have you ever encountered an example, whether on placement or in your own experience, where someone has been treated differently because of their skin colour, accent or where they were from? Why did it happen, do you think?

Summary and discussion

To summarise so far: we can see that there are a number of explanations for why people from Black and other ethnic backgrounds appear to have higher rates of mental illness and a different, often coercive, relationship with services. These explanations include:

* racist and prejudiced attitudes on the part of service providers and agencies of the state, such as the police
* lack of cultural sensitivity
* more frequent exposure to stressors in the form of, for example, unemployment
* adjusting to a new society
* racism generally

These explanations are useful when trying to understand the situation of people from ethnic minorities in relation to mental illness. However, Pilgrim and Rogers (1993) point to another, related concept that may help us in this context. They draw on Foucault's concept of seeing madness as part of the 'other', that is, groups of people who are regarded as being outside the norms of society and as constituting a threat to the order of society. In previous times people with mental illnesses were excluded from society, banished to the Ships of Fools that traversed European waterways in the Middle Ages, or to the asylums of the Victorian age. Here we see, they argue, a relationship between new racism and psychiatric discourse. In the new racism many of the explicit old racist practices of viewing Black and Asian people as being sub-human have given way to viewing people as a threat to 'British' social and cultural identity. This idea was noticeable during a speech made by Conservative MP John Townsend in the 2001 UK General Election when he claimed that immigration was undermining Britain as an Anglo-Saxon country. The new racism also deals with this supposed threat to social and cultural identity by using exclusion, this

time by excluding Black and Asian people from full social acceptance into British society on grounds of non-Christian religions, of diets, involvement in terrorism, or of other 'non-western/British' aspects of identity behaviour. Thus, psychiatric practice reflects, in its treatment of Black, Asian and Irish people, wider aspects of racism within society by further excluding these groups from full social inclusion by identifying behaviour and activities as pathological and insane.

5.5 Gender and mental health

'Gender' refers to the cultural differences between men and women, while 'sex' refers to physical differences.

Every review of the literature concerning sociology and mental health reaches the same conclusion when discussing *gender* – that women always display higher rates of certain mental illnesses than men (Foster 1995; Bebbington 1996). Much research has attempted to explain this particular phenomena with various results. Some explanations point to measurement artefact effects and to men seeking alternative outlets, such as drink, that mask depressive disorders; others point to role strain/conflict; while yet others indicate that social factors, such as poor housing or social class, are the cause.

Measurement artefact means that women exhibit higher rates of mental illness than men because the design of questionnaires and the way in which data is collected produces a 'statistical mirage', which artificially generates a problem where there is not one. Earlier work by Gove (1984), among others, indicated that faults with the way in which data was collected meant that women appeared to exhibit higher rates of depression.

In a substantial review of the literature relating to women and depression, however, Bebbington (1996) and Nazroo et al. in a recent study (1998) argued that there was little evidence of measurement artefact being responsible for the high recorded levels of depression in women. In a carefully constructed study, Nazroo et al. (1998) demonstrated that women did report more depressive episodes – whether distant, mild or exaggerated episodes. There was little evidence for men masking their depression by turning to alcohol or substance abuse as had been suggested by other studies.

What Nazroo et al.'s research did point to was the effect that gender roles and life events had on men and women. Looking at a range of crises that related to children, reproduction, housing, finance, work, marital issues, crime and health, the researchers concluded that women were more likely to develop depression if a crisis involved children, housing or reproduction. The chance of depression was increased if a woman's role identity meant that she attached greater importance to those particular areas. So, if a women feels a particularly close attachment to and sense of responsibility for children because of her role identity, then the chance of depression is much greater if there is a child-related problem, such as difficulties at school or drug misuse. For crises involving finance or work, marital issues, crime, or health there appeared to be no gender role difference.

One of the best known pieces of sociological research on women and

Figure 5.5 *Schematic representation of Brown and Harris' model of depression*
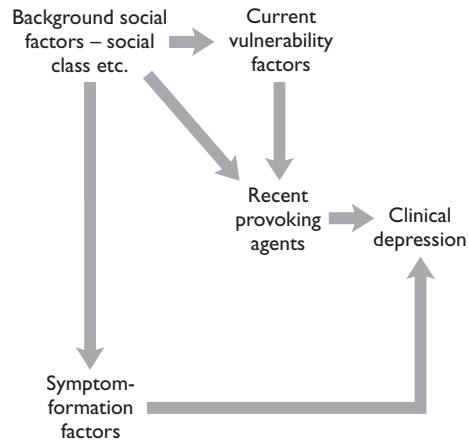
Source: Brown and Harris 1978: p. 265

mental health was carried out by Brown and Harris (1978). In this research they sought to analyse the relationship between social factors and mental health in the Camberwell area of London. From their research they developed a multifactorial model, which attempted to explain the intricacies and subtleties of why some women develop clinical depression while others, living in similar conditions, do not.

The model contains the idea that the onset of depression (the dependent variable) will occur if other factors are present (the independent variable). Key components of the model are:

- **current vulnerability factors** – these factors relate to events that have happened in a woman's past and indicate whether or not she may be more susceptible to depression. Brown and Harris identified four vulnerability factors:
  1 losing a mother before the age of 11
  2 presence at home of three or more children under the age of 15 years
  3 absence of any confiding relationships, particularly with the husband
  4 lack of full- or part-time job.
- **provoking agents** – here Brown and Harris identified various events that could occur in a woman's life, which could then trigger a depressive episode. The events mainly relate to loss and disappointment, e.g. death, losing a job or discovering a partner's unfaithfulness. Ongoing difficulties were also noted as being contributory; they included dealing with a variety of 'background' problems ranging from housing difficulties to headaches.
- **symptom-formation factors** – women over 50 years of age and women with low self-esteem were at greatest risk of developing depression.

One way of thinking about this approach is to imagine that someone is on a tightrope. The chances of falling are increased if there are any existing vulnerabilities, which means that the tightrope begins to sway, making it harder to maintain a sure footing. There is an even greater chance of falling if a provoking agent such as an adverse life event comes along and impacts on the person, making it likely that they will be knocked off. Finally, any possibility of staying on the rope may be diminished if balance is poor due to low self-esteem.

5.6 Suicide

On 8 April 1994 musician Kurt Cobain decided to take his own life and joined the list of various rock stars who have died early. However, his death was not an isolated tragedy, a one-off, but rather an instance of a trend that had been growing from the 1990s onwards: the increase in young male suicide. Even though suicide rates as a whole are down from the early 1980s, the suicide rate for young men has increased since 1982 by 67 per cent for young men aged 15–24, accounting for 20 per cent of all deaths for young people in that age group (MIND 1999). The highest rate for suicide though, is still found among older men (ibid.). Suicide often appears to be an unfathomable act, impervious to any analysis or systematic understanding. After all, how can any research be carried out on an action that takes place in isolated and lonely circumstances, where the subject is someone whose life has reached a certain place where ending that life appears a valid choice?
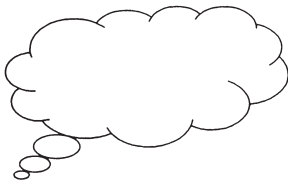
> *Do you think that there is glamour attached to the suicides of successful artistic people? If so why?*

There has, however, been much (perhaps too much) sociological work on suicide, mainly because of early work by functionalist Emile Durkheim. Durkheim used suicide as an example of how the most apparently individual of acts can be opened up to sociological investigation. First published in 1897, 'Suicide: a study in sociology', was the first sociological attempt to systematically understand suicide (Durkheim 1970). Not denying that individual circumstances could affect a person's decision to take his or her own life, Durkheim noticed patterns in suicide rates between countries and between different groups in the same society. Protestant countries had higher rates than Catholic countries, while Jewish societies had the lowest suicide rates of all. What was also notable was the constancy of relative suicide rates between countries. After further analysis Durkheim identified four different types of suicide:

Egoistic suicide: If an individual was not sufficiently integrated into society then they were at a higher risk of suicide. This explains why Protestants

were at greater risk than Catholics. The Protestant faith emphases individualism, while Catholicism emphases community, thereby creating greater integration for a community's members. In addition, people who were unmarried or childless were more likely to commit suicide than the married and those with children, because of the former's lack of integration with a family unit.

Anomic suicide: The opposite of egoistic suicide, this occurs where a society fails to regulate the individual, for example when a society collapses and all the usual norms and patterns of life fall apart, leaving people bewildered and unsure of what is happening. The classic example of this is the 1928 stock market crash that just about devastated American life, with people losing security, savings and their homes. Here the loss of all that was considered normal led to an increase in suicide rates.
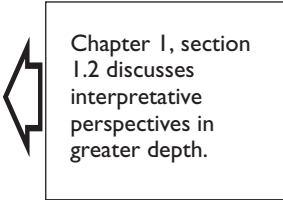
Altruistic suicide: Here a sense of duty, linked to a high level of integration into a particular society, leads someone to take their own life. There are numerous examples around the world: the Japanese Kamikaze pilots who flew their planes directly into American battleships in an attempt to sink them during the Second World War; the Hindu practice of suttee, where a wife kill herself at her husband's funeral; and the Irish Republican hunger strikers, such as Bobby Sands, who starved themselves to death in pursuit of their political beliefs.

Fatalistic suicide: This form of suicide is very rare in contemporary society and Durkheim only included it for historical interest. Mainly applying to highly restrictive societies, this type of suicide could be seen among slaves in ancient slave societies.

As with any other groundbreaking and important piece of sociology Durkheim's theory of suicide has attracted much debate, with many proponents and opponents. Some critics point out that suicide statistics are notoriously unreliable. Many coroners or doctors may record a death as due to some cause other than suicide, in an attempt to avoid problems for surviving family members. Other critics pointed out that his observations could not always be proved nor researched properly.

The strongest critique, however, came from interpretative sociologists such as J.D. Douglas (1967). He put forward two points:

1   All suicide statistics should be treated with caution, as there could have been collusion between officials who record and categorise deaths, and family and friends. The degree of integration here may affect the decision. The more integrated the suicide in a social group, the greater the possibility of a cover-up taking place.

2   Durkheim failed to take into account the motive for and meaning of the suicide. Suicide can be a way of communicating revenge, eliciting sympathy, dealing with guilt or a way of meeting cultural obligations. This information could be elicited by studying diaries and suicide notes.

Other sociologists have recently criticised theories of the interpretative approach of sociologists such as Douglas, and sought to construct more elegant and sophisticated theories of suicide. Taylor (1989, 1990) also agreed that statistics are unreliable and noted, in a study of deaths in the London Underground, a number of contributory factors that could lead to a death being recorded as a suicide, or not. These included whether or not the person had a history of mental illness, or the views and opinions of people who knew the deceased. If the coroner asked a close friend or family member then suicide would often be denied, while if the coroner asked a casual acquaintance then a verdict of suicide would be more likely.

Taylor then, went on to identify four different types of suicide. This categorisation is similar to Durkheim's, but Taylor's emphasis is less on social factors and more on what people think of themselves and their relationships with others and how certain or uncertain these feelings are is what is important here. These suicides divide into two main categories: ectopic, which relates to a person's view of themselves; and symphisic, that is concerning the person's relationship with others.

Ectopic suicides (self)

Submissive suicide – occurs when someone has decided that there is no point in going on and that their life is at an end. This may be because of the death of a loved one, or because of terminal illness. Any attempt at suicide is carried out with the full intention of taking one's life and may take place in an isolated place so as to avoid any discovery.

Thanatation suicide – relates to feelings of uncertainty, and the attempt at suicide is not as earnest as a submissive suicide, the person leaving it to chance as to whether they actually die or not.

Symphisic suicide (relationships)

Sacrifice suicides – here the person takes their own life in order to make others, such as partners or former lovers, feel guilty or incur censure from friends and family. Any suicide note will indicate on whom the blame for the suicide rests.

Appeal suicide – this occurs when someone is uncertain as to how others feel about them. The person who attempts suicide is not necessarily trying to end their life, but testing the reactions of others. The suicide attempt may be staged in such a way, in front of others for example, thus enabling the person who is making the attempt to see how much someone else cares about them.
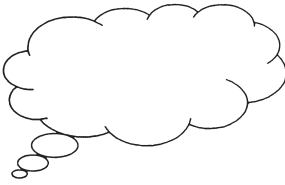
> *Which of the above theories do you find the most satisfactory in attempting to explain suicide – provide justification for your answer?*

The above three sociological theories of suicide all present interesting and different perspectives as to why people decide to take their own lives. Each has a particular strength or weakness, and in many ways a combination of all three provides some useful insights into why people attempt suicide. Durkheim offers useful ideas on how social pressures and wider aspects of a society affect suicidal behaviour, while Douglas cautions against accepting suicide statistics at face value and urges us to look at meaning. In Taylor's work we find explanations as to why some people leave notes, or attempt suicide in a variety of locations with different levels of secrecy or openness.

Summary

- Mental illness, particularly depression, is common within contemporary society.
- Many people hold negative images of mental illness. These negative images often associate mental illness with danger, whether to others or to the mentally ill person. Media portrayals of mental illness are often similarly negative. The stigma created by negative images can have an adverse impact on people with mental illness.
- Ethnic monitories have a different experience of mental health care than do white people. Afro-Caribbean young men are more likely to be perceived as difficult or violent and more likely to enter mental health care via the police. Cultural stereotyping and racist attitudes affect the care of people from ethnic backgrounds. This also includes white ethnic groups, such as Irish people.
- Women have a different experience of mental health care and mental illness from men. Women tend to have higher rates of depression than men. Stress created by gender roles is likely to be the cause of those higher rates.
- Overall suicide rates are decreasing but suicide rates for young men aged 16–24 are increasing. Various sociological theories point to a variety of reasons as to why people take their own lives. Durkheim stresses social and cultural factors. Douglas warns against accepting statistics at face value and stresses the need to understand individual meaning, while Taylor looks at feelings of uncertainty and certainty with self and others.

To see how well you have understood this chapter read the following case study and attempt the questions.

Case Study

John has recently been relocated into a community hostel that helps those with a variety of mild and non-violent mental illnesses to reintegrate into society. The hostel is situated in a reasonably affluent suburb near a sizeable public park.

It was during his fourth year at University that John first came into contact with the psychiatric services. Up till then John was a fairly standard student, competent but not especially noteworthy. This was probably due to his participation in a rather hectic social life of which he appeared to be one of the prime movers. This particular group of friends clubbed quite extensively at the weekends and some of the group took drugs. As he himself remarked to a case worker: 'Yeah, drugs were part of what we did at the weekends but it was nothing serious – dope mainly and speed. Well, speed most Fridays and Saturdays just to help us get that extra energy boost.'

In his third year one of this group was killed in a random accident. They had been out on a Friday night and John had encouraged everyone to try and drink and smoke as much dope as possible. After the club had closed they headed down to the nearby beach to watch the sun come up. It was there that John's friend slipped on a rock and fell to his death. Strong feelings of guilt overcame John as he felt to blame for the accident. He gradually became more withdrawn from his friends, his use of alcohol and soft drugs increased. At the start of his fourth year a relationship with another student fell apart. She found his increasingly pessimistic moods difficult to handle. In addition, his overall behaviour was becoming more compulsive – he constantly analysed what lay behind her words and actions. Invariably, all his conclusions were negative and he firmly believed that she was bored with him. After she left he ceased attending classes and his coursework suffered. He spent most of his time in his flat, unable to sleep and constantly fixating on what he had done wrong in his life. One night in an attempt to sleep he drank half a bottle of whisky and took some sleeping tablets. A flatmate found him unconscious on the living-room floor and rushed him to hospital.

In the following weeks he was advised to see a counsellor and was refered to cognitive therapy. He made some progress, but as the year went on his university friends finished their courses and moved out of the area. This left John feeling alone and isolated. Consequently his problems returned, and this time he was placed in the local psychiatric hospital. The seven months that he spent there seem to have made some difference to him. In his stay there he responded well to medication and to the various therapies, and hints of his former self appeared. At various social events the charismatic aspects of his personality, that had been quite strong during his university days, surfaced. However, the outside world still seemed problematic to him and he found it difficult to be among large groups of people on his own. In addition to this he had nowhere to stay, as he was no longer entitled to student accommodation.

It was then decided that the hostel was the best place for him as his family might find it difficult to care for him. His father had left home to set up a new life for himself and his new partner, a former office colleague, and his parents divorced. As a result of the separation his mother developed a severe long-term depression and found life generally difficult to cope with. Recently she had been experiencing some ill-effects from a course of Fluoxetine prescribed by her doctor. This led to her taking several days off work from the department store she worked in. Management were reasonably supportive but proposed restructuring of the department was causing her some anxiety because of the possible loss of a part-time assistant which would increase her work load. It was proposed that his father might help to care for him, but John did not feel that he was ready to re-establish such a relationship with his

father as he still felt some ambivalence towards him for leaving the family home.

Life at the hostel had until recently been going reasonably well. John was managing to socialise again and felt confident about interacting with the world at large. In fact, he had managed to get to know some local people his own age. They knew he was at the hostel but he claimed that he was a worker there and with his quick wit and outward appearance of calm there was no reason to doubt this. However, one day in the nearby supermarket John suddenly felt quite anxious and rushed out of the store, discarding his shopping as he left. This was witnessed by one of his new friends who started to have doubts about John's true identity.

1 Discuss how John's sense of identity has been affected by his mental illness. How important is maintaining a sense of identity for John?
2 What has happened in his mother's life that has led her to feel depressed? Which theory could help us understand her situation?
3 What passing technique does John employ?
4 If you are a health professional student what type of involvement would you have with someone like John?
5 The assumption is that John is white, but how might his treatment and subsequent care and recovery have been different if he was African-Caribbean?

Recommended reading

Goffman, E. (1968) *Stigma: Notes on the Management of a Spoiled Identity*. Harmondsworth: Penguin. **The classic text in understanding stigma.**

Philo, G. (ed.) (1996) *Media and Mental Distress*. London: Longman. **Very good and easy-to-read exploration of media portrayals of mental illness.**

Pilgrim, D. and Rogers, A. (1993) *A Sociology of Mental Health and Illness*. Buckingham: Open University Press. **Good, solid, accessible text covering a variety of issues to do with mental health.**

Prior, L. (1993) *The Social Organization of Mental Illness*. London: Sage. **A slightly more advanced text, but highly useful.**

The MIND website has a wealth of useful and interesting information and is available at: http://www.mind.org.uk/
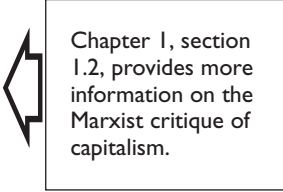
CLASS, CAPITALISM AND HEALTH

6.1 Introduction. Overview of growing discontent with global capitalism and the problems that it creates.

6.2 Poverty in the UK. Review of extent, measurement and distribution of poverty, with comments on causes and theories of poverty.

6.3 Poverty and health. Health differences between social classes, reasons for health inequality including diet/nutrition and geographic location.

6.4 Wilkinson and the psycho-social perspective. The relationship between income and health inequality, why social cohesion is good for health and how social stress affects biology.

Key concepts and terms
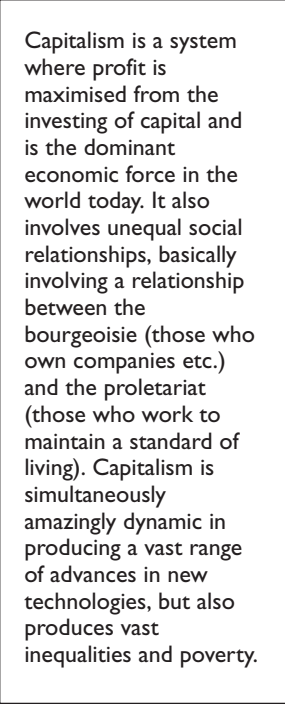
Anti-capitalism, capitalism, poverty, social cohesion, social exclusion, community.

Capitalism, class and health inequalities will be the focus of this chapter. There has been a considerable amount of research into why people from certain strata in society appear to have worse health and fewer good health opportunities than others. One possible reason is poverty, and there will be a discussion on poverty in the UK, looking at why it occurs and at some of the debates that surround it. The effects of poverty will be explored and we will focus on how people living in poverty adapt their lives and why they sometimes make apparently bad choices about aspects of health such as diet. However, throughout this chapter there will be an attempt to relate health inequalities to the capitalist economic system, the dominant economic mode of the world today. We will begin by making reference to events in Seattle and the anti-capitalist movement, and to the work of Wilkinson (1996), which attempts to identify the link between social and economic inequalities and poor health.

6.1 Introduction

Capitalism is a system where profit is maximised from the investing of capital and is the dominant economic force in the world today. It also involves unequal social relationships, basically involving a relationship between the bourgeoisie (those who own companies etc.) and the proletariat (those who work to maintain a standard of living). Capitalism is simultaneously amazingly dynamic in producing a vast range of advances in new technologies, but also produces vast inequalities and poverty.

A small-scale civil war erupted in early December 2000 in the northwest American city of Seattle. The streets were filled with tear-inducing gas while black-clad masked police fired rubber bullets and baton charged people who were dressed as turtles. Across the globe images of this confrontation were broadcast and received with a mixture of shock, disbelief, condemnation or approval. This event became known as the Battle of Seattle and marked the arrival on the world political stage of what has become known as the anti-capitalist movement. Those anti-capitalists demonstrating against a World Trade Organisation conference were drawn from a variety of backgrounds and political persuasions. Some were environmentalists concerned about endangered species, others were trade unionists battling to protect workers' rights from attacks by large corporations, while others were there to protest against globalisation and the power of multinationals. There were also many other groups with their own particular grievances and causes to champion. Even though there were substantial differences between the various groups present, in aims or organisation, there was one theme uniting and underlying them all: an opposition to the dominant global economic force of capitalism.

The majority of anti-capitalists focus, quite rightly, on the ways in which capitalism and globalisation affect the lives and conditions of people in developing countries – for example the use of cheap child labour by companies such as Gap – but capitalism also affects the lives of millions of people in the so-called developed world. Capitalism is a system that unequally distributes wealth across populations. A great deal of data, statistics and research (discussed later) clearly identify and describe this, but capitalism is also responsible for other forms of inequality across populations. One of these inequalities is health, and this will form the main focus of this chapter: how capitalism creates and recreates health inequalities.

How it does so requires investigations of several factors: some are obvious, others are not. One particular aspect of any capitalist society needs to be considered: inequality, and in particular poverty. Whether it is in the vast urban sprawls of Latin America or the rural backwaters of Scotland, poverty is a global issue, affecting the lives and life chances of billions of people around the globe. We will look at poverty within the UK and explore the relationship between it and the health of millions of people. However, poverty is not the only social factor that creates and recreates ill health for there are other deeper and less visible forces at work. Here, the work of Wilkinson will be considered, social cohesion and how societies that are more cohesive and less divided are healthier societies. The argument will then be taken a stage further to question whether capitalist based societies are actually capable of reforms and policies that could deliver cohesion and good health for all.

6.2 Poverty in the UK

So just what is the extent of poverty in the UK today? The answer is both shocking and surprising. Some measures put the percentage of those living on, near or below the margins of poverty at 33 per cent, while others place the percentage for people below the poverty line at 24 per cent (SPIU 1999). These figures reflect what is termed 'relative poverty'. The European Community offers the following definition of relative poverty:

> Persons, families and groups of persons whose resources (material, cultural and social) are so limited as to exclude them from the minimum acceptable way of life in the Member State to which they belong. (SPIU 1997: 1)

This is sharply different from what is known as absolute poverty, or the complete absence of clothing, shelter and food. We shall now look at how poverty is measured and at some of the debates that surround the concept of poverty itself.

> There are two forms of poverty: absolute poverty – the complete absence of clothing, food and shelter, typically seen in developing countries. Relative poverty – where people have a standard of living that is less than an acceptable standard of living in a given society.

Measuring the extent of poverty

There is a considerable debate as to how and why poverty is defined in certain ways and this has consequences for government policy and action. The Conservative government made the point that there was no poverty in the UK – but simply some people with less than others, a feature of any advanced industrial country. The debates that rage around defining and subsequently measuring poverty are interesting and challenging. It is not, however, within the scope of this book to pursue them in any great depth though a brief consideration will be given below.

So how is poverty measured? There are two main indicators that are used:

- households below average income (HBAI)
- income support/job-seekers' allowance levels (IS)

Households below average income

The first measure relies upon using 50 per cent of average income for a particular household (Table 6.1). The figures are published by the Department of Social Security and review income distribution throughout the UK. The figures are produced to look at income *before* and *after* housing costs. However, it is mainly *after*-housing-costs figures that are used because, for poorer people, housing costs are inescapable fixed costs and, using after-housing-costs figures provides a more accurate reflection of disposable income. The poverty line using this particular measure is shown in Table 6.1.

Table 6.1 *The poverty line in 1995/96 (in 1998 prices) defined as
50 per cent average net income* (after housing costs)

Family type 1995/96	£s per week
Single Person	73
Couple	134
Couple with 3 children (aged 3, 8 and 11)	223
All family types	134

Source: SPIU 1999: 10

Using this measure of poverty we can chart the growth of poverty since 1979, as Figure 6.1 indicates:

Figure 6.1 *Growth of poverty in the UK in percentages of population, 1979 to 1995–96*
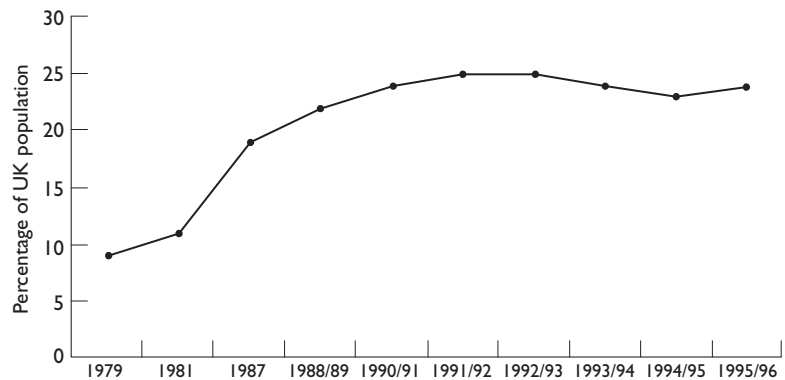
Source: SPIU 1999:13

Income support/job seekers' allowance

The second measure uses benefit levels (see Table 6.2) as a method of measuring the poverty line. Benefit levels are useful because they indicate an official minimum on which the government decides it is necessary to subsist.

Table 6.2 *The poverty line using income support/income-based
jobseeker's allowance* (after housing costs)

| Family type 1999/2000	£s per week
Single person age 25+	51.40
Couple	80.65
Couple with 3 children aged under 11	155.15
Lone parent with 1 child aged under 11	87.35
Pensioner couple	116.60

Source: SPIU 1999: 10
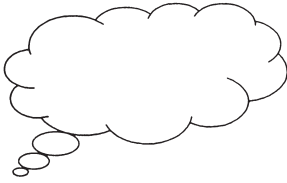
Do you think that the amount of money mentioned for various groups in Tables 6.1 and 6.2 provide for a reasonable standard of living?

Poverty affects a wide and varied cross-section of the community. The following groups, in particular, are vulnerable to poverty:

- women
- unemployed and low-paid people
- older and retired people
- ethnic minorities
- disabled people

One particular trend within the UK has been the number of children living in poverty. Somewhere around 1 in 3 children now live below the poverty line. In international terms this puts the UK almost at the top of the table, as Figure 6.2 indicates.

Figure 6.2 *Child poverty in percentages in various European countries*
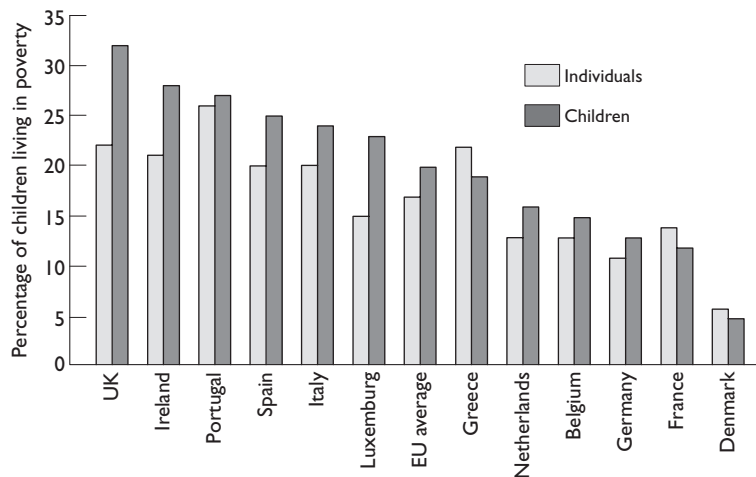
Source: SPIU 1999:14

As with the defining of poverty there is a great deal of debate as to what causes poverty; arguments rage on one side identifying **structural** reasons while others point to **individual** weakness. These ideas are summarised below:

Structural explanations

Poverty here is seen as the result of government policy and the booms and busts of the global economic system. During the 1980s in the UK the then Conservative government introduced free-market policies that led to a

Structural explanations of poverty highlight failures of government policy, and fluctuations in global economics as the root cause of poverty.

major readjustment of the UK industrial landscape. Many traditional heavy industries, such as coal mining and steel production, went into terminal decline. This resulted in the economic blight of many areas, particularly south Wales and northern England. It should be borne in mind that when a major employer in an area ceases production it is not just that the workers lose their jobs, but that the whole local economy suffers. Shock waves are sent through the local community resulting in difficulties for the local service sector and small businesses.

It was not just changes to industrial policy that led to an increase in poverty. Changes in taxation and policies concerned with the redistribution of wealth also had a major impact on poverty levels, according to this perspective. Again, during the 1980s, we see a dramatic shift taking place in policy direction. The Conservatives pursued polices that saw a move of wealth up the class scale, as opposed to across it.

Individual explanations

Individual explanations of poverty highlight individual weakness, and individuals taking advantage of state benefits.

This particular view of poverty gained prominence during the 1980s and 1990s, championed by commentators such as David Marsland in the UK and Charles Murray in the US. It attributes poverty either to individual weakness or fecklessness, or to people misusing welfare services. Murray developed the notion of an underclass consisting of people who have voluntarily absented themselves from the working world and who instead live off over-generous state benefits. Many adherents of this view called for the introduction of workfare-style policies, whereby eligibility for benefits is dependent on the completion of some form of training or work. Marsland points to the welfare state as being responsible for creating a 'dependency culture', where there is little incentive to work.
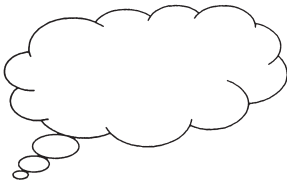
Which explanation do you agree with? Is poverty the result of structural problems or poor individual choices?

6.3 Poverty and health

Much research has demonstrated a strong link between poverty and health inequalities. In previous centuries, work by Booth (1902) (see pp. 84–5) and Engels (1987 [1845]) indicated that poorer people led lives that were likely to be more beset by disease and disability. In the early 1980s the classic Black Report laid out stark evidence for inequalities between social classes, genders and ethnic groups. In the 1990s a whole raft of reports further identified the link between poor health, poor survival rates and chronic ill health (Acheson 1998; Department of Health 1995; Shaw et al. 1999; and a whole host of smaller-scale studies). Let us look at a snapshot of what one

of those reports indicates about health and poverty. *The Widening Gap* report published by the Townsend Centre for International Poverty Research at Bristol University in 1999 (Shaw et al. 1999) found some quite disturbing results concerning the extent to which poverty adversely affects health. Examining each of the 621 parliamentary wards using wealth and health indicators, they identified that there were considerable differences in health, life expectancy and exposure to disease. The following Tables (6.3 and 6.4) summarise the differences in the Standardised Mortality Ratios and excess mortality for the areas with the worst health in Britain.

Table 6.3 *Worst health by area in the UK*

Location	SMR	avoidable deaths %
Glasgow Shettleston	234	71
Glasgow Springburn	217	69
Glasgow Maryhill	196	65
Glasgow Pollock	187	64
Glasgow Anniesland	181	63
Glasgow Ballieston	180	62
Manchester Central	174	61
Glasgow Govan	172	61
Liverpool Riverside	172	61
Manchester Blackley	169	60
Greenock and Inverclyde	164	59
Salford	163	59
Tyne Bridge	158	57
Glasgow Kelvin	158	57
Southwark North and Bermondsey	156	56
All	178	62

Source: Shaw et al. 1999

Table 6.4 *Best health by area in the UK*

| Location	SMR	avoidable deaths %
Wokingham	65	–
Woodspring	65	–
Romsey	65	–
Sheffield Hallam	66	–
South Cambridgeshire	66	–
Chesham and Amersham	67	–
South Norfolk	69	–
West Chelmsford	69	–
South Suffolk	69	–
Witney	69	–
Esher and Walton	69	–
Northavon	70	–
Buckingham	71	–
Total	68	–

Source: Shaw et al. (1999)

It is evident that there exists a disparity between a reasonably affluent area such as Wokingham (see Table 6.4) and a deprived area such as Glasgow Shettleston (see Table 6.3). The Shettleston area of Glasgow has an SMR over twice that of the national average, with 71 per cent of all early deaths being avoidable, while Wokingham has an SMR of just over half the national average with no avoidable deaths. However, it is always worth-while to reflect on what lies behind these rather cold and stark statistics. What we see here is that there are people living in different parts of the same country but leading quite different lives in terms of quantity and quality. The numbers of unnecessary deaths can be placed at 10,887 (Smith et al. 2000). Another study into health inequalities and excess mortality (Mitchell et al. 2000) also pointed to a substantial number of lives that could be saved each year if certain changes in social policy were made. The potential numbers of lives that could be saved and the policy changes that could bring that about are summarised in Table 6.5.

Table 6.5 *Lives saved by various changes in social policy*

No of lives saved per year	Policy change
7,597 among people under 65	If wealth inequalities were reduced to their 1983 level
2,504 among people under 65	If there was full employment
1,407 among those under 15	If child poverty was eradicated
11,508 in total	If all three measures were implemented

Source: Mitchell et al. 2000

If those 11,508 people had died in a tragic accident in the London Tube or as a result of a mistake made in a hospital procedure, then the outcry and national shock would have been overwhelming. However, these people died individually and unnoticed, hidden away in the forgotten housing estates and housing schemes of Britain's main urban areas; the invisible, margin-alised and excluded victims of the widening gulf in wealth and health.
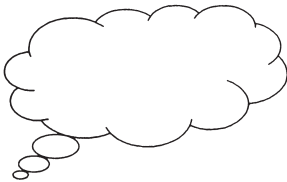
What do you think could be done to tackle health and class inequalities? Have you, on placement, encountered examples of how poverty affects lives?

Summarising some of the material looked at so far, the following points can be noted:

*   There exists a health gradient with people from social class back-ground 5 dying on average seven years earlier than those in class 1.
*   Babies born in class 5 households will on average weigh less than babies born in class 1 households.
*   People in social class 5 households are more likely to develop long-term debilitating disease.
*   Chances of surviving serious illness are less for those in social class 5 than for those in social class 1.

- Throughout a working-class person's life, the early deaths of friends and family are more common than for a middle-class person.

So just how does poverty affect and influence health? This, like so many other areas of study, has been subject to much debate. Many older sociology of health textbooks outline the four suggestions made in the Black Report (Department of Health 1980) (artefact explanation, social selection, behavioural/cultural explanation and structural/material explanation), but subsequent research has dismissed or diminished the influence of the first three of those suggestions (see Table 6.6). Increasingly, research has pointed to material and structural causes. We will look at how poverty affects diet and how material deprivation in terms of living in deprived areas affects health.

The Black Report (Department of Health 1980) was a classic research based report that mainly called for the tackling of poverty, among other strategies, to reduce health inequalities. The report was largely ignored by the Thatcher Conservative government of the time.

Table 6.6 *The Black Report: class and health inequalities*

Suggested reasons for health inequalities	Subsequent research
Artefact explanation The existence of health inequalities is due to the way in which the statistics are collected and the way in which we construct class.	If anything, the statistics under-report the extent of class and health inequalities.
Social selection explanation It is poor health that assigns people to lower-class groups rather than any of the effects of belonging to a lower class group. Thus it is the other way around, health affects our class, rather class affecting our health.	There may be some evidence of social selection at younger ages but the overall effect over a lifetime is very minor.
Behavioural/cultural explanations Ill health is due to people's choices and decisions; working-class people tend to make the wrong choices to smoke, drink too much and eat the wrong foods.	Even among people who follow 'healthy lifestyles' we find similar patterns of ill health. Lifestyle choices may only account for a quarter of social-class inequalities between social classes.
Structural/material explanations Poor conditions, such as bad housing, and low incomes make it virtually impossible for working-class people to lead a healthy lifestyle.	This perspective will be explored in greater depth in the rest of this chapter.

Source: Kirby et al. (1997). Reprinted by permission of Heinemann Educational Publishers

Diet and nutrition – rational responses to an irrational situation

Poverty has already been outlined statistically above, which is useful and highly informative, but it is also important to understand what day-to-day life is like for someone living in poverty. Let us start by challenging one misconception – that poverty is just a case of tightening one's belt and budgeting better by, let's say, buying cheaper foods. Poverty is much more than that as it entails a complete dislocation and reorganising of one's life

with many of the social norms and accepted patterns of cultural life being turned on their heads. People are driven to actions which, on the surface, appear to be bad economy or a misuse of limited funds, such as spending money on low-quality, high-fat foods or not buying cheaper bulk goods. However, on closer examination, we find that for many people these are rational responses to an irrational situation. It is illuminating to look at recent research into food-purchasing patterns among those living in poverty.

On one level, statistics indicate that people living in poverty make bad choices when it comes to nutrition, for diets are often high in processed sugars or fats – ingredients that contribute to heart problems, obesity and the risk of cancer. This raises the possibility that people living in poverty are incapable of making the correct choices because they lack knowledge or information, and therefore many health promotion campaigns aim at encouraging people to eat more vegetables and cut back on fats. However, the situation is perhaps a little more complex.

Dobson et al. (1994) researched 48 households, half of which were lone mother families, to investigate food purchasing and attitudes towards eating. What they found was a pattern of life in which food and eating lost most of their pleasurable social and cultural aspects – such as being enjoyable or something shared with friends and families – to be replaced with a strict discipline and constant economic restrictions. When shopping, any notion of experimenting with new or interesting products was put aside and choice limited to cheap brands and to foods that mothers knew would be eaten by their children. This last point is significant as it indicates why some people eat what in other circumstances would be regarded as 'bad' foods. Here mothers bought foods such as crisps or chocolates because they did not want to risk wasting money on foodstuffs their children might not eat. Here we see an example of a rational choice in irrational circumstances. It must also be noted that many of the families did have an awareness of healthy eating but were sceptical about the messages they received or about the costs involved in putting healthy eating into practice.

Other research on food purchasing indicates further difficulties facing those in poverty. The National Children's Homes (1991) survey on nutrition and poverty found that one tactic to minimise household spending is to skip meals altogether. They found that one child in ten and one adult in five skipped meals because of cost. However, it is not only people failing to choose the 'right' foods or opting not to eat for financial reasons, but also the availability of affordable food that is problematic. The National Food Alliance (BBC News 1998) points to the existence of what is termed 'food deserts', inner-city areas where cheap nutritious foods are not available because of the absence of large supermarkets. People in deprived areas have to rely upon corner shops or smaller retail outlets that do not have the same economy of scale as the larger chains, and as a consequence are more expensive. Again we see costs as being a contributory factor in limiting choice. Other research has indicated that for poorer people a greater percentage of their budgets is taken up with food purchasing than is the case with those who are better off (Blackburn 1991). What we see here is that

financial pressure is increased by having to spend the bulk of available income on attempting to keep body and soul together and maintain an adequate diet.

Overall poverty affects nutrition in the following ways:

- Choice is affected by limited funds.
- Food loses all social and cultural significance.
- Shopping for food is not a pleasurable experience and reinforces feelings of social exclusion.
- Purchasing 'healthier' options is avoided on grounds that they may not be eaten thus wasting already limited funds.
- The existence of food deserts makes it difficult for those living in impoverished areas to access cheap nutritious foods.
- Malnutrition is a problem among certain social classes in contemporary Britain.
- People living in poverty spend a higher percentage of their incomes on food than those who are not.
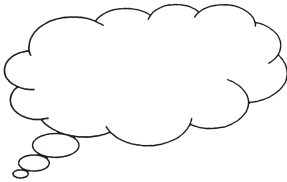
> *Students typically have low incomes – how has this affected your choice of food? Do you think you are eating an adequate diet?*

Geographic location and deprived areas

We have already seen some differences in geographical area and poverty across the UK in the discussion relating to the parliamentary wards of Glasgow Shettleston and London Woking. Now let us examine location and poverty in more detail. On a superficial level it appears that there exists a north–south divide in the UK. The further north and the further west one goes the more deprivation and more poor health one will come across.

One must take care here, as the picture is a little more complex. Poverty and deprivation may be disguised and camouflaged in what, on first glance, appear to be relatively affluent areas. A closer analysis of the data and research reveals that there exist pockets of poverty in the southeast where conditions are similar to the ones found in places such as Glasgow Shettleston. This is illustrated in a report by Dorling et al. (2000) into poverty and health inequality in London. Following Charles Booth's classic study of poverty in London in 1896 (Booth 1902), they found that not much had changed in the last 100 years. Booth's study involved a painstaking house-by-house, street-by-street analysis of poverty and wealth in London. He then produced a colour-coded map of London indicating the poorest areas in black and the most affluent areas in light yellow. What Dorling found was that Booth's map still held up as a very powerful indicator of where to find both poverty and ill health. This indicates, first,

that even in a relatively prosperous area such as the southeast of England there exist dense pockets of poverty, and second, that 100 years of apparent social progress and social policy have produced little change in parts of the UK.

6.4 Wilkinson and the psycho-social perspective

So far we have examined the effects of poverty and material deprivation on health and patterns of ill health. The evidence linking the two is quite convincing and many examples of health policy in the UK are already starting to reflect the need to take social deprivation and poverty into account. Some researchers and commentators, however, have recently been arguing that there are perhaps deeper factors at play. Richard Wilkinson (1996), and David Blane et al. (1996), for example, have broadened the debate and suggested a much richer and more complex basis to health inequalities. It is insufficient simply to look at poverty, even though that does have a considerable effect on health, but one must also look at how the very make-up and organisation of a society distributes different life chances across the social spectrum. This particular approach has been dubbed the 'psycho-social perspective' and, according to Elstad (1998), consists of three core assumptions:

1 the distribution of psychological stress is an important determinant of health inequalities in present-day affluent societies;
2 psychological stress is strongly influenced by the quality of social and inter-personal relations, and
3 the latter are determined to a large extent by the magnitude of society's inequalities.
   (Elstad 1998: 40)

This moves away from simply looking at how poor diet or so-called 'risk activities' affect and influence health, and concentrates on psychological stress, relative deprivation and how living in a society riddled with inequality affects the health of so many people. Let us now look at the work of Wilkinson and the issues that it raises, and in particular at the sources of evidence for the psycho-social perspective, namely:

• health and income deprivation
• social cohesion
• psychosocial causes of illness

Health and relative deprivation

Earlier in this chapter we saw how vast is the gap in health between the various social classes within the UK. In many ways this is not only shocking but also surprising, considering how advanced and developed

Countries that have a smaller gap between social classes tend, according to Wilkinson, to exhibit fewer health inequalities.

the UK is in comparison with other countries. As already noted, 10,500 people, one can argue, die as a result of health and poverty inequalities. Intuitively one would think that when a country's economy improved then there would be a resultant increase in life expectancy *and* general health. This assumption was challenged by Wilkinson's (1996) work in the 1980s and 1990s that demonstrated that in affluent societies it is relative, not average, income that affects health.

Using one of Wilkinson's (1996: 86) examples we can see his wider point. If we compare the UK to other countries we come across some interesting observations. A comparison of the class and mortality rates between England and Wales and Sweden provides a notable example, and is useful since Sweden and the UK are both affluent Western European nations. As Figure 6.4 illustrates, the mortality rates by social class produce some stark contrasts. England and Wales exhibit sharp differences between the social classes, while for Sweden those differences are marginal. Wilkinson (1996) suggests this is because of greater income equality in Sweden. He goes on to comment that if England and Wales had similar income distribution patterns to that of Sweden then there would be a dramatic improvement in the health of those in the lower social classes. It is also noticeable that the lowest social group in Sweden has a better mortality rate than that of the highest in England and Wales. So greater income equality would benefit not just the most deprived groups, but everybody.

This also raises a related question about wider inequalities in society. Marmot (1986), when investigating the health of civil servants who worked in Whitehall, makes some interesting points. Marmot (1986) looked at the health of different grades within the same occupation. What he found was that lower-grade civil servants suffered worse health than higher-grade civil servants. This again indicates that social divisions or the existence of hierarchies can have an adverse effect on health.

Figure 6.4 Class and health inequality, comparing England and Wales with Sweden
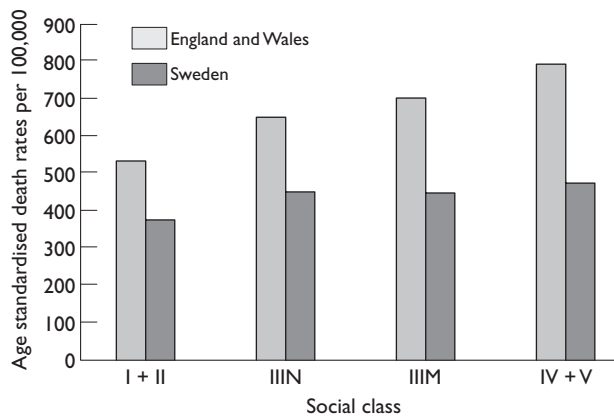
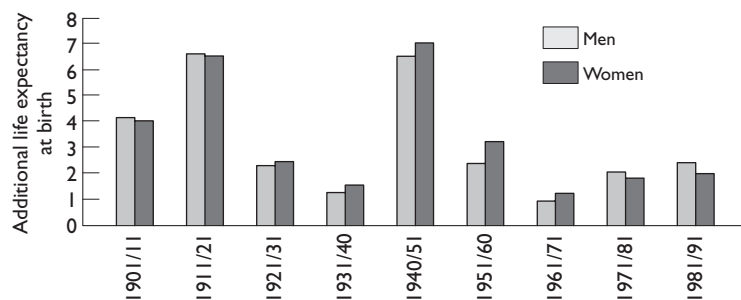Source: Wilkinson 1996: 88

Social cohesion

From the last section we have seen how inequality can lead to worse health for everyone, but particularly for those at the lower ends of the social scale. This raises the question of what are the characteristics of a healthy society. Wilkinson (1996) points to societies that exhibit high social cohesion. These societies emphasise mutual aid, narrow differences in income and a shared sense of purpose or belief. There exist several examples of societies that exhibit these characteristics, but the two which will be discussed in greater detail are Britain during the war years, and Roseto, Pennsylvania, USA.

> Social cohesion implies feeling part of a society or social group, often expressed through helping others, and placing emphasis on the group as opposed to the individual.

Both the First and Second World Wars are remembered with a multitude of complementary and contradictory images. One thinks of both the heroism and tragedy of the First World War, and the triumph over fascism but also the Holocaust of the Second. Many of the images also relate to privation, of people losing their homes in bombing raids or difficulties caused by shortages of various kinds. Nevertheless, one interesting fact emerges from the war years – the health of nation improved! As Figure 6.5 demonstrates, the greatest increases in life expectancy occurred during the war years. So how did this happen? One might expect it to be the introduction of rationing, whereby everyone could access a decent diet. Before rationing, the diet of many working class people was very restricted and deficient in vegetables and meat. However, there was no rationing during the First World War. Wilkinson (1996) suggests that the narrowing of income differences, the reduction in poverty, and a sense of social solidarity were more likely to have influenced this increase in life expectancy. Here we see an example of how people who live in a more egalitarian society, with a common sense of identity and of purpose, are healthier.

Roseto is a classic example of how social cohesion affects the health of people in a particular community. Research by Bruhn and Wolf (1979) has identified a very interesting relationship between the changing culture of the town and the health of its citizens. The town is situated in eastern Pennsylvania, USA, and was founded by Italian migrants in the 1880s. It

Figure 6.5 *Additional years' life expectancy at birth in England and Wales by each decade 1901–91*


Source: Wilkinson 1996: 114

was noticeably healthier than its neighbouring towns, with markedly lower death rates even in the mid-1930s, especially from heart disease which was 40 per cent lower. This was not due to factors such as diet, smoking or exercise. The diet of the people who lived there was very high in saturated fats, particularly lard. The reasons for this good health are, rather, attributable to social factors.

Neighbouring towns noted that Roseto, from its foundation, had a strong sense of social cohesion underpinned by a very egalitarian approach to life. There was a uniformity about the people, who eschewed any notions of competing with their neighbours; indeed there was a strong emphasis on the family and on helping neighbours. Bruhn and Wolf concluded that this acted as a strong protective factor against heart disease. However, as time passed, those original founding values were replaced by the more competitive individualistic culture of mainstream America. As a consequence, the protective effects of their social cohesion and egalitarianism were lost and the health advantage disappeared.

Work in the UK has revealed a similar picture where people are supported and are part of a cohesive community. Oakley and Rajan (1991) investigated social class and social support in relation to young pregnant women. Their findings were interesting for two reasons. First, they argued that the traditional idea that community and social cohesion were working-class phenomena was misplaced. It was mainly middle-class women who had a network of supportive social contacts. This led to their second finding, that the women who had supportive relationships with others gave weight to heavier, healthier babies. Again, we see the usefulness of some form of social contact as a way of predicting better health.

If we reflect back on the first half of this chapter when we surveyed statistics and research relating to poverty, we can view that discussion as not only about the terrible state of poverty today but as an indicator of the breakdown of social cohesion in the UK. We should also remember that between 1979 and 1998 the UK was governed by a party whose highest profile leader, Margaret Thatcher, declared that, 'There is no such thing as society; just individuals and their families'. If our society continues to become increasingly fragmented, with a widening gap between the rich and the poor, then we can expect the health of the poorest among us to worsen.
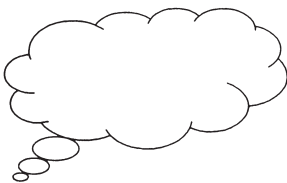
> *How cohesive is contemporary western society? Is there more emphasis on the individual or on the wider social group?*

Psycho-social causes of illness

So far we have looked at how levels of income equality and social cohesion have some effect on health. The purpose of this section is to follow the path

of the ill-health bullet as it leaves the smoking gun. How do all these social factors affect and interact with biology? What are the mechanisms that lead people who are poorer than others or living in circumstances that lack cohesion to become unwell?

It has always been a problem for sociologists to identify just what happens inside the body of someone who is at the centre of all these social problems. Here Wilkinson acknowledges recent developments in epidemiology and draws certain conclusions that relate the social to the biological. Essentially, we see here the effects of stress on the body. Again, looking back over the material we have so far discussed in relation to Wilkinson's ideas, we see individuals living in societies riven with inequalities, where they feel they have little or no stake in that society. We see people whose material circumstances are vastly inferior to others, resulting in feelings of inadequacy and failure. We see people living in atomised, individualised locations, cut adrift from friends, neighbours and families, with little or no access to support in times of difficulty. If we draw these different strands together, we then see a situation where endless stress will be an integral and inescapable feature of life:

> . . . the poor suffer the psychosocial effects of deprivation as well as its direct material effects. Indeed, it is important to recognise that as well as the greatest material deprivation, those at the bottom of the social hierarchy also suffer the greatest social, psychological and emotional deprivation, and this may well have a greater impact on their health than the more direct effects of material deprivation. (Wilkinson 1996: 176)

This stress can sometimes surface in the form of 'risk' behaviours such as smoking, drinking or drug use. However, do not think of these activities in themselves as causes of ill health, but rather as symptoms. For the individual these risk activities function as substitutes for some form of status, or as mechanisms for much-needed social interaction. At other times this stress may not be visible at all on the surface, but contained and unreleased. This continual bombardment of stress can have a highly damaging effect on the body. Research from a variety of sources (Brunner 1996; Saplolsky 1993) supports the view that people who are continually stressed become biologically damaged. The continual build-up of stress chemicals, such as corticosteroids, can damage the body, diverting valuable biological resources away from repairing the body, and leaving the immune system depleted and much more susceptible to infection and illness. Therefore, people who experience stress on a variety of levels on a daily basis are more likely to become ill.

Discussion

What we could be seeing here is an increasing body of evidence to support a growing social mood that the social and economic system that we live under cannot provide a sustainable and healthy life for all. On the one

hand, we see the work of people such as Wilkinson (1996), Blane et al. (1996) and Dorling et al. (2000), developing a clear case that various forms of social inequality are quite simply bad for us, in that they lead to the premature deaths of thousands and a lifetime of health disadvantage for tens of thousands of others. We also see a growing social movement, supported by writers such as Naomi Klein (2000), that is challenging the increasing expansion of capitalism around the world. If we combine the two we can see the possibilities of a new, more radical approach to understanding health – one that moves beyond blood and bones, and doctors and nurses; one that asks us to fundamentally challenge the economic philosophies that underpin our society. Most health reform and health policy relates to the organisation of health care and of health promotion. We are drawn to conclude from this evidence that the main cause of ill health is the nature of a capitalist society itself; one that is built upon inequality, one that cannot function without inequality. Unless we start to shift our attention to tackling the basis of life in western industrial societies, then the health inequalities outlined in this chapter will increase.

Summary

- There is a growing unease about how modern industrial-capitalist societies distribute wealth among their own populations and effect the development of poorer nations.
- There is extensive poverty in the UK, with the highest rates of child poverty in Europe.
- There are considerable health differences between social classes. People in social class 1 tend to live longer and more healthy lives than those in class 5.
- For people living in poverty, maintaining a basic standard of healthy living can be hard. Often basics such as healthy food can be either too expensive or unavailable in poorer communities. People respond to poverty with a variety of strategies, such as missing meals.
- Countries with wider inequalities in income distribution tend to have greater health inequality. Social cohesion also affects health, with greater social cohesion leading to better health.

Case study

The following extract is from David Widgery's (1991) book reflecting on his experiences as a GP working in the East End of London. Throughout Widgery conveys the hopelessness and tragedy of hundreds of lives wasted and worn out by the grinding poverty that he sees on a daily basis, whether in his surgery or on home visits. His experiences are common to most GPs working in what are termed 'deprived areas'.

The following extract is from a chapter of impressionistic notes made after a typical day visiting various patients, hence their rather hurried nature.

Back pain at midnight. Single seventeen-year-old in squat. Beside bed a signed photo. Not her boyfriend, a male stripper she had met the previous night. Virtually no possessions but emerged each morning in immaculate eye make-up and leather miniskirt. She'd fallen over in her mayonnaise factory. Says she works in puddles of pickle juice and oil. Later her child goes into care because of heroin. Looked after a woman dealer's dogs and got paid in heroin. 'But I shopped her, the cow.' She comes back occasionally, after dihydrocodeine.

Patients with high anxiety, low expectations. Exhibitionists: wrist slashers, plate throwers, overdose artists. Manic depressive with bits of paper . . . Odd, unmatching clothes (sign of Sally Army). Rants off, slamming door. Demented old lady with flat but no carpets. Cupboards but no food, aroma of corned beef, piss and scorched nylon. Full of fury: at the relatives, who had 'deserted' her, the social worker and me . . .

New patients with impossible demands, old faces with familiar problems. Batty girl: 'The paper in my head tells me to love you.' Entering old, gloomily lit areas of social disorganisation, homes where logic seems to have gone missing. Bare room: bar fire, meter, TV; many high-heeled shoes, about forty pairs! 'Keeping the vodka to one bottle a day, Doc,' she says and falls over.

1 What sort of society do David Widgery's notes describe?
2 Apply some of Wilkinson's ideas on social cohesion to the above case study.
3 How would you feel, as a health professional, working in an area like the East End of London as Widgery describes?
4 What could be done to relieve health and social inequalities?

Recommended reading

Bartley, M., Blane, D. and Smith, G. (1998) *The Sociology of Health Inequalities*. London: Jonathan Gabe. **A good introductory text on health inequalities**.

Blane, D., Brunner, E. and Wilkinson, R.G. (eds) (1996) *Health and Social Organization: Towards a Health Policy for the 21st Century*. London: Routledge. **A little more advanced but containing a great deal of useful information.**

Wilkinsor, R. (1996) *Unhealthy Societies: The Afflictions of Inequality*. London: Routledge. **A great deal more advanced than the previous two texts but ideal for students wanting to explore this topic in greater depth**.

There are some good web sites that provide excellent information on poverty and health issues. Despite being based in Scotland the Scottish Poverty Information Unit provides highly accessible and useful information on a range of issues regarding poverty across the UK: http://spiu.gcal.ac.uk/home.html

Specific reports relating to a variety of social issues, not just poverty and health can be found on the Joseph Rowntree Foundation web site, especially their 'Findings' pages. The homepage can be found at: http://www.jrf.org.uk/ and the 'Findings' pages can be found at: http://www.Jrf.org.uk/knowledge/findings/

THE SOCIOLOGY OF THE BODY

7.1 Key issues in the study of the body. Sociology's neglect of the body. The sociological significance of the body. The body as a bearer of values.

7.2 The civilised body: a controlled body and a 'clean' body. The 'private' body. The medical examination of the body. Elias and the civilised body. Cleanliness and hygiene.

7.3 The sculptured body: creating perfection. The thin body. The disciplined body. Transforming the body.

7.4 The 'failed' body: ill health and disease. The increase in chronic illnesses. Living with chronic illness.

7.5 Disabled people and disability. Definitions and debates surrounding disability.

Key concepts

The sociology of the body, embodiment, the civilised body, identity, chronic illness, normality, stigma and biographical disruption.

> The sociology of the body addresses how we use our bodies, how we engage with them and, fundamentally, seeks to understand the nature of the physical body. The key point to bear in mind is that the body is both 'natural' and the product of its social environment.

This chapter concentrates on the *sociology of the body* and what it can contribute to our understanding of health and illness. While there will be a strong emphasis on a theoretical approach to the human body, there will also be equal coverage of the significance of embodiment through an examination of the impact of living with chronic illness and disability.

7.1 Key issues in the study of the body

Until relatively recently sociologists have shied away from theorising and researching the human body. This reluctance is twofold. First, there is an unwillingness to be caught up in biological and determinist explanations of human behaviour. Sociologists have, for example, chosen to study gender rather than sex differences, since the latter is often used to defend inequalities between women and men. The concept of gender, on the other hand, removes the problem of the bodily differences and draws our

attention to the social construction of the terms 'male' and 'female' in terms of the values, beliefs and expectations placed on biological women and men. The second explanation for the general reluctance to embrace the body stems from the historical and cultural origins of the discipline itself. As the opening chapter illustrated, the founding fathers of sociology were primarily concerned to explain the social changes brought about by urbanisation and industrialisation. Early sociological texts indicate a preoccupation with topics such as urbanisation, religion, paid work and the role of the state. Physical differences between people mattered less than inequalities of class and status. Differences such as those between women and men and between adults and children were seen as belonging to the 'natural' world, and were unchangeable and fixed. In recent times, however, sociology has developed to include topics such as sex and gender, disability, and the physical and biological aspects of our lives. In addition to changes within the discipline of sociology, a number of social and cultural shifts have taken place which have resulted in a renewed interest in the human body. The body has ceased to be the preserve of the medical and scientific world and has become a major concern for sociologists. The figure below illustrates the main trends and developments.

Figure 7.1 *Bringing the body to the fore*

Body politics: Recognition that the physical body has a social and political status such that a different body (whether that is female as opposed to male, or a body with a disability) helps determine an individual's life chances. The feminist movement and the disability movement have played a central role in attempting to ensure that people have power over their own bodies.

Demographic changes: An increasingly ageing population draws attention to the physical changes arising from the ageing process and the consequences of living with an ageing body.

The prevalence of chronic illnesses: There has been a significant change in what Nettleton and Watson refer to as 'the disease burden'. Infectious diseases have now been replaced by chronic and degenerative conditions, many of which raise important questions about how a physically changed body impacts on our sense of identity and how people live with pain and discomfort.

Consumerism: An increased emphasis on the appearance and health of the body. People are concerned about maintaining their bodies in good condition and purchasing goods to help them do so. In this context, 'good' suggests youthful, slim and active.

Technological changes: Physical limitations of the body can be overcome, appearance can be changed, organs and limbs repaired and replaced. It becomes increasingly difficult to distinguish between the 'natural' body and the 'technological' body.

The body as an expression of our identity: The body becomes a means to express an identity. Diet, exercise and lifestyles can be portrayed as 'moral' or 'immoral' and 'irresponsible'.

Source: Adapted from Nettleton and Watson 1998: 4

Bodies are central to everything that we do and yet this centrality seems to have resulted in attitudes that very much take the body for granted; the body is so obvious it is hardly worth comment.

> If one thing is certain, it is that we all have a body. Everything that we do we do with our bodies – when we think, speak, listen, eat, sleep, walk, relax, work and play we 'use' our bodies. Every aspect of our lives is therefore embodied. Sometimes we may be more aware of our bodies than others but from the moment we wake, we are to a greater or lesser extent, consciously or sub-consciously relying on our bodies. (Nettleton and Watson 1998: 1)

Because of the fundamentality of the body it is of undoubted interest for students of sociology generally, and students of the sociology of health in particular. For Shilling, the human body marks the boundary between ourselves and others; it is a means of presenting 'both the uniqueness of each individual and a site for the marking of difference' (Shilling 1997: 65). Some of the most obvious differences to consider are those of gender, race and levels of physical ability, but the body may also be adorned with certain clothes (or not), paints, tattoos or ornaments. Shilling also observes that, over and above our own interest in our bodies, many professional groups in contemporary society are also concerned with the body. Clinicians, psychologists, social workers and physical educationalists take the body and what happens to it as their legitimate concern and intervene in the way in which we see our own bodies (Shilling 1997: 65). Ultimately the body is *the* subject of all research and work relating to medicine and health (Lupton 1995). Interest in understanding, shaping and intervening in the body are all central themes of this book – for example, the discussion of women's reproductive capacity. Control over the techniques of reproduction makes possible control over bodies, what happens to them, when, and how.

We have highlighted the significance of the body as a subject for students of sociology by emphasising the central role played by our physical selves in all that we do. Sociologists also seek to 'see' the body in more than purely physical and biological terms, drawing our attention to the two key 'social' aspects of the body. The first of these is the impact of environmental, cultural, social and political influences on the body, while the second emphasises that our knowledge of the body is shaped by certain dominant discourses such as medicine. Chapter 6 examines inequalities in health and presents evidence that indicates a relationship between social class and patterns of morbidity and mortality. Social class can be used as an indicator of the types of illnesses people experience, as well as their life expectancy. Historical evidence reveals that body shape and stature are influenced by environmental factors. Birke (1992: 74–5) suggests an almost circular process where biology (A), environment (B) and the outcome (C) all interact to transform one another. In her example, genetic inheritance interacts with nutrition to produce the final height of a child. Importantly, however, the final height of the child then influences the genes he or she passes on, which then interact with the environment – and so the process goes on. The second sense in which sociologists understand the body is in terms of our knowledge of the social construction of the physical. There is an inherent danger in understanding the body as only a social construction as this may impede the study of the body as a real and physical entity. Nettleton and Watson (1998: 2) point to a tendency for the sociology of the

'Embodiment' refers to the experience of living through and with the physical body. Our experiences are essentially embodied. For example we experience pleasure and pain through the body. Feelings of happiness and sadness are as physical as they are emotional.

body to suffer from theoreticism, where there is little or no reference to the empirical evidence about the lived experience of *embodiment*. This chapter will overcome this with a detailed consideration of the embodied experience of living with chronic illness.
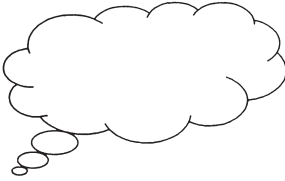
> *Identify how and when you are most aware of your body.*

7.2 The civilised body: a controlled body and a 'clean' body

> The concept of the 'civilised body' was developed by Norbert Elias. The term is used to denote a historical and cultural shift whereby the body is subject to increasing restraints that appear to limit the 'natural' body. The development of rules around eating manners is an example of how the body has become 'civilised'.

This section seeks to explore concepts of privacy and of the civilised, clean body. Views on what is appropriate bodily behaviour and who has access to our bodies have a key bearing on the delivery of health care as well as on our experience of illness. The physical examination of the body is central to the practice of medicine: it is this that allows practitioners to investigate whether or not the body is functioning normally. Doctors, nurses, physiotherapists, opticians and dentists are all required to touch the body, sometimes in intimate ways. Illness often entails losing some control over bodily functions. Migraine, for example, can involve uncontrollable vomiting, and food poisoning can lead to uncontrollable diarrhoea. Physical incapacity can necessitate the use of a commode, thus requiring someone to share what is not only an intimate act but also one that has overtones of being unclean. How we negotiate access to other bodies and how we think of our own are, therefore, key issues for the sociology of health.

As Nettleton and Watson (1998) have stated, we all have bodies and everything that we do we do through them. All bodies have the same basic needs in terms of food, water and sleep. We must all remove waste from our bodies in the form of urine and faeces. Whether through illness or over-indulgence, our bodies vomit and we have little control over this. All bodies have the same basic components but differ in size, shape and colour. These are all fundamental human experiences and activities and yet, particularly in contemporary western societies, the body and its functions are regarded with a degree of shame and embarrassment.

To explore these concepts in more depth we will examine the work of Norbert Elias, first published in 1939, in relation to manners and the development of 'civilised' society. Elias's (1982) historical account of the civilised body examines the development of preferred ways of behaving and of control over the physical functions of the body. Regulation of the body came to be associated with higher social status and refinement. Nettleton (1995: 116–17) argues that the civilising of the body involves three progressive elements (see over).

The development of ideas about the civilised body also demonstrates a concern to distinguish between human and bestial behaviour (Hawkes 1996: 20) and accords with Enlightenment notions about the higher self being associated with the mind, and the base self with the body.

Socialisation	People learn to conceal the natural functions of the body. We come to 'know' that certain functions such as defecating or vomiting are essentially private and potentially distasteful to others.
Rationalisation	We prize our ability to control our emotions. Anger may be felt but only expressed in an acceptable way.
Individualisation	Individual bodies are seen as separate from others. We demand a degree of personal 'social space' and privacy.

The work of Elias helps us to understand why people find intimate medical examination potentially embarrassing and why an inability to control the basic functions of the body can lead to stigmatisation. Control over our most basic bodily functions is something we require even in young children. As Nettleton suggests above, socialisation into the norms of any society entails learning that certain types of behaviour are private and potentially shameful when performed inappropriately. Mayall (1997) notes that much of the socialisation process is about teaching children to control their bodies and to be civilised. Young children are taught appropriate table manners, toilet trained, and taught the necessity of sitting still in preparation for schooling. Even at an early age, then, the importance of bodily control is underlined. Equally, the essentially private nature of the naked body and of sex is an implicit part of the concept of the civilised body. In her study of sex and sexuality, Hawkes argues that in medieval times nudity was not a source of shame and that sexual matters were discussed without any sense of embarrassment. She notes, too, that accompanying 'couples to the marital bed and celebration of the consummation were customs that persisted well into the seventeenth century' (Hawkes 1996: 22). After that period both nudity and sexual matters were moved 'behind the scenes', appropriate only in private (ibid.: 23).
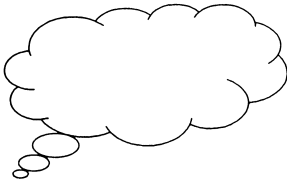
> *Identify examples of when the body is subject to regulation and control, in both medical and non-medical settings.*
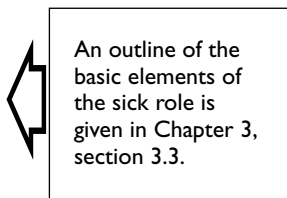
An outline of the basic elements of the sick role is given in Chapter 3, section 3.3.

How then do health practitioners deal with the potential discomfort that arises from physically intimate examinations? According to Lawler (1991), nursing staff have adopted a number of strategies to cope with potential embarrassment and shame, both on their part and on the part of the patient. There are a number of rules that appear to govern such encounters. The first is that patients should comply with requests for examinations because they are dependent on nursing staff. Here it is helpful to refer back to Parsons' model of the sick role because it too justifies access to the patient's body on the grounds of expertise on the part of the practitioner. In addition, the practitioner's own professional code of conduct is, arguably, meant to protect the patient from potential abuse and exploitation. By maintaining a degree of professional distance, the situation may be depersonalised. Lawler also argues that patients themselves are expected

to maintain a degree of modesty, while the nurse attempts to protect the patient's privacy. (Lawler 1991). Maintaining personal hygiene when ill often requires assistance with bathing but it is common for nursing staff to allow patients the option of cleaning their own private parts. It is ironic that while much of modern health care is premised on practices such as holistic care, being attended to by a named carer, and attempts generally to break down the barriers between patients and staff, it seems that there are some circumstances when a professional and distanced stance is appreciated by both parties.
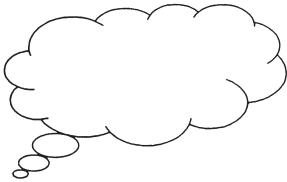
What are your experiences either as a patient being examined or as a practitioner undertaking an examination of a patient?

Chapter 3 dealt with the subject of the new public health movement, emphasising the extent to which governments are concerned with controlling individual bodies as well as the social body. Behind these developments lies the fear that without regulation bodies would be out of control. Disease and contamination of the body have been central concerns of the public health movement. Lupton (1995), for example, writes of the economic and political implications of disease in terms of absence from work.

Our discussion of medicalisation illustrated the way in which it is not just unhealthy bodies that come under the scrutiny of the medical profession; there is an important sense in which we are all judged to be 'at risk'. The issues of cleanliness and hygiene are important illustrations of this trend, because there is considerable emphasis on preserving health through cleanliness. Lupton (1995) provides an interesting historical account of just how our concept of cleanliness has changed over time.
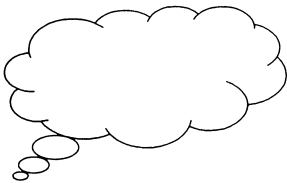
Consider the following examples of how, at varying periods in time, the body was kept clean and safe from infection and make a note of your personal reactions to them:

Being 'clean' meant that those areas of the body seen by others were free of dirt.

Washing was 'dry' in the sense that a cloth was used to rub the face and hands.

Bathing was not an option; immersing the body in water was thought to weaken it as the liquid might invade the body.

Once bathing became an accepted practice cold bathing was preferred as it was thought to toughen and invigorate the body.

The use of 'cosmetics' such as perfume to scent the body was seen as frivolous.

Source: Lupton 1995: 33–4

These examples of hygienic practices are in marked contrast to the values prevalent in most western societies. Personal hygiene is both desirable and, it might be argued, possible with the provision of indoor plumbing. We all sweat as a means of cooling the body down, yet the smell of sweat is shunned. Instead, we attempt either to prevent our bodies sweating (through the use of an anti-perspirant) or to mask the smell if the body does sweat (through the use of deodorant). Media images reinforce the message that bodies that are clean and perfumed are desirable bodies.

The desire for cleanliness extends beyond our bodies to our homes. The nineteenth-century push to improve the health of the nation focused primarily on instructing mothers in child-care practices and, significantly, in domestic hygiene. According to Hawkes (1996: 97) 'a good mother kept a clean home. Whiter whites were a sign of superiority'. The multitude of products that claim to be anti-bacterial or effective in combating the invisible threat of germs bears testimony to our fear of dirt and the negative moral connotations that attach to a lack of hygiene. Lupton argues that modern standards and beliefs about cleanliness are characterised by a fear of invisible germs and viruses. She comments in particular on a near-obsession with the cleanliness of toilets and the desire to have a visible indication of cleanliness 'displayed by a bright blue chemical being released every time the lavatory is flushed' (Lupton 1995: 35).

Among commentators on the sociology of the body, it appears to be accepted that we as a population are obsessed with hygiene and cleanliness. There is some evidence to suggest that this view is simplistic. Recent outbreaks of salmonella and the spread of hospital-acquired infections have revealed hygiene practices that are far from perfect. Professor Hugh Pennington of the Bacteriology Department of Aberdeen University, has been particularly critical of poor hygiene practices around the home. Among his main concerns is the use of washing-up bowls and re-usable dishcloths.

> Professor Pennington said that placing chopping boards and knives teeming with germs together with plates and glasses in a plastic bowl created the ideal environment for the spread of bugs.
>
> The experts said disposable paper cloths should be used instead of tea towels that could easily spread infection.
>
> They also recommended using 'good old fashioned bleach' in the kitchen rather than newer anti-bacterial products that were only vaguely effective.
>
> Source: www.news.bbc.co.uk (2002)

The beginning of 2002 heralded a major health crisis for hospitals in Scotland as hospital-acquired infections in general and the MRSA bug in particular led to the closure of the Victoria Infirmary, Glasgow, to all new admissions. Once again, the problem appeared to be poor hygiene practices. Hugh Pennington commented that infection control was being severely compromised by lack of basic hygiene practices, such as doctors and nurses failing to wash their hands between treating different patients.
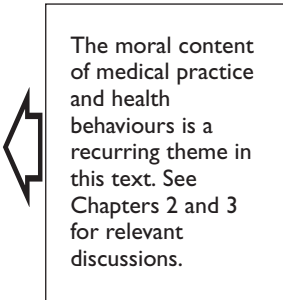
The discussion above has highlighted the ways in which bodily functions and intimate access to the body can present barriers in the caring relationship. It has been suggested that shame and embarrassment about the body are not natural but are socially cultivated, and the work of Elias has provided an insight into the development of concepts of the 'civilised body'. Our discussion now takes us on to images and perceptions of the 'perfect' body.

7.3 The sculptured body: creating perfection

Images of bodily perfection, most often images of women, are powerful but never static. Whether it is the voluptuous bust, tiny waist and rounded bottom of the nineteenth century, the androgynous figure of the 1920s, the curves of Marilyn Monroe or the taut, lean and muscular body of Madonna, images of how female bodies should look are powerful reminders of the extent to which people have aspired to the perfect body. The purpose of this discussion is to examine how and why people have tried to attain that 'good' body. A later discussion of disability and chronic illness will pose powerful questions about what happens when bodies are not and cannot be made perfect.

Diet is perhaps the most obvious way in which we control the size and shape of the body. As Lupton comments: 'skin tone, weight, strength of bones, condition of hair and nails are all commonly said to be directly affected by diet' (Lupton 1995: 40). An increasingly important aspect of diet is the desire to limit the intake of food. Bordo argues that types of fasting have been common throughout history, and are usually characterised by control over the body's appetites or by a religious desire to purify the flesh (Bordo 1990: 83). However, she notes a significant shift during the late Victorian era, when, 'for the first time in the West, those who could afford to eat well began systematically to deny themselves food in the pursuit of an aesthetic ideal' (ibid.: 83). So began what Bordo has described as the tyranny of slenderness.

> The moral content of medical practice and health behaviours is a recurring theme in this text. See Chapters 2 and 3 for relevant discussions.

In common with others, Bordo argues that body size is underpinned by a code of morality. The possession of a slender body suggests that the individual is in control of their body and their life. To achieve the 'perfect' body requires considerable time, effort and determination. Geri Halliwell recently achieved what she described as her ideal body; a body very much thinner that her previous form and made possible only with a strict diet and considerable time in the gym. In contrast, Helen Fielding's heroine, Bridget Jones, over-eats, smokes and drinks in response to what she sees as an unfulfilled life. The actress who played Bridget Jones in the recent film soon shed the extra two stone put on for her role, reverting to her original size 6 in contrast to the 12 of the heroine. It is interesting to note that almost half of all women in Britain take a dress size 16 or over. Benson suggests that the body is increasingly seen as an indicator of a person's moral character.
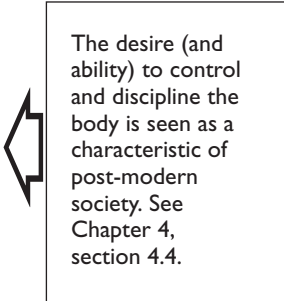
> The bad body is fat, slack, uncared for; it demonstrates a lazy and undisciplined 'self'. The good body is sleek, thin and toned. To have such a body is to project to those around you – as well as to yourself – that you are morally as well as physically 'in shape'. (Benson 1997: 123)

In the same vein, a muscular body has become what Bordo describes as a 'cultural icon':

> The firm, developed body has become a symbol of correct *attitude*; it means that ones 'cares' about oneself and how one appears to others, suggesting willpower, energy, control over infantile impulses, the ability to 'make something' of oneself. (Bordo 1990: 94–5)

Themes of controlling the body through will-power and discipline are frequent in accounts of people with eating disorders – a term which covers a range of behaviours from systematically starving the body, to over-eating, and finally to eating and purging the body through vomiting or the use of laxatives. Although there is not the space here for a detailed discussion of eating disorders, a number of points can be made about the denial of food and the desire to assert power and autonomy. Benson (1997) describes the refusal to eat as 'an inescapably political act' because it is most often associated with asserting control and/or registering a protest. The use of hunger strikes as a political protest is common and at the other end of the spectrum, a child's refusal to eat is a clear sign of defying parental authority. It has been suggested, therefore, that perhaps eating disorders such as anorexia may be a way of exercising power over the body, food intake being perhaps the only area of choice open to that person. Bordo examines limiting food intake in the context of a general cultural fear of 'fat' as an indicator of losing control over the body. In this sense, bodies have to be not only slender but contained, in the sense of minimising bulges and flab (Bordo 1990: 88–9).

| The desire (and ability) to control and discipline the body is seen as a characteristic of post-modern society. See Chapter 4, section 4.4. |

> Areas that are soft, loose, or 'wiggly' are unacceptable, even on extremely thin bodies. Cellulite management, like liposuction, has nothing to do with weight loss, and everything to do with the quest for firm bodily margins. (ibid.: 1990: 90)

Thus far we have concentrated principally on diet as a way of regulating the size and shape of the body, as well as being an indicator of a personal morality: thin bodies represent controlled and cared-for bodies; fat bodies suggest some sort of moral failing. There are, however, other ways in which the body can be managed and sculptured. Surgical intervention, most commonly in the form of cosmetic surgery to alter appearance, is an obvious example. Parts of the body can be enlarged or changed in appearance, as in the practice of breast enhancement. Far more radical, however, is the case of gender realignment, or sex change. Complex surgical procedures, combined with the use of hormones and counselling, can help a person complete the transition from male to female or vice versa. The body, and in particular the genitalia, are the most obvious indicators of our sex. Paul Hewitt writes movingly of his own experiences as a female-to-

male transsexual: 'It is not that I *want* to be male. I *am* male, and, like all transsexuals, I experience an overwhelming urge to bring the gender of my body into line with the gender of my mind' (Hewitt and Warren 1997: 75). Changing his outward appearance allows him to pass as a man. Male dress, male haircuts and clothes all play an important part in signalling to others that he is male, but more fundamental changes are needed; the possession of an artificial penis and the removal of both breasts. This alone should be evidence that the body is *the* ultimate means of displaying who we are to others.
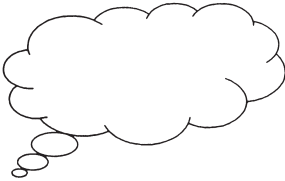
> Which new technologies have made us rethink our understanding of our bodies?

7.4 The 'failed' body: ill health and disease

We now continue these themes but move on to an examination of the ways in which disability and chronic illness transform the body and personal identity.

Increasingly, most heavyweight newspapers have a regular column written by someone with some form of chronic illness. Many are written from an 'open secret' position, in that both writer and reader know that at some point the author will die. Over the years we have seen columns and books dealing with, for example, HIV/AIDS (Oscar Moore with 'PWA' [People With AIDS]), breast cancer (Ruth Picardie with 'Before I say goodbye'). These glimpses into the life of someone with a long-term, probably fatal condition are deeply moving, and readers feel a deep sense of attachment to the writer. Such articles and serials are also indicative of how chronic illness is moving centre stage in terms of the general awareness of health and illness. Most people in the UK now will die of a chronic illness rather than from an infectious disease – much more than in previous centuries. The increase in the number of people with chronic illnesses raises several important issues:

- The dominance of medical science and its ability to cure all is challenged; its weaknesses and limits are exposed.
- The person with a chronic illness has to reconstruct aspects of their life and identity when facing a condition that will become a fundamental part of their existence.

We can see these concerns in this extract from Picardie (1998: 1), when she is corresponding with a friend about forthcoming treatment and her wider anxieties about her family:

> The latest news is that I didn't have the second lot of chemo yesterday, because my white blood cell count is still crap – they went in 'all guns blazing' (direct

quote from oncologist) first time round and it was obviously OTT. . . . Meanwhile, my hair is falling out with amazing rapidity – I estimate total baldness will be achieved by the weekend, so the whole thing will have happened in a week. It's getting awfully expensive – had my hair cut ultra short on Monday, and reckon I will have to have it shaved on Friday. I was a bit freaked out at first – it's really alarming running your hand through your hair and handfuls coming out. Makes you look sick, feel that you are dying, etc., which I am not. . . . Meanwhile, I am asking everyone I know to buy me a hat. I hope I don't frighten the children – I imagine I'll look pretty weird.

In this extract, Picardie records her ambivalence toward the chemotherapy treatment, which is resulting only in hair loss. She also battles to maintain 'normality' by seeking to minimise the impact and disruption that being bald may have on her children.

Sociologists such as Anslem Strauss, Ilene Lubkin and Michael Bury have developed useful perspectives and ideas for understanding the many complexities and subtleties that surround people with chronic illnesses. Much research has focused on how people readapt their lives, organise resources and present themselves to the outside world.

Bury has identified a variety of responses that emerge when chronic illness occurs in someone's life:

- biographical disruption
- adjusting to the impact of treatment regimens
- adaptation and management of illness

The key factor here is that these responses are *emergent* and not *sequential* in that different people will face and respond to different individual situations.

Biographical disruption

Think of your life as narrative, as a story that has been partially written with past events apparently well defined and recorded, the present unfolding, and the future a set of plans, ambitions and hopes. Now imagine that personal biography being radically altered as you learn that your body is failing, that cells are under attack or your brain is sending out a series of bizarre signals that prevent your limbs functioning as they once did. Suddenly, all that narrative, that 'biography', you have constructed for yourself and hope to build for the future is thrown into doubt. The present now has to be renegotiated, the future seems doubtful and the past a strange place. In short, you have to face a disruption in your concept of self and in your 'own biography.'
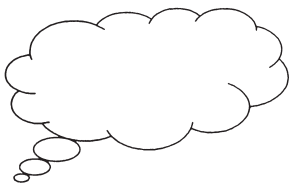
Think of your life as a narrative – what has been written so far and what have you plotted out for the future?

For someone with a chronic illness, biographical disruption relates to the reorganisation of life in a temporal and cultural context. Various ideas of self and of relationships with family, friends and colleagues will be challenged and re-evaluated.

Within the biographical disruption of life the individual will have to deal with the *consequences* and *significance* of the illness (Bury 1997). The actual symptoms of a condition will affect everyday life. Someone, for example, with petit mal epilepsy (Iphofen 1996) will have to live with the uncertainty of not knowing when or in what context they may have a seizure. This can make certain social situations fraught with risk, in terms of safety or, more importantly, of breaking social norms. For other conditions there are issues of self-care and managing symptoms on a daily basis. As mentioned in Chapter 1 illness also has cultural and metaphorical significance. People with chronic illness may have to respond to the way in which their culture and society perceive their condition. Certain conditions carry a social stigma when the illness is connected with undesirable states or social deviance. Younger people with arthritis feel that they are ageing prematurely (Singer 1974), while people with HIV/AIDS can be stigmatised as being 'junkies'.

There has been some debate surrounding this concept of biography being disrupted. Pound et al. (1998) argued that for older people development of a chronic illness, in this case stroke, was in some ways expected and regarded as a 'normal crisis'. The impact of the stroke, and the consequent disruption of biography, was mitigated by it being just one of many issues, such as poverty, etc., that faced this group of people. Reviewing the literature on biographical disruption, Williams (2000) offered a more important critique. Following Pound et al. (1998), he suggested that chronic illness cannot be seen exclusively as *disruption* but should be viewed as *continuity*, where chronic illness is expected and regarded as normal due to age and class. In the case of gay men with HIV/AIDS, the onset of infection or the development of AIDS can lead to an affirmation of political identity. Williams cites other examples, too numerous to mention here, but all with the same theme – that the context of someone's life has a strong bearing on how disruptive a chronic illness will be.
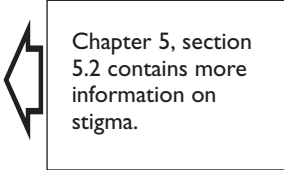
Impact of treatment regimens

One major adjustment for someone with a chronic illness is incorporating medical and clinical treatments within their daily life. These treatments vary widely in the impact that they make, but one central feature is that the treatments will often require a major reorganisation of time and a re-appraisal of what medical science can offer. For many people the actual treatment can have as much of an impact on their lives as the condition itself. Adjustments to daily routines and perception of self may have to be made when incorporating such changes as living with a stoma, having to drip-feed, undergo regular dialysis, and so on. The ways in which these changes are integrated or made part of someone's daily life can be a

difficult and potentially stigmatising process. Sometimes the actual treatment will have side-effects that are comparable to, or even worse than, the symptoms of the particular chronic condition.

MacDonald (1988) observed that for colostomy patients there was a strong tendency to conceal information about their stoma. The patients felt that the odours, noise and dealing with the bag in public places were potentially disruptive to normal social intercourse. Patients with rectal cancer were stigmatised in a variety of ways. In addition to having to bear the stigma of cancer, they also broke cultural taboos concerning faeces and their disposal. As a result, social situations became fraught with risk, with patients attempting to minimise the impact of the stigma, fearing embarrassment or disgust. Overall, for these patients there was some impairment of quality of life, even if they had managed to deal with their stomas in some way. Writing on stigmatising conditions Scambler (1989) noted that patients had the following three concerns when interacting with physicians:

> 1 felt stigma – a sense of shame and apprehension at meeting with discrimination;
> 2 rationalisation – a deep need to make sense of what is happening, to restore cognitive order; and
> 3 action strategy – a need to develop modes of coping across a diversity of roles and situations.
> (Scambler 1991b: 195)

He notes that physicians deal well with rationalisation but are less capable of handling felt stigma and action strategy in a satisfactory manner.

Pinder (1988) has noted that for some patients with Parkinson's Disease the side-effects of the medication are as bad as the symptoms of the actual condition. Here we can see the limits of medical science beginning to be exposed. Popular lay notions of science being able to solve everything are contested as its efficacy is cast into doubt.

Adaptation and management of illness

From the discussion so far we see that chronic illness can have a considerable impact on someone's life. Aspects of one's life may be thrown into question and have to be re-evaluated, while the treatment for the condition can produce a whole host of potentially stigmatising situations. Within this context people with chronic illnesses nevertheless seek to maintain some sense of self and identity. In the earlier quote from Picardie there was evidence of how she dealt with hair loss by having her hair cut short in an attempt to appear 'normal'. Bury (1991) describes these responses as coping, strategy and style.

Coping is a term used in a variety of contexts, commonly when someone is coping with the illness, whether successfully or not. It can also take on emotional dimensions and relate to how someone is holding on to some aspects of identity.

Strategy are the particular actions or resources someone utilises to deal with problems created by the illness and by social responses. They can range from breaking the day down into manageable chunks, or by avoiding the general public to minimise the risk of stigma.

Style is how one presents oneself to the social world in an attempt to maintain aspects of self.

7.5 Disabled people and disability

One of the potential consequences of chronic illness is a disability of some kind. Many of the conditions mentioned in the previous section can lead to some level of impaired function or changes in how the body operates in particular contexts. This section will explore issues of disability in general and in relation to chronic illness.

The first point to consider is what we actually mean by disability. Common images of disability often involve people in wheelchairs, images that are overlain with notions of dependency, weakness, misfortune and charity. As we have seen elsewhere in this book, there is no such thing as a neutral expression and all aspects of terminology and imagery are cultural products often reflecting issues concerning power and regulation. Disability is no exception and, in attempting to study disability, analysing and looking at what concepts lie behind various terms is a useful introduction. The following terms circulate in lay discourse about people with disabilities:

* cripple/crippled
* the handicapped
* deformed
* 'something wrong'
* the disabled

They may all appear to be quite separate terms, some more acceptable (the disabled) than others (cripple). However, underneath them all there is the same negative attitude towards people with impaired or disabled bodies. They all remove the person from the experience of disability and frame disability in terms of mechanical body parts gone wrong. Terms such as '*the* disabled' and '*the* handicapped' imply that there is no person there, but rather a medical condition with no personal narrative, identity or desires. Moreover, such expressions imply that everyone who is disabled has a uniform experience regardless of gender, class, ethnicity, age, sexuality or impairment. There is also a very negative history connected to the

word 'handicapped'. The term originates in the medieval expression to go 'cap in hand' or to beg. This carries the implication that people with disabilities occupy an inferior position in society as outsiders reliant upon charity and incapable of independently supporting themselves.
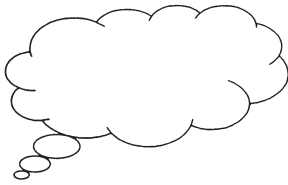
What terms for disability do you find acceptable and why?

We have discussed certain negative words and expressions used in connection with disability. There are other expressions that avoid some of these pitfalls. Indeed, they have been used already in this text: people with disabilities or disabled people. Both terms avoid medicalising people's existence, and also emphasise the person with their range of differences, emotions and identity. However, we can still question the language a little further – what do terms such as 'impairment' and 'disability' mean? Here we find another area of controversy. The following definition of impairment, disability and handicap was used by the World Health Organisation (1980) until quite recently:

Impairment
Any loss or abnormality, of physiological or anatomical structure or function. Thus impairment could range from a scar on the skin to a malfunction of the liver or heart.

Disability
Any restriction or lack of ability to perform an activity, as a result of impairment, in a manner or within the range considered normal for a human being, for example the ability to climb the stairs or walk to the shops.

Handicap
A disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfilment of a role for that individual (depending on such factors as age, sex and social and cultural factors). Handicap refers to the disadvantage the individual encounters, as a result of the impairment and/or disability, when compared with his or her peers.

This particular definition has been heavily criticised for its strong medical orientation and for placing the source of disability in the individual rather than in other wider factors. It also contains the implication that, by not being able, because of impairment, to carry out an activity considered normal, a person with a disability must therefore be *abnormal*. As writers such as Oliver (1993), note, the WHO definition follows a non-disabled person's view of disability, thus failing to understand or comprehend the full experience of someone with a disability. The model implies that it is the disabled person who must adjust and adapt to the world, because it is they who are problematic and not the arrangement of built spaces or social attitudes (Barnes et al. 1999).

Compare that definition with those proposed by Finkelstein and French:

Impairment
Impairment is the lack of part or all of a limb, or having a defective limb, organ or mechanism of the body.

Disability
Disability is the loss or limitation of opportunities that prevents people who have impairments from taking part in the normal life of the community on an equal level with others due to physical and social barriers.
(Finkelstein and French 1993: 28)

This is substantially different from the first definition we looked at. Here the emphasis is on societal factors such as the design of buildings or discriminatory attitudes of others, a far cry from regarding an individual's body as the cause of disability.

At the heart of this discussion is how we see or define disability. There is a range of models that various writers propose, but two models stand out in particular when it comes to conceptualising disability: the medical model and the social model:

- The *medical model* of disability has a strong emphasis on seeing disability as an individual tragedy where, by a quirk of fate either genetic or accidental, someone becomes disabled and their life is, in many ways, ruined. They are incapable of functioning in a productive manner and without the assistance, help and intervention of certain highly trained specialists their lives would be almost impossible. As a result, power and decision making is in the hands of the professionals. Physical dysfunction and the failure of body parts are emphasised in this approach, which strongly focuses on disability as due to the person, with other factors being ignored. This model is implicitly negative in its depiction of disabled people.
- The *social model* of disability argues that prejudicial attitudes, disabling environments and cultural barriers socially create disability. The focus here is on self-help and emancipation, as it calls for civil rights and for disabled people themselves to be empowered to make decisions about what support and services they receive. Disabled people are also more than capable of leading fulfilling lives that are productive, rewarding or as fraught with problems as those of non-disabled people, and that disability is no bar to sexuality. Ultimately, disability is a mixture of factors that includes impairments as well as cultural, social, material and attitudinal factors. This model is implicitly positive in its portrayal of people with disabilities.
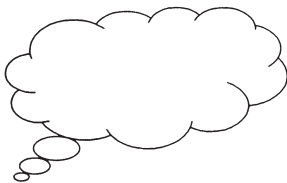
Which of the above models do you think your particular health profession follows? Did you find anything challenging in the medical model or social model?
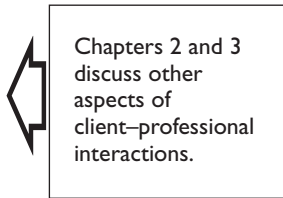
The medical profession and para-professions, such as occupational therapy and physiotherapy, have been criticised for following the medical model, whether intentionally or not (French 1992; Johnson 1993; Stalker and Jones 1998). Therapists or doctors often take the lead in therapeutic encounters, with the professional dominating the decision making on the grounds that they 'know best':

> the attitudes of physiotherapists were often perceived as patronising and undermining. . . . Prescriptive labelling and treatment of people according to impairment was seen as a denial of individuality and typical of therapist-centred physiotherapy. (Johnson 1993: 624)

This is the main challenge of the social model of disability, that all health professionals, not just physiotherapists, must change or reflect upon how they practice. Even though they may perceive themselves as losing power and overall control, they should defer more to the needs of the disabled person with whom they are working.

Chapters 2 and 3 discuss other aspects of client–professional interactions.
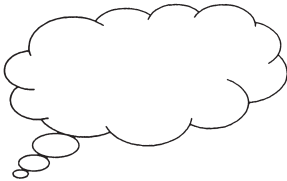
How do those last comments make you feel? Do you think that health professionals may not be as holistic as they portray themselves to be?

The phenomenological approach to studying the body outlined earlier in this chapter also provides some useful ways of investigating disability. The sociology of the body draws attention to two concepts of the body: the body as *korper* and the body as *leib* (Shilling 1993). '*Körper*' refers to the body as 'the objective, exterior, institutionalised body' (Williams and Bendelow 1998). This way of viewing the body is evident when anatomy or physiology is studied. The body is presented as a series of structures and constructions that can be described as objects that are without emotions and that are not seen as being part of a person. In many ways this is how medicalised views of disability operate. The disabled individual is not seen as a disabled *person* but as a *body* that has something wrong with it and, therefore, as something that can be 'fixed' or repaired. Moreover, as Edwards (1998) argues, seeing the body as a separate objective entity can make understanding disability difficult. He cites the work of Wendell who explores her experiences of ME (myalgic encephalomyelitis) (1996: 21–2) and her problems of trying to express the psychological and physical aspects of disability as not being separate.

'*Leib*' refers to the body as 'the animated, living, experiential body' (Williams and Bendelow 1998). Here the body is seen in an embodied context whereby the body and mind form the same entity and all aspects of the physical body; the emotions and personal narrative form one whole. This perspective allows us to see the body and the self as one and could overcome the problems of trying to conceptualise and explore the lived experience of disability, or as Overboe (1999: 24) puts it when discussing

disability in this context: 'Thus our "lived experience" would be an integral part of the atmosphere and tone for any change within our lives and our interaction with others, whether they be disabled or non-disabled.'

Focusing on the *Leib* experience can help us understand the emergent characteristics of disability and identity. Following this approach, Williams and Barlow's (1998) study of arthritis identified that body and mind, the embodied lived experience, were not separate. Subjects reported how feelings of self and identity emerged through the changes in their bodies. The women with arthritis felt themselves less attractive and feared that they were breaking a social taboo by displaying a 'pained' body in public. The influence of consumerism and notions of the body perfect were at play here, with the women feeling that they did not accord with these images. However, for some women still identifying themselves as feminine, clothing and make-up were the means to express this idea of self bodily.

Summary

- The taken-for-granted status of the body has detracted from the significance of the body for students of the sociology of health.
- Human experiences are essentially embodied and this is most true of health and illness.
- The body is a bearer of values and a means of representing our identity to others.
- The civilised body is one that is controlled both in terms of bodily functions and displays of emotion.
- The limits of the physical body are constantly being extended as scientific advances allow us to alter the appearance of our bodies and to replace diseased organs.
- Ideas about the body are underpinned by normative concepts of the 'good' and 'bad' body, the former being associated with bodily perfection.
- Any form of disease, but particularly chronic and terminal conditions, bring in to stark reality the limits and fallibility of the human body.
- A 'failed' body forces individuals to reassess their lives and sense of identity – though this is not necessarily a negative experience.
- Disability is a combination of environmental, social, cultural, material and physical factors. Acknowledging disability in this way asks fundamental questions of health professionals when interacting with disabled people.

Case study

Consider the following case study and then answer the questions below.

James was diagnosed with rheumatoid arthritis around the time of his eighth birthday. The condition has meant that at times his mobility has been

severely affected. Games and sports at school were something that he had to miss out on. Writing for long periods in exams became impossible in his final year and so he produced his work on a laptop in a room separate from the rest of his classmates. After finishing school, James wanted to enter a career in hotel management but this proved impossible as the type of work involved a considerable amount of being on one's feet, something James could not do without being in severe pain. Instead, he chose a clerical post in the Civil Service which would allow him to be seated for much of the day and to use a PC instead of physically writing.

1 Mobility was a problem for James from an early age. What kinds of activities and experiences do you think that he might have missed out on compared to other children his age?
2 How might you apply the concept of 'biographical disruption' to James' experiences as a young adult?
3 What kind of knowledge would you have expected James to accumulate about this condition? How would this differ from the knowledge of the clinician and what, if any, would be its relevance to anyone treating James?

Recommended reading

Birke, L. (1992) 'Transforming human biology', in H. Crowley and S. Himmelweit (eds), *Knowing Women: Feminism and Knowledge*. Oxford: Polity/Open University Press.

Bordo, S. (1990) 'Reading the slender body', in M. Jacobs, E.F. Keller and S. Shuttleworth (eds) *Body/Politics: Women and the Discourse of Science*. New York: Routledge.

Hawkes, G. (1996) *A Sociology of Sex and Sexuality*. Buckingham: Open University Press.

Hewitt, P. and Warren, J. (1997) 'A self-made-man', in A. Giddens (ed.) *Sociology: Introductory Readings*. Oxford: Polity. **A short article that raises some challenging points about the nature of gender identity and its relationship with our biological sex.**

Mayall, B. (1996) *Children, Health and the Social Order*. Buckingham: Open University Press.

Nettleton, S. (1995) *The Sociology of Health and Illness*. Oxford: Polity.

Nettleton, S. and Watson, J. (1998) *The Body in Everyday Life*. London: Routledge. **An excellent selection of articles about people's experiences of living with specific kinds of bodies. Particularly helpful are examples of living with chronic illnesses.**

Parker, J. (1993) *With this Body: Caring and Disability in Marriage*. Buckingham: Open University Press.

Shilling, C. (1997) 'The body', in K. Woodward (ed.) *The Politics of Identity*. London: Sage/Open University Press.

HEALTH IN A SOCIAL CONTEXT

The Challenge of Ageing

8.1 **The image and reality of ageing.** Signs and symbols of ageing. Negative images of older people. The experiences of older people. Sociological theories of ageing.

8.2 **Is there a demographic 'time bomb'?** Life expectancy rates. An ageing population. The diverse experience of older people.

8.3 **Health, illness and ageing.** Illnesses and diseases prevalent among older people. The social and medical models of disability.

8.4 **Ageism: the cost of care.** What is ageism? Health care and rationing. Discrimination against older people.

Key concepts

Chronological age, ageism, ageing, social model of disability, medical model of disability, and rationing

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The aim of this chapter is to introduce you to the social context of health and health care by exploring the challenges that ageing poses to the practice of medicine. To understand the nature of this challenge we need, first, to understand the social and cultural meanings attached to ageing as well as the scope of the challenge in terms of the number of older people in the population. Second, we need to have an understanding of the range and types of illnesses commonly associated with ageing and the extent to which the ageing process itself has become increasingly medicalised. Finally, we need to consider if negative images of ageing affect the treatment older people receive from the NHS.

8.1 The image and reality of ageing

It may seem a little strange to begin with an analysis of images of ageing before establishing the facts of ageing in terms of the numbers of older people, their economic and social circumstances or their health status. However, as should be evident from the opening chapter, facts do not

speak for themselves but rely upon interpretation and analysis. Thus, the facts themselves can only be understood in the context of the images and ideas associated with ageing. Phrases such as the 'demographic time bomb' can carry negative connotations as the increase in the number of older people in the population is seen as a problem. In the same way, assumptions about the negative health status of older people are coloured by perceptions about old age as a time of decline into frailty and dependence.
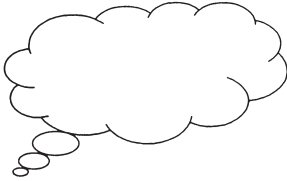
Before you continue with this section, make a note of your own perceptions of old age. Are you looking forward to experiencing older age?

Chronological age, literally the number of years a person has lived, is thought by sociologists to be an inadequate means of defining what is meant by 'old age', as age and ageing have different meanings in different cultures.

It is said that there are only two certainties in life, death and taxes. The body begins to age, change and develop from the moment of birth until its eventual death. Despite the fact that this is the fate of us all, old age is associated with negative images and attitudes. The earlier discussion of the sociology of the body illustrated the importance of our physical self for our sense of identity, and from this it is possible to see that the visible signs of ageing (greying hair and developing wrinkles, for example) act as a set of symbols, indicating the approximate *chronological age* of a person. Age itself, in terms of our chronological age, is not in itself inevitably stigmatising but certain signs of ageing are. Field argues that people who are chronologically old but are fit and active are not stigmatised in the same way as are those who are physically frail and dependent. On this basis he concludes that 'the negative stereotypes of old age seem to be based on an association between age, sickness and dependency. Negative stereotyping highlights dependency, sickness and the inability to perform socially' (Field 1992: 175). Field's analysis provides a useful starting point for a discussion of the assumed association between old age and ill health. However, as we will go on to discuss, many older people enjoy a life relatively free from sickness and dependency. In addition, the same negative stereotyping of individuals on the basis of sickness and dependency can, arguably, be seen in relation to people with disabilities. Such an association may, therefore, lead us to conclude that it is the assumption of dependency and of an inability to perform socially that is the source of the discrimination rather than the actual age of the person.

Ageing is a physiological and biological process whereby the body grows and matures.

Any explanation of why our images of *ageing* are mainly negative has to be placed within a social and cultural context. When we think about discrimination or disadvantage it is necessary also to contemplate privilege and advantage. In this sense, to understand the negative image of old age we need to consider why youth is so highly valued. Youth is clearly associated with notions of optimum physical performance (hence sports people are 'old' in their mid-thirties), cognitive ability and attractiveness. In contrast, old age is seen as a period of decline marked, for example, by loss of height and wrinkled skin. Fairhurst (1998: 258) argues that in the context of ageing 'decline' is an evaluative term, unlike the natural world where the term is not used in a normative sense. Fairhurst's analysis of ageing draws

our attention to the notions of physical attractiveness and appropriate appearance. The two phrases that sum up the association between youth, attractiveness and age are 'growing old gracefully' and 'mutton dressed as lamb' (Fairhurst 1998: 261). Both phrases make assumptions about age-appropriate actions and appearance. Mutton is older, tougher meat in comparison with youthful and tender lamb. Fairhurst's respondents all interpreted 'mutton dressed as lamb' as the wearing of 'inappropriate clothes, hair, make-up or jewellery' (Fairhurst 1998: 262).
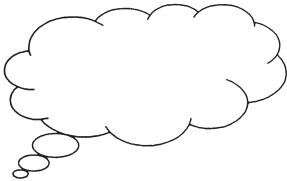
> *The term 'mutton dressed as lamb' is generally only applied to women. Are there any similar descriptions of older men dressing 'inappropriately'? If not, why do you think this is?*

Featherstone and Hepworth (1993) also draw our attention to the largely negative terms used to describe older people. Such words include 'wrinkly', 'gaga', 'biddy', 'fogey' and 'geriatric' (1993: 308). The biological process of ageing is 'shaped or constructed in terms of symbolic imagery, both verbal and non verbal' (ibid.: 308). Words and images are used as stereotypes to make sense of and describe the experiences of older people. The danger of such stereotypes is that they fail to reflect the complexity and diversity of people's experiences of ageing.

Both quantitative and qualitative analyses of the circumstances of older people suggest experiences that are rather more varied. Field, for example, argues that most older people (77 per cent) live with their spouse or alone but in their own home and near to other family members. Evidence from successive General Household Surveys indicates that women, because of their greater longevity, are more likely to live alone following the death of a spouse (Field 1993: 171). In terms of levels of income, it is clear that for many older people retirement from paid work is a pathway into poverty. Yet, despite this, a recent survey suggested that fewer pensioner households had reported worrying about money in the previous few weeks. Under 50 per cent of all single pensioners asked said that they had worried about money in the previous week, compared to 70 per cent of single adults (Scottish Executive 1999a: 68). Statistics from the Scottish Crime Survey (Scottish Executive 1999b) indicate that a significant number of older people feel unsafe when walking alone after dark. Of women aged 25–44, 35 per cent said that they felt unsafe, compared to 50 per cent of women aged 65 or over.

Moving from ones own home to residential accommodation is often seen as a clear sign of dependency. Norman's 1998 account, 'Losing your home,' suggests that the loss of a home is experienced as a bereavement in terms of its level of disruption to an older person. The move may well mean giving up a home and a neighbourhood, as well as household possessions. The loss associated with such a move is much greater if people 'are being moved in conformity with ruling social values which are offended by letting them stay where they are, or are forced to go by the

physical duress of having no viable alternative' (Norman 1998: 76). Bromley goes further by stating that the move to institutional care can undermine a person's sense of self and autonomy to such an extent that he or she increasingly conforms to societal expectations of senility (Bromley cited in Featherstone and Hepworth 1993: 314).
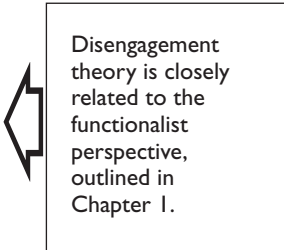
Relationships of dependency are also created and reinforced by institutions and professions whose primary role is to care for the needs of older people. Ageist stereotypes of older people as confused, childlike, dependent and potentially senile are often reinforced by the nature of institutional living. Featherstone and Hepworth suggest that social arrangements such as institutional care can create a self-fulfilling prophecy of senility (Featherstone and Hepworth 1993: 314). The provision of physical and social care not only creates a dependency on others, but also leads to an atrophy of existing skills; being 'taken care of' undermines one's ability to take care of oneself.

Thus far we have given consideration to images of old age. The following section is concerned with placing those images within a theoretical context. The aim of this discussion is to illustrate through a sociological analysis that, much more than simply a physiological experience age is fundamentally a social experience.

Sociological theories of ageing

Sociology offers a number of perspectives, all of which seek to explain the social situation, status and role of older people. Disengagement theory offers what might appear in the twenty-first century as a rather dated perspective on ageing and the role of older people. Cumming and Henry (1961) suggested that as people reach old age they gradually disengage from society, in terms of their social contacts, roles and responsibilities. The process of disengagement prepares the older person and society in general for the ultimate disengagement in terms of death or incapacity (Bond et al. 1993: 32). Disengagement theory is based on a broader functionalist perspective of society (outlined on pp. 10–11) with its emphasis on the roles, responsibilities and values that ensure the smooth running of the social structure. By disengaging, for example through retirement from the paid work force, individuals cease to be essential to the functioning of the social structure. On this basis their death does not result in any significant disruption since older people have ceased to be part of the work force.

Bond et al. (1993) highlight a number of problems with this particular perspective on ageing. They argue, first, that disengagement theory condones the social isolation and marginalisation of older people, which for many results in poverty and loneliness. Second, they suggest that this theory is based on an assumption that disengagement is a natural and inevitable occurrence. It is possible to argue that the theory is essentially ageist in the sense that it assumes identical experiences for older people. However, as Bond et al. (1993: 32) point out, many older people may still be

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Disengagement theory is closely related to the functionalist perspective, outlined in Chapter 1.
</div>

actively engaged in society, while for others old age is part of a lifelong experience of non-engagement and social isolation. The final criticism that can be made of disengagement theory is its failure to appreciate that certain social practices (such as enforced retirement from the paid work force) and cultural values (ageism) combine to ensure that disengagement does become the experience of many older people. In this sense, we can perhaps appreciate that disengagement is the consequence of a specific set of social arrangements rather than a natural and inevitable part of the experience of ageing.

In contrast to disengagement theory, an alternative explanation of the experience of older people centres on the social creation of dependency. The essence of this approach is that older people are constructed as dependent on the state, primarily through exclusion from the paid work force. Such exclusion also means that older people are further isolated from a wide variety of social settings, relationships and networks. Data examined in the previous section showed that older people are one of the groups most at risk of poverty because of their dependence largely on welfare benefits. The potential effects of retirement are, according to Bond et al. (1993: 34), poverty and restricted 'access to social resources in the form of a reduction in social relationships'.
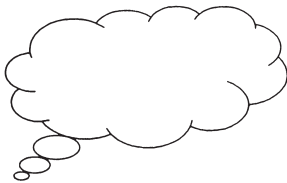
> *Which of the two contrasting theories do you find most useful in understanding the experiences of older people?*

The above section provided insight into relevant sociological theories of ageing. The following section moves on from this by examining trends in the development and growth of an increasingly ageing population.

8.2 Is there a demographic 'time bomb'?

Two of the most significant features of contemporary society are the increase in life-span and a decrease in infant mortality. These two factors have combined to ensure that living into old age is the common experience and that death before old age is the exception.

Table 8.1 *Life expectancy by year of birth*

	1861–1879	1930–1932	1960–1962	1970–1972	1980–1982	1990–1992	1995	1996	1997	1998	1999
Males – average life expectancy (years)	40.3	56.0	66.2	67.3	69.1	71.4	72.1	72.0	72.6	72.6	72.6
Females – average life expectancy (years)	43.9	59.0	72.0	73.7	75.3	77.1	77.6	77.7	78.0	78.1	78.0

Source: Registrar General for Scotland

The main reason for the increase in life expectancy is the reduction in infant mortality rates. The *Health in Scotland* report, published by the Scottish Executive (1999), tells us that in 1998 infant mortality rates were 5.6 per 1,000 live births, contrasting sharply with a rate of 126.4 in the period 1891–95. Equally, there has been a significant reduction in death rates in general for the same period. *Health in Scotland* points to levels of fertility as the main factor determining the age structure of a population, rather than increase in longevity. This report suggests that fertility rates have declined substantially until they are now only near replacement levels. The report predicts a 14.9 per cent increase in the number of people aged between 60–70 as those born in the 1960s reach their seventies. However, much of the sensationalism connected with the demographic 'time bomb' may well be exaggerated as the same section of the population is predicted to fall by 19.4 per cent in 2040 as the smaller numbers of people born in the 1970s reach their seventies. 'United Kingdom population projections anticipate stability in the number of older people during the 2030s and the beginning of significant declines around 2046' (Scottish Executive, 1999).

Table 8.2 *Population by age group* (1999)

Age Group	Percentage of the population
0–15	21
16–24	10
25–34	13
35–44	15
45–54	14
55–64	11
65–74	9
75+	6

Source: Scottish Executive 2000

The total number of people aged over 55, therefore, is roughly 26 per cent of the population. The main cause for concern is not so much the total numbers now, but more the projected numbers of older people in the future. There is an assumption that with an increasing number of people of retirement age, the burden on those adults in employment will be intolerable (Abercrombie and Warde 2000: 268). It is not difficult to appreciate that this change in the age distribution of the population may well have serious repercussions in terms of the provision of pensions, adequate housing and health care, for example. The challenge facing the NHS in terms of the provision of care for an increasingly ageing population will be considered in detail below (ibid.: 268). However, as we have already indicated, it is both difficult and potentially misleading to make statements about the situation of older people as if they formed one homogenous group, since the picture 'is complicated by different patterns of retirement, social class and gender' (ibid.: 268).

Table 8.3 *Population projections: 2004, 2009 and 2014* (Scotland)

Year	Age 45–64	65–74	75–84	85+
2004	1,270,431	442,563	279,463	82,707
2009	1,378,648	453,228	283,215	97,041
2014	1,438,834	503,459	298,172	106,059
Overall increase 2004–2014	168,403	60,896	18,709	23,252

Source: Information Statistics Division and National Statistics 2001: 9–10

Despite the fact that there is a statutory age of retirement for men and women, individuals may choose to retire before that time or, alternatively, to carry on with some form of paid employment past the age of 60 or 65. One factor that may determine a person's decision as to when to retire from paid work is the level of income they can expect to receive via state and personal pensions. Evidence presented by Abercrombie and Warde (2000: 270) for the years 1994–96, indicates that both gender and social class can be used as the basis for predicting whether an individual does or does not have a private pension. At one end of the spectrum, 79 per cent of women working full-time in professional occupations had a pension (an occupational and/or a personal pension), compared to just 39 per cent of women in unskilled manual occupations. The disparity is even greater when a comparison is made between women in the same occupational groups who work part-time. Of part-time professional workers, 67 per cent had a pension but only 16 per cent of part-time women workers in unskilled manual occupations had any pension. A similar pattern emerges when comparing the pension provision made by men as opposed to women. For example, 72 per cent of men in skilled manual occupations had pensions compared with 56 per cent of women.

The discussion so far has drawn attention to the complex nature of ageing and the diverse experience of older people. While it is inaccurate to think about older people as a homogenous group, it is nevertheless clear that there are sufficient stereotypical images of 'old age' to ensure some commonality of experience. A combination of negative images of ageing, exclusion from the labour market and an increased risk of poverty ensures that many may well fear ageing. Underlying themes of popular images of old age are those of decline, decay and disease. The following section assesses the accuracy of such images and considers the experience of ageing in terms of health status.

8.3 Health, illness and ageing

There is a close and sometimes naturally assumed association between ageing, disability and ill health. The figures below, however, indicate that many older people remain free of any long-standing illness or disability. For example, while 41 per cent of women aged between 60 and 74 did report a long-standing illness or disability, 49 per cent did not and, one can

assume, enjoyed reasonable health. A closer examination of these figures does, however, reveal some subtle but important differences. In terms of gender, older women experience more health problems than men of the same age. It is also clear that some distinction should be made between age groups within the catch-all category of old age. Field (1992) draws a distinction between the 'young old' and the 'old old', the former below 75 and the latter over 85. Although the cut-off points might seem a little arbitrary, they are, nevertheless, helpful in identifying a trend towards increased levels of disability and ill health among older people over the age of 75 (Field 1992: 276).

Table 8.4 *Presence of long standing illness, health problem or disability by sex and age*

	16–24	25–34	35–44	45–59	60–74	74+	Total
Male	9	11	14	26	40	47	23
Base	**745**	**1,534**	**1,705**	**2,219**	**1,932**	**744**	**8,879**
Female	9	13	16	27	41	53	26
Base	**940**	**2,034**	**2,075**	**2,515**	**2,591**	**7,532**	**11,687**
All adults	9	12	15	26	41	51	25
Base	**1,685**	**3,568**	**3,779**	**4,735**	**4,523**	**8,276**	**20,566**

Source: Scottish Executive 2001

The 1999 *Health in Scotland* report (Scottish Executive, 1999) indicates many similarities between the health experiences of older people and the general population, with four significant exceptions.

- Some diseases are more common among older people and these include cancer, heart disease and mental illness.
- Some conditions are found mainly among older people and include brain diseases such as strokes, dementia and Parkinson's disease.
- Some conditions have greater implications for older people. Acute and traumatic conditions such as falls and fractures may take longer to heal and have increased consequences for the mobility levels of older people.
- Older people have a greater likelihood of multiple pathologies whereby an apparently minor ailment might have serious consequences for the individual.

Field notes a further distinction between the health of younger and of older people in the tendency of the latter to experience diseases that are degenerative and chronic. Such diseases 'persist over a long period of time, are largely incurable, and typically get worse' (Field 1992: 176) suggests that the diseases that have the most serious consequences for older people are dementia, arthritis and stroke, leading to a greater level of disability and dependency on the part of the older person. The 1999 *Health in Scotland* report indicates that strokes are a catalyst for a range of other physical and mental conditions. The consequences of a stroke can lead to impaired physical ability, to depression and dementia.
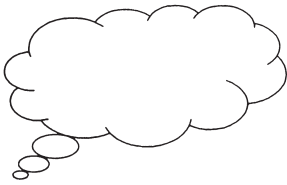
Field draws a distinction between the 'young old' and the 'old old'. How useful do you find this? At what age would you draw the distinction?

This account of ageing and ill health, however, is not intended to be a comprehensive medical account of the diseases and conditions most commonly associated with older people. The opening chapter made clear that a sociological understanding of health and medicine must place the experiences of individuals and groups within a social context. Ageing is an inevitable part of the human condition but images of ageing and the experience of growing old are not universal 'facts' but social constructions. It is impossible to understand fully the health status of older people without appreciating their immediate social context (standards of living and levels of income, for example), negative social attitudes towards ageing (such as assumptions that old age is inevitably one of decline, decay and ultimately death) or the social environment of illness and disability (lack of adequate funding for appropriate services, and a physical environment dominated by steps which are difficult to manage with limited mobility). Field argues that the impact of a chronic condition or disability is mediated by the degree of social support available to an older person, with those most isolated suffering the most adverse affects (Field 1992: 176). Thus, although there may be 'a clear association between ill health and chronological age, the two are imperfectly related' (ibid.: 176). Major studies of lay health beliefs also suggest that despite the fact that many older people experience ill health and some limitations to their mobility, many are stoical in their attitude. Older people tend to define health in functional terms; that is, the ability to do or to carry out certain actions. The range of such actions may be limited when compared to that of a younger person, but may nevertheless be adequate for the person concerned in their situation. When, however, an ailment or disease restricts activity there are serious social consequences that have to be considered.

Brocklehurst argues that older people can experience a gradual drift from a state of health and independence to disease and dependency on others. Acute illnesses may result in hospitalisation and subsequent loss of independence (Brocklehurst, 1978). Such arguments draw our attention to the social consequences of ill health in terms of isolation and dependence upon others. Deterioration in eyesight may undermine a person's ability to function confidently outside his or her own home, or manage form-filling. Field argues that something as commonplace as arthritis may lead to an inability to wash or dress oneself, resulting in increased dependence on others (1992: 177). Brockelhurst argues that drift from health to dependence should also be considered in the context of social and physical environments that may 'create' or exaggerate the significance of aliments. At this point it is relevant to consider how and under what circumstances impairment results in dependence. Johnson (1995) argues that poor eyesight, for example, may be considered an impairment in terms of an inability to function at all or to function adequately. However, the physical fact of

impairment has to be placed within a social context in the sense that poor eyesight means that someone is unable to read. Within this social context, the impairment is considered as a disability, a negative attribute that detracts from our ability to function 'normally'. Under these circumstances, a person becomes disadvantaged in comparison with others. Commentators from the field of disability studies have argued that impairment does not inevitably lead to disability and disadvantage, but given that able-bodied people dominate the social environment, anyone with a disability is seriously disadvantaged. This is what is referred to as the *social model of disability* and is most often contrasted with the *medical model of disability*; the latter sees the impaired individual as being the source of the disability, while the former argues that physical and social environments create circumstances under which individuals are disabled. The social model of disability offers the framework for 'understanding disability in which it is not the physical, sensory, cognitive or mental impairment of the individual that disables, but rather disability results from the structural handicapping effects of a society geared towards able-bodiedness as the norm' (Hughes 1998: 77). Using the social model of disability it is not difficult to see that many of the impairments experienced by older people, as well as by disabled people in general, are compounded by the physical and social environment. A physical impairment such as arthritis may lead to difficulty in climbing stairs but this difficulty becomes a serious disability if access to shops or houses, for example, can only be negotiated by means of stairs. The provision of lifts, ramps or other aids has the effect of minimising the potential disability. Field comments that a hearing impairment can result in reduced social interaction for older people, as they may lose the ability to hear what others are saying (Field 1992: 177).

> The social model of disability is premised on the notion that physical differences themselves are not the cause of disability and discrimination. Rather, it is the social environment (dominated by able-bodied people) that disables all others. In contrast, the medical model tends towards seeing a disability as an attribute of an individual and not, therefore, as a social problem.
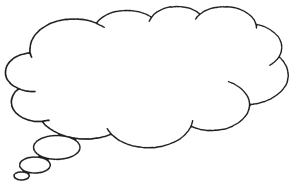
> *What are the main differences between the social and medical models of disability?*

The above discussion has sought to highlight the range, extent and consequences of disease and disability among older people. It is clear that while there are specific conditions associated with the onset of old age, it is also true that many people experience an old age relatively free of such complaints. Significantly, it has also emerged that the consequences of disease and acute conditions may be considerably different for older people than for the younger population. Older people have a greater tendency to experience multiple pathologies, with each condition compounding the one before. The health experiences of older people have also to be considered within a social context where ageing is seen in negative terms and assumptions are made about the inevitability of disease and decline as part of the ageing process. Given negative assumptions about the process and experience of ageing, it seems hardly surprising that many assume that depression is an inevitable side-effect of ageing.

8.4 Ageism: the cost of care

Previous discussions have underlined the extent to which medical knowledge and the practice of medicine is imbued with the cultural values of a particular society. The evidence considered above indicates that negative stereotypes in the form of *ageism* are prevalent in contemporary Britain. The purpose of this section is to consider further evidence that older people do not enjoy the same access to services and resources as other sections of the population. In the first instance, however, it is necessary to put our assessment in the context of the overall allocation of resources within the NHS.
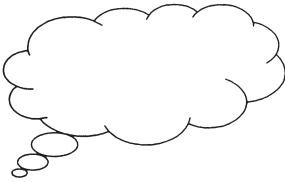
> *What examples of ageism can you think of?*

The most crucial issue to face the NHS is that of funding; how sufficient funds can be raised to maintain the services that are required. This has been a recurrent problem for successive governments and assumes that demands on the health service will only increase. Critics of this line of argument suggest that the crisis of funding is one created by the reluctance of all major political parties adequately to support the NHS. Draper, for example, has argued that too much funding goes towards sustaining the management structure rather than to patient services. In addition he argues that politicians and the medical profession have sustained the 'myth' of the bottomless pit of demand that 'suggests that people have an unquenchable thirst and uncontrollable appetite to spend their lives consuming health services' (Draper 1995 cited in Langan 1998: 41). However, there is insufficient space here to debate in more detail whether or not some *rationing* of services is inevitable. As things stand at present, rationing, or at least priority setting, is a fact of life for the NHS. The important question at this point is how and on what basis services are allocated. Rationing or priority setting happens in a number of ways, some overt and others covert. The following summary provides an overview of the main methods for rationing services.

Any one of these categories of rationing may well apply to older people. The capacity of an older person to benefit from a surgical procedure might be considered limited when compared with that of a younger person who may have more years to live to take advantage of the benefits. Research undertaken by the City and Hackney Health Authority in 1992 seems to reinforce the idea that younger people, and specifically children, are most people's priority for medical care. Respondents were asked to list in order of priority 16 categories of treatment. Age did appear to be a factor, since treatment for children with life-threatening diseases was ranked first, while long-stay hospitals and nursing homes for the elderly ranked tenth. (Langan 1998: 42–3). Negative images of older age are further overlaid by concerns about the cost of caring for an increasing number of older people. Evidence presented earlier indicates that people over 65 are set to become

Figure 8.1 *Methods of rationing health care resources*

Rationing through delay: by the appointment system and delays in seeing specialists.

Rationing through exclusion: refers to the power of clinicians to determine who is in need of treatment and the treatment to be used.

Rationing through the dilution of services: refers to the provision of some forms of treatment or services but not the most effective (nor sometimes the most expensive) forms. For example, some old-style anti-depressants (a typicals) may alleviate symptoms but have more side-effects. SSRIs are 'cleaner' but may cost more.

Rationing through deterrence: a cost may be attached to some treatments or services that may deter people from using them. Prescription charges are usually cited as an example, as are charges for eye-tests.

Rationing through denial of services: some treatments are simply not available through certain Health Boards or Health Authorities. Age is often a significant factor in determining access to some surgical procedures. Examples are cosmetic surgery and tattoo removal.

Source: Busfield (2000: 139) and Langan (1998: 46)

a larger proportion of the population, at least for the next 40 years or so. While it appears to be true that older people do make greater use of health services in general, it is also important to balance this view with evidence which suggests that most older people remain relatively healthy, a brief illness finally causing death (Wilson, 1991).

It is difficult to find precise evidence of systematic discrimination against older people as a whole. It is probably fairer and more accurate to say that there are sets of values that perpetuate the idea that older people's needs are of less importance than those of younger people. The evidence cited above from the City and Hackney Health Authority shows a general tendency to support the care of younger people rather than those who may be nearing the end of their lives. An important part of this argument is the suggestion that younger people have more to contribute to society than those who have retired from paid and productive work. (Busfield 2000: 169). However, bias in favour of younger people transgresses the principle of equal access for all to treatment on the basis of need. Busfield also comments that although older people may not be productive, they have been so in the past, which means that they have a right to treatment on the basis of past contributions (2000: 170).
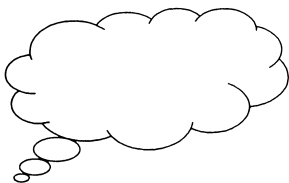
What arguments could be put forward to define the idea that young people, especially the very young, should have prior claim on medical resources?

As Chapter 3, section 3.1 makes clear, clinical autonomy means that medical professionals make decisions that may not always be in the best interest of, or coincide with the wishes of patients. Clinical autonomy allows for decision making on the basis of the possession of a specific body of knowledge and accumulated experience.

In many cases, the health needs of older people are similar to those of the population in general, so arguably it would be difficult to discriminate purely on the grounds of age. Where health care needs differ, however, it is often easier to argue that a form of age discrimination is taking place. In some cases, age discrimination can work to the advantage of older people. Recently, older people (and other selected groups) have been offered free flu jabs on the basis of increased risk, while those not deemed at risk have been required to make payment. However, when we turn to those diseases that are associated with the onset of old age, it is easier to see evidence of negative discrimination. For the purposes of this discussion, the example of the treatment for Alzheimer's will be addressed. There is no cure for Alzheimer's but there is a range of drugs available, each of which claims to relieve or delay some of the symptoms of this disease. Both the National Institute for Clinical Excellence in England and Wales and the Health Technology Board, Scotland, have recently come out in favour of prescribing drugs such as Aricept for the treatment of Alzheimer's. Until that time, however, many Health Boards and Health Authorities had a policy of not prescribing, partly on the basis of cost and partly on the basis of uncertainty about the effectiveness of the drugs. The extract below illustrates the potential consequences of rationing resources.

Life savings pay for drug NHS wouldn't fund
Mr and Mrs Dobson paid the price of living in a health authority that doesn't fund drugs for Alzheimer's disease with their life savings.

When, in her 70s, Mrs Dobson was diagnosed with Alzheimer's, her husband ended up selling his car and his PEP in order to pay for the drugs she needed to improve her symptoms.

The family GP told the couple that he was unable to prescribe the cholinesterase inhibitors, such as Aricept, in an attempt to check the decline in Mrs Dobson's health. But they were keen to give her the chance of having the treatment that could improve her memory and reduce her anxiety so they decided to pay to see a psychiatrist privately….

Quality of life
But it was worth it because the Aricept they paid for made a difference to Mrs Dobson's quality of life.

Even the GP agreed – but he still couldn't prescribe it. The situation the Dobson's found themselves in is far from unusual – the majority of the 45 health authorities in the UK that do fund Alzheimer's drugs restrict their use to specialists only.

The drug costs £100 a month and restricting them to a small number of patients is common.

In fact, Portsmouth does now pay for a small number of patients to receive Aricept or similar treatments.

But Dr David Wilkinson, consultant in old age psychiatry at Moorgreen Hospital in Southampton, is furious at what he sees as 'rationing by age. . . '.
www.bbc.co.uk (2000)

This example illustrates well the potential for discrimination against older people within the NHS.

This chapter has sought to place the discussion of health within the broadest social context possible. To do this we have used the example of older people, arguing that it is impossible fully to understand their health status and treatment by the NHS without first appreciating prevailing images of ageing, theories of ageing and the negative connotations associated with the demographic time bomb. Health exists within a social context and can only be fully understood in this way.

Summary

- Health needs to be considered within a social context, since prevailing values and socio-economic circumstances shape our experiences of health and illness.
- Ageism refers to a set of negative attitudes about the ageing process and older people.
- Many older people experience ill-health and poverty but it is also important to remember that within this section of the population there is a wide diversity of experiences, which means that, for many, older age is a time of relatively good health.
- Fears about the demographic time bomb are one illustration of a more general concern about the burden of an ageing population.
- In relation to the provision of health care, there is some evidence to suggest that older people are discriminated against in terms of being a lesser priority than other sections of the population.

Case Study:

The Watts have been married since 1946 when they met in Baden-Baden, Germany, as members of the armed forces in the immediate post-war period. Mrs Watt was an army secretary while Mr Watt had been in the Military Police since the beginning of the war. After their marriage both of them attempted to arrange their postings so that they would not have to spend too much time apart. Both of them left the army in early 1948 to pursue civilian careers.

Shortly after leaving the army Mrs Watt became pregnant with Christine, their only daughter. Once their daughter had started school Mrs Watt began working as a part-time secretary for a local legal firm, while Mr Watt found employment in the whisky industry.

Both of them did well in their careers with their daughter progressing through school and attaining good results in any exam she sat. The next main event in their lives was their daughter leaving home to attend Edinburgh University to read English Literature. After her finals she left University with a first-class degree and soon embarked on a doctorate. While researching her thesis she met Martin, a research fellow in physics. They were married in 1970. Two years later their first child was born. After she completed her PhD both Christine and Martin began teaching in local secondary schools.

In 1978 Mrs Watt retired from the legal firm where she worked. She had mixed feelings on leaving. She looked forward to spending more time on her

hobbies, particularly as a committee member of the local history society. However, she found it very difficult to leave the office where she had worked for so long and missed her former colleagues. Initially she found that her hobbies did not take up as much time as she had envisaged and found the days too long to fill with activities she enjoyed. Mrs Watt particularly welcomed the arrival of a second granddaughter that year. She would travel through to Edinburgh to help her daughter whose increasingly busy work schedule made it difficult for her to bring up two children. Mrs Watt drove through to Edinburgh about three times a week and enjoyed seeing her grandchildren who were always happy to see her.

However, at the start of the 1980s life became harder for Mrs Watt. She found it increasingly difficult to play with her granddaughters as she started to experience pain in her hips if she had been sitting down, and trips to the park became an arduous journey. As the pain began to limit her activity, she visited her doctor who, after X-rays, diagnosed osteoarthritis in her hips. Besides the physical pain preventing Mrs Watt from spending time with her grandchildren, her daughter mentioned that the girls had said that granny 'smelled funny'. This was very embarrassing for both Mrs Watt and her daughter to discuss. For Mrs Watt it was a sign that she was becoming an 'old woman'. In fact she found it difficult to move about and she felt apprehensive about leaving her house in case anyone noticed the odour that resulted from a UTI (Urinary Tract Infection). She still managed to travel through to Edinburgh but on a restricted basis and only when her daughter or son-in-law could collect her from the station.

Even though she was increasingly housebound, Mrs Watt tried to remain active within her household. The house was always tidy and cleaned every day. It was while cleaning one day in 1990 that she fell off a chair as she tried to dust a door mantle. She landed on her sofa instead of on the floor, which probably limited her injuries to a Colles fracture. At this point Mr Watt tried to encourage his wife to 'slow down a bit' and let him do more around the household. Christine, their daughter, tried to assist more with her mother's care but the pressures relating to work and the distance required to travel limited her to one visit every two weeks.

Unfortunately the Colles fracture was not to be her only injury. During the winter of 1999 Mrs Watt decided to go for a walk on a particularly crisp and clear day. A hundred yards from her home she slipped on ice and fractured the neck of her femur. Mr Watt noticed a change in his wife after she came back from hospital. Something of her former self was gone. She now lacked her usual confidence and sense of purpose and started to repeat herself during conversations. Mr Watt found that he had to take increasingly more care of his wife, which he was more than happy to do.

Lately, though, caring for his wife has taken more and more of a toll on Mr Watt. Both neighbours and his daughter noticed how drawn and tired he was looking. Part of the problem was that Mrs Watt was less sure of her footing and had started to fall frequently around the home. Moreover, she was becoming more disorientated and unable to hold meaningful conversations or remember recent events.

A few weeks ago Mrs Watt had another fall and was admitted to hospital.

1   To what degree is Brocklehurst's argument that older people can experience a gradual drift from a state of health and independence to disease and dependency on others relevant to this case study?
2   What are the factors that make Mrs Watt feel like an 'old' woman?
3   What type of medical and social interventions would be necessary to maintain Mrs Watt in her home and to help her husband with his caring duties?

Recommended reading

Field, D. (1992) 'Contemporary issues in relation to the elderly', in M. O'Donnell (ed.) *New Introductory Reader in Sociology.* Surrey: Nelson. **A brief but detailed introduction to ageing and health.**

Scottish Executive (1999) *Health in Scotland.* Edinburgh: Scottish Executive.

Scottish Executive (1999) *Scottish Household Survey.* Edinburgh: Scottish Executive. **A useful statistical source of information on older people.**

Scottish Executive (2001) *Scottish Household Survey Bulletin No. 5*, Edinburgh: Scottish Executive.

HEALTH CARE CONTEXTS

9.1 Introduction. Overview of what the chapter will explore and why the context that health care takes place in is important.

9.2 Organisations. Exploring the ideas of Weber, Foucault, Blau and looking at how organisations function.

9.3 Shifts in policy. The move from institutions to the community. Discussion of Foucault's, Scull's and Goffman's critiques of institutional care.

9.4 The community. Problems in defining the concept of the community and some of the problems associated with caring for people in non-institutional settings.

9.5 Care and carers. What is meant by care and some of the issues involved in caring for someone with a chronic illness or disability.

Key concepts

Organisations, bureaucracy, informal routines, surveillance, resistance, institutions, institutionalisation, community, community care, care and carers.

9.1 Introduction

All health care takes place in some context or location, whether it is a hospital, an institution or the community. Each of these contexts brings with it a range of issues and problems, all of which are open to sociological interpretation. This chapter will begin by looking at organisations generally and evaluate some of the major theories that attempt to understand institutions. Max Weber's classic theory of rationality and bureaucracy will be outlined, followed by Michel Foucault's views on the organisation of physical space and surveillance. How people subvert and manage to bend the rules will be examined next.

Where health care takes place is often decided by social policy, and

since the introduction of the 1990 NHS and Community Care Act there has been an increasing shift towards caring for people in the community as opposed to institutional settings. Critiques of institutional, or asylum, care will be discussed, focusing on the work of Foucault and Andrew Scull. More attention will be given to Erving Goffman's seminal work on institutionalisation and the negative effects of institutional care. Care in the community was proposed as an alternative and better form of care. However, it too is problematic. One difficulty is in trying to define what a community really is, with multiple and different uses of the concept of community in existence. Even if a definition can be agreed upon, there still exists a debate about whether community care actually changes anything and some comments will be made on how the community may just be an extension of the institution. Finally, there will be some discussion of issues facing carers in the community, highlighting what care involves and some of the problems facing carers.

9.2 Organisations

For many people the hospital is still the expected place or context for the provision of health care. Like many other examples of large organisations hospitals have complex bureaucracies, operate surveillance, and sometimes involve the management of thousands of bodies. Unlike other examples of large organisations, however, they are expected to effect a positive change in some of the people who enter through the front doors. This means that although we can use an array of sociological perspectives to understand large institutions, we must also pay attention to the differences that arise from making life-or-death decisions about people. Attention will be given to the classic work of Weber on bureaucracy and organisations. How the physical layout of a hospital and use of surveillance affect patients and staff will be examined with reference to the work of Foucault. How people 'subvert' organisations will also be discussed.

Weber, organisations and bureaucracy

The ideas of Weber (1997, 2001) and his ideas about rationality are a useful starting point. Weber saw all human activity as purposeful and in investigating society it is important to try and identify what meanings people attach to what they do; he termed this '*versthen*' or to understand. To this end he identified the following three forms of action:

1   *affective or emotional action:* action that results from an individual emotional state at a given time. If we feel happy and caring we may wish to spend longer with a patient or be more caring than we might if our mood is bad.
2   *traditional action:* we engage in certain forms of activity because we always have, to the extent that we may be unaware that we are doing

it. An example of this could be the British habit of saying 'sorry' or 'cheers' in a variety of situations even though we might not actually want to apologise or wish someone good health.

3   *rational action:* this is purposeful activity where there is an intended outcome to our actions. To achieve particular ends we must also take into account what we need and what the best way possible is of reaching our intended outcome. An occupational therapist devising a treatment plan, working out what goals a client can reach and what is required to reach those goals, is an example of this.

For Weber the key to understanding the modern capitalist period was the increase of rationalisation in every aspect of life. He saw a move away from spontaneity and the outward expression of emotion, towards a society in which every aspect is governed either by rules, procedures and non-spontaneous practices, all grounded in logical, rational science. To this end he characterised mankind's condition in modernity as living in an 'iron cage'.

Weber's analysis of bureaucracy and organisations is distilled into what he termed an ideal type. By ideal type he does not mean what an organisation should be but rather a pure form by which to measure a particular organisation. The closer to this ideal the more effective the organisation will be:
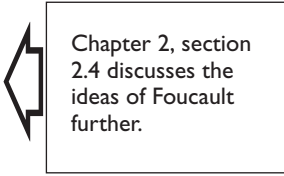
- **Everybody knows what they are meant to do** – everyone in an organisation should have a clear knowledge of what they are meant to do and what their responsibilities are.
- **It's clear who is in charge and who you are accountable to** – effective organisation requires effective leadership, which operates in a clear-cut, hierarchical manner.
- **Everybody follows the rules –** there are clear procedures and guidelines for whatever is undertaken within the institution.
- **Those in an organisation act with as little emotion as possible** – decisions are based on the rules and not on personal whims or desires.
- **Your position is a result of how well you can do the job reflecting knowledge and expertise.**
- **Work and home are entirely separate spheres** – no aspect of the organisation is owned by an individual and what happens in work cannot be used for private gain.
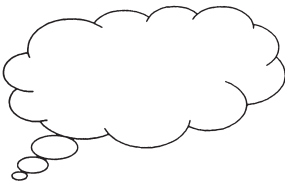
Do you recognise any of Weber's ideas in places that you have worked or had placements? If you do, did these make for efficient organisation?

Physical layout, surveillance and Foucault

Every hospital is a specifically designed building, with certain features that aid its particular function. In the case of hospitals we find rooms that are designed or designated as treatment rooms, operating theatres or consultation rooms. This may seem a useful and logical way of organising space so as to manage the complexities and functions of hospital work. Foucault, however (1970, 1979), argues that the design of architectural space is not always for some neutral utilitarian function, but often reflects power balances, authority and ways of controlling people. Prior (1993) discusses a mental health hospital built in the 1950s where there existed separate wards for black and white people, with less separate facilities for black people. This is a clear example of how prevailing 'racist' attitudes at the time were made 'concrete' in the construction of a building, with the intention to enforce a particular racist discourse on the people who were sent there for 'care'. Modern-day hospitals may not possess such obvious examples of control but space is managed for particular reasons. In NHS hospitals, in particular, most space is highly impersonal, with people on large open wards. Senior figures will often have their own spaces that are at a distance from the rest of staff to indicate their higher power and status.
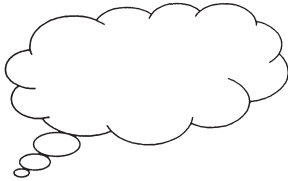
Next time you are in a hospital or surgery, look at the layout of physical space. Are there any power relationships that you can detect? Is the space organised so as to facilitate control over those who use it?

However, the most useful aspect of Foucault's work is on surveillance. Part of every modern organisation depends on, and subjects bodies to, surveillance. Surveillance can be seen to exist in two different forms:

- **direct observation** – this is where people are directly monitored or observed either by a superior or someone in a position of authority or responsibility. Again, think of a hospital ward and how the actual space (see previous comments) is set out so that someone can monitor what is going on. In addition to making sure that the patients are receiving care and their health is not at risk, surveillance also checks that they are behaving themselves and acting in a manner that complies with the rules of the institution. There is also surveillance of staff, to make sure that they are working and performing their tasks. This may sound innocuous but Foucault maintains that this creates a form of control whereby people become compliant to forms of authority or power.
- **written records** – an increasing and ever-growing aspect of contemporary life is the vast amount of data, whether electronic or written, that is kept about us. Each of us accrues numerous records concerning tax, educational attainment, criminal records, career progress, health and so on. These records are a more insidious method of control as

what is written down can have a dramatic effect on areas such as career and employment. In a health care context vast amounts of information can be kept about an individual. This information could have a bearing on how well someone is cared for and treated when they have, for example, potentially stigmatising conditions such as HIV or some form of mental illness.

This outline of the various theories about organisations may give the impression that we are either like Star Trek's 'The Borg', living as completely perfect rational, emotionless drones working for the greater good of the collective or organisation, or that we are being constantly monitored. However, other studies, and Foucault himself, noted that people develop ways of subverting the routines and overall controls of organisations. The more sociologists studied organisations the more they found layers of subtlety and nuance that were missing from Weber's account.

Blau and informal routines

Peter Blau (1963), for example, found that instead of workers rigidly sticking to the rules and complying with the bureaucracy, a whole host of informal working practices could develop. These informal practices, contra Weber, could actually improve the overall working of an institution. Often the complexities of what an organisation has to deal with cannot be covered by contingencies in the bureaucracy and certain flexibility is required, though never officially sanctioned. Workers can prefer these informal working practices as they can act as a relief or as a way of overcoming the effects of working for a potentially suffocating, alienating bureaucracy.
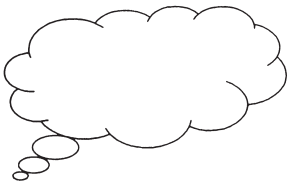
Have you encountered examples of working where informal routines were used that went against the formal rules? Do you think the informal routines produced a better, more efficient outcome than the formal rules?

Technological changes can also have an effect on organisations and bureaucracies. The recent and massive expansion of the Internet and computer-based technologies promises to change our working and private lives.

9.3 Shifts in policy – the move from institutions to the community

In 1990 the NHS and Community Care Act came into being, which saw a change in the organisation of health and social care in the UK. As well as reorganising hospitals into trusts and introducing GP fundholders, the Act also brought about a shift away from caring for people in institutions to caring for people in the community. It was argued that people cared for in

the community would receive a higher, more personally tailored standard of care than they would as anonymous faces within an institution. This shift in policy came about as a result of various influences that were ideological, political, or financial. Research had shown that institutional care had inherent problems that could be damaging to the health and identity of those being looked after. Writers such as Martin and Goffman, and more recently Prior, have noted that individuals can become institutionalised by their extended stay inside long-term places of care.
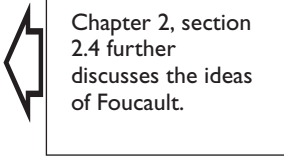
Institutions, or asylums as they were formerly known, have long been a feature of care within western countries and their contribution to providing effective care has been much debated. Some authors assert that by a rational progress various innovators develop new and more humane and effective techniques, while other authors note that institutions fit into the existing patterns of social control and act as agents for dominant social groups or the needs of capitalism. The writers Foucault and Scull were proponents of this view.

Foucault's critique of institutions

For Foucault the history and development of the asylum or institutional care is linked with the growth of surveillance, discipline and notions of scientific rationality from the period of the Enlightenment onwards. He concentrates on how the focus of the 'other' shifted away from the lepers of the Middle Ages who had been excluded from society, to the mad in the modern period. In the medieval period, leprosy and lepers were a pariah group, the 'other' of society, routinely rejected from social acceptance and admittance to everyday life. People who were mentally ill were regarded as possessed by demons or witchcraft. Later, the emphasis on scientific rationality and scientific investigation during the Enlightenment, led to increasing classification, and consequently increasing control of the population. The mad, those designated as irrational and lacking in reason, now came under particular scrutiny. Such a group posed a challenge to the new orthodoxy of rationality, and so it was they who were separated from society, this time not to leper colonies but to asylums and other places of containment (Pilgrim and Rogers 1993; Turner and Samson 1995).

Foucault highlights the use in the nineteenth century of Jeremy Bentham's Panopticon design for asylums. The Panopticon (the all-seeing eye) allows for the continual regulation and surveillance of inmates. A central tower allows observation of every cell whenever a guard or warden wishes. This gives the authorities great power to classify and control those in their charge.

Foucault is critical of what on the surface are seen as liberal and progressive forms of treatment. Figures such as William Tuke and Philippe Pinel are often credited with the treatment of mentally ill people out of the Dark Ages and into the Enlightenment. Tuke founded his famous Retreat near York in 1796, where kindness and benevolence were to be the moral

Chapter 2, section 2.4 further discusses the ideas of Foucault.

basis of treatment rather than the degrading, inhuman treatment that had existed before. Tuke wanted a 'desire for esteem' to replace 'the principle of fear' (Morgan et al. 1985: 152). A few years earlier, in 1792, Pinel had unchained the inmates of the Bicêtre asylum and founded his 'treatment moral'. For Foucault, though, these were not the humanitarian break-throughs that they are sometimes represented as being. For him, it was the replacement of one form of control (physical) by another (moral). The mad were no longer bound with chains but were bound with strict regimes and routines backed up by moral and religious teachings, a more subtle and insidious, but just as effective, form of control (Samson 1995). The purpose of these moral controls was to turn those in the asylum into 'docile bodies'; manageable, controlled entities who posed no threat to the authorities.
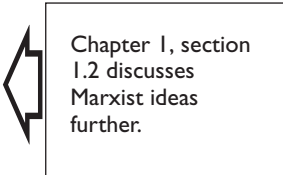
Scull's critique of institutions

The Marxist writer Andrew Scull takes a different position from that of Foucault in that he concentrates on the needs of capitalism, on the medical profession and on the effects of urbanisation on the development of the asylum. For him the asylum was a 'dumping ground' for those who were superfluous to the needs of capitalism and who did not fit into the new market-led economies that developed during the nineteenth century. The poor and unemployed who were capable of working were sent to the workhouses, while those who were incapable were sent to the new asylums. Thus the removal of potentially awkward members of society allowed for the smooth accumulation of capital.

Scull also draws attention to the opportunistic nature of the emerging medical profession. By absorbing Tuke's ideas on moral treatment into its body of scientific knowledge, the medical profession was able to persuade Parliament to pass the Lunatics Asylums Act and the Lunatics Act in 1845. This gave the medical profession a monopoly in the field of madness, and since they now had the power to define madness, as well as control it, they could ensure a steady clientele for their services (Pilgrim and Rogers 1993; Turner and Samson 1995). Throughout the nineteenth century there were substantial increases in the number of people inside asylums or classed as insane:

- in 1849 there were 27,000 inmates in 23 asylums
- in 1909 there were 105,000 inmates in 97 asylums

Both Foucault and Scull offer a view of the rise of the asylum that counters notions of a steady, value-free evolution of care for mentally ill people. For these writers, wider social and cultural forces influence and shape the development of institutions and asylums.

Goffman's critique of institutions

Whatever the origins of asylum care historically, there was a reappraisal of the effectiveness of institutions during the twentieth century, especially in the post-war period. During the 1960s when the 'anti-psychiatry movement', which included writers such as R.D. Laing and Thomas Szasz, started to challenge assumptions about the nature of mental illness and its treatment, favouring a more open, client-centred approach. Alongside this challenge to psychiatry, Goffman questioned the role of the asylum. In his seminal text *Asylums* (1975) he sought to delve beneath the surface of psychiatric institutions and expose the problems that asylum and institutional care could create. His basic premise was that the needs of the institution came before the needs of the client and this resulted in a change of identity for the client. In becoming institutionalised, the client's whole personality is transformed into a shadow of its former self, and motivation, independence and individuality are lost.

Goffman begins his analysis by observing that we live in a world of institutions, whether workplaces or religious, educational or military establishments. However, there are some institutions in society that are different. These he terms 'total institutions'. In these all the normally separate parts of daily life (such as eating, sleeping or leisure activities) take place in one setting: 'He suggested that the key process – the totality – was established by collapsing the normally separate social spheres of work, home and leisure, into one monolithic social experience,' (Morgan et al. 1985: 157). As a result patients inside a mental hospital can lead lives as a 'batch' – a term Goffman borrows from animal husbandry. Individuality is attacked and degraded as they become part of a homogenous group that carries out daily tasks and functions as part of a timetabled mass.

The loss of personality and sense of self begins on admission to a mental hospital when the patient embarks on what Goffman terms a 'moral career', which entails the removal of the patient's sense of identity. This he terms the 'mortification of self', which is followed by the 'reorganisation of self', which sees the institution replacing what it has taken away. This process may be carried out deliberately, for example in prisons, where the prisoner has his belongings and personal clothes removed and replaced by a standard prison uniform. Or it may be less deliberate, in the case of a mentally ill patient being provided with clothing from a hospital communal clothes store. This nevertheless has a similar effect to the prison uniform for it is the removal and denial of self-expression and its replacement with clothing that suits the needs of the institution rather than the person. Goffman describes quite elegantly how the patient responds to this reorganisation of self. Goffman allows for the patient to respond in a variety of ways rather than becoming automatically institutionalised. He noted that patients can adopt various strategies for dealing with life in an institution and can develop different ways of surviving in the 'underlife' of institutions. There are five broad responses that a patient can make to life in an institution:

1. *colonisation:* the patient adapts unenthusiastically to their new situation.
2. *conversion:* the patient accepts what has happened and becomes institutionalised.
3. *withdrawal:* as far as possible all contact is minimised.
4. *intransigence:* the patient resists attempts to convert their behaviour. This resistance can be quite aggressive.
5. *playing it cool:* this adaptation maximises chances of surviving the institution with much sense of self and identity intact. Involves minimising visibility and staying out of trouble.

The 1973 film *Papillon* (French for butterfly, with its connotations of freedom) provides an example of how people respond to life in an institution. Starring Steve McQueen and Dustin Hoffman, the film deals with the lives of two prisoners in the French penal colony of Devil's Island. Throughout the movie the harsh authoritarian regime seeks to force all inmates to become compliant to its authority. In the final scene McQueen displays his opposition and *intransigence* to the regime by making a daring escape bid, while Hoffman displays his *conversion* by declining to escape, content with life in the prison. Other cinematic representations of institutionalised life can be found in *The Shawshank Redemption* and, of course, *One Flew over the Cuckoo's Nest*.

Figure 9.1 *Institutionalisation*
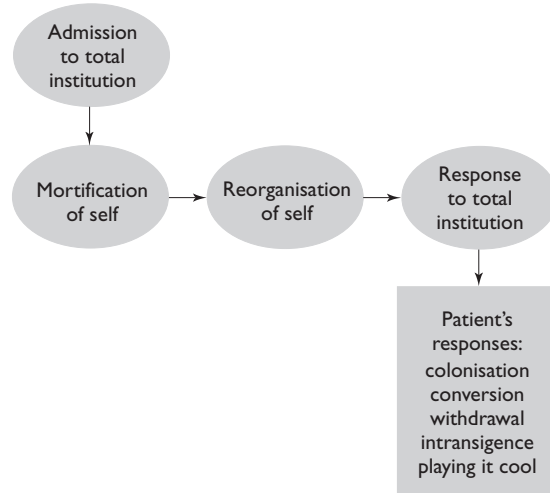
9.4 The community

The preceding section highlighted many of the problems that can arise from institutional care: dependency of clients on the institution, iatrogenic effects of care, difficulties in returning people to life outside the

institution. This may imply that life and care in the community, on the other hand, is problem-free and inherently good. Unfortunately much research has indicated that this is not the case. As with institutional care, there exist many problems with life in the community. GP David Widgery (1991) described returning people to the community as the 'sociological equivalent of Siberia'; the idea that people could disappear without trace and adequate support. In addition to the problems of finance and service provision there are problems of trying to understand what the term community means.

What is a community?

> Community is a contentious concept in sociology as its meaning varies from context to context. Usually referring to a topographical location, community also refers to lifestyles, ethnicity, or other shared characteristics, not necessarily in the same place.

Many British readers of this textbook may have an idea of a community as something similar to the depiction of life in popular soaps such as *Eastenders* or *Coronation Street*, where mainly working-class people live interdependent lives in a self-contained area. Occasionally the characters in these dramas may fall out, have arguments or even shoot one another, but essentially there is some form of social cohesion underpinning all interactions. If this were the case, then care in the community would make sense, as people could be returned to an area that was rich in mutual aid and neighbourly goodwill and support. This form of community was depicted in the classic research of Young and Wilmott (1961) into an 'urban village' in the working-class East End of London. In the brick-built, back-to-back streets they found strong examples of mutual aid and a community that cared for its members. Dense social networks were maintained by a 'mother-daughter link' and, around this fulcrum, support for family members and neighbours was organised. However, such examples are increasingly rare at the beginning of the twenty-first century. High unemployment, drug-related issues and social disintegration now blight many communities. The fabric of many areas has been altered by changes in social planning and post-war redevelopment. Chances of being part of a protective, supporting community are greatly reduced.

An initial problem is trying to offer a definition of community. There have been many attempts to provide one, but the main problem is that the term covers a heterogeneous collection of interactions, situations and forms. If we look at the following shortlist of what are referred to as communities, we can see some problems:

- student community
- gay community
- business community
- black community
- protestant community
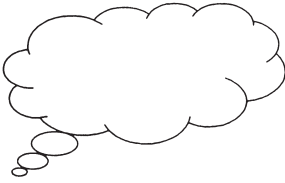
What community/communities do you feel you belong to? What do you share in common with other people in that community or communities?

Recently, the multinational coffee chain Starbucks has been marketing its cafés as being a form of community–home environment, a move that received a strong rebuke from anti-capitalist Naomi Klein: 'Starbucks pretend to sell us community, but they're selling coffee. This is a betrayal. Community is a strong and powerful idea, and I don't want it stolen from me' (BBC News 2001).

What all this demonstrates is that the notion, concept and ownership of 'community' is highly complex and contested. Among the above list we can find groups of people who claim to be part of a community but their reasons for claiming membership are varied. In some cases it is on characteristics such as race, in others it is on lifestyle, while religion or occupation may underlie the reasons for others. In some cases these terms will reflect a distinct geographical area (for example the 'Protestant community' may refer to people of a Protestant background living in the Shankhill Road in Northern Ireland). In other cases it may not refer to a distinct location. The business community will draw membership from people living and working in a variety of settings. At other times a claim to belong to a community is made because of a choice (people choose to study at university, therefore their membership of the student community is voluntary). For some, membership is based on an ascribed characteristic (because of skin colour someone may find themselves 'automatically' belonging to a particular community).

In an attempt to overcome some of these definitional problems Bell and Newby (1976) identified three ways in which the concept of community is used:

1   a topographical (geographical) expression
2   a local social system: interconnection between local people and social institutions
3   a human association with no logical connection with places or local social systems
    (Bell and Newby 1976)

This may sound interesting in terms of trying to crack an academic problem but when one turns to applying the conclusions to the real world, to people living in the community, then a few opposite points can be raised:

• What community do they belong to?
• Will someone care for ill or disabled members of the community?
• Will that community take care of people in need?
• Who else belongs to that community?
• Who represents that community?

After considering these issue, another question arises: does caring for people in the community necessarily improve health and avoid the potential problems inherent in institutions? Work by Prior (1993) indicated that in many ways the problems that arise inside institutions can be present in communities too. The thrust of his argument arising out of research into community care in Northern Ireland was that even though the location of care had shifted from institutions to the community, the actually substance of patients' daily lives had altered only slightly:

> For when all was said and done, they attended the same day centres as previously, they saw the same social workers, spoke to the same nurses (albeit wearing everyday clothes rather than uniforms), and usually lived with exactly the same individuals as they had done in hospital. For most people it was only the dwellings that were different. (Prior 1993: 192)

For many ex-patients, the places they were relocated to still retained many of the features of an institution, with, for example, locked doors or upper-storey windows that could only be partially opened. However, it was more than just design features of the buildings that echoed the institutions they had come from. It was also the daily routine and the staff they saw which also mimicked their experiences in an institution. Life was still lived according to timetables and they saw the same array of mental health workers. Even social events took place in the same locations as they had when the patients were in institutional care.
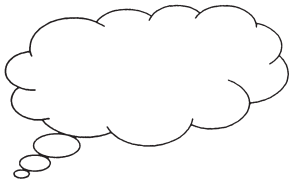
> *How did you react to the preceding paragraph? What do you think of group homes – are they a break from the institution or just the institution in an other format?*

One underlying point raised by Prior is that even though changes in discourse and treatment philosophies change practices towards treating mental illness, these chnges do not necessarily entail any dramatic shift in the overall circumstances of the patient. It was hoped that the movement away from care in institutions to care in the community would herald a new era of tailored, dignified treatment that broke down barriers and allowed people with mental health problems to become part of the community once more. As Prior notes, however, all that happened for many patients was just a change of dwelling. This move might also be into an area that does not regard former mental health care patients as part of their particular community, nor welcomes them into it.

9.5 Care and carers

As mentioned on p. 128, the NHS and Community Care Act (1990) introduced a variety of changes to the organisation of health and social care.

Informal care is a combination of service and affection, provided on the basis of kinship or friendship. It is also mainly unpaid.

One aspect of this policy was to increase the emphasis on care taking place in a non-institutional context, and to 'firm up' arrangements for informal care. The Conservative government had a variety of reasons for introducing this particular piece of legislation, ranging from efforts to rein in public spending, a belief in the family as a unit of care, and, as part of their general ideology, an attempt to reduce state provision and to increase individual and family responsibility.

The last paragraph illustrates one of the many ways in which the concept of care is used. Here it is in the context of policy, whereby a particular piece of policy lays out regulations or intentions about how care and caring for people should be carried out. But for most of us, talk of care, especially in an informal context, evokes images of emotions and feelings – though for those engaged in care work, caring is not just a state of emotionality. It involves onerous work and great physical exertion. Sometimes, care-giving can also inform ideas about gender roles, especially women's roles. These are the many facets of care and the way in which the concept of caring is used. This can make defining care difficult as it contains so many elements. That is not to say that it has not been attempted. Graham (1983) provides a useful definition of informal care. She sees care as being a combination of *service* and *affection*. Service relates to the 'doing' part of caring including all the physical aspects such as lifting and handling; washing and bathing; or collecting messages and preparing meals. Affection relates to the 'feeling' part of caring; this includes love and compassion.
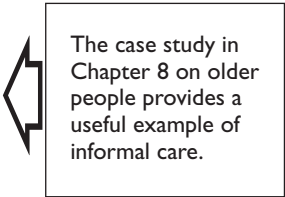
For most people informal care is provided and received on the basis of kinship or family ties (Qureshi and Walker 1989). As care can often involve intimate or physical contact, most people would like care to be provided by a family member, such as:

- spouse
- relative in lifelong joint household
- daughter
- daughter-in-law
- son
- other relative
- non-relative

Reciprocity is also a factor involved in kinship care, where kin have either cared for or will care for other kin.
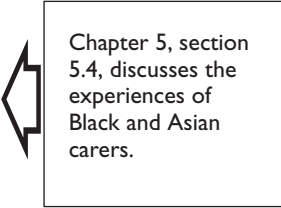
Gender, class and care-giving

Much of the literature on care points to women as being the prime care-givers within the family and society as a whole (Lee 1998; Malin et al. 1999). Summarising research, Twigg and Atkin (1994) point to how women are expected to care and how gender makes a difference when it comes to receiving additional support. Men find it easier to access services and are in some ways expected to put up with less than female carers. Morris

(1989, cited in Parker 1993) observed that men are less able to take on the caring role. However, one must be careful to avoid the simplistic assumption that all men and women have uniform experiences. Drawing on the 1985 General Household Survey, and following points made by Graham (1991) that class and race need to be taken into account Arber and Ginn (1992) indicate that care is multi-dimensional, with many criss-crossing structural factors. They found quantitative and qualitative differences between men and women according to their class location. The level of physical impairment was only one factor that affected the care experience of households from different class backgrounds; other factors were their ability to access and use different material, financial and cultural resources. Middle-class households had more money available to 'lighten the load' of care. This could be, for example, by building a granny flat, or buying aids and adaptations. There was also evidence that middle-class households utilised social services more, and were better at obtaining desired outcomes than the working-class households in this study. There was also a class and gender difference. Working-class men were much more likely to be involved in care, looking after someone at home, than were their middle-class counterparts. Looking after someone at home was also seen as more demanding, as it restricted employment and leisure opportunities.
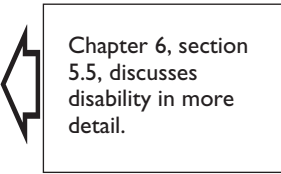
Experiences of care

The experience of care can vary from being fulfilling and satisfying to being draining and restrictive. As mentioned earlier, affection and feelings of compassion are major reasons for people taking on care work. By demonstrating affection and compassion the carer can realise a sense of purpose and achievement. For many carers, however, there were multiple problems, often to do with restriction, time and money.

Tozer (1999) noted in her research of families with two or more disabled children that the parental carers reported that family life was restricted and they were sometimes left feeling isolated. Dearden and Becker (2000) identified similar findings for young carers, when they reported that for young people involved in care educational opportunities were restricted. Feelings of restriction are commonly noted in research findings. Summarising research Twigg and Atkin (1994) observed that the problem was not so much restriction caused by carrying out care tasks, though that was important, but generalised feelings of anxiety at leaving the person being cared for on their own. Worries were expressed about safety, or about an unforeseen circumstance arising.

One of the commonest problems facing carers and the people they care for is poverty and financial hardship. Arber and Ginn (1992) noted that class differences were important and that, for those with money, accessing alternative support and services eased caring. However, for those without financial resources, such as the young carers in the Dearden and Becker (2000) study, dealing with poverty was a commonplace experience for disabled people and carers. The Scottish Poverty Information Unit (1998,

1999) reported that disabled people were likely to be impoverished for a variety of reasons. One was institutional discrimination whereby prejudicial attitudes prevented disabled people from finding well-paid jobs, but other factors included extra costs incurred through specific needs for medicine, food or transport, and for changes in the home environment. This has consequences for those involved in care when the overall household income is reduced. As Parker (1993) observed, when a husband gives up working to care for a disabled partner, or the male partner becomes disabled, the loss in income is substantial because of the higher income differential for men.

Summary

- Various theories attempt to understand organisations. Weber stresses rationality and bureaucracy; Foucault emphasises surveillance and physical space; Blau notes the existence of informal routines.
- Institutional care has been strongly criticised on the grounds that institutions act as a method of social control or a 'dumping ground' for so-called undesirables.
- Goffman critiques institutions for causing institutionalisation – an assault on self and identity.
- Defining community can be hard with definitions including places or shared characteristics such as ethnicity or class.
- Care in the community may create further problems and may not necessarily avoid the problems of institutional care.

Case study

Bill was admitted to Culliere Hospital 25 years ago diagnosed with a psychotic condition. Initially he was quite ill and had phases of believing that he could hear the thoughts of other people and that they were saying unpleasant things about him. After years of treatment and care the symptoms became manageable and their frequency declined, to the point that he no longer seems very ill any more. Over the years his role within the hospital has changed. He quite often assists with some of the group therapy sessions and has some responsibility for maintaining and tidying the art room. Bill was given that duty as he enjoys painting and is quite an accomplished watercolourist. Some of his work is hung in hospitals throughout the region. On Wednesdays and Sundays he even takes classes with some of the day patients, teaching them the basics of using watercolours. His skilled painting and control over the art room has sometimes led new members of staff to think that he is a part-time member of staff, perhaps a retired art teacher who wants to help in the hospital.

In many ways he feels happy and fulfilled in what he does and has expressed no desire to return to his family. However, recently the local health trust has been attempting to reduce the number of long-term patients in the hospital, with an eye to possibly closing the facility down altogether. To this end it has been decided by the hospital and social services that Bill is well enough to live in the community. This has made him feel highly anxious. He

does not want to lose his art room or the chance to take classes. On three occasions now he has been taken to a halfway house to see if he would like it there. His initial impressions were all negative. There was no art room and the neighbours in the street did not look particularly friendly, some actually appearing quite hostile. To settle him in he was told that he would still see the same occupational therapist as he had in the hospital, and that it would be possible for him still to hold his art classes in the hospital. This reassured him slightly, but ultimately Bill really wanted to stay at Culliere. After all, for him it was home.

1   How has the stay in Culliere Hospital affected Bill?
2   Do you think moving him would help his mental health?
3   Why might the local community not welcome the siting of a half-way home in their area?
4   Where do you think people are best treated or cared for?

Recommended reading

Goffman, E. (1975) *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates.* Harmondsworth: Penguin. **Seminal text which sets the scene on institutional care**.

Prior, L. (1993) *The Social Organization of Mental Illness.* London: Sage. **More advanced, but very interesting!**

Prior, P. (1995) 'Surviving psychiatric institutionalisation: a case study', *Sociology of Health and Illness,* 17 (5): 651–67. **A very useful case study**.

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