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HANDBOOKS

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nti sull' Cadmio preparato a freddo
a caldo to, che quello fatto a
ldo vien precipit gli alcali in fiocchi bian-
ssimi, e ello fatto a caldo forma con la po-
a un p ellissimo color di rosa,
olubile fisso posto in eccesso,
ntre pr essa per mezzo dell'am-
niaca anc si scioglie nuovamente
precipitato. osservato, che versando sul
bonato di Cadmio una soluzione di acido ni-
co, l'osside si scioglie lentamente senza cam-
r colore, e che gli alcali le precipitano nuo-
mente in fiocchi bianchissimi; ma che facendo
stessa soluzione a caldo si discioglie il metallo
olto più rapidamente, acquistando un color
sso ranciato. Questa soluzione, svaporandosi cri-
allizza in piccoli gruppi di prismi allungati,
quali sembra meccanicamente unita la materia
olorante.

Dell' Arsenico.

Sotto il nome di *arsenico*, Dioscoride e
eofrasto conobbero un minerale di colore rossa-
ro composto di solfo, e di questo metallo, im-
iegato dagli antichi per la pittura e per medi-
amento. Avicenna fa menzione dell' arsenico nel-

THE PALGRAVE HANDBOOK OF SOCIAL THEORY IN HEALTH, ILLNESS AND MEDICINE

Edited by
Fran Collyer

The Palgrave Handbook of Social Theory in Health, Illness and Medicine

Also by Fran Collyer

MAPPING THE SOCIOLOGY OF HEALTH AND MEDICINE: America, Britain and Australia Compared

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The Palgrave Handbook of Social Theory in Health, Illness and Medicine

Edited by

Fran Collyer
Associate Professor, University of Sydney, Australia

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Preface

All books have beginnings, even though it may be difficult to recall when those first ideas began to take tangible form. One of the certainties in the origins of this Handbook has been a deep respect for, and engagement with, social theory: a respect and engagement I share with many colleagues and friends in my disciplinary community. Surrounded by constant complaints about the inadequacy of social theory in the study of health and medicine, and the difficulties of convincing students (and colleagues from other disciplines) of the value in positioning theory at the centre of all good scholarship, at some point it became essential to act and address this with a substantial handbook. Behind this volume has also been a long-held dissatisfaction with the way we so often approach social theory in our publications (and also the classroom). Despite several decades of debate about the inadequacies and biases of the sociological canon, Marx, Weber and Durkheim continue to be defiantly paraded to the general exclusion of women theorists. While women's achievements and attempts at recognition have been severely hampered over the decades, there are, nevertheless, sufficiently important women theorists who have now been 'rescued' from obscurity and, with a little effort, can be placed in such a handbook. In addition to the on-going neglect of women theorists, our approach to social theory is generally ahistorical. All too often we offer theorists as disembodied subjects espousing universal truths and give little thought to the specifics of their lived experience in a given time or place. Yet it is only when we understand the *embodied* theorist and their social context, that their concepts and theories really begin to 'make sense'.

This Handbook addresses each of these matters. All chapters have two points of focus. On the one hand, they examine one or, in some cases, two social theorists, providing some biographical information and insight into the intellectual and social background of the subject. Certainly, it is the case that not all contributors have been comfortable with this sociology of knowledge approach to the Handbook, but there are quite a few who have drawn interesting conclusions about the notable links between a theorist's own life experiences and his or her theoretical frameworks. On the other hand, each of the chapters takes a health issue or topic, demonstrating the utility of the theoretical frameworks and major concepts for exploring or explaining these. As indicated by the list of chapter contents, both male and female theorists have been selected, from all time periods, and a broad variety of health topics are covered, including the experience of chronic illness, indigenous healthcare services, hospital bureaucracies, children's health, men's health, women's health, counselling and food and nutrition. The Handbook is organised chronologically in terms of the dates of birth of the theorists. The first was Harriet Martineau, born in 1802, while the most recent, and still very much alive, is Paul Farmer, born in 1959.

Admittedly, the book has been something of an experiment. Well-known scholars and a few early career sociologists of the sociology of health and medicine were approached and invited to contribute, with the choice of theorists largely in their own hands. When it became obvious that most potential contributors were selecting the conventional subjects of the sociological canon – despite hints about the need for an equal focus on women theorists and theorists generally less well known – more direct requests had to be made. Despite my best efforts, there are many women theorists who are missing from this book, though I console myself with the thought that it is at least a good start. It is of course, generally harder to locate information about women and 'other' theorists. There is less archival material available and much less in the way of commentary and analysis. Nevertheless some of the authors stepped up to the challenge, and the Handbook thus opens our eyes to some new and less well-known theorists, extending knowledge beyond the more common offerings in the sociology of health and medicine.

All books have their limitations, and in this case while there is an extended array of social theorists, the main focus remains on theorists of the West. This is understandable, given the European–American heritage of the discipline. Nevertheless future editions of the Handbook will hopefully extend such offerings to the countries of Asia, Africa and the Americas.

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Chapter 1

The Sociology of Health, Illness and Medicine: Institutional Progress and Theoretical Frameworks

Fran Collyer and Graham Scambler

As we write in the twenty-first century, the sociology of health and medicine sits as a distinct and growing speciality field of research and university teaching, found on all continents and within many countries, including the United States, eastern and western Europe, Australia, Britain, Japan, China, Brazil, South Africa and Mexico.

The sociology of health and medicine formed historically within the intellectual tradition of its parent discipline of sociology and was initially a Western, European and North American product. Assisted by generational change, vast social and political changes, as well as the development of new communications technologies; it is expected that in the twenty-first century, sociology – and the sociology of health and medicine – as fields of social practice and knowledge-making, will be increasingly diverse, as newer national sociologies strengthen and overcome the many structural impediments to contribute to these expanding global domains of knowledge production.

Organisations, associations, journals and the curricula

If we look closely at this history, the sociology of health and medicine began to take on an institutional form in the twentieth century with the establishment of the modern university system. The speciality field began its process of institutionalisation – that is, becoming concentrated, structured, formalised and broadly accepted as a legitimate and valuable scholarly activity – from about 1950. This coincided with the dominating presence of biomedicine and medical, professional power. As such, medical sociology can be seen to have developed in response to, and as a critique of, the biomedical paradigm (Nettleton 2006), and an argument can well be made that sociology itself – the parent discipline – had its institutional origins intimately tied to the professionalisation of medicine in the early decades of the twentieth century (see Collyer 2010). That said, the timing of the process of institutionalisation for the sociology of health and medicine was specific to each country. For instance, studies of the social aspects of health did not appear until the late 1960s in France, and the field has still to become institutionalised, in large part because its practitioners, unlike those in Britain, Australia or the United States, are full-time researchers rather than academic teachers and thus not required to produce curricula or textbooks (Herzlich 1985:121).

The *processes* of institutionalisation have also varied globally. In the United States for example, the field benefitted enormously from the 'lavish' amount of grant support from influential private foundations and the federal government between 1950 and 1970. This stimulated growth in the sociology departments and the Medical Sociology Section of the American Sociological Association (ASA) (Bloom 2000:27; Hafferty and Castellani 2007:332). It also encouraged an intense interaction between sociology and medicine (as well as the other health sciences), and Cockerham (2000) argues that it was the support from these disciplines that was critical to the growth of medical sociology, rather than from sociology itself, providing the fledgling medical sociologists with the 'early recognition, funds and jobs . . . that were not forthcoming elsewhere'. Thus in the United States, much of the stimulus for medical sociology, and much of the activity of medical sociologists, occurred outside the sociology departments, ensuring that initially at least research addressed the concerns of medicine, public health and health administration rather than the central questions of sociology (Zimmerman 2000:1814). Nevertheless the field developed within the parent discipline of sociology, with external funding encouraging sociologists to remain within the sociology departments, and grow the departments, while working on projects with medicine. In Britain, the 'impetus' for the formation of the field of medical sociology was also external to the sociology departments. Many of the original members of the nascent Medical Sociology Group did not work in universities in the 1950s and 1960s, and the group was decidedly multi- or interdisciplinary (Collyer 2012a:102–3). As Margaret Stacey and Hilary Homans (1978:282) noted at the time, there was little 'recognition on the part of mainstream sociologists that it is important to understand healthcare institutions if the society as a whole is to be understood'. Like their American counterparts, the early British medical sociologists largely pursued the interests of medicine, building a programme of sociology *in* medicine rather than *of* medicine (for a more detailed discussion of the debate over sociology *in*, rather than *of*, medicine, see Straus 1957; Cockerham 1983; Light 1992; Murcott 2001). Nevertheless, as Margot Jefferys (1986:52) points out, it was in the 1960s, in this interactive environment, that the 'medical model' (as it was later to be called) first came under scrutiny and criticism. In the Australian case, while the early networks of the 1950s were composed of individuals from many disciplines (particularly psychiatry), with an enthusiasm for the social aspects of illness, by the 1960s there were sufficient sociologists (and universities) for the formation of a Medical Sociology Section of The Australian Sociological Association (then known as the Sociological Association of Australia and New Zealand) (Collyer 2012a:125). Here the process of institutionalisation differed from those of both the United States and Britain, primarily because there was a close connection between the mainstream academic sociologists and the medical sociologists throughout the formative period. As occurred in the British case, there were many social psychiatrists and medical doctors participating in the annual Australian sociological conferences and seminars, making it relatively easy for sociologists to access the medical arena. Unlike the British and Americans, however, specialisation as a medical sociologist was not the norm in Australia until much later in the century (if at all), with many mainstream academic sociologists showing an interest in health or medicine at some time in their careers, and most importantly, there was an early and widespread acceptance of the subject as an appropriate focus for sociological investigation (Collyer 2012a:124,127). These three cases suggest the possibility for significant variation in the institutionalisation of the field, and as more is learned about disciplinary and sub-disciplinary formation in the Asian and African contexts, further lessons will no doubt be learned.

In the academic context, three of the major features of the institutionalisation of a discipline (or sub-discipline) are the formation of formal networks and associations, the establishment of academic journals and the production of academic textbooks. With regard to the latter, the French example above indicates the importance of academic textbooks to institutionalisation and, moreover, the way that the timing of such publications can indicate the relative development of the field from one country to the next. With the expansion of the university sectors of many countries in the nation-rebuilding programmes after the Second World War, textbooks became an important vehicle for distilling the essential concepts and subject matter of the disciplines, constructing and maintaining disciplinary identities and assisting with the socialisation of a new generation of intellectual workers. Taken as historical markers, textbooks point to the relevant level of institutionalisation of the disciplinary fields. In the case of the sociology of health and medicine, there were earlier books produced in the United States in the first half of the twentieth century, notably perhaps Elizabeth Blackwell's (1902) volume about medical sociology; one from James Warbasse (1909); and another from Henry Sigerist, called *American Medicine* (1934). Such books were, however, quite rare until the post-Second World War period, when the first modern textbook for medical sociology in the United States was produced in 1958 by Norman Hawkin, called *Medical Sociology*, followed in the same year by E. Gartly Jaco's edited collection, *Patients, Physicians and Illness*. In Germany, important first books included a sociology of the hospital from Juergen Rohde (1962), though the first textbook was from Johannes

Siegrist in 1974 (Cockerham 2000). In Britain the first one came in 1962 with Mervyn Susser and William Watson's *Sociology in Medicine*; in Australia, Athol Congalton and Jackob Najman broke new ground with their (1971) *Nurse and Patient: A Sociological View*; and in Iran it was with Manuchehr Mohseni's (1974) publication of *Medical Sociology of Medicine and Health*. In many of the developing countries, the first medical sociology textbooks appeared from the 1970s and 1980s. Initially, these were translations of American or British texts, but they have increasingly been authored by locals with greater local content and relevance.

A second marker of institutionalisation is the establishment of special interest groups within national professional associations. In many of the sociological associations, medicine and health were the focus of the earliest groups to form. These have tended to be much larger than other special interest groups and have had a sustained presence in the associations. The earliest such group appears to have been that of the Medical Section within the ASA. This originated in 1930, not long after the association itself began in 1905, though with various organisational and legal changes to the definition of a 'section' and the rules of operation, the Section wasn't formalised as an organisational body until 1955 and was reformulated again in 1962. The International Sociological Association (ISA) – which has divisions called 'research committees' rather than sections – began to host a Health and Medical Committee from 1963. Not long afterwards, The Australian Sociological Association (TASA) recognised a Medical Sociology Section in 1967; the British Sociological Association (BSA) followed in 1969 (Collyer 2012a:103); and the German Sociological Association in 1972 (Gerhardt 1989). There have also been independent societies, such as the German Society for Medical Sociology (formed in 1972); the Society for Study of Health and Medical Sociology in Japan (in 1974); and the European Society of Medical Sociology (in 1983). These 'sections' or research committees function in a similar way to the parent association, providing members with a research or teaching network, opportunities for collaboration and publishing, and assist with the building and maintenance of a professional identity.

A third marker of institutionalisation can be found in the formation of scholarly journals. Sociological associations often sponsor, auspice or own several academic journals, adding credibility and legitimacy to the scholarship of their members. The *Journal of Health and Social Behavior*, first published in the United States from 1960 as the *Journal of Health and Human Behavior*, was started as a private journal by E. Gartly Jaco as both editor and publisher. After some fierce negotiation over the under-writing of its costs, it became, in 1966, one of the ASA's official journals with the assistance of the Milbank Memorial Fund (Bloom 2000:24–5; Collyer 2012a:85). Section members of the BSA and TASA also produced their own health sociology journals. In Britain, the *Sociology of Health* *and Illness* began in 1979, and in Australia the *Annual Review of the Health Social Sciences* (now known as the *Health Sociology Review*) started publication in 1991. In neither case is ownership in the hands of the professional associations, though there is close collaboration between the various bodies (Collyer 2012a:108). A similar arrangement is in place for the journal *Social Theory and Health*, which began in 2003 and is affiliated with the European Society for Health and Medical Sociology.

These three markers tell us that the field began to institutionalise from the 1950s and was complete in several key countries, and at the international level, by the end of the 1980s. With the completion of the process of institutionalisation of a scholarly field, individuals no longer have to rely on individual resources and capacities when they enter public debates about the value of good healthcare, nor need demonstrate the strengths or shortcomings of a given health policy or programme. Although all steps in the institutionalisation process are a matter of negotiation and political struggle at the local, national and even perhaps the international level, institutionalisation marks the point at which material and cultural resources have become available to members of the field; public recognition and support have been won; and formal means of communication and interaction firmly established (Collyer 2012b:118). Thus by the 1990s, the sociology of health and medicine had achieved broad acceptance within the university sector, with many institutions recognising the worth of individuals specialising in the field and providing resources for undergraduate and (post)graduate teaching.

Commonality and divergence across the field

The institutionalisation of any scholarly field also marks the point at which a certain level of coherence or commonality of practice has been reached. In the current context, there appears to be some consensus about the main themes or questions of the sociology of health and medicine. For instance, it is said to offer an alternative to the limitations of the biomedical model of illness and to challenge medicine's claims of effectiveness (Nettleton 2006); demonstrate the patterning of health and illness according to social and economic conditions and explain this relationship (Fitzpatrick 2008; Freese and Lutfey 2011:67); investigate healthcare organisations and institutions, the provision of healthcare services and the social behaviour of healthcare providers and consumers of care (Cockerham 2000); study the Sick Role and the illness experience (Bird et al. 2000:2); and demonstrate the social shaping of medical knowledge (White 2009).

Despite the apparent consensus, there continues to be interesting global differences in the way the sociology of health and medicine is practised, researched and taught. Some hint of this is given in the different names for the field, for it is known as medical sociology in the United States and Britain, the sociology of health in Australia and both the sociology of health and medical sociology in Canada. Yet even these names do not always cleanly match the main trends in the field, and may instead reflect past developments (such as a well-known book title) or the preferences of a person of some influence who had been instrumental in establishing the local society, section or research committee. Medical sociologists with long experience in the field are often aware of national differences in the speciality field. For instance, Hafferty and Castellani (2007:335) point to the more theoretical inclinations of British medical sociologists in comparison to their American counterparts, the former's acceptance of qualitative methods and their preference for studying social class rather than socio-economic status. Other pointers to national differences can be found in empirical studies, such as those using content analysis to examine and compare the publications of sociologists of health and medicine. There have been several comparative analyses of the field applying this method, though the focus has generally been limited to American and British publications (for example, Clair et al. 2007; Seale 2008) with somewhat fewer studies inclusive of other countries such as Australia (Willis and Broom 2004; Collyer 2012a) or New Zealand (Collyer 2013a).

Such analyses can throw a spotlight on the shared concerns of sociologists of health and medicine which are not always apparent from one's personal experience in the field. For instance, in an examination of the research interests of sociologists of health and medicine from Britain, the United States and Australia, significant levels of shared interest are demonstrated across all three countries on the work context of health workers (for example, doctor–patient or doctor–nurse relationships), as well as matters concerning medical knowledge, methodology and epistemology (Collyer 2012a:236–7). Where the method of *context–content analysis* is employed – where demographic (context) data is taken from the manuscripts and compared with the (content) information derived from an analysis of the authors' papers (Collyer 2013b:3) – these studies can also provide information about the sociologists of health and medicine themselves. We know, for instance, that in Australia, there are more women in the field (69 per cent are women), whereas women make up approximately 50 per cent in the other two countries (Collyer 2012a:208). Also apparent are differences in where they work. While the methods of the study limit the field to sociologists who publish in the academic journals, and are thus unlikely to be employed outside universities; there is national variation in where our sociologists work *within* the universities. This in turn shapes the conditions of their work (such as their access to research grants), the rules by which their performance is measured (for example, preferences for publishing books rather than journal articles), and consequently the kinds of research interests they pursue and the methods they employ.

Armed with such information, it is not surprising to find that with proportionally more British sociologists working in faculties or departments of medicine than in either of the other two countries (Collyer 2012a:207), we get more studies of the illness experience focusing on the patient (Collyer 2012a:239). Equally, with the relatively high number of Australians employed in sexual health units, we get more studies of sexuality, gender and reproduction in that country than in Britain or the United States (Collyer 2012a:236–7). And it is the case that with the much greater level of health and medical research funding available to the Americans (Collyer 2012a:246), they have a much higher propensity for conducting large (and expensive) quantitative studies of health inequalities and the tracing of relationships at a population level between various social variables (such as race or socio-economic status) and specific health conditions (Collyer 2012a:241).

Theoretical perspectives in the sociology of health and healthcare

We have focused so far on the genesis, character and institutional consolidation of medical sociology in different parts of the globe. No sociology is theory-neutral, so whether we are considering sociology *in* or *of* medicine it is possible to identify theoretical premises. It is one thing to draw on theory unawares, however, as was often characteristic of sociology *in* medicine, and another to utilise it reflexively, which was more common within the sociology *of* medicine. In his introduction to a new edited collection, Cockerham (2012:9) states that:

> ... theory binds medical sociology to the larger discipline of sociology more extensively than any other aspect of sociological work. Theory is also what usually distinguishes research in medical sociology from socially-oriented studies in allied fields, like public health and health services research and allows it to remain unique among the health-related social and behavioural sciences.

Over the decades, sociologists interested in health, medicine and healthcare have drawn liberally on mainstream theories of modern societies and of social change. This volume is testimony enough of the growing richness of the resources being tapped. Our task here is to set the scene. In the early post-war years, the apprentice sub-discipline of medical sociology was largely an applied area of research. The turning point in many respects was the publication of Talcott Parsons' *The Social System* in 1951 (Cockerham and Scambler 2010:5). It was not just that Parsons offered a structural-functionalist analysis of health and medicine. So dominant was the Parsonian perspective at the time, and so eagerly had his long-awaited book been anticipated, that *The Social System* was an open invitation for sociologists to direct their attention to matters of health. Parsons, who had trained as a psychoanalyst, was interested in the roles played by professionals in the United States and elsewhere and opted to include physicians in his analysis. His concept of the Sick Role proved pivotal and is still cited and deployed as an ideal type in empirical research. His use of the works of Freud as well as those of Durkheim and Weber was a catalyst for others following in his footsteps.

Structural-functionalism emphasised the macro-level social processes, structures, norms and values external to individuals that served to integrate them into the wider society and moulded their behaviour. Social order trumped the exercise of free will. This was consonant with Émile Durkheim's (1951) theorising of suicide as a social rather than individual phenomenon: the singular act of taking one's life was determined, he argued, by a person's ties to society. This is apparent through the three predominant types of suicide: (a) *egoistic* (arising from social detachment); (b) *anomic* (arising from a state of normlessness); or (c) *altruistic* (arising out of a normative demand for suicide). It is the wider society, he contended, that creates the conditions in which people are compelled to respond to circumstances manifestly not of their choosing. So macro-social happenings like economic recessions can, and do, impact on individuals' health and decision-making. Elsewhere, Durkheim's (1964) documenting of a transition from mechanical to organic solidarity had clear ramifications for medicine in an historically novel division of labour where the professions came to develop a unique social role to maintain the moral, social order.

The most telling objections to structural-functionalism's emphasis on equilibrium and consensus came from (a) symbolic interactionism and (b) conflict theory, both of which matured in the United States. Symbolic interactionists critiqued the casting of individuals as largely passive role-players in large social systems. Using the works of Mead (1934) and Blumer (1969), they argued that social reality is constructed on a micro-level by individuals interacting with each other on the basis of shared symbolic meanings. Social reality, in other words, is produced by interacting agents capable of making choices, rather than by macro-systems and structures that channel them down 'option-less pathways' (Cockerham and Scambler 2010:7).

The focus of symbolic interactionist research, unsurprisingly, was qualitative in general and involved participant observation in particular. Its principal contributors to medical sociology were Anselm Strauss and Erving Goffman, although mention should be made also of Howard Becker and colleagues' (1961) input through their classic study, *Boys in White*. Strauss and Glaser's (1965) studies of death and dying, the hospital as a 'negotiated order' and innovation in patient care, as well as their formulation of grounded theory, have survived the test of time. Goffman's (1959, 1961, 1963) groundbreaking, dramaturgical ('life as theatre') analyses have also retained much of their perspicacity and thrust more than half a century after they were first published.

By the mid-1960s symbolic interactionism had become a significant rival or even successor to structural-functionalism. An offshoot, labelling theory, asserted that deviance is not a quality of the act an individual commits but rather a consequence of norms constructed and enforced by others. If, as Parsons argued, disease is a type of deviance, then it is the medical profession that, as Freidson (1970) was to maintain in his *Profession of Medicine*, 'creates' it. Physicians have not only been granted the authority to determine who is sick (and therefore entitled to enter the Sick Role) and who is not, *they also manufacture the very possibility of 'acting sick'*. In a celebrated study of mental illness, first published in 1966, Scheff (1999) contended that an appropriate aetiological theory of mental illness would start and conclude with physicians' definitions of the situation. As the 1970s progressed and gave way to the 1980s, however, symbolic and other branches of interactionism gradually lost their pre-eminence, in different parts of the globe, to different paradigms. Their methodological salience has nevertheless endured. Qualitative investigations into illness, disease and health encounters in general, and participant observation in particular, continue to be indebted to earlier pioneering interactionism.

What is conventionally termed conflict theory became another long-standing alternative to structural-functionalism. Inspired by the European tradition of Marx and Weber, conflict theory is based on the premise that society is not characterised by consensus but by the competing interests of different groups. Elites of one kind or another typically prevail. While those in the Marxian fold have emphasised the overriding importance of class, others have accented the roles of interest groups, political parties and so on. Marxist contributions have often been made in the shadows of the sociology of health, illness, disease and healthcare. In their different ways, Waitzkin (1983), McKinlay (1984) and Navarro (1986) challenged the status quo by asserting that the working classes are systematically disadvantaged in relation to the social determinants of disease, the nature of healthcare systems, healthcare utilisation and medical encounters. For some, the health sequelae of the collapse of the Soviet Union and its displacement by capitalism testified to the relevance of Marxism (male longevity in Russia fell 5.2 years between 1965 and 2005), while for others (those who interpreted the Soviet bloc as 'Marxism in practice') its demise seems to promise an ultimately healthier future.

The conflict tradition might also be the place to discuss the rise of feminist perspectives on health and illness from the 1960s. These feminist studies were stimulated by the same social forces which led to the formation of the Boston Women's Health Book Collective and the publication of the best-selling book *Our Bodies, Ourselves* (1973). Much of the earliest work focused on women's reproductive experiences – for instance, Bonnie Bullough's (1972) study of the impact of poverty on access to family planning services – but even work addressing broader issues often contained stinging critiques of the medical profession and the way women were treated within the healthcare system as either patients or nurses (for example, Ehrenreich and English 1973; Scully and Bart 1973; Comaroff 1977; Oakley 1984). In many cases, these feminist works were combined with the other major traditions, such as Marxism (for example, Doyal 1979) or interactionism (for example, Quadagno 1978), emphatically rejecting the functionalist paradigm for its treatment of women, gender and sexual identity (for example, Edwards 1983). Feminist perspectives eventually assisted in the birth of a field of men's studies (for example, Creighton and Oliffe 2010), sexuality studies (for example, Green 2007) and the theorisation of masculinity, broadening the conceptual field into one of gender relations where the focus is the construction of gender, rather than women or men in isolation (for example, Connell 1995).

As the chapters in this collection demonstrate, classic sociological theory still resonates in the sociology of health and illness. There were early attempts to introduce a more contemporary note (Scambler 1987). The twenty-first century has witnessed an emergence and consolidation of a number of new paradigms, some of which, inevitably, are indebted to work in the 1980s and 1990s (Scambler 2012). Pre-eminent among these 'influences' has been the post-structuralism of Foucault (Petersen and Bunton 1997; Petersen 2012). Post-structuralists rejected the notion, dominant in France in the 1960s, that there are discernible universal rules that govern social phenomena. Derrida's (1978) 'deconstruction' of texts, for example, suggested that written language was not as socially constraining, nor were its meanings as stable, as had been assumed.

Foucault focused on the relationship between knowledge and power, offering histories of the manner in which knowledge produced the expertise deployed by professionals like physicians to shape social behaviour. Knowledge and power, it was suggested, were so closely connected that 'an extension of one meant a simultaneous expansion of the other' (Cockerham and Scambler 2010:16). Foucault used the term 'knowledge/power' to represent this unity. In his studies of madness, clinics and sexuality, he showed how medical knowledge functioned to control and regulate behaviour. His focus on how, as part of this process, bodies enter the jurisdiction of professional experts helped usher in a *sociology of the body*. Turner's (1984) *The Body and Society* was the first broad treatment of this new branch of medical sociology. In Britain, the United States and Australia, innovative investigations of clinical and public surveillance, incorporating new conceptualisations of risk, of the control and phenomenological experience of the body and of the (re-)discovered field of emotions ensued (Lupton 1995; Petersen and Lupton 1996; Petersen and Bunton 1997).

Others used Foucauldian perspectives to analyse gender and health in general and the oppression of women in particular (see Sawicki 1991).

In similar vein, serial accounts of the *social construction* of phenomena previously assumed to be independent of our conceptual frames emerged, including health, illness and disease. One explicitly Foucauldian strand of constructionism denied the possibility of arriving at a single valid account of disease and the body. This strand challenged orthodox histories of medicine and the long-standing division between professional expertise and lay opinion. A second strand, laying more stress on active agency than did most Foucauldians, drew on the work of Berger and Luckmann (1967) as interpreted by Freidson (1970) (Olafsdottir 2013). While studies emanating from the Berger and Luckmann tradition have tended to favour 'weak' forms of constructionism, insisting only that all systems of knowledge owe their origins and authority to particular, time-bound socio-cultural frames; those arising from Foucault's 'post-structuralist' standpoint have often favoured 'strong' constructionist stances, implying that there is no rational way of addressing the relativity of 'time-bound socio-cultural frames'.

Sociological theory: Inclusions and exclusions

If Foucault has proved a deep and lasting catalyst for medical sociology, there have of course been many other influential theorists, and the deployment of mainstream theory and theorists has become more common over the last 20 years (Scambler 2001). A selection of essays published in 1987 set out to establish the relevance of each of Marx, Weber, Durkheim, Parsons, Freud, Goffman, Foucault, Habermas and Offe for understanding/explaining topics in the sociology of health and healthcare (Scambler 1987). In what might be seen as a sequel, in 2012, essays on Foucault and Habermas were again featured, but chapters on Bauman, Luhmann, Bourdieu, Merleau-Ponty, Wallerstein, Archer, Deleuze, Guattari and Castells were also included (Scambler 2012). In Cockerham's (2013) latest collection, significantly entitled *Medical Sociology on the Move: New Directions in Theory*, essays range over symbolic interactionism, social constructionism, Foucault, Marx and critical realism, fundamental cause theory, Bourdieu and gender theory, as well as topics such as reflexive modernisation, the rise and fall of the medical profession, medicalisation and social capital. What these three collections demonstrate is that a strong dialectic now exists between social and critical theory on the one hand and much, if by no means all, medical sociology on the other. Moreover, the sub-discipline now has firmer roots in European and Australasian soil (and increasingly elsewhere) and is less dependent on North American institutions and perspectives.

There is still a long road to travel however. Alongside these well-recognised theorists, have are many others that history has failed to remember. The case of Ludwik Fleck clearly illustrates the problems of the historiographic tradition, for many a significant work of scholarship is left on the shelf without recognition until years after the theorist has passed away. Moreover, the Eurocentric, American-centric, male bias of the sociological canon has only recently attracted well-deserved scrutiny. Women theorists of the nineteenth century, such as Florence Nightingale, Harriet Martineau and Charlotte Perkins Gilman, and of the twentieth century, such as Meg Stacey, Renée Fox and Anne Witz, have not been given the recognition of their male counterparts despite their contributions and their shaping of the body of work to which this volume is devoted. It is clearly time for their inclusion in the field. Annandale (2013) has made this case, going on to note that social roles of gender are currently undergoing rapid change. Theories based on assumptions of binary difference between men and women now seem dated as sociologists and others emphasise that the social relations of gender have become more fluid, complex and contested. New inequalities, she suggests, are forming at the intersections of gender with, for example, age, ethnicity and sexuality, and each of these has implications for health. Binary difference and diversity now sit side by side.

We cannot, in this brief introduction, anticipate the full range of theoretical inputs into the sociology of health, illness and healthcare, let alone do them any kind of justice. It has been our object instead to set the scene, institutionally and in terms of paradigms. Each chapter in this Handbook tells its own story, covering the explication, critique and application of a particular theorist. What these, in combination, suggest to us is the robust health of our sub-discipline and the ever-increasing relevance of social theory to the study of health, healthcare and medicine.

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Part I

The Nineteenth-Century Theorists

Chapter 2

Harriet Martineau and Charlotte Perkins Gilman: Forgotten Women in the Study of Gender and Health

Ellen Annandale

> It takes great strength to train
>
> To modern service your ancestral brain; To lift the weight of the unnumbered years
>
> Of dead man's habits, methods and ideas . . . (Gilman 1898, in Davis 2010:3).

This epigraph from a poem by Charlotte Perkins Gilman neatly conveys the theme of this chapter; it is indeed hard to lift the weight of the many years whence the 'habits, methods and ideas' of male classical theorists have presided over social theory. Charlotte Perkins Gilman (1860–1935) and the earlier Harriet Martineau (1802–1876) are the neglected contemporaries of the male theorists usually recognised as the originators of the classical sociological canon, such as Auguste Comte, Émile Durkheim, Herbert Spencer, Lester Ward and Max Weber. In this chapter, it is argued that an examination of their work provides a glimpse of how the sociology of health, illness and medicine might have been if the wider discipline of sociology had developed differently according to the precepts Martineau and Gilman endeavoured to bring to public attention. In particular, it proposes that as they grappled with the mind/body relationship in illness, especially as this concerned women, they advanced a nascent embodied sociology of health and illness and sociology of gender and health.

Biographies and social context of their work

Harriet Martineau was born in 1802, and Charlotte Perkins Gilman was born more than half a century later in 1860. Both died in their mid-seventies, Martineau of heart failure in 1876 and Gilman of breast cancer in 1935.

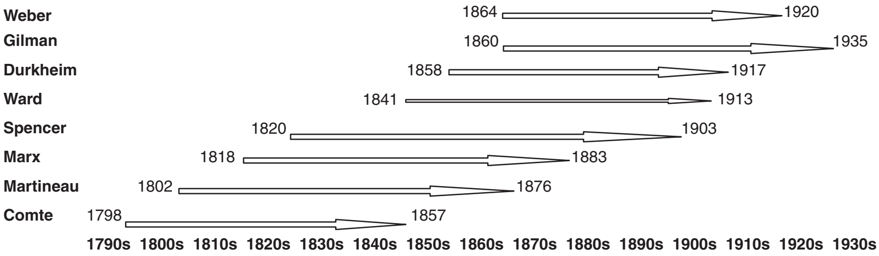

Figure 2.1 Timeline of theorists

Martineau lived most of her life in England, while Gilman resided in the United States (Figure 2.1).

As their biographies detail, both suffered significant illness throughout much of their long lives (see Martineau 1877; Gilman [1935] 1963). Martineau's childhood was beset with ill-health and she began to lose her hearing in adolescence; by age 21 she was near deaf and depended on a hearing trumpet for the rest of her life (Martineau 1877; Deegan 2003). In her late thirties, she became unwell while travelling in Venice and between 1840 and 1844 lived the life of an invalid sequestered in her rooms in a boarding house in the coastal town of Tynemouth in northern England. As a young woman, Gilman took strenuous efforts to train her body, being by all accounts an accomplished gymnast with a keen interest in the physical culture movement of the time (Davis 2010). However, she suffered from bouts of mental ill-health most of her adult life. Although not written in the first person, there is no doubt that the positions advanced in *Life in the Sickroom* (Martineau [1844] 2003) and *The Yellow Wallpaper* (Gilman [1892] 1973) were at least partially rooted in personal experience.

Neither had much in the way of formal education, and both were largely self-taught. This did nothing to curb their fervour for writing and for publishing their ideas in many formats. Martineau penned 70 volumes, including the sociological texts *How to Observe Morals and Manners* (1838) and *Society in America* ([1836/7] 1963), and her acclaimed translation of Comte's *Cours de Philosophie Positive* (Comte 1896). She also wrote dozens of articles and nearly 2,000 newspaper leaders and letters (Hoecker-Drysdale 2003). Gilman is credited with 2,173 lifetime publications comprising six books, including *Women and Economics* ([1898] 1906), and articles in outlets such as the *Forerunner* (a journal she published between 1909 and 1916) and mainstream journals such as the *American Journal of Sociology* (*AJS*) and *Publications of the American Sociological Society* (later *American Sociological Review*) (Madoo Lengermann and Niebrugge-Brantley 2004). Since they intended their work to have an impact beyond academia, the pair also engaged in fiction and advice-giving. For example, Martineau's *Illustrations of Political Economy* (Martineau [1832] 2004a), a blend of fictional narrative and principles of political economy, outsold Charles Dickens' serialisations (Madoo Lengermann and Niebrugge-Brantley 1998). Martineau's *Deerbook*, a novel of English village life (Martineau [1839] 2004b), and Gilman's science fiction tales, such as *Herland* (Gilman [1915] 1998a), and the aforementioned novella, the *Yellow Wallpaper* ([1892] 1973), are astute insights into health issues. Since neither woman held a salaried academic position, publishing – and, in Gilman's case, also public lecturing – were essential to their livelihoods. Gilman's life, in particular, was dogged by economic worries (Davis 2010). Nevertheless, and unusually for women of their time, each travelled far and wide. Martineau's research for *Society in America* ([1936/7] 1963) and *Eastern Life, Past and Present* (1848) took her to the United States and the Middle East. Gilman travelled back and forth across the United States to give public lectures and to Europe to attend conventions, such as the International Council of Women in London in 1899 (Davis 2010).

Although they were divided by place and their lives overlapped by less than two decades, they faced the constrictions of women's lives in analogous ways and in common with their contemporaries. Even so it is important to appreciate that they lived during significant social reforms, many of which concerned women. Although it isn't possible to go into detail here, the following are worth noting as context for the discussion of their sociology. At the time of Martineau's birth, most women of her native England had little choice but to marry (though she herself did not). In 1857, the *Matrimonial Causes Act* allowed divorce through the courts (rather than, as previously, by Act of Parliament). However, while a husband had to prove his wife's adultery, a wife also had to prove incest, bigamy, cruelty or desertion. Married women gained the right to own property in 1869 when Martineau was already in her late sixties. In 1882, the *Married Women's Property Act* restored women's rights to own and sell property. In the United States, the *Married Women's Property Acts* were instigated in 1839, some 20 years before Gilman was born. New York State had granted women the right to own and control their own property in 1848, which was to be followed by many other states during the 1850s. In Britain, women were able to vote with equal rights to men in 1928, some 50 years after Martineau's death. With the passage of the 19th Amendment, American women achieved the right to vote in 1920, when Gilman was 60 years old.

While the work of both can be described as feminist in today's terms, Martineau demurred from what she deemed the grandstanding of feminism and feminist organisations (Logan 2010). While Gilman was more publicly outspoken, Martineau was a noted abolitionist. Slavery occupied a central place in *Society in America* ([1836/7] 1963) and her other writings, such as *Demerara* (a tale set on a Guyana plantation) recounts the suffering, economic waste and unproductiveness of slaves (Martineau [1832] 2004a). Although Martineau never doubted the superiority of Western civilisation she considered it complementary to other cultures (Logan 2010). By comparison (and especially in later life), Gilman was convinced of 'deep, wide, lasting vital differences between the races' and feared the effect of immigration on Americans (Gilman [1935] 1963). Writing in *AJS* she referred to 'Negros' as a 'large body of aliens, of a race widely dissimilar and in many respects inferior', 'whose present status is to us a social injury' (Gilman 1908:78).

Their approach to sociology

In their bid to establish a new academic discipline, the so-called 'founding fathers' sought to distinguish sociology from psychology and from biology by demarcating its subject matter to the social sphere. Conventionally, this is considered to have fostered a social determinism within the discipline and the development of a decidedly dis-embodied sociology well into the twentieth century. The writing of the 'founding fathers' is saturated with gendered assumptions which denigrate women by tying them to the realms of body and nature and which elevate men through their supposed association with the mind and the social sphere (as remarked upon later, Ward was an exception to this). This was buttressed by the wider mid- to late nineteenth-century belief that weakness and illness were inherent to women's condition, as witnessed by the cult of 'hysteria' (see, for example, Jordanova 1999). Although Martineau and Gilman shared their male contemporaries' organic approach to the study of society and strong belief that sociology could aid society's progress, they decried the sex/gender distinctions and related deprecation of women upon which this was based. Indeed, part of the originality of their sociology lost to time is their overturning of these presumptions though a blended analysis of aspects of gender, health, illness and the body. In other words, while the gendered assumptions of the 'founding fathers' help to explain their casting of biology and the body aside, by bringing a sociological analysis of women's gendered condition to the heart of their work Martineau and Gilman could not help but make them a central sociological concern.

Martineau (1838) defined sociology as the direct observation of the surface *manners*, or patterns of social relationships between people in order to reveal a society's deeper *morals*, or social convictions. She saw the relationship between a society's declared and actual morals as a measure of its progress. Perforce, she asked, how 'is the restricted and dependent state of women to be reconciled with the proclamation that "all are endowed by their Creator with certain unalienable rights; among these are life, liberty and the pursuit of happiness?" ' (Martineau 1838:308). She advised that social relationships should be observed by reference to 'things', by which she meant institutions and social practices.

The health of a community, which she identified as 'an almost unfailing index of its morals', (1838:161) was a prime example of this. Thus she advised:

> . . . one character of morals and manners prevails where the greater number die young, and another where they die old; one where they are cut off by hardship; another where they waste away under a lingering disease; and yet another where they abide their full time, and then come to their graves like a shock of corn in its season (Martineau 1838:166).

Now it is important to appreciate that this work appeared well before Comte's *Cours de Philosophie Positive* (1896 [original 1830–1842 and translated by Martineau in 1853]) and Durkheim's *Rules of Sociological Method* ([1895] 1964). Like the later Durkheim, Martineau avers that the sociologist should focus on 'things' and not the individual discourse of persons (though the latter can help us to interpret the former). Sociology's project is 'to assess the extent to which a people develop "morals and manners" that produce or subvert this great end of all social life, human happiness' (Madoo Lengermann and Niebrugge-Brantley 2004:274). A conviction that Comte's system of the sciences and his science of society would contribute to human perfectibility and social progress explains Martineau's desire to make his work more widely available. Her translation of his *Cours* was a formidable task. She turned the original six volumes (of well over 4,000 pages) into a more readable two-volume text of around 1,000 pages. Comte was so impressed that he had the work back-translated into French. However, Martineau disagreed strongly with his casting of sociologists as the high priests of society and with his views on women (Hoecker-Drysdale 2003). For he maintained that woman's emotional and affective nature makes her less human than man and unfit 'for the continuousness and intensity of mental labour, either from the intrinsic weakness of her reason or from her more lively moral and physical sensibility, which are hostile to scientific abstraction and concentration' (Comte 1896:269). Consequently, for Comte, woman's place is in the family, the basic unit of social life. Naturally subordinate, her role is to modify 'the cold and rough reason that is distinctive of man' (Comte 1896:269). Continuing this theme, Durkheim maintained that women are asocial beings left behind in a state of nature. He held that the sexual division of labour in society is determined by the differential natures of men and women and the social functions that these natural differences serve (see Lehmann 1994).

The later Gilman was also strongly influenced by the evolutionary and reformist spirit of her age, including, in her early life, the socialist utopians like Edward Bellamy and the settlement workers such as Jane Addams (Gilman resided in Hull-House in Chicago for a short period) (Lemert 2003; Davis 2010). She was a follower of Lester Ward, the first president of the American

Sociological Association, and a member of this from its founding in 1895 up to her death. An advocate of women's rights, Ward developed a 'gynaecocentric theory' which posited female origins to life and proposed that the positive future of society lay in the advance of women (Ward 1888). Other influential theorists of Gilman's time were far less sanguine. For example, Herbert Spencer initially was in favour of women's suffrage (Spencer 1851), but retreated from this in his later work such as *The Study of Sociology* (Spencer 1873). There he depicts women's evolutionary nature as arrested by the reservation of vital power needed to meet the cost of reproduction which results in them falling short in intellectual faculties (Spencer 1873). Like Martineau before her, Gilman baulked at depictions of women by her male contemporaries and, in contrast to Spencer, positioned the development of equal relations between men and women as a decidedly positive factor in social evolution, most notably with regard to the economic sphere (Gilman [1898] 1906). She anticipated that only when women were reared with equality to men and 'with all human work open to them' would their bodies cease to be a liability (Gilman, quoted in Davis 2010:281).

Throughout her life, Gilman was staunch in the conviction that individuals – which included herself – should check any temptation to put the self first (Davis 2010:xvi). She whole-heartedly believed that we are made human through social relations and, therefore, that human life is the collective life (in later life, she was very critical of the competitive individualism of the 1920s' decade of the flapper, Annandale 2009). As Wegener argues, sociology's subject matter is the complex of human relations and Gilman is the 'social pathologist treating a badly diseased, even deformed, social organism or body politic' (1999:56). This is made clear in *Women and Economics*, which dissects the excessive sex distinction within American society (Gilman [1898] 1906) and concludes that men have created a masculine culture in excess, premised on a seemingly natural biological division of the sexes. This has emblazoned itself 'across every act of life, so that every step of the human creature is marked "male" or "female" ' (Gilman [1898] 1906:52). Yet she remained optimistic, remarking that while Harriet Martineau may have had to conceal her writing under her sewing 'because "to sew" was a feminine verb, and "to write" a masculine one', little by little it is becoming established that 'human work is woman's as well as men's' (Gilman [1898] 1906:53).

Health issues

The health issues that Martineau and Gilman introduce flow directly from their wider sociological concerns. For both, health is fundamental to our understanding of the social relations of a society, especially its gender inequalities. The catastrophic effect of confinement to the domestic sphere, upon marriage, for women's health is an enduring theme for both. As already observed, they had plenteous personal experience to draw on. Although Martineau was never a wife, she was no stranger to the demands of women's caring role and attributed her own fall into illness to extreme nervous tension from over work and caring for her invalid mother (Ryall 2000). Since she saw marriage as a form of bondage for women (Spender 1982), it is not surprising that she made the home a crucial site for the study of a society's morals and manners. The marriage–health association is explored comprehensively in the novel *Deerbook* where the village surgeon-apothecary, Dr Hope, fails to recognise the dis-ease to which his young wife Hester falls prey upon their marriage (Martineau [1839] 2004b). As Hester explains to her sister, 'life is a blank to me. I have no hope left. I am neither wiser, not better, nor happier, for God having given me all that should make a woman what I meant to be' ([1939] 2004:242). Fulfilling her 'destiny' as a woman makes Hester ill. She is only drawn out of her malaise when a cholera outbreak hits the village, and she works tirelessly alongside her husband in support of the sick.

Gilman agonised over whether to marry her first husband, artist Walter Stetson, fearing – with good reason as it would turn out – that the 'being' of marriage rather than the 'doing' or 'living' of public service would undermine her health. Two months before the wedding she wrote of being ' "lachrymose", full of forebodings of future pain' and increasingly '*miserable*' (quoted in Davis 2010:74, emphasis in original). The *Yellow Wallpaper* (Gilman [1892] 1973) is a graphic depiction of the mental illness that can follow marriage and motherhood. It mirrors Gilman's own decline soon after her marriage to Stetson. In her posthumously published biography, she recounts that she had had everything good before her: 'health and strength and hope and glorious work', but had thrown it all away in marriage (Gilman [1935] 1963:91). The famous Dr Weir Mitchell diagnosed hysteria and recommended his 'rest cure' to reorient her to her womanly duties. Memorably, she was admonished 'never to touch pen, brush or pencil as long as you live' (Gilman [1935] 1963:96). For someone like Gilman who strongly likened health with work, this meant utter ruin. Her torment was such that she would 'crawl into remote closets and under beds – to hide from the grinding pressure of that profound distress' of trying to follow this advice (Gilman in Hill 1980:149).

Some years later, she protested the early twentieth-century portrayal of the home as a fantasy. Rather than being a place of sanctity, she typifies it by lack of personal privacy, ill-health and mental challenge. While the husband 'finds his chief base outside, and bears up with greater or lesser success against the demands and anxieties of the home, the wife, more closely bound, breaks down in health with increasing frequency' (Gilman 1903:74). Her article in *AJS* presents the home as a means of establishing women's ownership by men, as a place where a man secludes his wife and where she becomes his servant:

> Let us suppose that the conditions of home life required every man upon marriage to become his wife's butler, footman, coachman, cook, every man, all men, necessarily following the profession of domestic servants. This is an abhorrent, an incredible idea. So is the other. That either sex should be the domestic servant of the other sex is abhorrent and incredible (Gilman 1909:598).

Martineau and Gilman both damned marriage for its impact on women's sexual and reproductive health. The *English Contagious Diseases Act* of 1864, which had been introduced to deal with venereal disease in the military, permitted 'military policeman' to examine, detain for up to three months and compulsorily treat prostitutes in port and army towns. Men who consorted with prostitutes were subject to no such treatment (Bland 1995). By then in her sixties, Martineau campaigned publically alongside Josephine Butler and others for the repeal of the Act. (The Act was eventually suspended in 1883 and repealed after three years.) Some years later, Gilman ([1916b] 1999) drew direct links between marriage, sexual disease and death in her short story *The Vintage*. Leslie, a woman of 'blazing health', is stricken upon marriage and ultimately dies. Unbeknownst to Leslie herself, her mortal illness is a direct result of her husband's syphilis which, to make matters even worse, is covered up by her doctor.

Their analyses of the marriage–health relationship make abundantly clear that there is nothing natural about either the situation of women or the state of their health. Both advanced that women's minds and bodies are atrophied owing to lack of physical activity and mental engagement. In their estimation – but not that of society or the male sociologists of their times – the obvious solution lay in women's economic independence from men and the family. Gilman in particular campaigned tirelessly for this. But both need to be credited with addressing the relationship between 'gender, work and health' some 40 odd years before it was taken up by feminist activists and academics from the 1960s and 1970s onwards. They were also at pains to point out that while employment was women's salvation, its conditions needed to change. For instance, Martineau drew attention to the plight of women in particular occupations, remarking, for example, upon the high incidence of spinal disease and blindness among needlewomen and the physical and mental pressures of the life of the governess which, she deduced, were enough to drive her to drink (Martineau 1861).

Given their injurious treatment at the hands of male medical men, it is not surprising that each developed critical commentaries on what is now termed the doctor–patient relationship. They not only criticised how the overwhelmingly male medical profession treated their patients (especially women), but also medical knowledge itself. In Martineau's case, this is evident in *Deerbrook* ([1839] 2004) and especially in *Life in the Sickroom* ([1844] 2003), where she counsels that the invalid, not the doctor, should be in charge. As Alison Winter (1998) explains, instead of conforming to the stereotype of the passive patient, Martineau successfully asserted her own sanity, troubling the power of doctors in the process. Similarly, Martha Cutter (2001) advances that Gilman's work shows how the patient disperses medical authority by reading her own disease and formulating her own treatment. Women doctors were a central concern of Gilman's. They appear in her fictional works such as *Dr Claire's Place* which concerns a woman doctor who 'rejuvenates' women suffering from mental illnesses (Gilman [1915] 1998b). Dr Claire not only advises rest but also contemplation and physical exercise and encourages her patients to engage with the doctor in the monitoring of symptoms and in diagnosis. As Wegener (1999) relates, for Gilman, the intense struggle for acceptance by women doctors was symptomatic of women's larger quest for professional acceptance and economic parity.

Embodiment

For Gilman (1916a), the harmony of self and society, body and soul rests upon an individual's conviction of doing work that is right and necessary. In a newspaper piece written in 1885 when pregnant with daughter Mary, entitled 'The Sin of Sickness', she proposed that 'it is the simplest, plainest, most unchangeable duty of every one of us . . . to live that our bodies shall be always ready for their best work' (Gilman quoted in Davis 2010:81). A credible interpretation of this is that illness can be prevented by an act of will or the force of reason (Davis 2010). Equally, Martineau proposed that the sick vindicate 'the supremacy of mind over body'; they can still *be* even though they cannot *do* ([1844] 2003:129). Thus she proposed that despite 'racking bodily agonies' and 'constant prostration of mind', the sickroom 'may become the post of the loftiest human speculation, and the portal of Heaven' ([1844] 2003:171,176). Hence, both theorists might be understood to propose that body is subordinate to the mind.

Yet, it can equally be argued that they paved the way for an embryonic embodied sociology. Martineau in particular maintained that illness fosters a heightened awareness of the mind/body relationship that enables a new and privileged insight into the social world (Sanders 1986; Annandale 2007). She refers to 'an abiding and unspeakably vivid conviction' of truth that 'arises out of a condition of protracted suffering'. Thus in reference the community of the sick, she writes:

> . . . by our being withdrawn from the disturbing bustles of life in the world; by our leisure for reading and contemplation of various sides of questions, and by our singular opportunities for quiet reflection, we must, almost

> necessarily, see further than we used to do, and further than many others do on subjects of interest, which involve general principles (Martineau [1844] 2003:44,116–7).

In *Life in the Sickroom* ([1844] 2003) and *Health, Husbandry, and Handicraft* (1861), Martineau draws attention to the taken-for-grantedness of the body in health and its intrusion when we are ill. For example, she explains that the maid-of-all-work 'does not think about her bodily condition at all; for there are no aches and pains to remind her. Some people go through life without ever having felt their lungs; and others are unaware, except by rational evidence, that they have a stomach' (Martineau 1861:160). Gilman reflected similarly, remarking that before she was ill (when pregnant) she could 'do anything . . . and never know I had a body. As for nerves I denied their existence' (quoted in Davis 2010:95). She maintains that 'equipoise of soul and body' is essential to good health. This is achieved through harmony between the individual and their social environment (Gilman 1916a:68). There are distinct continuities between these analyses and late twentieth- and early twenty-first-century accounts of the experience of chronic illness as embodied experience. For example, Havi Carel (2008) employs the concept 'health within illness' to convey the positive, creative experiences of personal growth, adaptation and rediscovery that occur in serious illness such as her own. Arthur Frank explores the way accounts of chronic illness as positive transformation are witnessed by others as moral tales (for example, Frank 1995).

The reception of their work

In what follows, three forms of contemporary revisionism pertaining to the 'classics' from general sociology, the sociology of health and illness and feminism/sociology of gender will be explored to gauge how Martineau and Gilman's works have been approached. (It should be noted that what follows is an indicative rather systematic review of how authors of textbooks and journal articles treat Martineau and Gilman.)

Although there are those such as R.W. Connell (1997) and Richard Hamilton (2003) who fail to admit Martineau and/or Gilman into the canon because they decline to identify them as credible sociologists, more generally speaking they are a constituent part of the wider recent recovery of 'lost sociologists' within the discipline. However, their 'inclusion' has been on restricted terms. A primary limitation is the tendency to convert health and illness from a sociological concern into a limited focus on their personal ill-health. This strips health of the place that they intended it to have as a barometer of social relations, especially as it concerns gender. For example, Mark Abrahamson's (2010) textbook includes a full chapter on Martineau (Gilman is mentioned but only as part of the ‘supporting cast’ who warrant notice alongside the ‘core thinkers’ such as Come, Spencer, Ward and others). *How to Observe Morals and Manners* is judged ‘extraordinarily sophisticated for her time’ (Abrahamson 2010:26). Beneficially, there is a subsection entitled ‘in the sick room’, but Abrahamson’s attention is captured mainly by Martineau’s own sojourn therein and quickly turns to a reflection on how her ideas anticipate Goffman’s (1963) insights on stigma and discredited identities. The section which follows ‘on women’ is not connected to the preceding discussion of illness. The *Blackwell Companion to Major Classical Social Theorists*, edited by George Ritzer, includes substantial chapters by Susan Hoecker-Drysdale (2003) on Martineau and Charles Lemert (2003) on Gilman. Health is touched upon by Hoecker-Drysdale (2003) in her discussion of political economy/macro sociology and the study of American society which she takes as the main focus of Martineau’s work. But again, where health appears in any detail the discussion quickly reverts back to her personal experience of illness. It is telling that Martineau’s theoretical achievements in ‘the sociology of illness and disability’ are left unelaborated due to space restrictions (Hoecker-Drysdale 2003:54). In other words, health is auxiliary to what the author judges to be more central aspects of her oeuvre. Lemert writes that Gilman’s ‘*The Yellow Wallpaper* achieved for the social criticism of gender relations what *Uncle Tom’s Cabin* had forty years earlier for race relations’ (2003:268). (Note that this anti-slavery novel was written by Gilman’s relative, Harriett Beecher Stowe.) Gilman’s own post-natal illness is remarked upon, but read predominantly through the lens of the perils of bourgeois domesticity rather than for what it conveys about health and gender. Thus even though health and gender are each touched upon – more often than not separately – in mainstream texts such as those illustrated here, no discernable credit is accorded to Martineau and Gilman for inaugurating matters of health and the body as sociological themes. It is no surprise therefore that Chris Renwick (2012) finds the ‘lost biological roots’ of British sociology in the works of the rivals Patrick Geddes (1854–1932) and L.T. Hobbhouse (1864–1929) and makes no mention of the earlier Martineau. She and Gilman are similarly left out of Steve Fuller’s (2006) account of the ‘hidden history’ of biology and the body in the classics.

It is then perhaps not surprising that general sociology still fails to credit Martineau and Gilman’s inaugural contribution to the sociology of health and illness, but we might anticipate more direct attention in twenty-first-century reflections on the origins of the sub-discipline. But there too we are generally disappointed (Annandale 2014). Fran Collyer (2010) appropriately points out that the founders’ interest in health and illness is commonly understated but those credited consist of male theorists, such as Saint-Simon, Marx, Durkheim and Weber. In a recent review of ‘sociological theory in medical sociology in the twenty-first century’, William Cockerham (2013) advocates a return to those theories which focus on social structures as a pathway to social interaction in relation to health. Predictably, it is Marx, Weber and especially Durkheim, dubbed the 'originator' of sociology, who are discussed. Their feminist contemporaries Martineau and Gilman, who undeniably made social structures their focus, receive no mention. Interestingly it is Maria Frawley (2004), a professor not of sociology, but of English, who identifies Martineau's *Life in the Sickroom* ([1844] 2003) as a prelude to the emergence of medical sociology in the twentieth century.

Collyer (2010) attributes the wider failure of present-day sociologists of health and illness to recognise the work of classical theorists' interest in matters of health and the body to their pinpointing of the work of Talcott Parsons as the 'official' beginning of the sub-discipline. As she explains, Parsons at once endorsed the authority of biomedicine and emphatically drew sociology's attention towards the *social* origins of illness (see, for example, Parsons 1951, [1937] 1968). Elsewhere I have argued that at the same time the sociology of health and illness was gathering momentum as a sub-discipline in 1970s, much of academic feminism was seeking to establish, first, that women are no more (or less) determined by their biological bodies than men are and, second, that the image of women's biology presented to the world is grossly misconstrued. This culminated in the proposition that women's oppression is socially caused, rather than biologically given (Annandale 2009). So here once again attention was directed towards the social. Within liberal feminist-inspired research on gender and women's health status, for example, gender was then and still often nowadays is expressed as a social variable relating to individuals rather than to the health-related embodiment of the wider social relations of a society (Annandale 2010).

Although the more recent and growing body of feminist writing on women's exclusion from the academic canon often includes Martineau and/or Gilman, their concern with health remains significantly under-acknowledged. The likely explanation for this is twofold: first, the drift, especially since the early 1990s, of feminism and gender theory away from matters of health and, second, the failure until quite recently of feminists and gender researchers to explore the complex interplay between the biological and the social in the production of health and illness (Kuhlmann and Babitsch 2002; Annandale 2009). This conspires to make the engagement of feminists and gender theorists with the work of Martineau and Gilman largely devoid of interest in health.

Back in the 1970s, Alice Rossi (1973) reclaimed Martineau as the first important women sociologist, yet no mention is made of health as a theme in her work. Ten years on, James Terry puts Martineau and Gilman 'on a par with the traditional male masters' (1983:253) but, similarly, makes no mention of health and the body. Dale Spender (1982) includes Martineau in her influential *Women of Ideas* but sidesteps *Life in the Sickroom* and health issues generally. Spender mentions Gilman's fall into mental illness and her treatment at the hands of Weir Mitchell, but omits to address the implications of this for feminist theory. Some years on, Mary Jo Deegan (1991) put Martineau first in chronological order of the great women in sociology and judged her work equal to if not greater than any man of her era, but she does not address her concern with health. Patricia Madoo Lengermann and Jill Niebrugge-Brantley (1998, 2003, 2004) are notable commentators on the early women classical sociologists whom they identify as having produced a 'distinctive or different voice from that typical of the texts' (Madoo Lengermann and Niebrugge-Brantley 1998:309). Martineau is singled out for her influence on public health and for her belief in human betterment and social progress through the identification of morals and manners. Sociology's subject matter is seen to encompass her work on suicide, epitaphs and health. Moreover, gender, as the 'main cause of social pain and dysfunction', is placed 'at the heart of her sociology' (1998:109). But even so health fails to appear under the 'major themes' of her work. The authors readily appreciate that gender and feminism are central to Gilman's work, but do not credit her contribution to the sociology of gender through the critical lens of health.

Anne Witz and Barbara Marshall quite appropriately argue that 'the social', 'the epistemic core of sociology' was defined by the classical sociologists *via* the exclusion of women (2004:21). They propose that women were heavily associated with corporeality from which men were distanced. Thus they argue that Simmel and Durkheim gave us 'individualised men and body-bound women' (2004a:22), and, while 'women are locked into and overwhelmed by their corporeality, men rise above it and are defined, determined and distinguished by their sociality' (2004a:28). Thus Witz and Marshall (2004:1) address the 'gendered inclusions and erasures' that have benefitted the male subject in the history of the discipline referred to in this chapter. Yet in spite of their interjection that women's lives and experiences need to be brought into view, they pass over that which is fundamental in this regard; namely, health. Martineau and Gilman receive only passing mention. Curiously, Caroline Arni and Charlotte Müller argue that Martineau contested the organising principles of the newly emerging sociology and widened its scope before it was narrowed down as a 'masculinist discipline' (2004:72). They point to her enlightened methodology and approach to study of society and to her questioning of gender divides, yet they make no mention to *Life in Sickroom* or to her wider interest in health issues.

In sum, although inevitably the focus varies, taken as a whole, late twentieth- and early twenty-first-century commentaries on Martineau and Gilman touch upon health, touch upon gender, but largely fail to bring them together in any systematic and sustained way. Where health is addressed, this is in relation to Martineau and Gilman's *own* health rather than to health as a foundation for the study of the well-being of a society in general and of women in particular. Within the wider discipline, the likely reasons for this can be traced to the marked tendency from the early twentieth century to around the late 1980s at best to overlook the contribution that Martineau and Gilman made to the discipline and at worse to obscure their concern with gender and with health and the connection between the two. While on the face of it we might have expected more attention from sociologists of health and illness and from feminists and gender sociologists, their oversight is explicable – though not justified – by what until very recently has been the strong political pursuit of the social causes of illness and of women's situation. This has conspired to cast a long shadow over a distinct, albeit embryonic, contribution to the study of health and of gender as embodied experience.

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Chapter 3

Karl Marx and Frederich Engels: Capitalism, Health and the Healthcare Industry

Fran Collyer

The nineteenth-century writings of Karl Marx and Frederich Engels have been fundamental to various *political* regimes in recent history, including that of the Bolshevik Revolution of 1917, Joseph Stalin's rule in the Soviet Union from the 1920s and Mao Zedong's communist China from 1949. Over the same period in many Western countries, their writings were condemned by the authorities and elites as little more than communist ideology. Their popularity as *political* texts fell alongside significant world events such as the collapse of communism in eastern Europe and the Soviet Union between 1989 and 1991, but rose with other events (such as the student movements of the 1960s and the global financial crisis of 2008), when the downside of 'free market' philosophies and globalisation became more apparent. As works of *scholarship*, on the other hand, their insertion into the intellectual diet of the English-speaking world was somewhat delayed, for many works went unpublished during their lifetimes, were restricted initially to the German and, later, Russian languages, and editions were often heavily edited by the regime or party in power. As a consequence, their works became part of the English-speaking intellectual sector only with the rise of the student and civil rights movements of the 1960s.

In the West, their works have always been contentious and controversial, and there have been, and continue to be, profound disagreements over interpretation and even disputes over the authors' intentions. Various disciplines have sought to engage with their ideas, particularly the political sciences, history and philosophy. For sociology, the texts are considered to offer unique and foundational frameworks of social theory. Indeed, in sociology, which also flourished with the expansion of the university sector in the developed countries from the 1960s, the works of Marx and Engels eventually became an accepted part of the official 'canon', with Marx heralded as a 'founding father' along with a few others including Émile Durkheim and Max Weber (Connell 1997). The pair have faired less favourably in the speciality field of the sociology of health and medicine where official founders include Talcott Parsons and Henry Sigerist, but not Marx and Engels (see, for example, Gerhardt 1989; Jefferys 2001; Cockerham 2005). The early writings of Frederich Engels on the poor health of the nineteenth-century British working class is usually included in these historical accounts, but rarely is there an acknowledgement of the extent to which he, with colleague Karl Marx, laid out a critique of health and medicine of the period, offering one of the first truly sociological theories of illness and disease (for an extension of this argument, see Collyer 2010, 2012).

This chapter remedies this oversight, beginning with a biographical portrait of the theorists, moving to an overview of three of the pair's main conceptual tools – notably historical materialism, capitalism and commodification – followed by a section outlining their critique of prevailing perspectives on health and disease and a thesis of the connection between capitalism and poor health. The remaining part of the chapter indicates how this theoretical framework has been extended in the twentieth and twenty-first centuries to highlight the intense commodification of health services and the creation of a worldwide, capitalist, healthcare industry.

Biographies

Karl Marx (1818–1883) was the son of a lawyer in the Rhineland of Germany, and spent his early life in a comfortable upper-middle class home where he was introduced to progressive ideas. The young Marx escaped military service due to poor physical health, but attended the University of Bonn where he proved himself a dismal failure, spending most of his time drinking and writing poetry. Marx's arrest for drunken, noisy behaviour and the carrying of prohibited weapons led his father to send him to Berlin to study law (Hughes et al. 1995:19; Nelson 1999a).

At the University of Berlin in 1837, Marx lost his preoccupation with Romanticism and became interested in Hegelian philosophy and history (Mah 1986:498). Combining his studies with a developing political activism – he came to lead the radical Left Hegelians – Marx completed a doctoral thesis on *The Difference Between the Democritean and Epicurean Philosophy of Nature* by 1841. Within five years, however, Marx had become a socialist revolutionary, rejecting Hegel's vision of a world of harmony and becoming committed to the view that the world was being torn apart by a hegemony of material interests (Mah 1986:503). With the Prussian authorities becoming increasingly intolerant of radical and widespread demands for representative and responsible government, Marx's hopes to become a university academic were not to be fulfilled, and he turned instead to journalism and became the editor of the liberal newspaper *Rheinische Zeitung*. An article on widespread poverty and corruption under the Czar brought him into conflict with the authorities. The paper's licence was revoked, and despite widespread demonstrations and petitions the decision was not overturned. Marx resigned his post (Hughes et al. 1995:20; Nelson 1999a:51), headed for Paris in 1843 and wrote the *Paris Manuscripts*, developing his analysis of economic life. Marx never became an academic. He founded and led the International Workingmen's Association (Nelson 1999a:55), dedicating his life to the overthrow of the capitalist order which he saw as the cause of oppression and the enslavement of the population (Hughes et al. 1995:18).

Frederich Engels [1820–1895], interestingly, was a capitalist – or at least the eldest son of a capitalist. Engels was born in Barmen in the Rhineland where his family were cotton manufacturers, though they also had a branch of their textile business in Manchester in England. Engels, like many other young, progressive German intellectuals of his time, reacted with some horror at the narrow and pious attitudes of his family and the social problems associated with industrial capitalism (Hobsbawm, in Engels [1845] 1969:7). He dropped out of school early and began writing under the pseudonym of Friedrich Oswald in 1838. Like others of his intellectual and social class, Engels leaned towards communism, and like Marx became a radical Left Hegelian at a young age. Indeed, his radical views were evident even at the age of 19, when he wrote *Letters from Wupperthal* (Engels 1839, see Bussard 1987:682).

The communism of Marx and Engels, and many of the intellectuals of their circle, was perhaps not surprising given the agitation and unrest in Germany and across Europe during the 1830s and 1840s. The French Revolutions of 1792 to 1799 had left widespread fear among the propertied classes of the working classes, the destitute and the poor. From the 1830s, the working class movement built in strength, and political agitation culminated in the European revolutions of 1848: a series of short-lived and barely coordinated demands for political and social reform across about 50 countries, including the Austrian empire, Germany, France, Poland and Italy. These uprisings left thousands of people dead and many of the leaders were executed or exiled.

Marx and Engels first met, albeit briefly, in 1842, moving in similar social and political circles that included Leftists Bruno Bauer, Max Stirner and Moses Hess. Engels' father tried to remove him from this radical environment by sending him to Britain to continue his business training. In England, between September 1844 and March 1845, Engels wrote many articles but also *The Condition of the Working Class in England* ([1845] 1969). He was only 24 years old at the time. This book argues that the working class were living in conditions worse than those provided to farm animals (Hughes et al. 1995:21).

In 1844, Marx and Engels met again in Paris. This time the meeting was more successful and the beginning of a very productive partnership. Marx edited some of Engels' papers, including one on the centrality of private property to the economic system, and another on scientific socialism. By 1845, Marx had become well known to the French authorities and he was finally expelled in the January of that year. He and Engels moved to Belgium where there was greater political freedom, joined the German Communist League and set up a Communist Correspondence Committee. Their primary aims had now crystallised:

> The philosophers . . . have only interpreted the world, in various ways; the point is to change it (Engels *Theses on Feuerbach* [1845] 1975:423).

The pair wrote *The Germany Ideology* in 1945–1946, and in 1847 the *Manifesto of the Communist Party*. After its publication, Marx and Engels were deported once more. They returned to Cologne where they founded a newspaper, the *New Rhenish Gazette*, and an organisation called the *Rhineland Democrats*. Later that year, in 1848, Engels was forced to flee the country, while Marx continued to publish until 1849 when the authorities prosecuted him for incitement to armed rebellion. He was acquitted but expelled from Prussia, leaving the country for London with his family (Hughes et al. 1995:22). The pair spent much of the rest of their lives as exiles in Britain.

While Engels was independently wealthy, Marx and his family lived in relative poverty, sustained on the small amount of money Marx could earn from journalism, loans and advances from publishers, the sale of his books, gifts from friends – particularly from Engels – the sale of family assets and speculation on the stock market (Mahon 1990:760). Marx died in 1883 after a life of chronic poor health. On 14 March, his daughter reported that he walked from his bedroom to his study, sat in his armchair and quietly fell asleep for the last time (Nelson 1999b:108). Engels lived a further 12 years.

On the partnership of Engels and Marx

Questions about the nature of the partnership between Marx and Engels, and the relative contributions to their substantial oeuvre, have long been debated within intellectual circles. While recognised as an equal in Russian literature, Engels is portrayed as an assistant at best in Western circles (Seed 2010:8–9) – and largely portrayed himself in this light – that is, as only an editor of Marx's works, a biographer and acolyte. Scholars have taken sides on the issue, with Collins (1985:56–62) for instance, defending Engels as the more original thinker of the pair, often taking the lead for Marx to follow; while others have resolved to 'steer a middle course' or conclude that no decision can be made because their works are so contradictory they are open to all forms of interpretation (Hughes et al. 1995:41).

As with all human endeavour, the outcome of history is only ever the beginning of a story. Efforts to dis-entangle their individual contributions have been entwined with the complex social history of how their works have been received and utilised. For instance after Marx's death, significant developments occurred in the German factories and Engels became engaged in public and intellectual debates about the possibilities of the new laboratory sciences. It is claimed that he presented their work as a synthesis of Hegelian dialectics and the positivism of the emerging sciences, and scholars have debated whether or not Marx would have agreed with that view. Nevertheless during the Second International (1889–1916), it became an article of faith that there was full agreement between Marx and Engels (Colletti 1975b:13). During the late 1920s and 1930s, there were efforts to make their works accessible to German scholars, and these editions combined their work and minimised perceived differences between their perspectives. After 1930, as Western Marxism became more theoretical and philosophical and located within the universities – and when Marx and Engels' early works finally began to become more readily available – there were efforts to remove Engels' alleged synthesising of their perspectives and re-insert Hegel's influence into – what were now seen as – Marx's texts. Later efforts, for example by Louis Althusser [1918–1990], offered structuralist interpretations of Marx's work devoid of Hegelian idealism. For Althusser, this scientific, structuralist interpretation was to be found in the 'mature Marx', where Marx sought to identify the deep and hidden structures which govern social life (Hughes et al. 1995:65). In the same years after World War Two, a somewhat contradictory, 'humanist' Marx also appeared (Carver 2001:9284), much of this claiming to be the 'real' Marx. In contrast, many have blamed Engels for the determinist view of history and the 'vulgar Marxism' of the nineteenth century and its take-up by the Communist Party of the Soviet Union in the twentieth century (Hughes et al. 1995:41).

Reflecting on this social history, it becomes apparent that assessments of Engels' contribution to the partnership have often been conflated with ideological positions taken with regard to scholarly debates over positivism, structuralism, agency and the role of ideas in human history. Significant also have been the changing social contexts filled with both pro- and anti-communist fervour, where the close association between Engels and Marxism made him an heroic figure in the socialist countries but far less acceptable to the scholars (and authorities) of the capitalist West. Marx, on the other hand, was portrayed within the Western canon as a social theorist and philosopher, and with his philosophical texts 'sanitised' of Marxism, they were more readily admired and accepted by Western scholars.

This social history renders it difficult to fairly assess Engels' contribution to the partnership, but there is evidence that he has been unfairly treated by Western scholars. Though it was the case that Engels spoke publically and often about the virtues of his friend, edited the manuscripts and wrote Marx's biographies; it is also the case that many of the works bearing Marx's name were co-authored, and many of Marx's rough manuscripts were almost completely rewritten and reorganised by Engels (including volumes two and three of capital, with volume one heavily edited by Engels) (Seed 2010:8–9). Engels was well published and the more famous of the pair prior to their partnership (Carver 2001:9282), and from 1844 organised new editions of their works (including the *Communist Manifesto),* and revised many others, writing prefaces and editorial notes. He also wrote many of his own works on Marxism after Marx's death, popularising their ideas, reaching a wider audience than had Marx, and within these provided the philosophical underpinning for their concept of historical materialism (Colletti 1975a:9–10). Additionally, Engels brought something to the partnership that Marx did not have. While Marx referred to himself as a historian, speaking of how it 'is the task of history . . . to establish the truth of this world' (Mazlish 1990:731), for Marx, to be an historian meant, in the Germany tradition, to offer the *logic* of history. Through collaboration with Engels, who undertook the fieldwork into the living conditions of the industrial workers and thus provided the empirical materials for their analysis of class and capitalism, the pair were able to shift from an abstract knowledge to empirical, historical, fact (Mazlish 1990:738). And perhaps most importantly, Engels conceived and contributed many of their key ideas, some prior to their partnership, as evidenced in his 1844 'Critique' of English political economy, which had a great influence on Marx (Carver 2001:9282); plus his early analysis of the evolution of industrial capitalism, his conceptions of the periodic cycles of crisis and prosperity of capitalism, the importance of a reserve of workers to capitalism, and of the birth of an *international* working class, all found in *The Condition of the Working Class of England* (Engels [1845] 1969). Whole volumes could be written on this issue, but in consideration of this evidence, the decision has been taken in this chapter to regard their works as very much a joint project.

Theories, approaches and concepts

The works of Marx and Engels have been constantly revisited – particularly since the 1960s – with new questions being asked about how they should be interpreted and their contemporary relevance to sociology. In this part of the chapter readers will find an examination of their approach to the scientific inquiry of the nature of society, which came to be known as historical materialism, and two of their theoretical concepts, capitalism and commodification. In the process it will become evident that the materialist approach to inquiry is an essential part of the thesis that the economy of any society is an historical product, and, as such, is *socially* organised and structured. From our twenty-first-century perspective, these ideas hardly seem subversive, but in the nineteenth century, the very idea of inquiring into and making a 'science of society' was disturbing to the monarchy and the elite, for whom religion provided a sufficiency of answers and did not stir up questions about social class or political power (Carver 2001:9281).

A materialist approach to history

Engels and Marx built the intellectual scaffolding for the construction of their theories of historical development, class and capitalism through their critiques of Bauer, Feuerbach, Stirner and others. The pair were very much adverse to prevailing understandings of history. They wrote, 'civil society is the true focus and theatre of all history, and how absurd is the conception of history held hitherto, which neglects the real relations and confines itself to spectacular historical events' (Marx and Engels 1970:57–8). Their offering of a materialist approach to history was very much an alternative to Hegelian philosophy, with its overtly religious mission to 'restore to the uprooted individuals of revolutionary Europe a sense of wholeness and unity with history and the existing world' (Mah 1986:499).

Marx and Engels took issue with Hegel's view of historical change, for the latter conceived collective consciousness as the driver of change, where human agents, aware of themselves as human agents, make choices about the kind of agents they are, and, given a set of options brought about by the social conditions of that historical period, bring about new forms of human community (Pinkard 2001:6633). Thus Hegel interpreted the historical process to be about the development of the human mind, with the whole of human history merely a series of progressive stages with humans increasing their collective, rational, understandings of the world (Hughes et al. 1995:25).

As early as 1844, Marx began to offer an alternative to Hegel's idealist vision of the world, and argue that reality and human misery spring from economic life. Engels also thought along these lines. He wrote:

> ...while I was in Manchester it was tangibly brought home to me that economic facts, which have so far played no role or only a contemptible one in the writing of history, are, in the modern world at least, a decisive historical fact (in Hughes et al. 1995:40).

Together the pair developed a *materialist conception of history* (a term coined by Engels and later known as historical materialism, see Carver 2001:9283), which rejects the notion of historical change as driven by the ideas, plans and choices of humans, and instead begins with the material circumstances of the people, with the way humans transform their environment as they produce what they need for their own sustenance, protection and well-being, and how these activities and circumstances subsequently lead to the production of ideas, culture and political institutions. As they state, 'men, developing their material production and their material intercourse, alter, along with this their actual world, also their thinking and the products of their thinking. It is not consciousness that determines life, but life that determines consciousness' (Marx and Engels 1970:42; also 1976:37). In this, historical materialism inverts the prevailing orthodoxies of the German intellectuals of the 1830s and 40s, and as such, 'turns Hegel on his head'. Frederich Engels (1970:162), in his *Speech at the Graveside of Karl Marx*, wrote:

> Just as Darwin discovered the law of development of organic nature, so Marx discovered the law of development of human history ... that mankind must first of all eat, drink, have shelter and clothing, before it can pursue politics, science, art, religion, etc.

Historical materialism eventually developed into an imperative in their writings, becoming a characteristic feature of Marxian analysis, that is, a focus on the way members of a society have historically come to produce, and socially organise, the products they require for their subsistence. It also became recognised as offering a grand theory of society, explaining patterns of social organisation, the formation of institutions and even the consciousness of the people as a consequence of material productive forces. Of course, Marx and Engels did not entirely leave Hegelian philosophy behind. They too saw history as progressive, positing an eventual society where people would be free from exploitation and alienation. This ideal world, however, would come about through revolutionary changes in the material conditions of life, not the increasing rationality of humankind.

Capitalism

The dominant economic theories during Marx and Engels' lives were those of English political economists Adam Smith [1723–1790] and David Ricardo [1772–1823]. These theorists challenged the protectionist and regulation-centred view of mercantilism, proffering the more radical idea that unrestrained competition (the 'invisible hand' of the market) would bring wealth to societies, and moreover, as long as the market was unfettered by state interference, the pursuit of individual self-interest would engender social harmony (Hughes et al. 1995:35). Engels and Marx adopted some of their ideas but strongly rejected others, in particular criticising the political economists for failing to see the historic nature of the economic system. Instead Marx and Engels argued that private property is an historical artefact, unique to only some societies, and held in place only through state protection (Hughes et al. 1995:36). (Engels regarded the system of private property as one of 'licensed fraud' ([1844] 1959:166).) Marx and Engels also had a very different moral view of the economic system, for they regarded private property as responsible for the breakdown of genuine social relationships, and the making of profit from human labour as exploitation (see Engels [1844] 1959:161–8; Marx [1844] 1959). They insisted a social system should operate to satisfy human needs, not simply to produce profit.

For Marx and Engels, capitalist society is an historically unique, socially constructed, economic system which brings wealth to the elite members of society but increasingly impoverishes the working class (Marx and Engels [1848] 1960). Central to capitalist society – and unable to be divorced from its operation – is its division into two classes, the property owners and the propertyless workers. While other, more orthodox theories of the economic system may speak of capitalism as a system of industrial or financial capital, defined by profit seeking, competition and the accumulation of capital; only theories inspired by Marx and Engels will use the concept of capitalism in its fullest sense to connote a system of class-derived capital. Thus for Marx and Engels, capitalism is a system of conflicting social relations, and it is based on a fundamental social antagonism between the few who have capital, and the majority with only their labour power to sell. It is this relationship which gives rise to the capitalist form of social organisation, with its capitalist institutions, its capitalist division of labour and its specifically capitalist ideas and forms of consciousness.

Central to Marx and Engels' exposition of capitalism is the system's capacity to destroy previously existing modes of life and its unstoppable expansion:

> The bourgeoisie, wherever it has got the upper hand, has put an end to all feudal, patriarchal, idyllic relations. It has pitilessly torn asunder the motley feudal ties that bound man to his 'natural superiors', and has left remaining no other nexus between man and man than naked self-interest, than callous 'cash payment'.... The bourgeoisie cannot exist without constantly revolutionising the instruments of production, and thereby the relations of production, and with them the whole relations of society.... All fixed, fast-frozen relations, with their train of ancient and venerable prejudices and opinions, are swept away, all new-formed ones become antiquated before they can ossify. All that is solid melts into air, all that is holy is profaned, and man is at last compelled to face with sober senses his real conditions of life, and his relations with his kind (Marx and Engels [1848] 1960:223).

Thus capitalism replaces other forms of exchange, other forms of society – whether feudal, traditional or socialist – and the bourgeoisie continue to reach out nationally and internationally for markets for raw materials, for cheap labour and the investment of financial capital.

Yet one of the many paradoxes of capitalism is its dual nature. Rather than offer a fully determinist, and negative, view of capitalism, Marx and Engels theorised its processes as both destructive of traditional forms of social life and potentially creative of a new social order. Regarding human history as progressive and dialectical, as a series of contradictory 'stages' each overcoming the problems of the past, capitalism is portrayed as one phase of history, with more change to come. In *The Communist Manifesto* (Marx and Engels [1848] 1960), we are told capitalism contains within it the seeds of its own destruction, its own 'grave diggers'. While it is, fundamentally, a system of exploitation, its destruction of existing social relations and its capacity to generate wealth for a society on an unprecedented scale, simultaneously assists with the birth of new forms of resistance: '... with the development of industry, the proletariat not only increases in number; it becomes concentrated in greater masses, its strength grows, and it feels that strength more'. 'Modern industry' brings with it new forms of communication, new and faster forms of transport, ensuring the proletariat not only become conscious of their exploitation, but are able to bond together into collectives and organise resistance to the capitalist order. The escalation of political struggles under capitalism, and the growing propensity for fragmentation within the ruling classes, brings in its stead legislative reform for the improvement of social conditions. It is in the paradoxes of capitalism, so eloquently theorised by Marx and Engels, that we can come to understand the formation and growth of public health measures and national healthcare systems: a matter taken up in a later section of this chapter.

Commodities, production, consumption and alienation

The orthodox view of commodity production in the nineteenth century was much as it is today – that the market produces goods in response to human needs and demands. Engels and Marx took issue with this, insisting that under capitalism, commodities are produced in the interests of capital and not to the benefit of humankind. This argument rests on the pair's understanding of human nature and human needs. In the first place, they reject the representation of human nature or the human 'essence' as 'a fixed and immutable abstraction inhering in each single individual' (Colletti 1975a:43). Second, they discard the idea of society as a mirror of nature, and third, the proposition that human needs are merely 'natural, reasonable expressions of life' (Marx and Engels 1976:502,507; also Marx 1976:391). Instead, they insist, commodities are the products of human labour, and the process of satisfying human needs, and even the formation of human needs, are all *social, historical* processes. Thus they posit the individual as a 'social being' whose 'essence is the aggregate of social relations' (Colletti 1975b:430), and human needs, passions and desires as historically determined, changing over time as humans go about the process of producing the things they need for survival:

> ... the 'inward nature' of men, as well as their 'consciousness' of it, i.e., their 'reason', has at all times been an historical product (Marx and Engels 1970:507).

In Engels and Marx's theoretical framework, there is a dynamic, mutual shaping of material and social bodies. As humans go about the business of living under the unique, historical, social conditions of capitalism, the environment, human consciousness, the human body, human nature, and human needs themselves, are all transformed (Marx and Engels 1976:37,46,493,541,561). This means that under capitalism, humans come to have peculiarly *capitalist* forms of sociality, and *capitalist* forms of needs that go beyond the basic needs of 'food and drink, housing and clothing' (Marx and Engels 1976:44). Moreover, capitalism ensures a *capitalist* relationship of exploitation comes to exist between all people as they take their place in the labour market:

> The capitalist process of production, therefore, seen as a total, connected process, i.e., a process of reproduction, produces not only commodities, not only surplus value, but it also produces and reproduces the capital-relation itself; on the one hand the capitalist, on the other the wage-labourer (Marx 1976:724).

As a consequence, humans become compelled to become *consumers* of capitalist commodities and *producers* of these goods. These are associated with different social relationships under capitalism.

First, as *producers* of commodities for the capitalist market, humans are exploited as their own labour itself becomes a commodity to be bought and sold on the market. Workers are paid less than the value of their labour, a transaction made possible because under capitalism, labour can produce a value greater than it costs to reproduce and maintain it (that is, the cost of food and shelter for the labourer). In this process, the worker becomes 'alienated'. This notion is used by Marx and Engels to describe the way capitalism, as an historic form of production, strips humans of their humanity and potential for self-fulfilment. In dividing individuals from the object of their production, capitalism alienates their 'species being' – that which makes individuals distinctly human – and turns it 'into a means of his individual existence' (Marx [1844] 1975:329). Capitalism alters work from an harmonious relationship between the worker and nature – where the worker is able to fulfil their essential needs and their 'species being' – to an estranged relationship and a life of drudgery as the worker is separated from the objects of their production and from their fellow workers. Alienation therefore describes a process where our own labour, and its products, comes to be seen as something external and no longer part of ourselves.

Second, as *consumers*, humans are compelled to purchase capitalist commodities in a process that ensures their alienation. Capitalist commodities can be material products or products of the mind, and as Marx wrote in *Capital*, 'appear as autonomous figures endowed with a life of their own', with an 'enigmatic', 'mystical' quality (Marx 1976:163). This is because commodities are the products of human labour, yet they have a social character and an origin that remains obscure, because alienation 'transforms every product of labour into a social hieroglyphic. Later on men try to decipher the hieroglyphic, to get behind the secret of their own social product' (Marx 1976:165,167). Marx and Engels gave the church and the state as examples of such products (which not surprisingly led to the pair being considered radical, see Hughes et al. 1995:32), arguing that humans created the ideas of a god and a state, and now take them as 'givens', subjecting themselves to their authority. Other products also take this alienated form however, and consequently humans fail to question their need for them or their very presence on the market, and are unable to see it is the 'market' that determines what will be available and when. Instead, confronted with a plethora of 'choice', there is no suggestion of the toils of inequality through which they came to be produced, nor of the interests hidden behind these 'choices':

> Thus, in imagination, individuals seem freer under the dominance of the bourgeoisie than before, because their conditions of life seem accidental; in reality, of course, they are less free, because they are to a greater extent governed by material forces (Marx and Engels 1970:87).

In the place of 'choice' and 'freedom', the reality is that consumers are compelled to consume more and more products. 'Needs', which were not present in human society prior to capitalism, become evident (in other words, are socially constructed) in the new context, and commodities to address these are created for the market. For Marx and Engels, there is no immediate end in sight as capitalism remorselessly expands:

> Under the system of private property [i.e., capitalism] . . . each person speculates on creating a *new* need in the other, with the aim of forcing him to make a new sacrifice, placing him in a new dependence and seducing him into a new kind of *enjoyment* and hence into economic ruin. Each attempts to establish over the other an alien power, in the hope of thereby achieving satisfaction of his own selfish needs. With the mass of objects grows the realm of alien powers to which man is subjected, and each new product is a new *potentiality* of mutual fraud and mutual pillage. Man becomes ever poorer as a man, and needs ever more *money* if he is to achieve mastery over the hostile being . . . the expansion of production and needs becomes the inventive and ever *calculating* slave of inhuman, refined, unnatural and *imaginary* appetites – for private property does not know how to transform crude need into human need (Marx 1976:358–9).

Marx and Engels on illness and disease

Marx and Engels had quite a bit to say about illness and disease. This is unsurprising, given the dreadful living conditions of the working class at that time, but may also have been a consequence of Marx's own suffering, for he had various chronic conditions that were, according to Nelson (1999a), lifelong and exacerbated by a lack of exercise, poor diet and too many cigars. Mahon says he 'chronicled the healing practices of many members of the medical profession, and of the German spas, as he wandered Europe and North Africa pursued by death' (Mahon 1990:749). Marx also wrote about suicide and its relationship to class (see Mahon 1990), and Engels, though a much healthier individual, produced a complete volume on the subject of the ill-health, suffering and poverty of the British working class ([1845] 1969). In their various writings, they challenged prevailing perspectives on ill-health, poverty and disease, and produced one of the earliest, identifiably sociological theories of health and medicine.

As with their other social theories, this one grew from critiques of the works of others. For a start, there were many medical theories of disease in use during the mid-nineteenth century, with no particular theory dominant. It was a period well-prior to the establishment of the biomedical orthodoxies of the twentieth century, where successful claims for disease as a physiological-biological phenomena were in place by the 1930s in many Western countries. Popular theories of the nineteenth century included not only galenism and astronomy, but also miasma, 'filth' and contagionism (though it is important to note that such names are modern constructions of historians of medicine, and were unknown at the time). Such theories stand in stark opposition to Engels and Marx's philosophical orientation towards the world, for, as already noted, they saw neither nature nor human nature as fixed or unchanging qualities of life, and perceived the human body to be other than a merely 'natural' body which passively responds to a fixed physical environment (Marx and Engels [1844–1846] 1976:502). Marx and Engels acknowledged the 'stagnant pools' and 'putrefying vegetable and animal substances' that 'give off gases decidedly injurious to health . . . and poison the atmosphere' of the working people's quarters in the big cities (Engels [1845] 1969). Yet the lack of drainage, garbage collection and poor design of the houses, while associated with disease and ill-health, were not, for Marx and Engels, the ultimate or fundamental cause of disease. Nor do they entirely blame the lack of medical care, or the widespread use of poisonous and toxic medicines – though these all contribute to the poor health of the working class (Engels [1845] 1969:134–5). Like their contemporary Florence Nightingale (1860; also Rosenberg 1992:95,102), Marx and Engels challenged theories that were individualistic and reductionist, seeing these as obscuring the true nature of the problem and justifying a lack of political action to prevent disease. Instead Marx and Engels argued that ill-health and disease are a product of the way humans organise and act on their social world as they go about working and living in a particular kind of society.

Marx and Engels also responded to contemporary debates about the connections between disease and poverty. During the eighteenth century, the notion of *poverty* as the cause of illness and disease was widespread (Lawrence 1994:46), and the theory continued to be propounded in the nineteenth century by social reformers such as William Farr (Hamlin 1998:144). The more prevalent view at the time, particularly among the elites, was that poverty was the product of the weaknesses and inabilities of the poor themselves. Marx and Engels took particular issue with this liberal view of disease (Marx and Engels [1844–1846] 1976:490) and challenged those who closed their eyes to the consumptives, the overworked and the starving (Marx and Engels 1976:47). They also took on Malthus as a representative of the bourgeoisie for his ‘open declaration of war on the proletariat’, for Malthus voiced the ideology of Social Darwinism, proposing that the poverty and starvation of the working class are an inevitable consequence of the laws of nature (Engels [1845] 1969:309). In contradistinction to liberalism, Marx and Engels proposed the association between poverty and disease to be a social, not individual, phenomena. The utter poverty and diseases of the working class, Engels termed ‘social murder’ ([1845] 1969:59), for not everyone lived in these same conditions. Some people – the poor – suffered from ill-health and disease more than did other groups. In 1844, he placed the blame for this misery at the feet of the bourgeoisie (Engels [1845] 1969:139–40). Thus Marx and Engels were arguing for a new theory of disease which was radically different from those popular at the time: liberal theories, where disease results from the ‘inherently weak’ bodies of the poor; medical theories, where disease stems from a fixed, natural entity or pathogen; and the evolutionary theories of Social Darwinism, where disease is natural and inevitable, eventually eliminating the weaker races and ‘improving’ the human species. Over the next two decades, Marx and Engels developed the theory of capitalism – a socio-economic system with a particular form of property rights, class relations and political representation – as the causal force which produces the moral and physical degradation of the working class. In such a society, the *very bodies* of the workers become the property of the bourgeoisie (Marx 1964:114).

Health and the healthcare system

Engels and Marx’s writings have inspired several generations of medical sociologists, who have not only greatly extended the original analysis to show capitalism as a social formation with a particular form of production that continues to cause unequal health outcomes across populations (Chossudovsky 1983; Nguyen and Peschard 2003), but also produces historically unique types of healthcare systems, new commodities, new means to manage, control and alter our minds and bodies, and new relationships between ourselves and nature. In this section we look at the relevance of Marx and Engels' main concepts – historical materialism, alienation and commodification – to the analysis of health and healthcare systems.

Historical materialism, capitalism and the healthcare industry

Marx and Engels' commitment to historical materialism provides us with a crucial means to understand health, healthcare and healthcare systems in the contemporary context. Unlike other methods of analysis, this insists on recognising the historical nature of current systems of healthcare, the way these have been produced through struggle and conflict, and how they continue to change with such developments as new production methods or forms of exchange, new technologies, the opening or closing of markets and shifts in world trading patterns. While other medical sociologists take the clinic and the patient–doctor relationship to be the central concern of modern healthcare, Marxian inspired sociologists focus on the production of 'health' through the formation of a capitalist, healthcare *industry*. They seek to demonstrate the healthcare system as a site for commercial transactions – a marketplace – and a site for the production and consumption of capitalist commodities. Thus the boundaries of healthcare are extended well beyond the clinic, for the healthcare system is composed not just of hospitals and medical centres, but research and diagnostic laboratories, pharmaceutical firms, medical equipment manufacturers, health insurance companies and so on. The healthcare *systems* of capitalism therefore have many working parts, entwined by the relations of capitalist production and exchange.

The growth of Marxian analysis in the sociology of health and medicine in the 1960s and 1970s challenged prevailing functionalist analyses (for example, Carr-Saunders and Wilson 1933; Parsons 1951), debating the basis of power of the medical profession and its changing relationship with other occupations and the nation-state (see, for example, debates over professionalisation and proletarianisation, Haug 1988; Coburn 2006). Since the 1970s, one of the more prominent Marxian propositions has been the lack of independence of the medical profession from the class structure, and the way it operates in tandem with the dominant class to maintain the healthcare system and assist the capitalist economy (for example, Johnson 1972; Navarro 1976; Waitzkin 1983; Willis 1994). Within this framework, the professions are central to capitalism, exploiting ill-health, and assisting the nation-state through their surveillance of the population, maintaining social order and engaging in various forms of social control. In developing, applying and credentialing innovations in industry sectors such as pharmaceuticals, the professions also assist with the creation and pursuit of corporate profit, maintaining the hierarchical structure of society and the inequalities of health and perpetuating a form of health system that favours the elites. Moreover, under a capitalist system, it is the elites and the middle class which benefit most from health services: capitalists make profit on the stock exchange or in the ownership of businesses (including medical practices and hospitals), and managers, doctors, social workers, politicians and teachers make a good living from selling their 'expertise' as professionals. From this perspective, the central aim of capitalist medicine is profit, not the creation of good health (Mathews 1992). Where better health *is* the outcome, this is a mere coincidence of opposing interests.

Contemporary Marxian analysis has also focused on the buying and selling of healthcare services and organisations (including hospitals, clinics and diagnostic laboratories) in both national and international markets. These practices intensified from the 1980s, particularly in the United States, where the state has traditionally taken only a small role in the provision of services. One of the earliest to note this phenomenon was Relman (1980), who described the escalation of corporate medical power in terms of a 'medical industrial complex'. Inspired by Marxian theories of capitalism, other studies of the new industry in the United States rapidly followed (for example, Navarro 1986; Lindorff 1992; Hafferty and Light 1995; Light 2004). Researchers have continued to follow the growth of private, for-profit, corporate medicine, and the threat to public systems of care in countries as diverse as Italy (France and Taroni 2005), South Africa (van den Heever 2011), Australia (White and Collyer 1998; Collyer et al. 2014), Britain (Pollock et al. 2001) Malaysia (Phua and Barraclough 2011), and Chile (Waitzkin et al. 2007).

Marx and Engels were writing in the mid-nineteenth century, and since that time there have been very real gains to populations from widespread public health measures and the creation of national healthcare systems. Each such gain has been the outcome of intense and protracted political struggle. For instance, in the case of Victorian Britain, new sanitation measures and systems were produced amidst opposition from medical groups, local and national governments and economic elites (Hamlin 1998). Likewise, in the Australian case, the establishment of a universal health insurance scheme through the national taxation system in 1975 (initially Medibank, now known as Medicare) was bitterly opposed by the medical profession and other political and economic elites, and each change of government brings new threats to its continuation (de Voe and Short 2003). However, even as health outcomes generally improve across the populations with the expansion of capitalist healthcare, the rise of new market giants – many of them operating transnationally – are fundamentally altering the basis of these hard-won national healthcare systems. Recent studies have indicated the important role of governments and state-run healthcare systems in improving health outcomes and ameliorating the more negative effects of market-driven healthcare (Esping-Andersen 1990; Coburn 2004). Some of these come down to essential differences between the 'logics' of the modern state and the market. Where democratic governments have a duty to provide for the citizenry, corporations have legal obligations to their investors, and these take priority over their social obligations to patients or customers (Pollock et al. 2001). Hence the replacement of publicly provided or publicly financed services by others owned or run by private, for-profit corporations presents a serious challenge to the governance of the state in its efforts to produce healthcare services on the basis of equity of access, accountability, cost at the point of service and quality of service. Moreover, with several decades of data now available for analysis, scholars have been able to demonstrate the many problems wrought by private medicine, including escalating costs, a lack of accountability, over-servicing and poor health outcomes, in stark contrast to publicly funded and controlled systems which consistently show lower health costs, more accessible services and better health outcomes (for example, Shi 1994; Elola et al. 1995; Pollock et al. 2001; Giarelli 2004; France and Taroni 2005; Himmelstein and Woolhandler 2008).

Despite the problems of corporate medicine, it is currently the favoured approach to building or maintaining healthcare services in both developing and developed nations: in the former case, governments seek corporate investment to build healthcare systems where none currently exist, and in the latter, to reduce state responsibility for existing public services or improve cost efficiency (Collyer and White 2001:4; Nguyen and Peschard 2003:466; Collyer et al. 2014). The prevailing ideology of neo-liberalism – the 'ruling ideas' of the epoch (Marx and Engels 1976:67) – works in conjunction with the processes of alienation, helping to explain how it is that researchers find it difficult to counter assertions about the 'greater efficiencies' of the private sector, and convince others of the social and material consequences of corporate medicine. Instead of explaining the rising costs of healthcare in terms of changing demographics or higher patient demand for expensive technologies, Marxian analysis points to the inclusion of new items in the national healthcare budgets, that is, paying not just for services but also a substantial contribution to the cost of corporate profit.

Health and illness as commodities

Over the past four decades, medical sociologists inspired by Marxian analysis have been exploring the form of medicine developed under capitalism. The general consensus is that capitalist medicine is characterised by a focus on cure, rather than the prevention of disease, and it is 'objectified' medicine, that is, it focuses on specific parts of the body – an organ, limb, the lymph system – thus separating the 'social individual' from the physical body, often leading to complaints from patients about the loss of identity as they become 'the cancer' or 'heart attack', and obscuring the social determinants of ill-health. Moreover, with commodification, 'health' itself becomes a commodity to be bought and sold, relationships between professionals and patients are purchased on the market and new 'needs' are continually created in the pursuit for profit. Medicine under capitalism is characterised by the provision of 'technical' artefacts as solutions to the problems of ill-health, creating a highly profitable industry (Bates and Lapsley 1985), and consumers, unable to see the 'artificiality' of these needs, are pressured to purchase the commodities on offer. For some scholars, commodification is teamed with another concept, medicalisation, which describes the way new medical categories are increasingly constructed to account for, and offer solutions for human problems: problems that may have previously been considered under the cloak of religion, law, education or even magic. As such, medicalisation is about the increasing use of medical theories, concepts and frameworks to explain social phenomena, social differences and behaviours, or, as Filc (2004) suggests, it is about the de-socialisation of disease. As conceived by Conrad and Schneider (1981), and explored by Williams and Gabe (this volume, chapter 39); explanations for the drivers behind medicalisation are varied, and the concept is not necessarily reliant on a specific social theory or perspective. Thus Marxian accounts form a specific subgroup, combining medicalisation with concepts such as ideology, class, commodification and objectification, to demonstrate the inequalities and exploitation of healthcare in capitalist societies, as well as the capacity of medicine to harness these 'newly created problems' to build new markets and make profit from human suffering. Examples of medicalisation include childbirth (which has become, in the twentieth and twenty-first centuries, a medical 'problem' with a medical solution); the process of breastfeeding and the creation of a new category of professional – the lactation consultant – to teach women to feed their infants; and even new drugs for sexual impotence and the behavioural 'disorders' of children. The increasing replacement of previous approaches to problems by the consumption of new products or techniques, argues McKinlay (1977), is not necessarily because they are technically safer or more efficacious, but merely an outcome of the commodification process of capitalism.

In recent decades, the commodification process has been extended from the production of basic commodities, such as medicines and machines, to the commodification of body parts and even bodies themselves. In this process, people and bodies are transformed 'from a human category into objects of economic desire' (Scheper-Hughes 2001:293). Human organs, for example, form the basis of a worldwide trade in transplantable body parts, where commodification has created two classes of people: organ buyers and organ sellers (Scheper-Hughes 2001). Research has indicated that the trade in body parts, and also bodies themselves (where living persons are used in clinical trials or research experiments), follows class lines. It relies heavily on the use of poor and marginalised populations as subjects and donors, while the profits and the benefits of the trade are expatriated to wealthy countries and population groups (see, for example, Marshall and Daar 2000; Nguyen and Peschard 2003). In this process, the body is reduced to a 'source of raw material for saleable products' (Andrews and Nelkin 1998:53), and yet the cruelties and inequalities of organ exchange and the commodification process are obscured by a rhetoric of 'gift exchange' (Sharp 1994; Scheper-Hughes 2001:304).

Much of the analysis of the commodification of bodies comes from scholars using this concept in conjunction with feminist theories, even though neither Marx nor Engels was to offer a useful analysis of women's experience. An example of the impact of the commodification process on women's bodies can be found in Emily Martin's (1987) work, where reproduction and childbirth are objectified and de-humanised in the machine-like processes of the capitalist economy. Others decry the way women's bodies are utilised as 'laboratories' for medical science (Rowland 1992), or targetted by cosmetic surgery, an industry where patients are subjected to 'oppressive, idealised standards of beauty, where physical appearance drives definitions of self and social worth', and where its 'violence' is sexist, racist and ageist (Scheper-Hughes 2001:307–8). Also investigated are genital surgeries for transgender and intersex populations, wherein there is the promise of liberation but the result is a fetishising of gender dualism, so that the potential for multiple genders and sexual bodies is reduced to only male and female (Scheper-Hughes 2001:308). These surgical practices have come to involve multiple countries and an industry known as medical tourism (for example, Jeffreys 2009). Marxian analysis combined with feminism makes evident the fact that under capitalism, our bodies become a project that is to be shaped, transformed and produced – we are commodified – but also alienated. As wealthy individuals strive to attain the perfect body, they appear to have the freedom to choose but the likelihood of escaping the demands of capitalist society are small.

The commodification process has also come to encompass entire populations at the same time as it focuses on microscopic parts of human life – the DNA – and even the commodification of knowledge itself. Marxian analysis has focused on the utilisation of health and medical knowledge by powerful groups to their own advantage, and how this knowledge is commodified under capitalism, so that medical categories, such as 'diseases', do not appear to embody social relations, but are presented as if they were part of nature (Figlio 1978). Karl Figlio's (1978) case study of chlorosis – a disease of young girls in nineteenth-century Britain – demonstrates the capacity of medical knowledge to conceal the social relations which underpin and cause ill-health. In this case, the category of chlorosis redirects attention from the growing importance of adolescent labour in the capitalist labour market and the poor working conditions of the factory system, and posits blame on the 'inherently weak', individual, female, body.

Marxian analysis has also inspired scholars to theorise the knowledge 'industry' itself, as knowledge becomes, in this new historical period, more than a means to power and market advantage, but indeed the very 'source of profits in modern global markets' (Drahos and Braithwaite 2002:39,52). In this context, the market itself has been reconfigured as nation-states structure the market not only by enacting national legislation but also by entering into international trade agreements concerning intellectual property rights. And in regulating the system and protecting knowledge as 'private property', nation-states ensure that the larger share of the benefits ends up not with the inventors of knowledge, but among corporate players with the capacity to erect barriers around these knowledge products (for example, through licensing arrangements) and defend them in both the legal and political arenas. Hence it is the countries behind the development of the intellectual property systems that are the major beneficiaries, with developing countries being net importers of knowledge. Even Australia, with its developed country status and significant capacity for knowledge production, nevertheless pays out significant sums in licensing and patent fees (Drahos and Braithwaite 2002:11).

As transnational corporations increasingly claim ownership over the ever-expanding field of biological and medical knowledge, commodification intensifies, public health is compromised and health inequalities exacerbated (Negri and Hardt 2001; Nguyen and Peschard 2003:466). This becomes a significant problem for developing countries. For example, countries most in need of medications for diseases such as HIV/AIDS suffer from the high cost of drugs and also their under-supply, because worldwide intellectual property relationships work against their pharmaceutical sectors and prevent them from being part of the major political coalitions working in the trade (Shadlen 2007). Marxian analysis thus demonstrates the broad range of consequences of capitalist production for the health and well-being of all the world's populations.

Concluding thoughts

In the nineteenth century, Marx and Engels offered a critique of prevailing medical theories and liberal ideologies. Medical theories they found to be reductionist and essentialist, assuming disease to be a product of an 'abstract' nature; and liberal ideologies, which held the poor responsible for their own ill-health, were said to obscure the fundamentally social cause of disease. Marx and Engels answered with a theory of the dynamic and mutual shaping of material and social bodies in a world where nature is transformed by human production, as well as a theory of a causal relationship between capitalism, the living conditions of the proletariat, and the infirmities of the body.

Although health, healthcare and systems of healthcare have changed significantly since the nineteenth century, the theories of Engels and Marx are still relevant. Contemporary sociologists have extended these to show the historical nature of health and healthcare, and the unique form of medicine established under capitalism. While capitalism has produced wealth for the major economies, and made it possible for wealthy nation-states in the twentieth century to build public healthcare systems and fund internationally agencies (such as the World Health Organization) to improve the health of populations; the neo-liberal ideologies of capitalism have, since the 1980s, led to the widespread dismantling of these, instead supporting private healthcare systems that enhance capital accumulation and world trade and further embed the inequalities of the class system. While a state of health for some populations still refers to sufficient daily sustenance, shelter and protection from infectious disease; among the wealthy classes 'health' has come to mean an extended life span, and even the possibility of purchasing a new kind of human body, much 'improved' on the old model with replaceable parts and various designer features. This is a state of being unlike that of any previous epoch. As we have seen in this chapter, Marx and Engels have offered the methodology of historical materialism to effectively guide our analysis of the healthcare system. Their insights have been used by many scholars to move beyond the rhetoric and the ideologies of capitalism to acknowledge that healthcare has been different in the past and it is possible for it to be better in the future.

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Chapter 4

Florence Nightingale: A Research-Based Approach to Health, Healthcare and Hospital Safety

Lynn McDonald

Florence Nightingale (1820–1910) is known for her work in the Crimean War (1854–1856), the founding of professional nursing after it and her pioneering work in statistics, but less for her social research approach to health, healthcare and hospital safety, or her contribution to sociological theory more generally.

In this chapter, Nightingale's approach to research methodology will be set out, with examples of the research she produced. This made her an early contributor to what would become 'evidence-based healthcare'. Her holistic, environmental definition of health and priorities for healthcare will be explained. The chapter then proceeds to her systems approach to the reform of the whole Poor Law system, the 'social welfare' of that time, reforms only very partially achieved. While nursing is not the main subject here, it should be noted that her work in fostering its early development went on alongside her work on these other reforms.

When Nightingale began her work as a social and healthcare reformer on return from the Crimean War in August 1856, there was no publicly funded system of medical or hospital care. Hospitals were dangerous places, with death rates of 10 per cent of admissions, even in the top teaching hospitals of London. Her substantial achievements, which will be outlined in this chapter, should be seen in light of the difficult conditions of the period.

Biography

Florence Nightingale was born in Florence, hence her first name, of English parents on an extended wedding trip. She was raised in considerable luxury in two country homes, one in Derbyshire, base of the Nightingale fortune in lead mining and quarrying, and a larger home in Hampshire, with periodic stays in London. Her maternal grandfather, William Smith, was a radical MP and early abolitionist. The family was Unitarian primarily (three grandparents), but the one grandparent Nightingale knew was fiercely evangelical Church of

England. Unitarians were at the extreme end, doctrinally, from the Church of England, rejecting any notion of divinity in Christ; evangelicals not only considered Christ to be both human and divine, they called for personal commitment through conversion or being 'born again'. She respected Roman Catholicism for its according a serious role to women, as nuns, but remained in the Church of England, although always at odds with its theological and political conservatism.

Nightingale experienced a 'call to service' at age 16, which she understood to be from God, and which she interpreted to mean to serve, later to 'save', especially the sick poor. However, her family did not permit her to nurse, then a lowly and disreputable occupation, when 'ladies', such as she was, did not work outside the home at all. She was educated at home by her classically trained father and benefited greatly, between the ages of 16 and 18, from a lengthy family tour of Europe during 1836–1838. She travelled with family friends up and down the Nile and across Europe during the course of 1849–1850. She was in Paris and Rome for the great political upheavals of 1838 and 1848. At age 33, finally, she was permitted to take a position as lady superintendent, albeit unpaid, at the genteel 'Establishment for Gentlewomen during Illness' in Harley Street, London. A year and a half later, in October 1854, she left it for the Crimean War, to lead the first team of women the British Army ever sent to nurse in war.

The Crimean War was fought by France, Britain and Turkey (the Ottoman Empire) against tsarist Russia, then a rising power as the Ottoman Empire was in decline. Russia had encroached south of the Danube, into the Ottoman Empire. It retreated, but the 'Allies' made the fall of Sebastopol, Russia's port on the Black Sea, their goal, and invaded in September 1854. It was a brutal war with a high death rate, running, for the British, at around 22 per cent.

The high reputation Nightingale gained from the Crimean War enabled her to pursue her calling post-war. She returned as a heroine, was invited to Balmoral Castle to meet the Queen and the Secretary for War and undertook to write an analysis of what went wrong in the war – notably the causes of the high hospital death rates. This turned into an 853-page treatise, *Notes on Matters Affecting the Health, Efficiency and Hospital Administration of the British Army* (Nightingale 1858, excerpts in McDonald 2010a). On this she worked closely with Britain's most outstanding medical statistician, Dr William Farr, Superintendent of Statistics at the General Register Office, who nominated her to the Royal Statistical Society – she became its first woman Fellow in 1858. Nightingale was also made an honorary member of the American Statistical Association.

Hospital safety was a concern from the time of the high death rates of the Crimean War to the end of her life. It is noteworthy that she published papers on hospitals as early as 1858, or two years before her famous *Notes on*

Nursing: What It Is and What It Is Not (Nightingale 1860; the second edition is in McDonald 2009; a cheaper edition, with simpler language, *Notes on Nursing for the Labouring Classes*, 1861, is in McDonald 2004). Nightingale expanded her 1858 papers on hospitals into a full-length book, *Notes on Hospitals*, in 1863.

In 1860, the Nightingale School of Nursing opened in St Thomas' Hospital, London, the first secular nurse training school in the world, paid for with the funds raised in her honour during the war. It also paid for a midwifery-nurse school, an experiment that was not successful. Its problems led to her producing another pioneering study, now on maternal mortality post-childbirth (Nightingale 1871, in McDonald 2005).

The Nightingale School sent out teams of trained nurses to bring in the new professional standards elsewhere in Britain, Australia and Canada. Nursing leaders from Europe and the United State came to it for advanced training and mentoring by Nightingale. She did not take on any actual nursing position after the war, but made her influence through her writing, and as the director of the Nightingale Fund.

Nightingale, soon after the Crimean War, turned her attention to India, although she never visited it, to give some 40 years of her working life to healthcare there. This took her into issues of famine prevention and relief, scientific agriculture, credit and land tenure (Nightingale 1864, in Vallée 2006:183–94; Nightingale 1873, in Vallée 2006:710–45; Nightingale 1889, in Vallée 2007:353–7), medical care for women, and opposition to child marriage and the harsh treatment of widows. Late in life she produced papers and pamphlets on rural health, or health promotion at home for rural dwellers, both for use in Britain and India.

Nightingale's substantial writings, both published and unpublished, are now available in a 16-volume *Collected Works of Florence Nightingale* (McDonald 2001–2012; a short book with highlights from it is McDonald 2010b). She is still esteemed for her statistical work (Cohen 1984; Stone 1997), and hospital architects (for example, Taylor 1991; Verderber 2010), less so by nurses, at least in western countries. Nightingale is both read and respected in Japan and India. Many in her home country even attack her (see Nightingale website). Victorian heroines are not in fashion and what she actually did as a major healthcare reformer, systems analyst, and political activist is scarcely known.

Of the many biographies of Nightingale, the best remains the two-volume official biography (Cook 1913). There is an excellent overview of her life up to the end of the Crimean War (O'Malley 1931), and a still useful bibliographic source (Bishop and Goldie 1962). The best of the new biographies report on research not in those earlier works, however, with the irritating practice of referring to Nightingale and other women, but not men, by their first names (Bostridge 2008). There are good, short, collections of her letters (Goldie 1987; Vicinus and Nergaard 1990).

Nightingale always had her detractors, the most famous of whom was critic Lytton Strachey, for his whimsical essay in *Eminent Victorians* (Strachey [1918] 1967). The first academic attack on Nightingale's reputation was by an Australian medical historian (Smith 1982). This was followed by a convoluted attack blaming her for the high death rates of the Crimean War, with the express assertion that her hospital had the highest death rates (Small 1998). Smith's and Small's claims have been addressed in detail, with references to primary sources and comprehensive statistics, and are not repeated here (McDonald 2000, 2010c, 2014; within the *Collected Works*, McDonald 2001:843–7, 2005:1039–53, 2009b:9–11, 2010a:32–40).

Nightingale's methodology

Social science research in Nightingale's day was at an elementary level. The need for empirical data to substantiate or refute a theory was widely recognised, from the emergence of British empiricism in the seventeenth century and its wide acceptance in the eighteenth-century Enlightenment (McDonald 1993). The Census was well established, and central governments collected birth, death and marriage statistics, with varying amounts of other institutional data, such as hospital mortality. Britain was as advanced as any in her day, although the French pioneered medical and criminological statistics (Guerry 1833; Scrive 1857). British researchers conducted large surveys on poverty (Mayhew 1851–1852). These studies gave tables with data, sometimes with charts, although with no tests for statistical significance. Pearson's correlation coefficient was still decades away. The quantitative analysis of mortality and morbidity was a work in progress.

John Stuart Mill's *A System of Logic* (Mill 1843) gave Nightingale her philosophical grounding, and L.A.J. Quetelet's (1869) *Physique Sociale* her research methodology. She annotated the latter work extensively, and wrote a tribute to Quetelet following his death (McDonald 2003:40–64). Underlying both of these sources was her Christian faith, for God made the world and runs it by laws, which can be ascertained by careful empirical research, preferably quantitative. With the knowledge of these laws people can intervene to effect change for the better, to improve health and lower mortality rates by changing what would now be called the 'social determinants of health'. In practice, this meant clean air and water, safe childbirth, schooling, decent housing and workplace safety.

Nightingale's annotations on her copy of *Physique Sociale* show how much she absorbed of his views. For example:

- Consecrated blunders in medicine prove the need of statistics. Statistics must be made otherwise than to prove a pre-conceived idea (in McDonald 2003:30).

- She queried 'what would become of the patient' if left alone? 'Medical statistics: perhaps a sick man [is] best left to nature. Different treatments [have but a] small influence on the death rate' (30). Another annotation is suggestive: 'To judge of therapeutics, one must find out what would become of the disease left to nature' (in McDonald 2003:21).
- Applying the same principle to hospitals, she observed that their death rates depended on the way they are kept more than on the treatment employed. Administration saves more hospital patients than the best medical science (in McDonald 2003:31).

While Nightingale never published any list of instructions on research methods, her own practice is obvious, and still useful as a guide to beginning researchers. Note the respect accorded to official sources, paired with the need to flesh them out by interviewing or de-briefing officials. Her own reports on India were written entirely in London, but were so realistic that many people thought that she had visited it. Nightingale's statistical mentor was William Farr, with whom she produced polar area charts on preventable mortality in the Crimean War, and which would become iconic. She followed the advice of Pastor Theodor Fliedner of the Kaiserswerth Deaconess Institution always to add personal stories. This can also be seen as care to use both quantitative and qualitative data appropriately:

1. Get the best information already available, particularly official statistics and reports.
2. Interview experts as well, for greater context.
3. If the available information is inadequate, collect your own.
4. Draw up a questionnaire, in consultation with those who use the information concerned.
5. Test the questionnaire on a limited basis.
6. After revision, send it out generally.
7. Use tables to report basic findings in detail.
8. Use charts to convey key results vividly.
9. Use examples, especially personal stories, to illustrate major findings.
10. Provide recommendations for change based on the conclusions.
11. Before publication, send out the report to experts for criticism (informal peer review), and revise accordingly.

While Nightingale's purpose in conducting research was always practical – to solve a problem or to improve a system – she was painfully aware that any new measures put in place might not be better than what it replaced, or better than doing nothing at all. She learned much about unintended consequences from her Crimean research, and it was reinforced by Quetelet's examples in

Physique Sociale. With this cautious view, she recommended on-going monitoring for any new programme on whatever subject, be it healthcare, education, or hospitals.

The British government collected data in large quantities in her day. It was early to collect birth, marriage and death statistics and had a highly regarded census. Nightingale's concern was that the data collected were so underused. Cabinet ministers and senior civil servants could be using the 'enormous amount of statistics at this moment available at their disposal'. But, although most were university educated, they did not benefit from the available data, which accordingly were 'almost absolutely useless'. They had received no education whatever on the point upon which all legislation and all administration must, to be progressive . . . ultimately be based. 'We do not want a neat arithmetical law; we want to know *what we are doing* in things which must be tested by results' (Nightingale letter 1891, in McDonald 2003:110).

Nightingale sought to get a chair or readership established at the university that educated the most policy-makers in the United Kingdom, Oxford, to teach Quetelet's 'social physics' (McDonald 2003:105–28). She did not succeed, a matter lamented by the great statistician Karl Pearson (1924:424).

Getting the research done and out was only the first stage of any operation for Nightingale. Reports were not 'self-executive', so that recommendations had to be spelled out carefully, and a media campaign launched to gain support for them. On really difficult matters, like health in India, this meant concerted work over many decades. In some cases she got nowhere in seeing recommendations acted on, notably her study of mortality and morbidity in colonial aboriginal schools and hospitals (McDonald 2004:163–83). She managed to get the Colonial Office to send out her questionnaires – the colonial secretary, the duke of Newcastle, was an old Crimea hand. However, the data returned, from numerous colonies around the world, were shoddy. She made the best of them, to conclude that mortality rates were roughly twice as high as they were for English children of the same ages (McDonald 2004:170). Moreover, most of the mortality was the direct result of preventable diseases. She thought that the Colonial office should follow up her work with routine monitoring. However, it did nothing and Nightingale abandoned the subject. She was making headway with India, she believed – Britain's largest colony – and she put her time and energy into making reforms there.

Nightingale on health and healthcare

When Nightingale set to work, roughly at the middle of the nineteenth century, medical science was still very rudimentary. Anaesthetics were new and experimental (Nightingale promoted their use; the principal medical officer in the Crimea opposed). Antiseptic surgery was still another decade off (Joseph

Lister published his successful experience with it in 1867). Much progress had been made in the eighteenth and early nineteenth centuries in physiology and anatomy, but there were few drugs that worked and few cures. Blood letting, blistering and violent purging from the bowel were frequently used (Nightingale herself was bled for an ailment when young). Frustrated by the inability to halt the great fevers that killed so many, doctors experimented with what were lethal substances. Metals, even lead and mercury, were commonly employed in what came to be termed 'heroic medicine' (Singh and Ernst 2008). British, French and American medicine were similar in these respects, as can be seen by examining their medical journals, medical textbooks, and books on 'materia medica'.

Nightingale was aware that medicine as practised by the best qualified doctors could do little. No doubt that is what prompted her to assert that medicine was not the 'curative process', nor was surgery: 'Neither can do anything but remove obstructions; neither can cure; nature alone cures. Surgery removes the bullet out of the limb, which is an obstruction to cure, but nature heals the wound' (Nightingale 1860, in McDonald 2009b:683). She would thus favour doctors who were cautious in their choice of treatment.

Nightingale's definition of health in her entry on nurse training in Quain's *Dictionary of Medicine* was short: 'Health is not only to be well, but to be able to use well every power we have' (Nightingale 1894, in McDonald 2009b:735–6). This positive definition would become widely accepted, although nursing professors would later produce longer definitions, but not necessarily better ones. The World Health Organization's definition of 1948 is similar to hers: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.

Disease was a reparative process, an effort of Nature to remedy a process of poisoning or decay. Pain and suffering were symptoms, not of disease, but of lack of fresh air, light, warmth, quiet, cleanliness, punctuality, or diet, hindering Nature's reparative process. She went on: 'It is often thought that medicine is the curative process. It is no such thing'. Nor was surgery. Both removed obstructions. The role of the nurse, 'in either case, is to put the patient in the best condition for nature to act upon him' (in McDonald 2009a:683).

One could still accept Nightingale's view of the nurse's role being 'to put the patient in the best condition' for healing, but her belief that neither medicine nor surgery cures is out-dated. Both professions have changed radically since, although iatrogenic and nosocomial disease remain and new pathogens evolved. Given the paucity of effective treatments, and the high death rate from surgery (from disease, after a successful operation), her statement – for her time – was fair.

Her 'environmental' understanding of causes can also be seen in the importance she saw in collecting data on what would now be termed the 'social determinants of health'. Housing was key, and Nightingale argued for the addition of a question on it in the decennial census for 1861 (McDonald 2003:95–103). ‘The connection between the health and the dwellings of the population is one of the most important that exists’ (McDonald 2003:98) she wrote. Whether people lived in hovels, stables, cottages, flats, cellars, or mansions was the ‘very foundation question of social statistics’ and might be ‘solved by the census’ (McDonald 2003:99). The year before, in a letter to the International Statistical Congress, held in London, chaired by Quetelet, she noted that statistics ‘demonstrated’ the decline in mortality by improved dwellings, citing a decrease from 24–25 per 1,000 to 14 (McDonald 2003:84). She was not successful in getting housing added to the census, although it is of course now a standard item wherever censuses are conducted.

Nightingale also argued for a regular question to be added to the census on health status, to enable on-going monitoring of the whole population. Mortality statistics were collected, she acknowledged, but indicators other than simply not dying were needed:

> We should have a return of the whole sick and diseases in the United Kingdom for one spring day, which would give a good average idea of the sanitary state of all classes of the population (letter to Farr, in McDonald 2003:96).

Nightingale’s approach to health and healthcare can be seen as conservative, even minimalist. The lowest level of intervention was always to be preferred. Her own experience of unsafe hospitals led her always to consider them as the last resort of healthcare. Herewith her scheme, never written up as such, but clear in her writing:

1. Promote health through clean air, water, decent housing and nutrition, safe childbirth, and schools for children (objectives far from reality for her time, Nightingale 1860, 1863; McDonald 2004).
2. When illness occurs, home visits by the doctor and nurse should be the first choice for intervention (Nightingale 1860, 1863).
3. Hospitals should be used only when absolutely required for medical or surgical treatment, especially for children (Nightingale 1863, 1893).
4. Every hospital should have a convalescent branch associated with it, preferably at the seaside (which had the best air), to move patients at the earliest possible time (in McDonald 2012:169–70).
5. Treatments, especially hospital stays, should be monitored for their effectiveness, using common definitions and careful methods of collection (in McDonald 2003:83–5).

By the time Nightingale published her final, expanded, edition of *Notes on Hospitals,* in 1863, she had had more than five years to review the progress made since her initial post-Crimea papers on hospitals, first given as conference papers in 1858 (Nightingale 1859, in McDonald 2012:43–72). She saw no reason to think that hospitals were getting much better, although she collaborated with leading architects and engineers who held the same principles. She accordingly added a preface, which opens with her famous call for a 'Hippocratic oath' for hospitals akin to that for doctors on qualification, 'to do the sick no harm':

> It may seem a strange principle to enunciate as the very first requirement in a hospital that it should do the sick no harm (Nightingale 1863, in McDonald 2012:82).

Nightingale had seen that careful attention to the 'laws of health' could result in striking improvements. Death rates in the British Army in the first winter of the Crimean War were an appalling 23 per cent of troops sent, compared with only 11 per cent for the French. Yet, in the second winter, the British death rate fell drastically to 2.5 per cent, thanks to the able work of the *Sanitary and Supply Commissions*, while the French rose to 20 per cent (Chenu 1870:131), although they experienced the same weather and camp conditions. The French sent no commissions and made no comparable changes to their camps and hospitals. By comparison, the death rate of the United States Army in the Vietnam War was 2.3 per cent.

How did these great declines in death rates occur? Both the *Sanitary and Supply Commissions* sent out by the British government to the war zone were headed by top experts, with well-formulated terms of reference. Their members worked prodigiously to apply the best knowledge available. Nightingale learned both principles and practical research methods in the process, to apply them for the rest of her working life. No wonder that she came to have great confidence in the possibility of reforms working, and to aim high.

In our time now, when deaths from hospital-acquired infections and prescription errors cause scandal, Nightingale's advice might seem more timely than ever. She learned caution both from Quetelet and her own experience of war nursing, and never let up on urging that high standards be set, and data collected to determine how well or badly they were being met. She not only was an early advocate of frequent hand washing, she became ever more specific as to the best disinfectants, at what concentrations, to use. It was not enough to post rules to prevent 'finger poisoning' or septicaemia, but that they be appropriate for those intended to use them – nurses and surgeons might need different directions (McDonald 2009a:344). Getting hospitals today to implement simple rules of cleanliness continues to be a challenge (Gawande 2004; Maxworthy 2008).

The reform of the workhouse infirmaries

Arguably Nightingale's greatest achievement was the introduction of quality nursing (as opposed to that by drunken 'pauper' nurses) in the workhouse infirmaries, the only recourse for the vast mass of the poor in the United Kingdom. The great civil hospitals were fee paying, albeit typically with 'charity' wards. For every patient in a regular civil hospital, there were five in the workhouse infirmaries (Abel-Smith 1964:46). These infirmaries had basic medical attendance, but no budget for drugs, and no trained nurses. Bed sharing was common. A number of philanthropists and matrons were making improvements in nursing in the regular hospitals, but none in the workhouse infirmaries. Nightingale made it her mission, and saw much progress made, although far short of the establishment of a comprehensive system of agencies for the aged, sick, infirm, and children she sought.

The first opportunity to introduce professional nursing care occurred thanks to the offer of funding by a Liverpool philanthropist, William Rathbone, who had already become a Nightingale ally on nurse training and visiting nurses. He funded the experiment, which began in 1865, and soon proved its worth. Nightingale next used media attention surrounding a scandalous case of a London workhouse death from lack of nursing to argue for a thorough enquiry – not into that case – but the care provided in workhouses generally (McDonald 2004:329–42). To change the system in London required an Act of Parliament, which was duly adopted in 1867. This, however, was only permissive legislation, enabling workhouses with enlightened governors and willing boards to make the improvements, without requiring them to do so. Subsequent reforms had to be made piecemeal, and many were. With the benefit of hindsight, one can see that these improvements were the first steps to a full public system.

Nightingale's vision of system reform went well beyond even that bold measure, to the virtual dismantlement of the punitive Poor Law system. At that time, nearly all recipients of public assistance had to enter the workhouse to receive support, 'indoor relief', as it was called. The conditions were intended to be harsh, to deter people from taking public assistance over a job – so that the worst job should be preferable to entering the workhouse. She not only understood that even the most willing workers lost their jobs in an economic downturn, but recommended that the state-provide work in such conditions. A note from 1868 queried if the state could not 'at least in exceptional times of distress . . . give productive work at remunerative prices' (McDonald 2003:403). This albeit brief intimation pre-dates by decades John Maynard Keynes's comprehensive work on 'counter-cyclical' spending and job creation in the Depression (Keynes 1936). Nightingale also recommended that the state assist unemployed workers to find new jobs. Labour exchanges and employment centres in time were established in many countries, and some would go much further in retraining workers for new work.

Nightingale thought that the problem was not so much that workers did not want to work, but that they did not know what to do when laid off. In a magazine article, 'A Note on Pauperism', she observed: 'Starvation does not teach geography' (Nightingale 1869, in McDonald 2003:137). She noted also that the Poor Law itself discouraged people from moving.

Nightingale recognised that the vast majority of inmates in workhouses had little choice. Old age, physical and mental disability, illness and industrial accidents, were not conditions amenable to deterrence. Her faith gave her sympathy with the sick poor – they were 'brothers and sisters in affliction'. Her understanding of 'God's laws', meaning the laws of natural and social science, gave her confidence to argue that such profound system changes were feasible, given adequate knowledge. To this end she set out the 'ABCs of workhouse reform' in a note in 1865:

> A. To insist on the great principle of separating the sick, insane, infirm, and children from the usual pauper population of the metropolis....
> B. To advocate a general metropolitan rate [tax] for this purpose and a central administration.
> C. To leave the pauper and casual population and the rating for [taxing] under the boards of guardians as at present.... Centralise all the sanitary powers at present exercised by the guardians ... provide a scheme of suburban hospitals and asylums:
>
> 1. For sick;
> 2. For infirm, aged and invalids;
> 3. For insane and imbeciles;
> 4. Industrial schools for children (Nightingale note in McDonald 2004: 337–8).

Nightingale also stated that she would rather do away with the word 'incurables' if she could, for 'good treatment and good nursing' were limiting that category year by year (McDonald 2004:365).

The principle of classification (A) allowed the crucial distinctions to be made to plan appropriate treatment for the vast majority of inmates, all but the wilfully unemployed. The 'central administration' (B) was essential for economies of scale. It also enabled cross-subsidies from the richer boroughs of London to the poorer. The requirement of Parliamentary oversight (C) was to enable a new regime to emerge, distinct from the old, parish-based workhouses with their stigma. In fact, as the system developed, old workhouse infirmaries were linked with previous regular hospitals, and new names assigned.

In an 1866 letter to Edwin Chadwick, who was identified with the harsh 'no outdoor relief' requirement of the Poor Law, Nightingale argued for an entirely different approach, along the lines of the ABCs of workhouse reform:

- Sickness, madness, imbecility, and permanent infirmity are general inflictions affecting the entire community (mainly, too, brought about by the wretched sanitary state of our streets) and are not, like pauperism, to be kept down. The sick or infirm or mad pauper ceases to be a pauper when so afflicted.
- Two distinct kinds of administration were thus needed: one for all the categories of sick and long-term disability, plus children, the other for regular 'paupers' (in McDonald 2004:347).

Note that Nightingale's ABC vision dates to the mid 1860s (there are several versions of it). It was not until the Minority Report of the Poor Law Commission of 1909 that the next significant step occurred towards the establishment of a comprehensive system.

Nightingale and classical social theory

Nightingale's working life overlapped that of Karl Marx and Friedrich Engels, in ways that make a comparison interesting. She never commented on any of their work, which did not become well known until quite late in her life. (Durkheim's and Weber's work was too late for her to have known.) When Engels published *The Condition of the Working Class in England* (1845), Nightingale was visiting workhouse infirmaries and formed the goal of changing them radically (in McDonald 2004:223–30). The same year that Marx published *A Contribution to a Critique of Political Economy* ([1859] 1904), Nightingale published *A Contribution to the Sanitary History of the British Army* (1859a), a short but powerful indictment of current policies, showing how they led to high hospital death rates. In 1867, Marx published the first volume (in German) of *Capital*, his major work (Marx 1977 [1867]). That same year the parliamentary committee studying workhouse infirmaries published its report, which included Nightingale's well-argued brief on establishing training and nurse organisation in workhouse infirmaries, a major reform (Nightingale 1867, in McDonald 2004:367–90).

Marx, Engels and Nightingale were all fierce critics of the poverty and inequality produced by the industrial capitalism of their day, and of the laissez-faire 'political economy school' that forbade intervention, on pain of doing greater harm. Marx and Engels, however, held that capitalism could not be reformed, but must be (and would be) overturned and replaced. Nightingale believed that fundamental reform was possible, although reformers should always start small to ensure their intended reforms worked. Marx's messianic classless society was fore-ordained, Nightingale's future open. Marx and Engels specified a dictatorship of the proletariat, as a necessary phase for the new society to emerge; Nightingale's vision included a place for all – no class was to be sacrificed and the contributions of all were needed - a constant theme of *Suggestions for Thought*.

Nightingale lines up with mainstream social scientists who believed in the possibility of applied work, based on comprehensive research and adequate theory. She herself saw profound changes accomplished in her lifetime. When Engels published his *Condition of the Working Class in England* in 1845, the rich were in fact getting richer and the poor poorer. However, the great gap began to diminish soon after that and continued to decline for a long time (it is now increasing again in many countries).

The gradual rise in life expectancy in the United Kingdom in the second half of the nineteenth century, which continued and increased in the twentieth century, shows how reforms in conditions could bring measurable results. Estimated life expectancy in the United Kingdom was 36 years in 1800, 40 years in 1850, 48 years in 1900 and 69 years in 1950. Data on mortality rates over the same period show declines, the top reasons for which were better nutrition and sanitary improvements, very much in line with Nightingale's views on sanitary reform (McKeown and Record 1962:97–8). Not only did income disparities decline, the better conditions the great mass of the people attained let them live longer.

An interesting point of convergence: both Marx and Nightingale had a high opinion of the empirical methodology of Quetelet, and both rejected Auguste Comte's grandiose 'positive philosophy', although not positivism as a methodology akin to empiricism. Nightingale, however, would differ both from Marx and Engels, as would other mainstream sociologists, on the role of human agency, and from the political economists, with their 'iron law of wages'. For Marx and Marxists, the new communist society would be brought about only when the contradictions between the means of production and the relations of production were right. The mainstream theorists argued for human agency: people could alter their institutions, even fundamentally. Nightingale not only accorded much greater scope to human agency than Marx and Engels, she also had a healthier respect for the ability of the biophysical world to influence the social. Here she departed also from most mainstream theorists who have paid less attention to those factors than we might want now, knowing the extent of environmental degradation already caused as well as the rising threat of global warming. With the benefit of hindsight, Nightingale's core principles and views look better and better.

Nightingale should be taught with other classical sociological and political theorists. Marx and Engels occupy the extreme left; Herbert Spencer, David

Ricardo and the 'political economy school' the extreme right; and Nightingale, with Quetelet and a large number of mainstream, liberal, reform-oriented sociologists, including Durkheim and Weber, occupy the mainstream middle. What most sociologists today actually do resembles much more her principles and methods than those on either side.

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Chapter 5

Émile Durkheim: Social Order and Public Health

Kevin Dew

In this chapter, concepts developed by Émile Durkheim will be used and applied to public health to explore the role of public health in contemporary society. The first section contains a brief biography of Durkheim, and in the second, relevant concepts will be explained, focusing on Durkheim's concerns for social solidarity; the importance of his particular ontological position grounded in the concept of *homo duplex*; and the moral forces of anomie, egoism, altruism and fatalism that he sees as underlying social order. His view that contemporary society suffers from an excess of *anomie* and *egoism*, and that social institutions need to develop to temper those forces, is discussed.

The third section of the chapter discusses how Durkheim applied his concepts to the study of social order in his famous book *Suicide*. Work that has drawn on this type of analysis is reviewed – in particular, work on the role of neighbourhoods in providing forms of integration and regulation that can protect people from anomic social forces.

The fourth section of the chapter will consider how public health can act as a social institution to temper anomic forces and foster social order. This will take an historical and cross-national perspective describing how the function of public health has varied over time. In the early period of modern public health, measures functioned to promote a stronger nation-state and enhance productivity. In the latter period, public health has also taken on a role in promoting social justice in the face of neo-liberal ideologies and the power of commercial companies marketing health-damaging products. The chapter concludes by discussing the utility and limitations of Durkheimian ideas in relation to the study of health.

Durkheim provided a range of concepts and approaches that have been influential on sociology generally. His methodological approach, seen clearly in his study *Suicide*, laid the foundations for the quantitative study of 'social facts'. As will be shown, his use of concepts like anomie, the division of labour and the cult of humanity can be picked up and usefully applied to a range of contemporary social issues.

Biography

Émile Durkheim was born in Épinal, France, in 1858 and died in 1917. His father, Moïse, was a Rabbi (Émile's Jewish forename was David) and his mother, Mélanie, was from a horse-trading family (Fournier 2013). Durkheim's home life was one of austerity, adhering to the rules and regulations of Jewish practice, and being part of an historically persecuted religious minority Durkheim noted the strong sense of solidarity within the Jewish community. Events during his formative years had a profound impact on Durkheim and his work. The surprising defeat of France in the Franco-Prussian war of 1870, when Durkheim was 12, led to a widespread desire for regeneration in France and, for Durkheim, an 'urgent need for a science of societies' so that the administration of the country could be 'truly grounded in the nature of things' (Durkheim [1900] 1973:164). Durkheim was also committed to the ideals of the Third Republic, which was established following the French surrender to the Prussians in 1871. The ideals of democracy, secularism and science can be seen as closely aligning with Durkheim's approach to his academic work (Fournier 2013). In addition, the Jewish community in France supported the French Republic as its liberal views were seen as important to its survival and development. An overarching concern with the means by which social order could be obtained in the face of upheaval, instability, external and internal threats is a driving force of Durkheim's approach to sociology.

Although Durkheim did not coin the term 'sociology' – that was an achievement of Auguste Comte – he is often referred to as 'the founder of sociology' and was the first professor of sociology. In a recent extensive biography of Durkheim, Fournier argued that Durkheim brought about a revolution within the human sciences and founded sociology as a science (Fournier 2013).

Relevant concepts

How to position Durkheim's work in relation to the intellectual currents of his time is debated. Durkheim developed his thinking through engagements with, and critiques of, a broad range of work including that of English and American anthropology, German experimentalism and empiricism, and French rationalist philosophy.

Durkheim was preoccupied with establishing sociology as a science and a distinct discipline that could be taken seriously and that had its own method. For Durkheim, the young discipline of sociology was threatened by dilettantes and charlatans who too readily resorted to imaginative speculation without a firm basis, and Durkheim positioned himself as a rational empiricist, engaging in logical argument based on evidence. For example, Durkheim's concern with social trends in suicide and the different rates of suicide by social group was to demonstrate the phenomenon of suicide as a social fact – a phenomenon that is different from individual motives. Social facts 'are ways of acting, thinking, and feeling . . . existing outside the individual consciousness' and are 'endowed with a coercive power' (Durkheim 1938:6). Social facts include customs, conventions, ways of existing, ways of being, and the currents of social life that are external to and constrain the individual. In his book *Suicide*, Durkheim argued that 'there can be no sociology unless societies exist, and that societies cannot exist if there are only individuals' (Durkheim [1897] 1952:38). In so doing, Durkheim followed the precepts of the French philosopher, Émile Boutroux, a mentor of Durkheim's, arguing that sociological analysis and explanations provided different insights to those of psychology. Boutroux contended that each science must have its own principles of explanation, so for the science of sociology the explanations must be based on social principles (Jones 1997). By drawing on statistics, comparisons over time and between groups could be made to demonstrate social currents, and to suggest explanations for the variable rates of suicide (in particular, see Fournier 2013:228–52). The empirical focus distinguished sociology from philosophy with its rationalist focus. In this, we can see the influence of the empiricist moments in the work of Montesquieu and German empiricism on Durkheim's work with its emphasis on induction and the concrete (Jones 1997).

Durkheim was influenced by the early ethnographic work of English and American anthropologists, in particular he cited the work of Robertson Smith who, through his studies of the religion of the Semites, concluded that religion was the basis of social order (Fournier 2013). This informed Durkheim's later work on religion, culminating in *The Elementary Forms of the Religious Life*, which is another expression of his demonstration of sociological explanations. Here religion, something regarded in his time as 'extra-sociological', is explored in relation to its social origins, social practices and social functions (Fournier 2013). A number of valuable concepts articulated by Durkheim in his study of religion can be drawn on to understand contemporary health issues, such as the place and role of public health (Dew 2012).

Durkheim has been described as a functionalist seeking to explain relationships between systems, but Taylor and Ashworth position him as a realist investigating the structures behind what is observable (Taylor and Ashworth 1987). The social facts that Durkheim was concerned with in such works as *The Division of Labour*, *Suicide* and *The Elementary Forms of Religious Life* were sources of moral authority in society. Durkheim's efforts to develop a scientific study of moral forces in society was influenced by the French rationalist philosopher Charles Renouvier who called for such a science (Fournier 2013). For Renouvier it is because we are social beings that we have moral sentiments; morals are not instinctual. Durkheim explored moral forces such as the division of labour and religious representations that can act as sources of social solidarity.

Durkheim used the concept of organic solidarity to describe an increasingly diverse contemporary society, which he contrasted with the more undifferentiated form of mechanical solidarity that applied to societies where people were more homogeneous. Durkheim's understanding of this social transition was shaped by the work of the German sociologist Ferdinand Tõnnies and his discussion of social life based on *gemeinschaft* and *gesellschaft,* and Herbert Spencer's evolutionism, which used the metaphor of society as an organism becoming more complex and heterogeneous with the intensification of the division of labour (Fournier 2013). Durkheim contrasted the kind of work and interactions that would occur in a society comprised of small villages, where mechanical solidarity prevailed, with the work and interactions that occur in larger urban and industrialised settings, where organic solidarity prevails. In these very different societies, different forms of social cohesion and integration would be evident. In supporting his argument, Durkheim drew on historical and contemporary descriptions of social formations including ancient Celtic and Roman society, Hebrew society and North American native societies.

Durkheim noted four moral forces in society: altruism (a commitment to a higher order outside of the self), egoism (individuality and free thinking), fatalism (inescapable limits to human action) and anomie (insatiable desiring). Modern society is characterised as one that has high levels of egoism and anomie (Taylor and Ashworth 1987). Excess egoism is associated with a lack of integration into society, and excess anomie is associated with a lack of regulation and restraint (Durkheim [1897] 1952). This description is applicable to any society where a complex and increasingly specialised division of labour develops. Jones noted the importance of the work of Jean-Jacques Rousseau on Durkheim's view of moral forces, in particular the view that unregulated desires cause anomic states (Jones 1997).

Durkheim viewed society as having an existence of its own that is not just the adding together of all the individuals in that society. Drawing on the work of Rousseau, as articulated in *Social Contract*, Durkheim explained human nature with the concept of *homo duplex*. He deployed this concept to illustrate the state of tension for humanity between anomic desiring (represented by the individual will), and the cohesion and constraint imposed by collective representations seen in societal institutions. This duality is inescapable. We are driven by our individual will but constrained by the social (Ramp 2003). Our will is irrational and based on biological needs and is in conflict with society (Mestrovic 1988), and needs to be restrained for social order to exist. Although for Durkheim society is external to us and constrains us, it also inspires and liberates us, lifting us above ourselves and providing some liberation from our biological being (Jones 1997).

Without social mechanisms to constrain egoism and anomie, pathological consequences – such as suicide – will follow. Durkheim looked to a number of possible sources to constrain egoism and anomie such as occupational groupings and religion, with the religion of modern society being based on science and subject to the critical elements of science (Durkheim 1915).

Durkheim believed that with the development of modern society, science would come to play an increasingly important part in the lives of everyone and would encroach upon the domain previously controlled by religion. Yet religion would still be important. Durkheim argued:

> For a long time to come, there will be two tendencies in any society: a tendency towards objective, scientific truth and a tendency towards subjectively perceived truth, towards mythological truth (Durkheim [1955] 1983:91).

These mythological representations or truths may not be seen as religious but have the 'character of dogma, and are not questioned' (Durkheim [1955] 1983:91). Democracy and progress are examples of mythological representations from this Durkheimian perspective.

The relation of scientific thought to religious thought for Durkheim is not simply one where science equals truth and religion equals falsity. The experience of religion is not inferior to the experiments of science (Durkheim 1915). More fundamental to this is the fact that Durkheim perceived all categories of thought to be of religious origin, and this included the scientific category of thought. For example, communal activity or communal life with its associated rites gives rise to the abstract category of time (Durkheim 1915). Individuals would not develop this concept of time by themselves, but can only do so in relation to others. Durkheim saw both religious thought and scientific thought as attempts to translate the realities of nature, humanity and society into intelligible language. They differ in that science brings in a spirit of criticism and attempts to set aside passion and subjectivity but religion will continue to fulfil a speculative function that science does not (Durkheim 1915). The social practice of religion would also go beyond science, as science is always incomplete and the social practices of science do not unite society in a collective fashion.

Durkheim was a rationalist and a believer in science, but he was aware of the problems of science and its socially constructed aspects. Both religion and science are collective representations that mark an objective truth (Hamnett 1984), but Durkheim was unable to give science a position of epistemological privilege over other types of thought, including religious thought.

The state also provides a means of moral constraint but again not in a simple and unproblematic way. Durkheim argued that the historical growth of the state is a cause of the rise of the cult of humanity, and that 'the stronger the State, the more the individual is respected' (from *Lecons de Sociologie: Physique Des Moeurs et du Droit*, cited in Lukes 1973:240). The state is a particular organ in society that works for the collectivity and develops collective representations which exhibit higher degrees of reflection (Durkheim [1894] 1957). It has an important moral role in society in protecting the individual and ensuring that the exchange of goods and services occurs in a just manner (Durkheim [1894] 1957).

So, for example, in the workplace, problems arise from either an absence of regulation (anomie) on one level, or coercive regulation (forced division of labour) on another. In the anomic division of labour, a lack of regulation results in an increase in competition and class conflict. A lack of regulation may involve unrestricted competition or an absence of agreement over the regulation of prices and incomes. A forced division of labour is a morbid form where constraint is imposed without any moral foundation (Durkheim [1893] 1984). The rules of the division of labour are unjust, such as when there is an irregularity of opportunity for a particular social group (Thompson 1982). To overcome anomic workplaces and a forced division of labour, the state is required to take on the role of securing the conditions under which individuals can develop their potential.

On the other hand, Durkheim was very concerned about the possibility of an inflated state (Ramp 2003). He argued that a 'society made up of an extremely large mass of unorganised individuals, which an overgrown state attempts to limit and restrain, constitutes a veritable sociological monstrosity' (Durkheim [1893] 1984:liv). So Durkheim saw the need for social institutions that can temper the tendencies of the state.

This brief introduction to important Durkheimian concepts is sufficient to signal the particular concerns in his work. In sum, there are moral forces at play in society that need to balanced so that society can function in a healthy manner, and particular social institutions have this role of balancing these moral forces. Durkheim set out his examination of social forces in his famous study of suicide.

Suicide

Durkheim was interested in suicide, which has been very influential in social studies of health, as a means of gauging the 'quantum' of happiness in a society. The level of health and illness of a society can be expressed in abnormal acts – and suicide is one of these (Fournier 2013). Happiness is not to be equated with the satisfaction of desires but is a result of moderation, harmony and balance (Fournier 2013). According to Durkheim, happiness equates with a state of health, and health:

> . . . implies the harmonious development of all functions and these cannot develop harmoniously unless they moderate one another, that is, contain one another mutually within certain bounds, beyond which sickness begins and pleasure ceases (Durkheim [1893] 1984:183).

Sociology has a particular role in achieving this harmony because it can identify pathology and sickness in a society. The sociologist is then something of a diagnostician, similar to a doctor (Fournier 2013). And further, the diagnostic sociologist can propose a treatment plan.

In *Suicide*, published in 1897, Durkheim asked 'should the present state of suicide among civilized peoples be considered normal or abnormal' (Durkheim [1897] 1952:361). The question suggests that a particular level of suicide is normal and an indication of a healthy society. Some pathology, or deviance, is inevitable in society and can even have a positive function. Similarly, Durkheim famously argued that crime is normal and 'a factor in public health, an integral part of all healthy societies' (Durkheim 1938:61). Crime serves a number of functions, such as allowing us to identify the boundaries between right and wrong and even being a force of innovation and change. In relation to suicide, Durkheim concluded that the excess rate that he found in his time was pathological. The treatment plan was the development of occupational groups or corporations 'of all workers of the same sort' (Durkheim [1897] 1952:378) to better regulate and integrate individuals.

The subtitle of *Suicide* is 'a study in sociology'. Durkheim wanted to show what was particular about sociological explanations, taking what could be regarded as the most 'individual and private act' (Fournier 2013:229), the taking of one's own life, and demonstrating the broader social influences on that decision. As such, the decision is not so personal after all, but in terms of Durkheim's argument, is an effect of the levels of egoism and anomie in a community. There are differences in suicide rates across time and across communities in relation to age, marital status, religious affiliation, economic upheaval, warfare and so on. The argument in *Suicide* is based on the interpretation of painstakingly accumulated and analysed statistical data, as well as other material drawn from ethnographic studies of different cultures and studies of different historical periods and religions. The 'rational' argument about social currents affecting the level of suicide has an 'empirical' base. Through his 'comparative' studies Durkheim rejected certain explanations for understanding the nature of suicide, such as heredity or madness, in favour of sociological ones.

In *Suicide,* Durkheim developed an approach that has been drawn on by health researchers since, particularly in the field of public health. From a Durkheimian perspective the public health research approach of epidemiology can be seen as an instrument determining the pathological and the normal. It does this by comparing mortality and morbidity rates along such dimensions as class, gender and ethnicity, as well as making comparisons of health services utilisation, stage of diagnosis and so on. The comparison between groups allows us to consider whether these various health outcomes are appropriate or not. As such, public health explicitly links Durkheim's concern for justice with his concepts of the normal and the pathological.

Neighbourhoods, integration and regulation

In addition to Durkheim's method, his concepts have influenced quantitative approaches in medical sociology and social epidemiology. The concept of anomie has been deployed by researchers and Durkheim's concerns about integration have influenced the way researchers have drawn on the concept of social capital (Razzell and Spence 2005; Whitley and McKenzie 2005). This section illustrates how Durkheim's ideas have been deployed in current research.

Durkheim's concept of the social fact has been translated in social epidemiology into ecological (or structural) variables in analysis. These variables refer to the characteristics of groups and not the particular characteristics of individuals who compose those groups. One clear example is population density (Ward 2007). As noted, Durkheim placed a great deal of weight on the impact of population density on social interaction and the societal types – with high levels of population density promoting a complex division of labour (and thus a form of organic solidarity). Researchers have also looked at the influence of different regulatory regimes on suicide rates. An Australian study found that suicide rates in New South Wales are higher under conservative governments than Labor governments (Page et al. 2002). The authors argue that this reflects higher levels of anomie under conservative governments as opposed to Labor governments, with the latter promoting more regulatory regimes in the labour market as well as in education and health. Durkheim's concepts of social integration and regulation have been used to explain changes in suicide rates in eastern European countries following the collapse of the Soviet Union (Kõlves et al. 2013).

The concept of social or neighbourhood fragmentation can also be seen as a social fact. It is not a property of the individual but of the group. Durkheimian-inspired analyses that explore the associations between health outcomes and the characteristics of neighbourhoods have been used to illuminate the causal pathways between social networks and health (Ivory et al. 2011). In the 1990s, an index known as the Congdon Index, was developed to quantify social measures of neighbourhood fragmentation and this index was based on the levels of private rental, single-person households, mobility and marital status by neighbourhood. Conforming to a Durkheimian world view, it was found that increasing social fragmentation was associated with higher suicide rates. An observation that led to the attempt to develop such an index was that in London in the 1980s the highest suicide rates occurred in affluent areas (Congdon 2004). As such, a materialist explanation for suicide where it would be an outcome of deprivation did not hold. But a Durkheimian explanation, based on a lack of regulation fostering anomie, could.

Ivory and colleagues drew on Durkheim's concepts of integration and regulation to explore their impact on mental health at a neighbourhood level (Ivory et al. 2011). In their study, it was found that both social deprivation (material resources) and social fragmentation (the level of integration and regulation) were associated with mental health outcomes, but neighbourhood fragmentation had a greater negative impact on women, particularly unemployed women. Material deprivation had a stronger association with non-mental health issues, such as bodily pain. We can note here how drawing on Durkheimian methodological frameworks can give rise to evidence that contest some of Durkheim's more contentious views.

To take the example of gender, Durkheim drew on research to suggest that 'in all countries of the world women commit suicide much less than men'. Noting that women were also less educated, he argued that 'they govern their conduct by fixed beliefs and have no great intellectual needs' (Durkheim [1897] 1952:166). Here we have a possible social explanation, lower levels of education, explaining a social outcome, lower levels of suicide for women. If education leads to 'free thinking' this can generate higher levels of egoism, which in turn can promote suicide. However, Durkheim goes on to suggest that men are more complex social beings than women, and because of this, if they are widowers, they are not so easily satisfied 'with a few devotional practices and some animals to care for' and therefore have greater rates of suicide (Durkheim [1897] 1952:215–16). Further, he argued that women's sexual desires are more limited than men's, so the restraining institution of marriage is protective of men but does not have the same protective effect for women (Durkheim [1897] 1952). This can be interpreted as men and women being biologically different. That is, instead of a sociological explanation, Durkheim appears to take a biologically essentialist reading of gendered differences in responses to suicide. If instead we were to be generous to Durkheim, we could read these gender differences as being a consequence of the customary social roles assigned to men and women in late nineteenth-century France, where men like Durkheim were the heads of the household and women oversaw the domestic sphere.

If we read Durkheim's interpretation of gender differences as resting on biology, then this contrasts with his demand that social facts must be explained only by other social facts, and not reduced to the psychological or an outcome of 'organised matter' and biological explanation (Durkheim 1938:145). However, the research by Ivory and colleagues demonstrates that women are not better off out of the labour force, as would be suggested by the Durkheimian position on a gendered division of labour. In particular, work could act as a buffer in cases where women lived in fragmented neighbourhoods. Such research also raises intriguing questions, such as why fragmented neighbourhoods have a more negative impact upon unemployed women than upon unemployed men.

Neighbourhood research and research on social integration (Kushner and Sterk 2005; Thorlindsson and Bernburg 2009) illustrate ways in which medical sociology and social epidemiology can draw on Durkheimian concepts in contemporary research, and in doing so can come to conclusions that contest Durkheim's interpretation of some social phenomena, such as different social outcomes by gender.

Public health as a moral force

Durkheim's approach to the study of the social world in *Suicide* has clearly had an influence on medical sociology, but the development of his ideas in *The Elementary Forms of the Religious Life* have not had such an obvious uptake. Nevertheless, his work from this period can be a source of insight for understanding the role of health institutions in contemporary society.

Durkheim argued that in modern society a cult of humanity would perform the roles and functions that were performed by traditional religion in pre-modern society. A cult, for Durkheim, is a social institution, and he generally refers to religions as religious cults. The increasing division of labour and social differentiation in modern society requires a different form of religion that has at its centre that which we all hold in common, our humanity. This cult would be based on rationality and science but have a function that science alone is unable to perform – to act as a force of moral regulation to constrain anomic desiring. This new religion would emphasise social justice and sympathy for human suffering. In this section, the idea that public health can usefully be considered as a cult of humanity will be considered.

As an institution, public health has varied over time and across societies. The sanitation movement in European countries in the nineteenth century had a particular focus on infectious diseases. It concerned itself with issues of water quality, sewerage disposal, food quality, and the use of vaccinations (Hardy 2001; Smith 2007). In the mid-twentieth century, led by epidemiologists in the United Kingdom, risk factor epidemiology developed, which was oriented to chronic disease such as respiratory and cardiac conditions with a focus on lifestyle factors of diet and exercise (Susser 1998). In the latter part of the twentieth century, there has been an additional focus on the social determinants of disease, most notably articulated at the United Nations Conference on Primary Health Care held in Alma Ata, Kazakhstan, in 1978 (World Health Organization Regional Office for Europe 1985). A social determinants perspective focuses on issues of housing, employment and social organisation more generally as possible sites of intervention to improve health outcomes for populations (Gross Solomon et al. 2008).

The role that public health played in European countries and their colonies in promoting a stronger nation-state can be seen in the early development of the 'medical police' in Germany in the eighteenth century (Rosen 1993). The medical police were state bureaucrats whose goal was to regulate all aspects of life to promote the nation's health. Appropriate diet, clothing, sanitation and recreation were prescribed in detail to produce a population of healthy individuals. The state's concern with the health of the population to ensure the strength of the state is a recurrent issue in public health. It can again be seen in Britain's response to a perceived degenerate population who could not serve in war efforts. In the late nineteenth century, military screening revealed that many men were unfit to serve. A high rate of rejection of potential recruits for military service for the Boer War at the end of the nineteenth century clearly signalled a crisis in the physical degeneration of the British people (Hardy 2001). To counter this concern, more attention was given to support women and children so that future war recruiting would be more successful (Hardy 2001). In Durkheim's homeland the concern about the military capacity of its neighbours heightened disquiet about the health of the nation. Durkheim's desire to develop a science of society to improve the lot of France was matched by attempts to improve the population's physical health to support a strong nation. Cities, like Paris, were transformed by the building of drains, fountains and parks and improvements were made to the housing stock, including the replacement of cesspools with sewerage systems (Latour 1994).

The concept of medical police openly acknowledges the social control aspect of public health. In order to bring about communal changes in health, individual freedoms may have to be limited, and non-conformists may need punishment, potentially bringing the concerns of a well-intentioned state and concerns about individual rights and freedoms into conflict (Feingold 1998). We see here clearly the concern that Durkheim had about the need to balance different institutional forces so that there is a desired level of constraint on individuals requiring a level of regulation, but not at the expense of the development of an inflated state.

Public health measures have also developed to address issues of social equity and indigenous development. A public health focus on social development, education and land reform started in rural areas in Europe and North America and was taken up in India and other 'third world' countries supporting calls for nationhood and political independence (Murard 2008). The organisation of public health and the delivery of public health measures can vary greatly in non-European countries. For example, in rural China a 'barefoot doctor' system was introduced in 1958 to train village aides to deliver healthcare and public health services. The training time for these doctors was as little as ten days supplemented with on-the-job learning (Murard 2008). The example of China alerts us to the different ways in which state, professional and public health concerns can be configured. A Durkheimian analysis of the barefoot doctors initiative could focus on the integrative and regulatory functions of this form of public health delivery.

Public health activism has also been aimed at tempering the negative impacts of the nation-state on the population. We can see this in World Health Organization's (WHO's) very broad definition of health, which is conceived as a state of physical, mental and social well-being, not just the absence of disease and disability (World Health Organization Regional Office for Europe 1985). Health promotion principles, fostered by health promotion activists at international forums like the Alma Ata conference, focus on equity and the social determinants of health including education, housing and food provision. Such goals have been incorporated into WHO declarations, a recent example being the *Rio Political Declaration on the Social Determinants of Health* in 2011. A goal of this internationalist form of public health is to use health promotion as a means to 'reduce the scope of politics' (Gross Solomon et al. 2008:2). In other words, the institutions of public health that operate at an international level can act to cushion nation-states against the whims of national politics. Public health advocates from around the world, but particularly in Europe and North America, also attend to global issues, and have been critical of the way in which the expansion of global markets result in a worsening of social and health inequalities (Labonté and Schrecker 2009). Efforts to control multinational companies involved in the selling of health adverse products like tobacco is an example of this. Public health researchers have called for income redistribution policies to end poverty and end inequalities in health (Evans 2007). Such concerns about the impact of national and international social policy on health outcomes draw public health advocates into the policy arena, where lobbying activities become an important feature in public health work (Evans 2007). The WHO Committee on the Social Determinants of Health forcefully displays this perspective in its claim that 'social injustice is killing people on a grand scale' (CSDH 2008). Actions to address the social determinants of health are extensive, including fair financing of economic development, gender equity and political empowerment. Durkheim had concerns about the absolutist tendencies of the state that needed to be tempered – and here we see public health acting in this moderating role.

Public health is, then, a potential buffer against the negative impacts of unregulated capitalism, for it argues that state and international agencies need to act to protect the community from the health adverse effects of capitalism. As such, public health can be seen to align with Durkheim's cult of humanity, as at the heart of the cult of humanity is a concern for social justice. Public health may at particular times and places align with the state and work to empower it. Public health itself can also be seen as an institution which, if unregulated, would suffer the same anomic consequences of other institutions and potentially become another sociological monstrosity. As such, public health can temper and moderate the impact of other institutions, but drawing on Durkheim's perspective, it is also required to have checks and balances.

Considering public health and its development through the lens of a Durkheimian perspective provides some insights into the relationship that public health has with the state and the individual. Public health promotes certain kinds of restraint, particularly in relation to such basic human activities as diet and exercise, and as such is an important actor in contemporary society where the restraints of traditional forms of authority, such as religion, have been loosened. But in addition public health is in conflict with laissez-faire economics and so acts as a restraint to the free market, promoting the regulation of products and services that may work against the health of the public.

Concluding comments

Durkheim's concepts have been drawn on by many health sociologists in their research and theorising. As an indication of just some others, his concept of abnormal forms of the division of labour has been used in the analysis of transformations in the US medical profession (Fryer 1991), his concept of anomie has been used in explaining differences in mortality rates of life-threatening diseases (Wen and Christakis 2006) and his concept of social or collective representations has been used in interpreting responses to influenza pandemics (Abeysinghe and White 2010). As such, Durkheim's work continues to provide fruitful interpretive and theoretical insights for contemporary researchers. On the other hand, there are aspects of Durkheim's theorising that are not taken seriously now. His perspective on gender differences resulting from the division of labour have been well surpassed by social change.

We can perhaps discern some quite distinctly different Durkheims. There is the social constructionist who argues that the concepts we use and the moral forces that constrain or uplift us are generated through social practices. There is the rational empiricist who seeks out social laws that can be verified and tested against evidence. In order to identify these social laws, concepts like happiness have to be operationalised by calling upon something like suicide statistics. And as has been well rehearsed in the sociological literature, the compilation of suicide statistics is a social practice that is context-bound and contingent. Jack Douglas clearly articulated this position in stating:

> Once we follow the 'disembodied numbers' back to their sources to see how they were arrived at and what, therefore, they actually represent, we find that they are based on the most subjective of all possible forms of activity. That is especially true in the case of suicide statistics, which are the result of coroner's evaluations of the 'intentions' of the actors involved (Douglas 1970:6–7).

It is an extraordinary feature of Durkheim's work that it has inspired both epidemiology and ethnomethodology. As regards the latter, the subtitle of Harold Garfinkel's *Ethnomethodology's Program* is 'Working out Durkheim's Aphorism' (Garfinkel 2002). Taylor and Ashworth argue that the contradictions in Durkheim's work are a result of his 'refusal to take the easy option' (1987:55). In contrast, Jones (1977) argues that Durkheim can be seen 'less the ideologue preoccupied with a kind of sociological metaphysic than a pragmatic and opportunistic *bricoleur*, casting about for tools that might be used to solve real social and political problems'.

Durkheim is seen by Jones as desiring to reform French thought to move it away from rationalism, with its focus on the abstract and the logical relationship of ideas, towards an empiricism based on careful observation and experimentation (Jones 1997). Durkheim described himself as a rational empiricist, in that a focus on facts alone was not enough as facts needed to be explained (Fournier 2013). Durkheim's famous dictum – to treat social facts as things – can be seen in this light. That is, rather than the sociologist being limited to the world of ideas, the sociologist is to engage in the concrete, in things (Jones 1997). This focus on the concrete and real-world concerns has made Durkheimian approaches and concepts accessible to medical sociologists. In his biography of Durkheim, Lukes asks whether Durkheim's work should be taken as 'a body of explanation, or as a body of ideas with explanatory possibilities' (Lukes 1973:34). Given the wealth of influences that Durkheim has had in so many different domains in sociology generally, and medical sociology in particular, it would be safe to conclude that Durkheim's work has been rich in explanatory possibilities.

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Chapter 6

Émile Durkheim and Thomas Luckmann: Religion, Post-Christian Spirituality and Mental Health

Rosemary L. Aird

Religion and spirituality influence the way people conceive themselves, others and the world around them, as well as how they behave. Mental health professionals are increasingly being asked to consider their clients' religious and/or spiritual beliefs when devising their treatment plans. Together, these circumstances make the study of religion and spirituality an essential area of learning for those working in the mental health field. The current body of knowledge on the relationship between religion/spirituality and mental health is, however, predominantly based on institutionalised forms of religion. It therefore provides little insight into the nature of this relationship for non-institutionalised forms of religious expression. The uptake of 'spirituality' – commonly termed post-Christian or New Age spirituality within sociology – has become increasingly widespread in nations with a Christian heritage over the past few decades. This represents a major social transformation: a phenomenon which has received considerable sociological attention in terms of the processes that have driven the shift from institutionalised to privatised forms of religion in modern societies, but has yet to be considered with regard to the potential implications of this change for mental health.

This chapter focuses on the works of two sociologists, Émile Durkheim and Thomas Luckmann. In the late nineteenth century, Durkheim was the first to demonstrate a link between religion and mental health at a population level, and also took a leading role in formally establishing sociology as a distinct discipline. His classic theories on religion and the social causes of suicide, identify key characteristics of institutionalised and privatised religion that potentially influence mental and emotional well-being in different ways. Thomas Luckmann is a twentieth-century sociologist who has written extensively on religious change in industrialised nations with a Christian heritage during the post-Second World War period. His theorising on religion also includes specific attention to the role played by New Age commercial enterprises in the formation of individual world views in contemporary societies. While Durkheim's perspective is uniformly structural-functionalist in approach, Luckmann's theory is based on a combination of this same approach and phenomenology.

Together, the works of Durkheim and Luckmann provide the ideal platform from which to examine both religion and New Age spirituality and their respective connections to mental health. This analysis demonstrates the relevance of both classic and contemporary sociological theories to issues confronting societies in the present.

Biographies

The prevailing social circumstances and personal experiences of Émile Durkheim and Thomas Luckmann during their lifetimes are keys to understanding their perspectives on religion. War affected each of their lives in profound ways.

Émile Durkheim (1858–1917) was born in Èpinal, Lorraine in north-eastern France, and grew up in an orthodox and traditional Jewish family. His father, grandfather and great grandfather were all rabbis, and it was expected that Durkheim would follow this family tradition (Lukes 1985:41). Even though his early education was directed towards this end, Durkheim decided to pursue an alternative future while still a schoolboy (Lukes 1985:39). A Roman Catholic school mistress is known to have fostered his interest in mysticism for a brief time during his school days (Lukes 1985:41), but Durkheim was an avowed agnostic by the time he was a young man (Pals 1996:90).

The Germans occupied his hometown during the Franco-Prussian war when he was 12 years of age. In writing about this period later in his life, Durkheim stated that he witnessed anti-Semitism firsthand and recalled that Jews were blamed for all French defeats (Lukes 1985). While Durkheim was an outstanding pupil in his early school years, he experienced significant difficulties with his studies subsequently. Durkheim failed his preparatory studies for gaining entry into his preferred educational institution (the École Normale Supérieure) two years in a row, under the weight of family responsibilities and financial difficulties forced upon him after his father became ill. He was successful, however, in gaining admission to the École on his third attempt (Lukes 1985:42). He subsequently studied in Germany and his writings during this period brought him public recognition, which in turn, led to him gaining a teaching position at the University of Bordeaux (1887–1902). Here, Durkheim taught the university's first social science course and later he gained a position at the Sorbonne (1902–1917), where he became a full professor in 1906 and Chair of Education and Sociology in 1913 (Calhoun et al. 2012:197).

Durkheim's views about society were strongly influenced by a number of earlier French thinkers including eighteenth-century philosopher Baron de Montesquieu, an eighteenth-century socialist thinker Comte de Saint-Simon and the famous nineteenth-century French thinker August Comte (Pals 1996). The work of Herbert Spencer and prominent German thinkers influenced his embracing of organicism, which underpins his theory of society; while other German thinkers influenced his ideas about morality, including Wagner, Schmoller and Wilhelm Wundt in particular (Calhoun et al. 2012:197). Friendships forged at the École also shaped his ideas, with the suicide of one close friend being thought to have informed aspects of his theory on suicide (Lukes 1985). Durkheim completed four major works and these have continued to influence and be drawn upon by scholars across numerous disciplines to the present day. His first two books were *The Division of Labour in Society* ([1893] 1933) and *The Rules of Sociological Method* ([1897] 1982), but it is his last two books that are drawn upon in this chapter. His seminal work, *Le Suicide* published in 1897, was not only the first scientific research to demonstrate a link between religion and mental health, but also one of the very first investigations into social influences to use consistent and organised statistical methods (Simpson 1952:11). These methods are still used in the social sciences to the present day. He outlined his theory of religion in his final major work *The Elementary Forms of the Religious Life* published in 1915. The following year (early 1916), Durkheim learnt that his only son was killed in the First World War during a military campaign in Serbia. Grief-stricken, Durkheim found it difficult to work or write, subsequently had a debilitating stroke and died months later at the age of 59 in 1917 (Pals 1996:91).

Thomas Luckmann was born in Slovenia in 1927. The First World War affected the lives of his parents, and Luckmann sustained a minor injury in the Second World War after voluntarily enlisting in the German air force (to avoid being forced into the infantry by the Third Reich). His injury led to him being sent to a military hospital and after liberation by American troops, he was interned in a US prisoner of war camp and released six months later (Estruch 2008:534). At just 18 years of age, Luckmann refused to return to Slovenia which had become part of the then Communist Yugoslavia and became a stateless person until much later when he obtained nationality in the United States. He retains this to the present. He worked as a private chauffeur, a janitor for a block of flats and a Wall Street secretary prior to gaining a scholarship to fund his studies at the New School for Social Research in New York (Estruch 2008:534). Here, the trajectory for Luckmann's future intellectual career was set in motion. He was exposed to the classical authors of European sociology (particularly Durkheim and Weber) and introduced to phenomenology by Alfred Schutz who was part of the New School. One of his professors, Carl Mayer, was instrumental in sparking Luckmann's initial attention to religion

(Estruch 2008:535). Unlike Durkheim, Luckmann initially had little interest in this topic, but a series of circumstances led to him carrying out fieldwork as part of Mayer's investigation into the situation of Churches in post-war Germany. This research project gave Luckmann the material he used for his doctorate in 1956 and also provided him with insight into the state of the sociology of religion in Europe. This insight, together with his experience in the United States, laid the foundation for the writing of his book, *The Invisible Religion*, published in 1967 (Estruch 2008). Luckmann also published a joint work entitled *The Social Construction of Reality: A Treatise in the Sociology of Knowledge* with his longstanding friend Peter Berger (Berger and Luckmann 1966) just a year before. Both Luckmann and Berger were Carl Mayer's research assistants (Estruch 2008), and each one became a prominent figure in the sociology of religion in the 1960s and 1970s (Furseth and Repstad 2006:57).

Perspectives

Luckmann's (1967) work, *The Invisible Religion*, and subsequent publications (1999, 2003) provide context to both his and Durkheim's perspectives on religion as well as reasons for the little sociological attention directed at post-Christian spirituality and its connection to mental health.

The Invisible Religion

This work was released around five decades after the publication of Durkheim's theory of religion and contains overt criticism of the sociology of religion for its lack of theoretical advancement since the respective theories of Durkheim and Weber were proposed. Luckmann (1967:18) argued that in limiting its attention to institutionalised forms of religion (predominantly along denominational lines), the sociology of religion had abandoned its classical position and become narrow and trivial. He also suggested that the relevance of sociology for contemporary societies was primarily 'its search for an understanding of the fate of the person in the structure of modern society', that the key significance of religion for sociological theory had been lost, and that the state of theory within the sociology of religion was 'regressive' (Luckmann 1967:12,18). This work identified the 'invisibility' of privatised forms of religion, a concept that remained central to his theorising efforts in the late 1990s and early 2000s.

Luckmann (2003) proposed that part of the reason for the loss of interest in religion among sociologists during the post-Durkheim and post-Weberian period was their belief that religion is incompatible with modern society and merely a passing phase in human evolution. Many embraced secularisation theories, which propose that humans will gradually outgrow religion following the separation of church and state and increasing secularisation in contemporary societies, along with other processes associated with modernisation (including increasing industrialisation, urbanisation and rationalisation) (Stark 1999). Observed declines in church attendance throughout Europe during the eighteenth and nineteenth centuries were taken to indicate that religion itself was indeed in a state of decline, lending support to the plausibility of these theories (Luckmann 2003:276). For Luckmann, however, social transformations that occurred during that period in history represented a metamorphosis of religion and not its decline. He disagrees that religion is a 'passing phase' and instead argues that 'it remains a constituent element of human life' (Luckmann 2003:276).

The dominance of secularisation theories within the discipline of sociology throughout the latter part of the twentieth century has served to hamper its theoretical and empirical progress. It was only in the 1990s that 'spirituality', and the role played by the New Age movement in the rise in popularity of this term in wider culture, started to capture sociological attention (see, for example, Heelas 1993; Roof 1993; Woodhead 1993; King 1996). While all of the social sciences have faced substantial challenges in defining and measuring religion and spirituality in ways that differentiate one from the other, sociology still lags behind other disciplines in its consideration of spirituality (Holmes 2011:34).

Durkheim and Luckmann: Definitions of religion

Together, Durkheim's and Luckmann's definitions of religion identify fundamental differences between institutionalised and privatised forms of religion. Durkheim identified all religions (past and present) as having one common characteristic, which is that they 'presuppose a classification of all the things, real and ideal, of which men [*sic*] think into two classes or opposed groups' – the *sacred* and the *profane*. He defined religion as:

> . . . a unified system of beliefs and practices relevant to sacred things, that is to say, things set apart and forbidden – beliefs and practices which unite into one single moral community called a Church, all those who adhere to them (Durkheim [1915] 1964:47).

Durkheim theorised that unified systems of religious beliefs and practices gave rise to the development of a 'collective consciousness', which plays a fundamental role in maintaining social order within society. Group worship of a god or gods place emphasis on the interests of the entire group over individual interests from Durkheim's perspective, and this helps to preserve society as a functional entity. Privatised forms of religion were another matter altogether for Durkheim however. He distinguished the beliefs and rituals of individuals from those of collectivities by terming them 'magic'. He argued that there are no lasting bonds made between 'magicians' and the individuals who consult them, or between individual adherents themselves – and likened these individuals to the 'sick' clientele of a physician (Durkheim [1915] 1964:44). For Durkheim, the primary factor that differentiated magic from religion was that adherents of a 'magician' were not members of a group of people leading a common life.

Consistent with a Durkheimian perspective, Luckmann also conceives institutionalised religion to be a vehicle for the development of a commonly shared moral framework, which he terms a 'unitary moral order'. But rather than conceptualising religion in terms of beliefs and practices, Luckmann (2003) conceives it as meaning systems that are 'collective religious representations'. From his perspective, institutionalised and privatised forms of religion are both manifestations of religious expression.

The contribution of classic theory to understanding the religion–mental health relationship

Durkheim identified *social integration* and *moral regulation* as being two key benefits afforded to members of an institutionalised religion that are unavailable to adherents of privatised religion. These two concepts are cornerstones of his theory of suicide, as factors that promote individual well-being. Durkheim's ([1897] 1952) analysis of national European data from the latter part of the nineteenth century shows that numerous social factors (including religion, marital status, age, gender, having children, war and political upheaval) are associated with variation in suicide rates. This led Durkheim to conclude that individual mental states cannot explain these patterns and therefore suicide rates must be linked to social factors such as group norms, experience and religious ideology rather than the characteristics of individuals and their personal circumstances. He developed a typology of four suicide types based on the degree to which individuals are integrated within and morally regulated by their societies – *egoistic*, *anomic*, *altruistic* and *fatalistic* suicide. Of the four, Durkheim's concepts of egoism and anomie are most relevant in the consideration of the influence of institutionalised and privatised religion on mental health in contemporary societies.

Durkheim argued that a lack of social integration promotes egoism, while insufficient moral regulation leads to anomie (normlessness). Without strong ties to society, Durkheim ([1897] 1952:213–14) believed that egoistic individuals are 'bereft of reasons for existence' and prone to depression. Anomie, on the other hand, leaves individuals free to do as they please. Durkheim's proposition that privatised religion (or 'magic') fails to promote either social integration or moral regulation for its adherents provides a theoretical foundation from which to examine institutionalised and privatised religion and their connections to mental health. The following section considers Luckmann's analysis of the evolution of religion over time to the present, a stage in history which, for him, represents a change in the relation between the individual and society (Woodhead 2013:34).

The evolution of religion across time to the dawning of a 'New Age'

Like Durkheim, Luckmann uses a structural-functionalist approach when considering the first three of four stages of religion's evolution over time. During the first stage, Luckmann (2003:277) posits that archaic societies were characterised by a simple division of labour with ideas of the sacred being based on the entire social structure and little differentiation of religious functions apart from special roles assigned to ancestors, totems and shamans. He identifies the second stage as having taken place around 4,000–6,000 years ago, a period marked by progressive functional differentiation of social institutions, increasing complexity in the division of labour and political organisation and the formation of social classes. It was at this time, that Luckmann believes that religion achieved 'a distinct institutional location in the social order' (Luckmann 2003:278–9). Religion acquired a 'visibly separate location in a special set of social institutions' during the third stage, exemplified by development of the Christian churches (Luckmann 2003:279). Luckmann adopts a phenomenological approach in considering the fourth and current stage in the evolution of religion. He identifies specialised institutions as no longer holding a monopoly in the production and dissemination of world views and suggests there is now an open 'market' of world views, with collective religious representations being produced and distributed by churches, sects, new religious organisations, New Age commercial enterprises and the mass media. Luckmann refers to this stage as the 'privatised, social form of religion', involving entirely new arrangements where 'a unitary moral order no longer exists' (Luckmann 2003:83).

Luckmann (1999:256) also argues that the new competitive marketplace really only offers individuals three main options, religious forms associated with (1) the New Age, (2) fundamentalism and (3) ecological movements 'which combine both fundamentalist moral features and holistic New Age elements'. While the New Age phenomenon is widely referred to as a 'movement', Luckmann (1999:255) states that it 'is anything but a movement in the accepted sense of a social movement' because of its diffuse nature. Nevertheless, he conceives the beliefs and practices that fall under the New Age label to be the best illustration of invisible, privatised religion in contemporary society, and says they involve:

> ...the 'new occultism', and various programmes favouring the 'spiritual' development of the individual. They are highly syncretistic. They gather diverse psychological, therapeutic, magic, and marginally scientific as well as older 'esoteric' materials, repackage them, and offer them for individual consumption (Luckmann 1999:255).

Some sociologists disagree entirely, however, with Luckmann's conception of New Age beliefs and practices as being representative of religious expression.

For example, Bruce (2006), who is an avid proponent of the idea that secularisation is bringing about the demise of religion, conceives New Age beliefs and practices to lack the necessary features required for them to be conceived 'religious'. Rather, he conceives these to be evidence of an increasing secular society, asserting:

> . . . [r]ather than seeing the New Age as compensating for a decline in Christianity, we should see it as an extension of the surgery, the clinic, the gym, or the beauty salon. It is primarily concerned with physical and psychological well-being (Bruce 2006:42).

Others, such as Wood (2007:9), criticise the scholarly use of the term 'New Age' because 'no case has been convincingly made that an area of religious belief or practice that can be described as New Age exists'. Nevertheless, work undertaken by numerous scholars supports Luckmann's ideas about New Age world views and their features.

Aldred (2002) notes that the popularity of New Age spirituality was evident in the United States as far back as the 1980s, when New Age commercial enterprises marketing spirituality, and 'Human Potential' entrepreneurs promising the 'unlocking of inner potential', gained inroads into the corporate, government and university sectors; at that stage, the New Age industry was already generating billions of dollars in sales. Research by Houtman and Aupers (2007) shows that New Age spirituality (measured by 'belief in a spirit or life force' and four other indicators) had expanded most in the Netherlands, Belgium, Ireland and the United States between 1981 and 2000, but that the highest levels of affinity with New Age spirituality were in France, Great Britain, the Netherlands and Sweden. Although Australia was not one of the countries included in this particular study, survey results from 1998 reveal that slightly more Australians believed in a non-traditional 'spiritual or higher power or life force' (39 per cent) than in a traditional Christian belief in 'a personal God' (37 per cent), that more than a quarter (27 per cent) of Australian respondents believed in reincarnation, around one-fifth (18 per cent) often or occasionally sought direction from a horoscope, just under one-tenth (9 per cent) practised Eastern meditation and 7 per cent used psychic or crystal healing (National Church Life Survey 2004).

Other research undertaken over the past two decades identifies the centrality of the 'spiritual' in New Age world views, as well as the fundamental shift in the individual–society relationship that the embracing of New Age thought represents. New Age philosophy is underpinned by the notion that all life is spiritual in nature, and that human beings are at a stage when both individual and mass consciousness are undergoing a fundamental change (William Bloom cited in Heelas 1993:104). This 'mass consciousness' is very different from the

Durkheim's notion of the 'collective consciousness'. Instead of there being a unified moral framework shared by a group leading a common life that enables the latter to form, within New Age world views, it falls to each and every individual to raise their own consciousness in order to contribute to a widespread change in mass consciousness. Belief in the idea that 'all life . . . is the manifestation of Spirit' (William Bloom cited in Heelas 1993:104) serves to legitimise the many beliefs and practices that fall under the 'New Age' label. Because causal reality is seen to lie in the spiritual realm and 'spiritual teachers' can be found in both the material world and the spirit world (William Bloom cited in Heelas 1993:104), all manner of spiritual 'gurus', New Age entrepreneurs, spirit-channellers, clairvoyants and the like are readily accepted as either conduits to the spiritual realm (the true reality), or as providers of guidance on ways for individuals to gain access to their own inner, spiritual wisdom. Religious faith and scientific reason are both rejected as vehicles of truth, with faith being placed instead in one's own 'inner voice' and 'intuition' (Houtman and Aupers 2007:307). The uniqueness of the individual is also emphasised within New Age world views. Possamai (2000:306) found that the most common declaration made by New Agers he interviewed was that 'we're all different, we're all at different stages and we're looking for different things'. Heelas (1996:26) notes that New Age spirituality emphasises self-responsibility (not social responsibility), with its 'cardinal' value being freedom from 'the past, the traditional, and internalised traditions'. This desire for freedom from all traditional forms of authority is grounded in the view that 'we malfunction because we have been indoctrinated . . . by mainstream society and culture' (Heelas 1996:18).

From a Durkheimian perspective, several features of New Age spirituality have the potential to undermine individual mental health by (1) promoting moral individualism and casting mainstream rules and regulations as the cause of people's problems (insufficient moral regulation) and (2) failing to promote social integration (by emphasising *self*-responsibility and not *social* responsibility). The following section considers recent evidence that suggests Durkheim's nineteenth-century ideas about the religion–mental health relationship remain pertinent to the present.

Evidence related to religion, post-Christian spirituality and mental health

Large etiological studies that have access to individuals' beliefs or practices *and* measures of their mental health currently provide the best opportunity for detecting links between religion, spirituality and mental health. These kinds of studies fall within the most dominant tradition of work undertaken by sociologists in the area of mental health (see Horwitz 2012). Only a handful have been conducted which investigate religion and spirituality as separate entities. These were undertaken in Canada, the United Kingdom and Australia (see details of these studies in Table 6.1).

While these studies measure religion and spirituality in different ways, their findings are remarkably consistent and provide insight into differences in outcome for world views that are reflective of traditional religion and of post-Christian spirituality. Individuals with beliefs, values or an understanding of life that reflect a 'spiritual' world view have higher rates of mental health problems (Baetz et al. 2006; King et al. 2006; Aird 2007; King et al. 2013). Most interesting is that there appears to be little difference in outcome between individuals with a religious world view and groups whose world view is neither religious nor spiritual, apart from them being less likely to have ever used drugs or to consume alcohol at hazardous levels (King et al. 2013). Religious participation in the form of regular church attendance however, appears to be connected with lower levels of depression, anxiety and addictive disorders (Baetz et al. 2006). Weekly church attendance also appears to lower the risk of anti-social behaviour for Australian males in young adulthood (Aird 2007).

Other research by Aird and colleagues (2010) indicates that the thoughts and feelings of individuals differ considerably by virtue of their conception of the divine being traditional or non-traditional in nature (as God or as a spiritual or higher power other than God, respectively). Believers in a spiritual or higher power other than God were found to be almost six times more likely to believe in witchcraft, voodoo or the occult and more than four times likely to believe in telepathic communication. These particular beliefs fall under the New Age label, as identified by Luckmann (1999). Most noteworthy is that this same group was also around twice as likely to believe they are special or unusual and destined to be important, indicating that young adults who hold a non-traditional conception of the divine are more likely to consider themselves to be either superior to, or different from, other people (Aird et al. 2010). Findings for believers in God and believers in a spiritual or higher power were similar with respect to being more likely to feel that the world was about to end, to feel as if their thoughts are echoed back to them and to feel that things in magazines and on television were written especially for them; no doubt these latter two experiences are reflective of the tendency of both groups to believe that spirit communicates with them (Aird et al. 2010). Only believers in God were likely to feel that they had sinned more than the average person (not surprising given that the idea of 'sin' is part of Christian doctrine). What is striking about these results is that young adults who held a non-traditional conception of the divine were more likely than those who reject this belief to endorse six of seven items reflecting 'disturbed' thoughts, four of six items capturing 'suspiciousness', as well as both items capturing 'grandiose' thoughts (also considered to reflect narcissism) (Aird et al. 2010). Other studies based on smaller samples have also found that individuals with a spiritual orientation are prone to both magical

Table 6.1 Religion, spirituality and mental health from three western countries with a Christian heritage

Country	Authors	Design and sample	Religion	Spirituality
1. Canada	Baetz et al. (2006)	Cross-sectional $N = 37{,}000$ aged 15 years and over	Higher frequency of church attendance – lower risk of psychiatric disorders.	Higher spiritual values – higher risk of depression, anxiety and addictive disorders.
2. United Kingdom	King et al. (2006)	Cross-sectional $N = 4{,}281$ aged 16–74 years from six ethnic backgrounds	No difference in common mental disorders between those with a religious view of life and those with neither a religious nor spiritual outlook.	Spiritual life view without religious practice twice as likely as those with a religious view to have a common mental disorder.
3. United Kingdom	King et al. (2013)	Cross-sectional $N = 7{,}403$ aged 16–97 years	No difference between religious understanding of life and those with neither a religious or spiritual outlook, with the exception that the religious group were less likely to have ever used drugs or be a hazardous drinker.	Those with a spiritual understanding of life without religious participation more likely to have used drugs (ever and during past 12 months), to be drug dependent, to have abnormal eating attitudes, generalised anxiety disorder, and phobia, any neurotic disorder and to be receiving psychotropic treatment.

Table 6.1 (Continued)

Country	Authors	Design and sample	Religion	Spirituality
4. Australia	Aird (2007)	Cross-sectional and longitudinal $N = 3{,}705$ aged 18–24 years	Lower risk for anti-social behaviour for males attending church on a weekly basis only. Lower risk for anti-social behaviour for females who were unsure of God. No effect from maternal religious background (belief in God, church attendance, and religious affiliation) on young adult anxiety/depression or anti-social behaviour.	Elevated risk for males and females who believe in a spiritual or higher power other than God for anxiety/depression and anti-social behaviour.
5. Australia	Aird et al. (2010)	Cross-sectional $N = 3{,}735$ Aged 18–24 years	Believers in God more likely to have 4 types of delusion-like experiences.	Believers in a spiritual or higher power than God more likely to have 16 types of delusion-like experiences. Young adults unsure of a spiritual or higher power other than God more likely to have nine delusion-like experiences.

and suspicious beliefs (Saucier and Skrzypinska 2006), mystical experiences and high narcissism scores (Stifler et al. 2005).

Strengths and weaknesses

While the categorisation of post-Christian spirituality as 'privatised' religion is the subject of disagreement among sociologists (see Woodhead 2013), the binary classification institutionalised/privatised religion – common to both Durkheim's and Luckmann's work – provides a theoretical basis from which to compare rates of mental health problems according to whether individuals have a world view that is traditionally religious or reflective of New Age spirituality. Durkheim and Luckmann have also been criticised for taking a structural-functionalist approach in their respective theories of religion (Lukes 1985; Furseth and Repstad 2006). Nevertheless, from a mental health perspective, the function of religion is fundamental to understanding its influence on individual mental and emotional well-being (see Schieman et al. 2012). The evidence cited in this chapter suggests that Durkheim's concepts of social integration and moral regulation remain pertinent in the present, particularly with respect to what Luckmann refers to as the most invisible form of privatised religion – world views that fall under the New Age label. The thoughts, perceptions, and mental health of those who embrace world views that are consistent with features identified by Luckmann and other sociologists as being New Age, appear to be starkly different to those with either a traditional religious or a non-religious/non-spiritual world view. The consistency in findings showing that New Age spirituality is associated with a range of mental disorders, including depression, anxiety (reflective of egoism), anti-social behaviour and substance use disorders (reflective of anomie), as well as persecutory, grandiose and suspicious ways of thinking (also reflective of egoism), therefore supports Durkheim's theory.

The evidence related to religious participation lends partial support to Durkheim's belief that religion provides moral regulation, given that a religious understanding of life was found to discourage drug use and excessive alcohol consumption (King et al. 2013), and frequent church attendance was connected to lower levels of both addictive disorders (Baetz et al. 2006) and anti-social behaviour in young adult males (Aird 2007). Durkheim's belief that religious membership promotes social integration is also supported by higher levels of church attendance being linked to lower levels of anxiety and depression (Baetz et al. 2006). The lack of difference in mental disorders other than addictive disorders between the religious and the non-religious groups in the United Kingdom (King et al. 2013) suggests that a religious outlook on life (institutionalised religion) affords little benefit over and above a non-religious/non-spiritual outlook (no religion), apart from a disinclination to use drugs and drink excessively. Nevertheless, Christian values have been codified in law in Western countries with a Christian heritage, and the similarities in outcome between these two groups may be indicative of a commonly shared moral framework at a societal level that is a legacy of Christian religious tradition. If this is the case, Durkheim's theory can be conceived to still hold some relevance with respect to the function of religious values in today's world.

Luckmann's theory provides a basis for conceiving the emergence of New Age commercial enterprises as part of the de-monopolisation process in the supply of religious world views. The marketing of spirituality, personal growth, and the unlocking of human potential as commodities (in the form of books, CDs, seminars, retreats and so on), represents a supply chain that is overtly capitalist in nature. This is arguably one of the most intriguing aspects of the New Age phenomenon, given the proclivity of those who hold New Age world views to reject mainstream traditions, values and norms. Paradoxically, the provision of religious world views for financial profit would appear to represent the wholehearted embracing of the most dominant of all established mainstream values in the West – capitalism. New Age spirituality may be a perfect fit for modern society in this regard.

One significant weakness of Durkheim's and Luckmann's perspectives, and which concerns the structural-functionalist approach used by both, is that they ignore aspects of traditional religion that have led to a mass exodus from any involvement with religious institutions in Western countries. Widespread disenchantment with institutionalised religion arising from issues of power and conflict between religious authorities and individuals, and with the divisive by-products of religious doctrine and dogma such as religion-based bigotry and prejudice remain unconsidered.

Conclusion

Research into the religion–mental health relationship that examines both religiousness and spirituality as separate entities is in its infancy. It is thus far too early to draw the conclusion that New Age spirituality is a *cause* of mental disorders. The evidence to date may simply reflect the circumstance that people with mental health problems are more prone to take up New Age beliefs and practices in Western capitalist societies. Longitudinal research is needed before any claims of causality can be made. It may also be that individuals who embrace New Age world views are the ones who struggle most with life in late modern society because of their disenchantment with the very structures that Durkheim identified as performing functions that help to preserve society. If this is the case, the question needs to be asked whether the New Age movement has inadvertently created yet another 'vehicle of truth' – founded on ideas presented by countless self-appointed 'authorities' on the 'real' meaning of life – with just as much potential for alienating and disempowering its followers as the long-established traditions they reject.

Finally, religion and New Age spirituality, in particular, are currently being seen by some sociologists as having little consequence for either the individual or society in today's world. Durkheim's and Luckmann's theoretical contributions and the evidence presented in this chapter suggest the opposite may be true. This should give cause for reflection among those who dismiss the New Age phenomenon as being either benign in influence, non-existent or indicative of religion being merely 'a passing phase' in human evolution.

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Chapter 7

George Herbert Mead: Meanings and Selves in Illness

Linda Liska Belgrave and Kathy Charmaz

George Herbert Mead is widely recognised as the father of symbolic interactionism, a theoretical perspective that gave new direction to research in diverse fields of study. His dynamic theory of action based on meaning, agency and process challenged conceptions of social structures as fixed and stable and has been fruitfully used to examine facets of chronic illness, our main substantive focus here.

Mead's extensive theory has been taken in diverse directions, ranging from structural forms of social psychology to metaphysics (Joas 1985). We explicate Mead's theory, with major classic and contemporary interpretations, highlighting three key, interconnected pieces of his theorising that are particularly valuable in studies of illness: (1) meaning and action, (2) the continual development of self and (3) temporality. We illustrate the value of this theory by tracing two lines of enquiry in the growing literature on the experience of chronic illness: biographical disruption and loss of self. By adopting Mead, we can address tensions between agency and structure by studying how people with chronic illnesses understand and experience health, illness and care and act in relation to both.

Biography

George Herbert Mead was born in Massachusetts in 1863, the son of a puritanical clergyman and a mother who taught at elite preparatory schools (Mead and Mead 1938; Athens 2007). His father joined the faculty of Oberlin College, then a seminary, when Mead was seven. Reading and studying social issues and relationships were among his main pursuits as a boy (Mead and Mead 1938). Mead attended Oberlin College, graduating in 1883. Although Oberlin offered few courses at the time, Mead developed a strong foundation in classics, which served him throughout his career, and a sense of social responsibility, reflected in his lifelong commitment to social reform (Joas 1985). At Oberlin, Mead and his close friends, Helen and Henry Castle, provided each other the intellectual stimulation that the curriculum lacked. Helen later became Mead's second wife, after an accident took Frieda Steckner, his first.

After Oberlin, Mead tried teaching at a school, which ended badly, then began surveying for railroads and tutoring, reading voraciously all the while (Mead and Mead 1938). He entered Harvard University in 1887, where he came to know William James, graduating with an MA in Philosophy in 1888. Next, Mead went to Europe for further studies in philosophy and psychology. Here he continued his friendship with the Castles (Mead and Mead 1938), studied with such luminaries as Wundt (Athens 2007) and Dilthey (Joas 1985) and became politicised.

Although he never obtained a PhD, Mead joined the faculty of the University of Michigan in 1891. There his friendship with John Dewey greatly influenced him (Athens 2007), though the full nature of Dewey's influence remains uncertain (Joas 1997). When Dewey moved to the University of Chicago in 1894, he persuaded Mead to join him and Mead stayed there until his death in 1931. The importance of the university and city of Chicago for Mead's work cannot be overstated. The University of Chicago encouraged using science to solve practical problems such as those suffered by Chicago, a rapidly growing, industrial city, with a large population of unskilled immigrant workers (Joas 1985). Mead became involved with Hull House, the struggle for women's rights and the Pragmatist intellectual project, all of which influenced both his theory and politics.

Mead published many articles, but never laid out his theory of social psychology in a cohesive, single text. He was in the midst of revising his philosophy when he died (Morris 1938). The lack of a comprehensive theoretical statement lingers in symbolic interactionism (Joas 1997). The books typically considered to contain Mead's most important works consist of compilations of unpublished or unfinished works, notes taken by a stenographer who attended his lectures and other materials. These edited volumes traditionally give authorship to Mead, a practice that influences how they are read (Silva and Vieira 2011). *Mind, Self, and Society* (1934) represents the major systematisation of Mead's social psychology.

Pragmatist philosophy, and Mead's thought, have broad and deep roots, ranging from classical Greek and Hellenistic thought (Prus 2003) to elements of Darwin's theory of evolution (Reynolds 2003a). Key concepts from early Greek intellectuals, such as reflectivity and the importance of process, appear as features of Mead's theory. His classical education shows in his frequent referencing of Aristotle (for example, in *Philosophy of the Act* in 1938), that Prus (2003) links to symbolic interactionism and illustrates, poignantly for illness studies: 'All human happiness or misery takes the form of action' (Aristotle's *Poetics* 6). Darwin's view of behaviour as adaptation to the environment heavily influenced Mead. Combining it with his view of life as 'processual and emergent by nature', spawned the underpinnings of symbolic interactionism (Reynolds 2003a:41). From Scottish Moralism, Mead gained an appreciation for social life as the basis for selves and minds (Reynolds 2003a). Similarly, German Idealism influenced the pragmatist and symbolic interactionist understanding that people respond not to some 'objective' reality, but to their definitions of a world they create (for details, see Joas 1985).

Pragmatists from multiple disciplines spanned analytic levels, viewing persons as inherently social, while acknowledging their biological and evolutionary aspects (Meltzer et al. 1975). This integrated approach foreshadows contemporary interest in embodiment, attention to genetics and meso analysis linking various levels of human experience. This influence runs throughout Mead's work. While Mead is the major theorist underlying the symbolic interactionist perspective, to treat this perspective as solely his individual achievement would be inaccurate and would defy his legacy. Therefore, some contributions to symbolic interactionism from others are noted below.

Mead, meaning and social interaction

Mead offers a radically social and process-oriented approach to analysing the essential oneness of individuals and society. His individual is an abstraction from society: '[T]here has to be a social process going on in order that there may be individuals' (Mead 1934:189), and 'the behaviour of an individual can be understood only in terms of the behaviour of the whole social group of which he is a member...' (Mead 1934:6). While he solidly grounds the individual within the social, Mead takes the human biological organism into account, especially its evolutionary capacities (see Mead 1934, throughout).

Joas organises Mead's thought into three themes:

> Confidence in the emancipatory prospects of scientific rationality; a striving to root 'mind' or 'spirit' in the organism; and the attempt to elaborate a theory of inter-subjectivity that would conceive of the self as socially originate (1985:33).

He captures his interpretation of Mead's work in the concept of 'practical intersubjectivity', illustrating Mead's ability to see beyond apparent contradictions between the (micro) theory of action and (macro) structural theory that ignores human agency.

Meaning and action

Meaning and social interaction are integral to Mead's theory. Meanings are practical, tied to concrete situations and positioned towards actions. Meaning is neither inherent in phenomena nor some sort of metaphysical stuff, but exists within interaction.

> Meaning is . . . a relationship between certain phases of the social act; it is not a physical addition to that act and it is not an 'idea' as traditionally conceived . . . objects are constituted in terms of meanings within the social process of experience and behaviour through the mutual adjustment to one another of the responses or actions of [actors] (Mead 1934:76–7).

Thus, meaning is emergent and exists in the field of experience. It develops out of social acts and is revealed in them. Meanings shape our actions. We experience, give meaning to and interact with the world as selves.

Self

Mead's conceptualisation of self is perhaps more used than any other part of his work (Athens 2005), generally and in illness studies. Selves, the seats of human agency, are inherently social. Selves are not inborn, but arise though social interaction (Mead 1934:140). The self is a *reflexive social structure* that is both subject and object to itself. The subject 'represents the person's spontaneous, impulsive tendencies [and] is the spontaneous spark of energy within the actor' (Reynolds 2003a:75); it is biologically grounded and 'gives the sense of freedom, of initiative' (Mead 1934:177). The object aspect consists of the perspectives, definitions and expectations of others, individually or collectively, depending on the situation (Reynolds 2003a:75). It is 'the self [the person] is aware of' (Mead 1934:175). People experience themselves indirectly, from the perspectives of others (specific or generalised) (Mead 1934:138). The self is also *process*, an on-going conversation between subject and object. This reflexive self process is active, the source of human agency, giving people their ability to direct their own behaviour, make decisions and act in their environments (Weigert and Gecas 2003:280). '[I]nter-subjectivity is the interdependence of the individual and the group, and the personal that is attained is not a copy of the group, but a self in action' (Dodds et al. 1997:498). Selves incorporate our sense of who we are, how we fit into the social world and more.

Temporality

Beyond these contributions, Mead's (1932) view of temporality rejects conventional perspectives of time as well as of history. For Mead, reality exists in the emergent present and, thus, is novel. We see the past and project the future through the eyes of the present. Mead contends that both past and future depend on the present, which frames defining and understanding each. If the view from the present reconstructs the past, the past is always open to reinterpretation (Maines et al. 1983). Similarly, the anticipated future is also given in people's understandings of the present. As we experience present selves, we do so with an awareness of both past and future selves, an often sharpened aspect of living with chronic illness. These ideas complement Mead's explication of the processual nature of meanings and self-construction.

Symbolic interactionism

Much of what we know as symbolic interactionism comes to us through the posthumously published, edited volume of Mead's work, *Mind, Self, and Society* (1934), and the work of his student and primary interpreter, Herbert Blumer, particularly his *Symbolic Interactionism: Perspective and Method* (1969). Although such interpretations are open to reinterpretation and critique (for example, Athens 2005; Puddephatt 2009; Huebner 2012), they provide the core understanding of the perspective. We focus on that core understanding, with particular attention to concepts used in research on health and illness. Our review is neither exhaustive nor definitive, but provides a view of Mead's theory, with some contemporary debate, that can stimulate further theorising and new research.

To demonstrate the rich pragmatist context within which Mead worked, we note several symbolic interactionist ideas contributed by others but not always attributed to them in early depictions of the core of the perspective. Mead's work clearly reflects some of these ideas while others were integrated into the perspective later. For instance, Dewey saw 'reality' not as inherent, but as a whole made up of people, their environment and ways of thinking, arguing that meaningful existence depended on language (Meltzer et al. 1975). For Mead, language is the first, and most important, social institution (Athens 2007). The idea that society provides the means to express our human creativity, fundamental in symbolic interactionism, comes from James (Meltzer et al. 1975). W.I. Thomas and Dorothy Swayne Thomas taught us that '[i]f [people] define situations as real, they are real in their consequences' (1928:571–2). Symbolic interactionism owes Charles Horton Cooley for the idea of the 'looking-glass self' – we learn who we are by reflecting on how we *think* others see and evaluate us with how we feel about both. Contemporary symbolic interactionism adopts Cooley's view of the individual and society as 'two sides of the same coin' (Reynolds 2003b:61).

Mead's writings have been analysed for compatibility with social theorists from varied disciplines and perspectives, including Alfred Schutz, Anthony Giddens, Jürgen Habermas and Randall Collins. Some with compatible, even similar, ideas cite Mead while others ignore his work (see Joas 1997). Nonetheless, symbolic interactionism is the major theoretical perspective grounded in Mead's work and the primary means of bringing his thought to theory and research in health and illness.

The social, interactional and processual nature of meaning shapes this perspective. Blumer (1969:2) makes this clear in his oft-cited premises of symbolic interactionism:

1. human beings act towards things on the basis of the meanings that the things have for them;
2. the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows; and
3. these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters.

Puddephatt (2009) objects, stating that Blumer's interpretation is too social, downplaying Mead's inclusion of the organism–environment interaction as a source of meaning. Charmaz (1980) and Snow (2002) each point out that people act in taken-for-granted ways until their actions are somehow disrupted or made problematic. Then they engage in an explicit interpretive process.

Building on his basic premises, Blumer laid out the core of symbolic interactionism, using what he termed 'root images' (1969). First, Blumer insists that society exists 'in action and must be seen in terms of action' (1969:6). Thus, other ways of studying society, such as looking at cultural norms, values and so on, or social structure as positions, roles and the like, examine only the results of actions while ignoring the actions themselves. Because 'society consists of individuals interacting' (Blumer 1969:7), *interaction* is the heart of the matter, a process consisting of individuals fitting their actions to those of others. In order to be effective and interpretable, each actor must take into account the other's point of view (Blumer 1969:9). Interpreting actions (own and other's) relies on symbols as an inherent part of the process. While non-symbolic interaction (for example, moving to avoid bumping someone on the bus) occurs, most social interaction is symbolic. This is Blumer's primary interest, although others focus more on non-significant and/or routine interaction (for example, Puddephatt 2009; Daanen and Sammut 2012).

People live in worlds made up of physical, social and abstract objects that people create. The nature of these objects, no matter how concrete or abstract, lies in their meanings, which arise out of the definitions of actors and those with whom they interact. These meanings tell actors how to see the objects and act towards them (Blumer 1969:10–12). Even routine, taken-for-granted meanings are social products, defined by the anticipated actions of those involved (Daanen and Sammut 2012).

These 'root images' come together in action. To act in the world and guide one's own behaviour, one must interpret that world (Blumer 1969:15–16). Therefore, in order to understand human action we must study the process of defining. We do this best by examining behaviour as joint or collective behaviour, which cannot be reduced to an aggregate of individual actions. Joint or collective behaviour differs from individual behaviour precisely because actions of multiple actors are linked in social interaction (Blumer 1969:16–20). Even recurrent, repetitive, relatively predictable patterns of social action require actors to interpret the action and are open to reinforcement (if the usual patterns are followed) or change (if they are not). When we extend this process to large, complex social networks of routinised interaction, we can mistake them as self-operating institutions that somehow exist independently of human actors and actions. However, Blumer reminds us that institutions function 'because people at different points do something, and what they do is a result of how they define the situation in which they are called on to act' (Blumer 1969:19).

Mead's attention to social institutions has been somewhat lost, as contemporary theorists struggle to connect interaction at the micro level to the macro level of society. Athens (2005) reminds us that Mead discussed institutions as a special form of interaction and provided a hierarchy of institutions from language, at the base, through science, at the top. As structural as this might appear, these institutions are processes and do not exist independently of the selves whose actions constitute them. For instance, conflicts that interfere with institutional social acts can prompt actors to modify institutions which, subsequently, changes both selves and communities (Athens 2005). Katovich and Maines (2003) suggest approaching the interwoven patterns of interaction that constitute society as a framework for organised, yet indeterminate, interpretive actions at varied levels of analysis. Martin brings this full circle by reminding scholars that Mead spoke of the reflexivity of nations, as well as selves (2005). We argue that re-incorporating this side of Mead's theory can enrich current sociological work in health, illness and medicine.

The development of chronic illness as sociological and medical problems

To understand how Mead's ideas have influenced the study of chronic illness, we need to understand the context of its emergence. This field emerged in the 1960s and 1970s after medical sociology took form as a specialised area of sociology. As Fran Collyer (2012) observes, the development of medical sociology is intertwined with the emergence and institutionalisation of sociology as a discipline. In the United Kingdom and Australia, the discipline mainly emerged after the Second World War whereas in the United States it began in the early twentieth century but expanded slowly. Collyer (2012) points out that in the 1960s (1) the dominance of structural-functionalism waned in the United States, (2) the distinction between a sociology *in* medicine and a sociology *of* medicine arose in the United States and the United Kingdom, and

(3) critiques of the 'medical model' of care appeared. Studying chronic illness from patients' rather than practitioners' perspectives logically followed these changes and took root in the United States and the United Kingdom.

Social scientists of medicine credit the historian of epidemiological demography, Abdel R. Omran (1971), for theorising an 'epidemiological transition' from acute to chronic illness in developed nations (also see Omran 2005), despite his greater interest in seeking a decline in fertility rates (Weisz and Olszynko-Gryn 2010). Omran's theory of the epidemiological transition gained ascendancy in the 1990s. Markers of this transition included increased life expectancy, reduced infant and maternal mortality and women's greater life expectancy than men's. Fewer deaths from acute illnesses accompanied these changes, and thus the incidence of chronic conditions grew in Western societies as populations aged. The revisionist application of Omran's theory to non-Western societies elicited some criticism and refinements as well as praise as a useful explanation for the rise of chronic illnesses. Chronic illness is a problem throughout the world but many epidemiologists view its significance in broader terms than longevity alone. Epidemiologists who study non-Western societies now include lifestyle as causing chronic illness and some evince concern about poverty and resulting health disparities (see, for example, Ramahi et al. 2010). Epidemiologists begin from the standpoint of medically established definitions to study chronic diseases and hence look at them from the 'outside'. Qualitative researchers pursue learning what having an illness means to people, what they experience and thus take an 'insider's view' of illness. These sociologists distinguished chronic illness from chronic disease. The term 'chronic illness' refers to the person's subjective and social experience of illness, regardless of whether physicians validate it with a medical diagnosis. 'Chronic disease', in contrast, means the accepted medical indicators of a pathological condition. Hence, a person may experience illness without a diagnosis of disease and conversely someone may have a disease but not experience an illness.

Epidemiologists have long been aware that disadvantaged people generally develop chronic health problems at younger ages, in greater numbers, and with more dire results. Attention to such health inequalities has increased in recent decades, with various explanations offered, including access to resources, social capital, culture and the like (for example, Kawachi 2010; Lahelma 2010), with culture often a euphemism for 'problematic difference' (Bradby and Nazroo 2010). Link and Phelan (2010:5) argue for treating social conditions as fundamental causes, because when faced with health threats, some can 'deploy a wide range of resources . . . that can be used individually and collectively in difference places and at different times to avoid disease and death'. Such work is primarily conducted by approaching chronic (and other) conditions from the 'outside'. It is time for symbolic interactionists to show how beginning from the 'inside' can contribute to this line of inquiry.

Mead and the study of chronic illness

Mead's social psychology formed a silent yet discernible backdrop in early efforts to theorise the social structuring and experience of chronic illness, disability and dying in the United States (for example, Davis 1963; Glaser and Strauss 1965, 1968). His social psychology underlies Chicago School *traditions* that influenced interactionist medical sociologists to look at self, meanings and interaction. These traditions led to the development of the second Chicago School, some of whom were leading medical sociologists. Mead's significance resides in the intellectual lineage his work engendered as well as on direct reliance on it. Later generations of medical sociologists adopt the perspectives, methods and emphases of a Meadian approach but typically cite scholars in the second Chicago School and their students rather than Mead. In addition, the citation customs of the 1960s also fostered rather scant citations that belie Mead's significant influence on numerous second Chicago school sociologists and those they inspired.

Nonetheless, Mead influenced early US ethnographers in medical sociology who demonstrated that Talcott Parsons' (1951) concept of the sick role had limits. This concept theorised an abstract patient–physician relationship in a model of acute illness and thus could account neither for an altered patient–physician relationship nor for what it meant to live with chronic illnesses and disabilities (see, for example, Davis 1963; Roth 1963; Freidson 1970). The concept of the sick role assumed the recovery of patients who made rational decisions to follow their physicians' advice, which Parsons assumed to be valid, and to take a legitimate absence from adult roles to get well. Ethnographers challenged Parsons' assumptions about recovery, roles and rationality. Opposition to Parsons is apparent in their works while homage to Mead is not.

Instead, Mead's influence becomes evident in these early medical sociologists' research approaches, conceptualisations and arguments. They looked at agentic social actors and dynamic relationships between meaning and action. Ethnographic and qualitative research meant different starting points and standpoints than a structural analysis of institutional relationships as Parsons had provided. Ethnographers studied life in natural settings and observed that different definitions of illness, treatment, uncertainty and recovery emerged in social interactions between health professionals and patients, definitions that may be contested. Chicago traditions framed enquiry in works such as *Awareness of Dying* (Glaser and Strauss 1965), *Boys in White* (Becker et al. 1961) and *The Profession of Medicine* (Freidson 1970).

A Meadian perspective underlies major studies of chronically ill people's everyday lives and their meanings and actions. This focus began in the 1960s with works such as *Passage through Crisis: Polio Victims and Their Families* (Davis

1963), and *Timetables: Structuring the Passage of Time in Hospital Treatment and Other Careers* (Roth 1963), and gained momentum with *Chronic Illness and the Quality of Life* (Strauss and Glaser 1975). Later inductive qualitative studies such as *Having Epilepsy: The Experience and Control of Illness* (Schneider and Conrad 1983) and 'Chronic Illness as Biographical Disruption' (Bury 1982) shared assumptions with a Meadian perspective. Through studying chronic illness sociologists established that medical care took a different form than in acute illness. People were only patients for small parts of their lives (Conrad 1987). *Living with* chronic illness became the goal rather than seeking a cure and fighting to overcome illness. Managing daily life, controlling symptoms and avoiding stigma took precedence in people's lives and in qualitative studies of chronic illness from the 1960s to the 1980s (Fagerhaugh 1975; Reif 1975; Strauss and Glaser 1975; Schneider and Conrad 1980, 1983). One of Schneider and Conrad's (1980:92) interviewees said her parents insisted that her diagnosis of epilepsy remain secret: 'Couldn't tell a soul. I couldn't tell my grandparents who lived next door. I couldn't tell my cousins, my best girlfriends'.

The turn from managing daily life to meanings of chronic illness for self, identity and biography brought Mead's social psychology or one consistent with him more explicitly into purview. Bury (1982; see also Locock and Ziebland, this volume, chapter 37) reflects the latter, while Charmaz (1983, 1991, 1995, 2011) and Corbin and Strauss (1987, 1988), build on Mead.

For Mead, the development, maintenance and change of self are social processes. The self develops and unfolds as people act and interpret their lives and worlds. Chronic illness jolts middle class people's lives and results in a reappraisal of self, identity and biography. Charmaz (1991:243–4) interviewed a man who said, 'In terms of functioning and doing stuff that I used to do.... I may not be able to do that again', but he tried to look on the bright side: 'This is a rare opportunity you have to sit and look at things and from a state of quietness, [after] a state of getting caught up in this rat race we all make for ourselves'.

For poor people, chronic illness may be another in a series of misfortunes and, if so, bears a certain continuity to earlier life and elicits less surprise (Cornwall 1984; Abraham 1993). Poverty, family crises and legal issues may all supersede problems caused by chronic illness (Charmaz 1991), even when the illness is potentially life threatening (Ciambrone 2001). Much of the early literature, however, takes diagnostic shock and/or experiencing disruptive symptoms as a starting point of analysis. Researchers have studied what these events mean to people who experienced them, as is consistent with Blumer's (1969) premises about meanings.

Experiencing serious chronic illness may involve gains for some people – in insight, personal attributes, strengthened bonds and new-found gratitude – and profound losses for those whose physical health had been unproblematic. Such gains and losses can affect self and identity. Whether occurring suddenly or over years, people with chronic illness lose valued attributes – physical functions, roles and relationships, activities – and time. Identities are built on actions and definitions. Subjective views of self and social categorisations of individuals assume intensified meanings when shrouded in difference. Mead's focus on action and meaning spawns tracing the development and consequences of these meanings. Learning concretely how daily measures of chronicity intrude upon one's life fosters a redefining of self. Routine rituals of self-care often require far more time, strength and help than before becoming ill or having a flare-up of illness. A woman with multiple sclerosis said:

> Often during exacerbation, I need to lie down and allow myself to rest for two hours a day and at that time, also, I need more sleep, I need twelve hours of sleep a night. My day is shortened . . . by what I need to fit into the day. Then, in addition, it's shortened because activities take me longer. My time is almost regulated by the symptoms of exacerbation (Charmaz 1991:54).

Chronic pain intrudes beyond functionality. An elderly immigrant who could barely walk because of her arthritis found ways to accomplish things, but could not escape the pain:

> Sometimes I cry. Not all the time, but sometimes . . . . Pain. It's no go away, the doctor say. I spend money for [brand name] aspirin. It no do nothing (Belgrave 1990:488).

Thus, chronically ill people's awareness of losses of function, speed, endurance and effectiveness measure a changed body and contribute to an altered view of self.

Mead argued that body and self were separate; however, consistent with his thinking is the notion that social and subjective interpretations of one's body have consequences. The research literature on biographical disruption and loss of self takes into account the self as process and the self as structure, whether or not the authors acknowledge Mead. Relatively few authors' analyses of chronic illness explicitly build on Mead (but see Charmaz 1991, 1995; Adams et al. 1997; Lombardo 2004; Hubbard et al. 2010). Instead, many authors rely on Michael Bury's (1982) classic article 'Chronic Illness as Biographical Disruption', and/or Kathy Charmaz's (1983) 'Loss of Self: A Fundamental Form of Suffering in the Chronically Ill', so we explore the lines of enquiry these two articles represent for the study of chronic illness.

Bury and Charmaz's social psychology of illness

Bury predicates his concept of biographical disruption on the disjuncture between ill adults' past and present lives and aims to move beyond his contemporaries' descriptions of managing illness. Bury cites the symbolic interactionist tradition but aims to theorise the experience of illness. To do so, he draws explicitly upon Giddens' (1979) concept of radically disruptive critical situations rather than relying on Mead. Since that time, scholars have viewed his work as within the symbolic interactionist tradition (Hubbard et al. 2010) or as complementing it (Lawton 2003; Pierret 2003).

The logic of Bury's argument rests on the pervasiveness of disruption. He argues that chronic illness disrupts people's lives, assumptions about their lives and the world and their place in it. Previously taken-for-granted certainties become uncertain. An earlier belief in a life ahead dissolves when facing death. Loss and suffering become immediate realities. An earlier unproblematic body now forces new, unwelcome attention. Declining health may undermine independence and disrupt previous relationship reciprocities. Thus unanticipated biographical tasks emerge because loss and uncertainty elicit people's reflections on their futures and re-examinations of their assumptions about themselves and their lives. Numerous later studies, including Charmaz's (1991, 1995), question Bury's assumptions and ask if, when, how, for whom and to what extent chronic illness is a biographical disruption (for example, Carricaburu and Pierret 1995; Williams 2000; Ciambrone 2001; Pierret 2007; Gisquet 2008; Hinojosa et al. 2008; Locock et al. 2009).

The concept of biographical disruption highlights how time, uncertainty and the rippling effects of chronic illness affect personal and family life. This concept fits Mead's argument that as human beings, we can interact with ourselves because we have language and therefore can appraise our actions and evaluate ourselves. Shortly after Bury's article appeared, Strauss et al. (1984), and later Corbin and Strauss (1988), took up biographical work as a significant accompaniment of chronic illness. They show Mead's influence and link biographical work and the reconstruction of self. Corbin and Strauss (1987:257–9) see reviewing, re-evaluating and refocusing life as ways of reconstituting biographical work about self and identity and of coming to terms with 'body failure'. They contend that people form self-conceptions through bodily experience.

These themes also emerge in Charmaz's work, although she addressed changing relationships between body and self (1995) and argued that disruption was one of several ways people experience illness (1991). Like Bury, she began theorising the consequences of loss and uncertainty for chronically ill people's selves and moved away from managing illness (for example, Charmaz 1983, 1987, 1991, 1995, 2011). In her 1983 article, she links loss of self directly to suffering and shows how the erosion of former self-images, identities and ways of being in the world contribute to it. Analysing loss and suffering not only speaks to uncertainty and biographical discontinuity but also brings vulnerability, risk, stigma (Pescosolido, this volume, chapter 18), embodiment (Albrecht; Rudge; this volume, chapters 38 and 32) and emotions into focus. Chronic illness causes tensions between body, self and identity that 're-emerge with each disruptive episode or with deteriorating social conditions' (Charmaz 1995:659). At these times, people with chronic illnesses experience loss of whatever degree of unity between body and self they had previously defined or assumed. One woman said:

> I felt that even a little strain – I was pushing myself and I knew it, you know. I knew that things that I used to do easily without any strain at all were a challenge. And so I was real aware of it (Charmaz 1995:662).

When illness progresses but plateaus for lengthy periods, such markers of change often fade in memory. Nevertheless, these moments of realisation may become immediate turning points, marking people's efforts to make a comeback or somehow regain a valued self (Charmaz 1987, 2011).

Conclusions

Symbolic interactionism and related perspectives have been fruitfully used to examine multiple aspects of the experience of chronic illness. However, the full potential of symbolic interactionism has not yet been realised. Ostensible limitations of Mead's theory perhaps lie in how we apply his theories and develop lines of inquiry in empirical research. As Peter Conrad (1987:12) points out, we must differentiate biographical work from identity work, which entails daily acts of repairing interactions to preserve public identities and to avoid damage to self. The questions become: at what point do recurrent efforts to effect successful identity work become part of biographical reconstruction? At what points does it become a collective concern and lead to change? As medical sociology moves across the globe, such questions must be situated in their social, economic, cultural and temporal contexts. Researchers have used Meadian social psychology to study individual agency and action in chronic illness and given their studies the stamp of developed nations. Yet researchers throughout the world can also apply the *logic* of Mead's theories of action, meaning and temporality to diverse, local groups and larger collectivities, enriching and advancing our theory everywhere.

Looking beyond social psychology, we propose that symbolic interactionism offers conceptual tools to examine unsolved health-inequality problems. Symbolic interactionism brings to the mix a view of structures of inequality as social processes. Michael Schwalbe et al. (2000) offer an interactionist theory of the reproduction of inequality that suggests points of entry for such analyses. To paraphrase, 'Instead of asking, for example, What effect does race have on [health]? – as if we knew what "race" is and that it is the same everywhere – we would ask, How do people think, feel, and act here, such that some [illness] inequality is a result, whether intended or not?' (Schwalbe et al. 2000:441). In order to advance social justice research, Charmaz (2005:522) suggests a focus on meaning, processes and action to uncover how individual experience and social structure come together. Who better than symbolic interactionists to examine processes of inequality and illness?

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Chapter 8

Max Weber: Bureaucracy, Formal Rationality and the Modern Hospital

William C. Cockerham

This chapter applies Max Weber's concept of formal rationality to modern hospitals. Weber ([1922] 1978:85) defined formal rationality as the purposeful calculation of the most efficient means and procedures to realise goals. Formal rationality is the type of thinking and logical deduction that people use to determine what is most important in particular situations and the most effectual method they should use for reaching desired goals. Tradition, sentimentality, outmoded customs, piety and various other types of potentially less effective ways of doing things are discarded in favour of the most efficient action that can be calculated to achieve the ultimate outcome: what some call the 'bottom line'.

Weber (1923, [1905] 1958) argued that formal rationality is dominant in Western society, underlying the spread of capitalism, and linked to modern social structures through bureaucratic forms of organisation. He went on to say that the most rational and efficient form of organisation in managing complex human activity is the bureaucracy with its specialised tasks, hierarchy of formal offices with fixed channels of communication, emphasis on written and recorded orders and so on. Although bureaucracies are an outgrowth of rationalism, Weber observed that bureaucracies also contain inherent tendencies towards dehumanisation, since their processes and decisions are based on the organisation's impersonal rules, practices and policies. In fact, Weber warned of the possibility of bureaucracies becoming an 'iron cage' in which individuals find their freedom of action constrained and their activities over-regulated by rigid procedures.

Hospitals have not been a perfect match for Weber's concept of bureaucracy because of their dual system of authority – administrative and clinical – that requires a high degree of decentralisation in accomplishing clinical tasks. However, in hospitals in advanced societies, especially those with some form of bureaucratic managed care, the level of clinical authority may be declining to the extent that the organisation of work is more consistent with Weber's concept. This situation will be reviewed in the remainder of this chapter.

Biography

Max Weber (1864–1920) is one of the foremost sociologists of all time. Broadly trained in economics, law, history and philosophy, his academic contributions were in the newly emerging field of sociology that he helped establish. The insights he provided allowed him to rank with Émile Durkheim as one of the two greatest figures in sociology's classical period. Although he lived at the beginning of the twentieth century, his influence has persisted because many of his ideas are still relevant to contemporary social conditions. As his most recent biographer (Radkau 2009:3) points out: 'Weber is currently one of the thinkers through whom the social sciences have acquired a distinctive complexion and against whom one can often sharpen one's own thinking: he seems to grow and grow as you keep reading his texts'. While he did not write on health topics, his work nevertheless influences medical sociology as it does much of sociology today.

Weber was born in Erfurt, Germany, in 1864, the oldest of eight children. His father, Max Weber, the senior, moved the family to Berlin where he was employed by the city government and elected to the Prussian Parliament and later the German Reichstag. His mother, Helene, was a voluntary worker for charities supporting the poor. Growing up, Weber was exposed to an intellectual atmosphere in his home, as various leading academics and politicians gathered there regularly to discuss current events (Radkau 2009:5). Weber attended universities in Heidelberg and later Berlin, followed by a year of mandatory service as a reserve army officer in Alsace. He returned to Berlin and earned his doctorate in 1889 in law and economics, followed by marriage to his second cousin, Marianne, and professorships at Freiberg and Heidelberg. It was at Freiberg where Weber advanced his famous argument that sociology should be value-free; that is, sociologists should not use their personal values and prejudices to determine their conclusions about society. Rather, sociologists must be objective in reporting their findings in order to portray social conditions as accurately as possible, regardless of their political and social philosophy. This position starkly contrasted with that of Karl Marx and his supporters (Marx and Engels [1888] 1976:620), who argued that philosophies should be used to actively change society in order to meet social and political goals.

Weber's career was interrupted when he began suffering from a nervous disorder in 1898 that caused him to resign from his teaching post in 1903. He had been severely affected by the death of his father in 1897, two months after a heated emotional argument between the pair: a quarrel that had never been resolved (Radkau 2009:65). Weber's wife's large inheritance from her family supported the couple financially when he was unable to be employed. In the meantime, he gave periodic public lectures, took over the editorship of a major academic journal, helped found the German Sociological Society and published one of his most important books, *The Protestant Ethic and the Spirit of Capitalism*, in 1904–1905. In this, he detailed how a lifestyle of entrepreneurship, investment, thrift and hard work associated with the Protestant ethic among early Calvinists stimulated the rise of modern capitalism.

Weber also spent 14 months in military service during the First World War in Heidelberg, beginning in 1914, where he helped organise army hospitals and was responsible for staff discipline. Weber was released from army duty in 1915 because of his health. His scholarship, despite occasional relapses of illness, was extraordinary as he wrote on law, religion, art, politics, organisations and institutions, and economics. His complete recovery was slow, and it was not until 1918 that he felt well enough to resume normal university lecturing with a temporary position in Vienna, followed by an appointment in Munich in 1919. His most comprehensive work, *Economy and Society*, was published in 1922, two years after his death in 1920 from a lung infection at the age of 56.

His friend and colleague, the philosopher Karl Jaspers (1989), referred to Weber as the greatest German of his time. ‘Max Weber’s essence’, states Jaspers (1989:113), ‘seemed to stand between a vanishing and a rising era’. The vanishing era was traditional European society with its remaining vestiges of feudalism, and the rising era was modernity. Weber had noted this transition in his first study in 1890 of the social changes taking place in the agricultural areas east of the Elbe River in Germany brought on by urbanisation and industrialisation. He did not go on to formulate a general theory of society, but he did provide a wide range of lasting concepts, axioms, hypotheses, theses and suggestions for sociology (Käsler 1988:213–14). It was a major strength of his sociology that his questions were framed against the background of history (Mommsen 1989).

A personal excursion into Weber’s writings confirms that health issues were not part of his work. For example, there are only two sentences about health in the *Protestant Ethic and the Spirit of Capitalism* ([1920] 1958). One in which Weber ([1920] 1958:158) notes that Calvinists regarded idleness as a sin and even ‘taking more sleep than is necessary for health (six to at most eight hours), is considered worthy of total moral condemnation’, and the other where he (Weber [1920] 1958:163) observes that ‘[t]o wish to be poor was, it was often argued, the same as wishing to be unhealthy’. The focus of the first comment was in relation to wasting time and the second pertained to the pursuit of wealth as a ‘calling’; health itself was secondary. Elsewhere in his writings, health matters are clearly not an interest. Even though he served as a military hospital disciplinary supervisor in the medical corps in 1914–1915 and held educational classes for the wounded, he did not turn his sociological focus towards a study of healthcare in any capacity. Yet, ultimately, his influence in sociology was so extensive, it extended into the field.

Formal rationality

As noted, Weber ([1922] 1978:85) had argued that formal rationality was dominant in Western thinking and essential to the rise of capitalism along with the Protestant ethic. Drawing upon his studies of Oriental societies, he found that traditional patterns of reasoning or rationality in Asian countries were different from the West. The formal form of rationality that was most characteristic of Western society was by no means absent or insignificant in Asian civilisations (in fact, today it is especially prevalent in China, Japan, Singapore and South Korea), but in the past 'it operated from entirely different premises and accordingly it had a totally different impact upon the social fabric' (Mommsen 1989:161). The rationality prevalent in traditional Asian societies was strongly influenced by Confucianism and emphasised the abstract and the ideal, while advocating a lifestyle oriented towards harmonious social relationships and an avoidance of embarrassment or loss of face. Conformity, deference to superiors and obedience to traditional rules and customs were stressed. In the West, in contrast, the prevailing form of rationality was focused more on the practical than the abstract, and strict codes of behaviour, dogma and tradition were disregarded if they impeded progress, creativity or the achievement of practical goals.

Weber therefore distinguished between two major types of rationality: formal and substantive. Formal rationality, as previously defined, is the purposeful calculation of the most efficient means and procedures to realise goals, while substantive rationality, common in traditional Asian societies, is the realisation of values and ideals based on custom, piety or personal devotion. Weber described how, in Western society, formal rationality became dominant over its substantive counterpart as people sought to achieve specific ends by employing the most efficient means and, in the process, tended to disregard substantive rationality because it was often cumbersome, time-consuming, inefficient, and stifled advancement on the basis of merit. This practical or formal type of rationality led to the rise of the West and the spread of capitalism.

Weber did not believe that formal rationality characterised Western society as a whole, but that it did indeed emerge as a more popular way of thinking than substantive rationality. In fact, it was rejection of substantive ends and values in favour of calculated efficiency that made the West unique. This form of rationality featured the freedom to inquire, experiment and dispute, while it emphasised a concern for the practical over the abstract and a belief in the continued possibility of improvement unhindered by cultural, ideological and political orthodoxy.

The next step in Weber's analysis was to show how formal rationality was operationalised through the spread of the Protestant ethic that promoted the rise of capitalism. Capitalism existed in the ancient world and the Middle Ages, as well as in non-Western societies, but it took on a peculiarly Western form as it reached its fullest state of development earlier in western Europe and North America. Weber ([1905] 1958) finds that the Protestant ethic, which originated among Calvinists, especially Puritans, was a major factor in this outcome in that it encouraged hard work, thrift, self-discipline and entrepreneurship. Puritanism and other forms of Calvinism emphasised (1) the glorification of God, (2) pre-destination (the belief that when a person is born, his or her ultimate fate (heaven or hell) had already been decided according to God's plan) and (3) the notion of work as a 'calling' from God. Weber did not claim that this doctrine caused capitalism, butmaintained there was a strong affinity between early Protestantism, with its concept of salvation through the pursuit of a secular calling, and the lifestyle necessary for the development of modern capitalism.

In the *Protestant Ethic and the Spirit of Capitalism* ([1905] 1958:121), Weber explained that the fulfilment of a person's duty in worldly (economic) affairs became the highest form of moral activity for these early Protestants. Faced with uncertainty about personal salvation since their fate was predetermined, they responded to the psychological pressure this belief caused by interpreting economic success as a sign that they were indeed blessed and going to heaven. In this context, individuals were therefore 'called' to work and be a success. Rationally organised work was thus conceptualised as a moral good and idleness, as noted, a sin; all of which, in Weber's view, evolved into a particular lifestyle in which people accepted responsibility for their own material and spiritual well-being in that one led to the other. They were, in effect, driven by their religious beliefs to be successful.

Weber's curiosity about the Puritans was aroused in 1901 by a study conducted by one of his students in Baden, Germany. This study found that local Protestants owned more capital than the average Catholic or Jew, were more likely to be entrepreneurs and constituted the greatest proportion of highly qualified technical and sales personnel (Käsler 1988:73). Weber wondered why this was the case. Utilising historical studies, he traced the origin of Protestant entrepreneurship to sixteenth-century Calvinist merchants in various cities in northern Germany and nearby countries. These businessmen had formed the Hanseatic League, an association of merchants linked together for economic advancement and protection in the Baltic region. The Hanseatic League was a dominant economic power in northern Europe in its time. The Calvinists, however, did not believe in acquiring wealth so that they could live in luxury. Rather, they emphasised rational, continuous hard work and saving and investing one's earnings. The incentive to succeed was reinforced, in turn, by the assurance of a place in heaven that success in business signified for them.

Therefore, according to Weber, a Protestant work ethic oriented towards individualism, personal achievement, purposeful calculation, investment and a high value of income-producing activities fostered a spirit of enterprise that stimulated the growth of early capitalism. Capitalist entrepreneurship generally consistent with the Protestant ethic's orientation towards work as a value for both the individual and the community, along with the emphasis on effort, self-discipline and innovation in reaching objectives became normative in the West before it did elsewhere. Western-style formal rationality, however, not only is behind the spread of capitalism, in Weber's view, but is also linked to modern institutional structures through the development of bureaucratic forms of organisation. As Weber ([1905] 1958:25) points out, 'modern rational capitalism has need, not only of the technical means of production, but of a calculable legal system and of administration in terms of formal rules'.

Bureaucracy

Before discussing Weber's concept of bureaucracy, it is useful to briefly review his insights on authority. Weber ([1922] 1978:215) identified three distinct types of authority: (1) traditional, (2) charismatic and (3) rational-legal, with the latter providing the framework for bureaucratic decision-making. Traditional authority is the authority of a monarch based on the sanctity of past traditions that are handed down from one generation to another. People obey the monarch because they believe he or she has the right to rule. This right is not based on reason, but tradition. Charismatic authority rests on devotion to an exceptional individual whose personal qualities of heroism, personality, character and/or perhaps wisdom inspire obedience. Such authority is often expressed dramatically and associated with radical change. However, as Weber points out, charismatic authority is not, by its nature, stable or lasting. Charisma can be maintained only for so long, and, once it becomes routine, begins to have less effect on people. Therefore, Weber explains, it is the fate of charismatic leadership eventually to be transformed into traditional or rational-legal authority once it slips over time into everyday routine. That is, the charismatic leader eventually adopts either a traditional or a rational-legal approach to leadership if he or she stays in power.

Rational-legal authority, in contrast, rests on a belief in the legality of enacted rules and the right of those occupying positions of authority under such rules to issue commands. Obedience is thus owed to legal orders and extends to persons whose office gives them the authority to issue those orders. People who obey orders issued from such authority do so because they are members of the organisation or society that has recognised the authority's right to give these orders.

In this situation, people are obeying impersonal rules, not the personal commands of a sovereign or charismatic individual. Rational-legal authority is the basis upon which bureaucracies operate and is intended to apply to all people over whom it has legal jurisdiction. It follows orderly procedures for appointments and dismissals from office, appeals, decision-making, allocations of areas of responsibility and similar matters. Authority is attached to the office, not to the person holding the office. When the person is no longer the office-holder, he or she no longer has the authority that goes with it. Rational-legal authority is the dominant authority system in the world.

Weber's ([1922] 1978:809) concept of formal rationality at the macro level and his ([1922] 1978:24) notion of *zweckrztionalität* (calculation of purposeful goal-oriented action by individuals) at the micro level, along with his observation noted above of the replacement of traditional and charismatic forms of authority by rational-legal systems, are all part of a general *process* of rationalisation constructed on principles of efficiency and calculation. This process includes the rise of the bureaucracy as the most efficient form of rational-legal organisation in managing complex human affairs. In *Economy and Society* ([1922] 1978:956–8), Weber described bureaucracy as a rational and impersonal division of labour characterised by the principles of office hierarchy and levels of graded authority (lower offices are supervised by higher ones), as well as by fixed and official areas of jurisdiction governed by laws or administrative regulations. In bureaucracies, tasks are specialised; communication between the hierarchy of offices with their designated channels of communication and authority is based on written and recorded orders; there is a sharp separation of official from personal identity in the management of work; and rules and regulations are intended to be objective and logical in their application.

What makes Weber's theory of bureaucracy distinctive is that it sees bureaucracies evolving in business, government, religion, education and elsewhere (medicine can be included) as an outcome of the process of formal rationalisation. Although bureaucracies are an outgrowth of rationalism, Weber notes they also contain inherent tendencies towards dehumanisation, since their activities and decisions are generally impersonal. Weber ([1922] 1978:988) analysed the manner in which modern bureaucracies impose rigid rules and regulations – an 'iron cage' – on people in the name of efficiency and warns of the possibilities of bureaucracies becoming so rigid and inflexible that individuals find themselves trapped and their lives over-regulated as 'a small cog in a ceaselessly moving mechanism' travelling along a 'fixed route of march'. Weiss (1987) argues that this process is irreversible (because people have chosen it) and leads inevitably to the individual's disenchantment with the modern world. For example, Weiss (1987:159) states, Weber, without a doubt, 'was convinced that the process of progressive rationalisation would lead increasingly to the restriction of the free play of action and have an obligatory character independent of the will of individuals'.

However, Weber's prediction can also be seen as more of a warning than a certainty, since his writings contain evidence that he also viewed rationality as a force to enhance human freedom. An excellent example of this view is Weber's (1946:124–5) statement that:

> ... we associate the strongest empirical 'feeling of freedom' with precisely those actions which we know ourselves to have accomplished rationally, i.e., in the absence of physical or psychic 'compulsion'; actions in which we 'pursue' a clear conscious 'purpose' by what to our knowledge are the most adequate means.

Consequently, while Weber considered the bureaucratic aspects of formal rationalism as an inevitable phenomenon that people in modern societies simply have to endure, he nevertheless seems to have viewed formal rationality as means to also achieve creative goals through the exercise of logic (Roth 1987; Mommsen 1989). Rationality provides individuals with a basis for self-responsibility and allows them to chart their own goals and aspirations by assuming control over their circumstances and engaging in opportunities for creativity and self-expression. Weber's focus was on determining the political and social conditions that, in the course of history, promote responsibility and creativity despite institutional forces like bureaucracies that tend to stifle individual initiative (Mommsen 1989:196). Although bureaucratic procedures can be inflexible and tedious, the bureaucracy remains the most efficient type of organisation yet devised to manage complex work.

The modern hospital as a bureaucracy

The rational goal-oriented action that takes place in hospitals differs somewhat from the relatively rigid organisation portrayed in Weber's concept of bureaucracy. This is because patient care can require a flexible, non-bureaucratic response, especially in critical or emergency situations. It might therefore appear odd that Weber formulated his concept of bureaucracy after serving as an army hospital disciplinary officer and administrator early in the First World War. However, Hillier (1987:194) credits this experience as the catalyst that influenced him to examine the nature and structure of bureaucratic organisations. Weber had lacked trained bureaucrats, and his administration has been characterised as 'loose'; therefore, in his final report on leaving his post, he emphasised the need for a professional bureaucracy in hospitals (Hillier 1987:194).

Weber's perspective on bureaucracy can be applied to the general organisation of hospital work as it accounts for the effects of organisational goals and the manner in which authority and control are exercised hierarchically. The key to hospital efficiency and its effectiveness as an institution is its coordination of the work performed by various departments and individuals focused on the overall objective of patient care. Hospital work represents a complex and highly specialised division of labour whose elements are both interlocking and interdependent. In order to accomplish its tasks and coordinate its activities, the hospital's hierarchy of authority is well defined. Within its walls, hospitals engage in multiple and simultaneous functions, including clinical practice, nursing, laboratory and other testing, training, research and education. Additionally, patients have to be treated, housed, fed and nursed. Hospitals have been accurately described as a hotel, a school, a laboratory and a place for treatment (Wilson 1963). The primary goal of the hospital, however, is that of providing medical treatment to its patients within the limits of contemporary medical knowledge and technology in relation to the hospital's available resources.

The overall supervision of general and specialised hospitals comes under the auspices of its governing body, such as a board of trustees, a corporate group or government agency. Whereas the medical director and the hospital administrator are both directly responsible to the governing body, they are typically only indirectly responsible to each other. Consequently, the authority system of the hospital operates on a dual level: clinical and administrative. This system is an outgrowth of the organisational division in hospitals between bureaucracy and professionalism. The basis of the division between bureaucracy and the professional (here, the physician), consists of the professional's insistence on exercising an autonomous judgement on patient care, while the bureaucrat (here, the hospital administrator) seeks to follow a rationally based management approach that favours the efficient coordination of the hospital's activities through formal rules and impersonal regulations applicable to all persons in all situations, including physicians.

Since the physician's professional norms can set specific limits on the hospital administrator's authority and vice versa, the result has been the system of dual authority. The occupational groups in the hospital most affected by its system of dual authority are the nurses and auxiliary nursing workers who perform healthcare tasks on a physician's orders. Nurses are responsible to the physicians for carrying out their orders, but they also are responsible to the hospital's administration for following its standardised procedures. Even though the communication and allegiance of ward personnel tend to be channelled along occupational lines within and towards the 'administrative channel of command', medical authority can and does cut across these lines. Although this system may at times result in an overlapping of responsibility, it nevertheless functions because all involved share a common goal of providing quality patient care (Strauss et al. 1963).

In a study of a psychiatric hospital some decades ago that shows how this system operates, Strauss and his associates (1963) found that hospital rules governing the actions of the clinical professionals who worked within its setting were not rigid. These researchers observed that some of the hospital's procedures were the result of negotiation between the administration, the medical staff and other hospital employees. The individuals involved had varying degrees of prestige and power, were at different stages in their careers and had their own particular goals, reference groups and occupational ideologies. The hospital administration, on its part, tended to take a tolerant position towards institutional rules in the belief that good patient care required a minimum of 'hard and fast' regulations and a maximum of 'innovation and improvisation' when needed. Thus, there was continual negotiation of the medical rules: what they were and whether they applied in a particular situation and not in all circumstances. What held the hospital staff together was the sharing of a common goal to return their patients to the outside world in a better condition than when they entered.

While hospital services are oriented towards patient welfare, hospital rules and regulations are nevertheless designed for the benefit of hospital personnel, so that the work of treating large numbers of patients can be more efficient and easier to perform. Consequently, the sick and the injured are organised into various patient categories (such as maternity/obstetrics, orthopaedics, surgery, paediatrics, psychiatry and so on) that reflect the medical staff's diagnosis of their problem and are then subject to standardised, staff-approved medical treatment and administrative procedures. While it can be argued that standardising patient care results in increased organisational efficiency – and ultimately serves the best interest of the patient – it is clear that hospital bureaucracy is organised to expedite the work of the staff and involves bureaucratic control over the patient's activities and restriction on movements.

In order for the hospital to function effectively, it has therefore been necessary to construct a decentralised system of authority organised around a generally acceptable objective of service to the patient. While the administrator directs and supervises hospital policy, the medical staff has traditionally retained control over medical decisions. Hospitals, however, can be held legally responsible for what happens within its premises. This means hospitals have responsibility for patients separate from that of physicians. Liability for patient care results in the hospital imposing more of its rules and regulations on physicians, raising the standards of qualification required for staff privileges, and generally reducing the amount of professional discretion and autonomy physicians have traditionally been allowed to exercise. This is especially the case in corporate-owned profit-making hospitals, but also extends to non-profit and government-owned facilities. Thus, control by hospital administrators may affect not only professional discretion, but also professional effectiveness, as the practitioners within the hospital are provided with better coordination of services and staff support. Enhanced coordination and control of services are already being provided to hospital administrators through the information systems made available by modern computer technology. In all probability, the hospital administration in non-profit, profit-making and government hospitals have increased control over the staff through computerisation of information as a basis for decision-making.

Studies of hospital bureaucracies typically begin with Weber's concept, even though it is clear that his model is not totally compatible with the norms of hospital authority. Nevertheless, the trend today is more towards his model than away from it. The essence of the conflict between bureaucracy and the professional (such as a physician) consists of the professional's insistence on exercising an autonomous individual judgement, while the bureaucrat (here, the hospital administrator) seeks to follow a rationalistic management approach that favours the efficient coordination of the hospital's activities through formal rules and impersonal regulations applicable to all persons in all situations. But in contemporary times, legal liability, computerisation, government regulation, private and government insurance fee schedules, and organisational changes like managed care have eroded the professional status and autonomy of physicians in making independent decisions, and, correspondingly, bureaucratic managers of hospitals have assumed greater control. Weber's concept of bureaucracy is therefore more applicable to hospitals today than ever before.

Managed care

Managed care plans emerged in the early to mid-1990s as private healthcare in the United States experienced a major reorganisation. Changing from a largely office-based, fee-for-service system to an increasingly group- or organisation-based managed care system, American medical practice took on a dramatically different new structure more in line with Weber's notion of bureaucracy. Some of this restructuring was in response to the anticipated health reforms of the Clinton administration that died in Congress because of political opposition, especially from the small business owners' lobby that did not support the higher costs to them associated with the measure. Another important factor was a 'buyer's revolt' by business corporations and insurance companies seeking to control healthcare costs by controlling medical work (Pescosolido and Boyer 2010; Stevens 2010). The medical market was under considerable pressure to control costs, and managed care was thought to be the most effective means for doing so. In 2011, about 91 per cent of all Americans with some type of health insurance were enrolled in some form of managed care. In 1988, only some 29 per cent of the insured were members of such plans. Managed care refers to health organisations, such as health maintenance organisations, preferred provider organisations, high deductible health plans, point of service plans and managed care organisations that serve Medicaid (public health insurance for the poor) recipients. These organisations 'manage' the cost of healthcare by monitoring the work of doctors and hospitals, limiting visits to specialists within a particular managed care network and to all physicians outside it and requiring prior authorisation for hospitalisation.

Managed care changes the patient–physician relationship by inserting a case manager in the decision-making process. The case manager represents the bill payer, the insurance provider, who certifies that the care to be rendered is both effective and the least costly alternative, and also authorises hospitalisation. Another feature of managed care is its reliance upon capitation financing. Capitation (per capita) financing is a fixed monthly sum paid by the patient and the person's employer, or covered by the state in the case of Medicaid, which guarantees care to that person and perhaps the person's immediate family, with little or no additional cost. Healthcare providers, in turn, must provide necessary care and are not paid for any additional services. This measure discourages inefficient and unnecessary treatment. Patients are also allowed to see a specialist only after being screened by the primary care physician who routinely cares for them. Since specialist care is usually more costly, the primary care physician serves as a gatekeeper to the use of specialists and is usually rewarded by keeping referrals to a minimum. Finally, patients are required to use the physicians within the managed care network, unless there is a medical emergency outside the plan's geographical area.

Managed care organisations evolved because corporate and government purchasers of healthcare faced excessive spending by the physician-dominated system, and a new concept was needed to control costs. Light (2004) finds that a large new secondary industry arose in support of managed care organisations. These new businesses designed benefits, selected providers, managed services, defined outcomes and established systems measuring quality and performance. The control of managed care was stripped away from physicians as the managed care model became a product of big business. The attraction for business corporations was to keep costs down through greater efficiency and bureaucratisation that would nonetheless provide a pipeline into the huge profit potential of the healthcare market. No longer is managed care the alternative healthcare delivery model that it once was, rather it has become the dominant model in the United States.

According to Pescosolido and Boyer (2010:396), this situation has also significantly altered the professional position of physicians by making them more subject to limitations set by the government, insurance companies and the demands of employers who purchased managed care plans. This led to a dramatic decline of their power in the medical market in the United States (Light 2004). In recent years, the managed care approach has lost some strength with regard to cost controls, but has adapted by devising new provisions and practice arrangements, thereby remaining the leading US model.

We also see a somewhat similar trend taking place elsewhere in advanced societies. For example, in the British National Health Service (NHS), increased bureaucratic control is likewise associated with a long-term decline in the influence and power of the medical profession in maintaining exclusive control over the provision of health services. As Michael Bury (2010:412) explains, the British NHS and its socialised system of healthcare delivery – which provides access to care to all citizens as a right paid for out of tax revenues – has undergone considerable change in the last several years. Many of these changes pertain to the introduction of various funding schemes, such as allowing private for-profit care in public hospitals, establishing trusts for hospital care that can issue contracts for services to business corporations and other purchasers of care, and various bureaucratic measures to improve efficiency.

One especially notable modification related to Weber's concept of bureaucracy is what Bury (2010:413) calls the rise of 'managerialism' that is characterised by a series of government initiatives enhancing the power of managers and reducing the influence of the medical profession in decision-making and funding. This process is made easier by the fact that the NHS is owned and operated by government, and the workforce, including most physicians, are government employees. Only a minority of healthcare providers, whose numbers are increasing, are in private practice. What has occurred has been the growth of management systems responsive to political decisions and the implementation of policies imposed on healthcare from above by the government under the name of modernisation. Thus government policies 'may bypass resistance from the medical profession and be implemented directly by NHS managers' (Bury 2010:414). This has especially been the case in relation to budgetary matters and cost controls.

Deprofessionalisation

Weber's notion of formal rationality has also been applied to the concept of 'deprofessionalisation'. Deprofessionalisation essentially means a decline in a profession's autonomy and control over clients. It does not mean a profession becomes less professional, but that the profession is undergoing a loss of power. Freidson's (1970a, 1970b) seminal work on the medical profession in the 1970s described American medicine's professional dominance over patients and its relations with external organisations, including the federal government. Medicine was *the* model of professionalism, with physicians having absolute authority over their work and ranked at or near the top of society in occupational status by sociologists. However, Ritzer and Walczak (1988) observed the loss of *absolute* authority by American physicians as their treatment decisions came under increasing scrutiny in the late twentieth century by patients, healthcare organisations, insurance companies and government agencies.

Ritzer and Walczak found that government policies emphasising control over healthcare costs and the rise of the profit motive in medicine identified a trend in medical practice away from substantive rationality (stressing ideals like serving the patient) towards greater formal rationality (stressing rules, regulations and efficiency). Government and insurance company oversight in reviewing and approving patient care decisions, the rise of private healthcare corporations hiring professionals as employees and controlling their work, in combination with a higher level of consumerism among patients, all contributed to decreasing the autonomy of medical doctors and their professional power. Thus, the 'golden age' of medical power and prestige ended, as medicine's efforts to avoid outside control left open an unregulated medical market in the United States that invited corporate intrusion for profit and public demands for government (bureaucratic) control to contain costs. Once again, we see formal rationality and its offspring, bureaucracy, influencing medical care.

Conclusion

Weber noted the early dominance of formal rationality over its substantive counterpart in the West and its role in spreading capitalism, as well as promoting the rise of the bureaucracy for managing complex human activities. While not a perfect fit for hospitals, such institutions have nevertheless adopted bureaucratic procedures as the basis for their managerial structures. As we move into the future, the hospital bureaucratic model appears to be coming closer, not further, from Weber's concept. Consequently, when it comes to hospital bureaucracies and other areas of medical sociology, Weber's work still informs us about the effects of social conditions associated with the onset of modernity.

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Part II

The Early Twentieth-Century Theorists

Chapter 9

Ludwik Fleck: Thought Collectives and the Sociology of Medical Knowledge

Kevin White

One of the most important – indeed the only early – sociologist of medical knowledge went unacknowledged in his lifetime and was left in obscurity until a series of chance events in the 1970s led to his rediscovery. We are still sorting through the implications and applications of his work as this chapter shows. Ludwik Fleck spent most of his professional career in medicine, in particular on disorders of the blood. While he gained a solid professional recognition, the anti-Semitism of the pre-war years and the subsequent war cast a long shadow over many Jewish scholars.

Biography

Ludwik Fleck was born 1896 in Lvov, Poland. He studied medicine, graduating in 1922 at the age of 26 and immediately moved into specialised research in bacteriology and infectious disease, becoming the head of the bacteriological and chemical laboratories of the State Hospital of Lvov. In 1935, he was dismissed from his then post of Head of the Social Sick Fund in Lvov with the growth in anti-Semitism. Between 1943 and 1945, he was incarcerated in Auschwitz and Buchenwald where he was kept alive to develop a typhus vaccine for use on German soldiers. His two sisters were killed. After the war, Fleck resumed his research into bacteriology and microbiology. For his scientific work he received many honours: the state scientific prize for his work on epidemic typhus fever; he was admitted to the Polish Academy of the Sciences in 1954; and received Poland's highest scientific degree, the Doctorate of Medical Science in 1955. Fleck became Professor of Medicine at the University of Lublin and in 1957 moved to Israel where he, and his wife Ernestina, were reunited with their only son. Fleck died in 1961.

In a series of papers published in the 1930s and culminating in the publication of the *Genesis and Development of a Scientific Fact* ([1935a] 1979), Fleck also worked in the sociology of scientific knowledge. Relative to other sociologists of knowledge of the period, this work can claim the most radical extension of the principles of the sociology of knowledge, critically interrogating the natural sciences (and in particular the medical sciences). This chapter sets the scene for the development of Fleck's thought, outlines his sociology of medical knowledge and concludes with an overview of the now significant research being conducted in a Fleckian mode: work which utilises his concepts of 'thought collectives' and 'thought styles'.

Setting the scene: Fleck's thought collective

While interest in the work of Ludwik Fleck has recently been revived and revisited, his place within the history of the sociology of knowledge has remained under-examined. Fleck was brought to the attention of scholars by a passing reference to his work by Kuhn in the second edition of the *Structure of Scientific Revolutions* ([1962] 1970). Indeed, as Kuhn points out in the preface, he underestimated the impact of reading Fleck in 1949 (Kuhn 1970:vii). Had Kuhn even cited Fleck in his bibliography, leading to Fleck's 'discovery' by the English-speaking scholarly community, the whole course of the social constructionist account of medicine would have been accelerated. Kuhn had read Fleck in the German while a doctoral student and, as he was to more fully acknowledge in the foreword to the English translation of *Genesis and Development*, certainly took from Fleck the insight of the sociological nature of scientific thought. Kuhn's work has generally been seen as strongly influenced by his reading of Fleck, with some commentators seeing a direct line of influence between the concepts of Kuhn and the work of Fleck. Fleck's concepts of 'thought style' and 'thought collective' have been understood to correspond to Kuhn's 'paradigm' and 'scientific community'. Fleck conceptualised a thought style to provide an account of why scientists in different disciplines, or even in the different parts of the same discipline, saw the world the way they do – that is, in what constitutes a scientific puzzle, how to study it and what counts as evidence about it. A thought collective unites all those scientists with the same thought style (more on this below). However, as Canguilhem has argued, in the history of science the question of who was the originator of an idea is both fraught and pointless, since notions of precedence reflect particular constructions of the history of thought. The development of an idea reflects the culture within which an individual is working and 'the meanings he thinks he sees emerging from his own past': a point with which Fleck would completely agree (Canguilhem 2000:62).

It has been suggested that Fleck worked in an intellectual vacuum, producing his ideas about the social nature of scientific endeavour independently of any socialisation within a social scientific discipline. Hedfors (2006, 2008) has argued that Fleck's career in medicine was a marginal one, and that he was untrained for both sociological and philosophical work.

As outlined above, Fleck was highly regarded for his medical research, and yet a casual glance at Fleck's biography would seem to affirm an idiosyncratic exposure to sociology. Surprise has been expressed about his intellectual formation, the sources in his bibliography and his seemingly limited foray into the sociology of knowledge (for example, Baldamus 1977). As Baldamus points out, in constructing his arguments, Fleck refers only to nineteenth-century sociologists such as Jerusalem, Lebon, Durkheim and Levy Bruhl, but not to then-contemporary sociologists of knowledge such as Lukacs and Mannheim, or the Americans such as C. Wright Mills.

However, I will argue that Fleck was part of a thought collective in the 1930s which saw the flowering of the sociology of knowledge in his own native Poland, as well as in Germany and the United States. As Fleck himself pointed out: 'The individual within the collective is never, or hardly ever, conscious of the prevailing thought style, which almost always exerts an absolutely compulsive force upon his thinking and with which it is not possible to be at variance' (Fleck [1935a] 1979:41) – and it is to the existence of this thought style that we owe Fleck's work and can locate his oeuvre. While trained in the natural sciences, Fleck was, as was his countryman and contemporary Malinowski (1884–1942), interested in the logical structure of science. Malinowski ([1925] 1948) argued that non-Western forms of cognition were not restricted to magic and religion; Fleck argued that Western science was imbued with magic and religion. Thus, in their theoretical work and empirical research, both sought to reverse the taken for granted views of, in Malinowski's case, the 'native' as superstitious, and, in Fleck's case, the 'scientist' as always and innately rational.

Formative intellectual training

Fleck's training at Lvov's John Casimir University prepared him in his epistemological perspective. Casimir was at the centre of developments in the conventionalist accounts of science and logic in the 1920s and 1930s, with the physicists and precursors of relativity theory Henri Poincarre (1904) and Pierre Duhem being influential. The conventionalist's argument is that phenomena can be explained equally well by a wide range of theories, and that the adherence of a scientist to any particular explanation is the result of an agreement by the scientist's community to describe the world in this way. Thus scientific knowledge is always relative, always open to change, and does not reveal reality. As Gonzalez et al. (1995) have established, three of the professors in this tradition were very influential for Fleck and would in turn have received his constructivist theories of medicine well. Fleck was in close touch with Kazimierz Twardowski (1866–1938), head of the Department of Philosophy – a radical conventionalist who supervised the doctoral dissertation of Kazimierz Ajdukiewicz (1890–1963) – and with Leon Chwistek (1884–1944), a constructivist logician and philosopher of science, who rejected the claim that mathematical logic would provide the key to understanding reality, since there was more than one reality. As such, Fleck was well aware of arguments developing against logical positivism in this period and certainly very much influenced by them (Gonzalez et al. 1995). At the same time, the Polish philosophy of medicine was into its third generation of professional academic life, and Fleck published his early papers on the sociology of medical knowledge in *The Archive of the History and Philosophy of Medicine* (Giedymin 1985).

Simultaneously, in France, the sociology of medical and biological knowledge was flourishing in the work of his contemporaries Gaston Bachelard (1884–1962) and Georges Canguilhem (1904–1995). Bachelard, a constructivist philosopher of science, was interested in the psychology of science ([1938] 2002) and the formation of the scientific mind ([1940] 1968). Bachelard argues that tightly held ways of looking at the world form an epistemological obstacle, that is, that ways of thinking result in the development of barriers to scientific knowledge. These epistemological obstacles give way under the impact of epistemological ruptures, which do not change the way of thinking of the scientists, but present them with a whole new way of seeing their world and transforming it. Thus science is not progressive but discontinuous, and change is dependent on the psychology of the scientists. These epistemological breaks, the discontinuities in science, mean that for Bachelard, as with Fleck in his analysis of syphilis, new theories have old concepts embedded within them; the old concepts are transformed in the process of being integrated into the new ones.

Bachelard also sought to show how the production of concepts in science is the same as the production of concepts in daily life, involving both practical and theoretical features, and coalescing around artefacts in what Bachelard calls 'abstract-concrete knowledge'. Again the parallels with Fleck's account of both the theory and practice of the Wasserman reaction is evident.

Georges Canguilhem (1904–1995) was an epistemologist of science and biology and Bachelard's successor at the Sorbonne in Paris. Canguilhem's central point was that 'every science more or less gives itself its own given', and that science is always carried out in a cultural frame. His key works are *The Normal and the Pathological* ([1943] 1991) and *Ideology and Rationality in the History of the Life Sciences* (1988). Like Fleck, Canguilhem was trained in, and practiced, medicine during the Second World War. Canguilhem taught the history and philosophy of the life sciences at the Sorbonne, where he sponsored Foucault's doctoral thesis (later published as *Madness and Civilisation*). He argued that what constituted a state of health or disease was the product of definitional processes of medicine rather than a biological fact.

German and American contexts

The sociology of knowledge was also flourishing in Germany and the United States during this same period, but its application was not extended to medical and biological thought. In Germany, Mannheim's *Ideology and Utopia*, published in German in 1929 (English translation 1946), was also a marker of the strength of the sociology of knowledge thought collective. Mannheim argued that the individual speaks the language of his or her group and thinks as his or her group does. How we know things, according to Mannheim, 'presupposes a community of knowing which grows primarily out of a community of experiencing prepared for in the subconscious' (Mannheim 1972:28). Knowledge is not the achievement of an individual but of the group they are socialised into, and it is the group that provides the *Weltanschauung* which orders reality, guides our explanation of it, and provides the resources to communicate about it. In Mannheim's approach, the validity of scientific ideas is socially produced:

> ...we see therefore not merely that the notion of knowledge in general is dependent upon the concretely prevailing form of knowledge and modes of knowing expressed therein and accepted as ideal, but also the concept of truth itself is dependent upon the already existing types of knowledge (Mannheim 1972:262).

There is, in short, no independent 'sphere of truth itself'. Mannheim dismisses philosophical relativism and argues that his approach is relational and grows out of the question, addressed to all knowledges: 'In connection with what social structures did they arise and are they valid?' (Mannheim 1972:254). However, like the earlier sociologists Fleck chastises for their 'pious reverence for the sciences', Mannheim holds back from allowing the relational production of scientific facts, and in the context of this paper, of medical knowledge. Mannheim suggests that natural science 'is largely detachable from the historical social perspective of the investigator'. This is a position that, as we will explore further, Fleck would not accept. What is important, though, is that Mannheim's early twentieth-century German sociology would have formed part of *Weltanschauung* inhabited by Fleck.

The story of the sociology of knowledge in the United States is very complex, particularly given Robert K. Merton's rejection of Mannheim's Marxist influenced approach. As Kurt Wolff (1970) has suggested, the professionalisation of American sociology, its claims to objective scientific knowledge and the rise to dominance of positivistic survey research under Paul Lazarsfeld at Columbia University, were hardly conducive to any relativising claims about the social determination of knowledge. Nevertheless, it was picked up by the

Marxist-influenced, C. Wright Mills. Mills, in his 1939 paper ‘Methodological Consequences of the Sociology of Knowledge’ (reprinted 1963), argued:

> In acquiring a technical vocabulary with its terms and classifications, the thinker is acquiring, as it were, a set of coloured spectacles. He sees the world of objects that are technically tinted and patternised. A specialised language constitutes a veritable a priori form of recognition and cognition, which are certainly relevant to the results of inquiry . . . different technical elites possess different perceptual categories (Mills 1963:459–60).

The point of this brief overview is to suggest that constructivist accounts of science operated as a thought collective that Fleck was unaware he was part of. To quote Fleck himself, discussing this possibility:

> Although the thought collective consists of individuals, it is not simply the aggregate sum of them. The individual within the collective is never, or hardly ever, conscious of the prevailing thought style, which almost always exerts an absolutely compulsive force upon his thinking and with which it is not possible to be at variance (Fleck [1935a] 1979:41).

In this section, I have been concerned to sketch in the thought collective of which Fleck was a part: the early sociology of scientific and biological knowledge. Hence Fleck’s work was not an isolated occurrence. It was developed in the context of Polish philosophy, influenced by the contemporary developments in quantum physics, with the work of Duhem and Quine being influential at *Lvov*. At the same time, his countryman, contemporary and anthropologist Malinowski was arguing that Western science was not unique but imbued with magic and religious assumptions, while in France the philosophers and historians of biology and medicine, Canguilhem and Bachelard, were demonstrating precisely how culture bound apparently objective biological knowledge was. At the same time, the more limited – in the sense of not applying to the physical sciences – sociology of knowledge was flourishing in Germany, particularly in the work of Mannheim in Germany and Mills in the United States. So the thought collective of pre-Second World War European philosophy, sociology and the history of medicine was a constructivist and relativist one in which Fleck’s work provides a particularly striking example with its application to medical science.

The sociology of medical knowledge

Despite his earlier work as a constructivist sociologist of science, Robert Merton, one of the most influential sociologists of science, later argued that the scientific method epitomises the communal sharing of results, the search for universal truth, disinterested objectivity, unflinching originality and a scepticism of what has gone before (Merton 1973). Indeed, this is the image of science taken for granted in Western society. In the work of Talcott Parsons (1951), the social roles of the medical professional and the patient were identified. Furthermore, he made the important point that medicine should be conceptualised as a social organisation rather than as the outcome of the workings of a natural science. However, within the discipline, his work was developed in a way that emphasised the functional aspects of the professional and patient roles as social control mechanisms of motivated deviance. In short, the sociology of medicine developed in such a way that the knowledge base of medicine went unexamined.

This lack of focus on the social production of medical knowledge was a characteristic of both the sociology of health and of medical history (Wright and Treacher 1982). Since medicine and medical knowledge were seen as natural sciences, it was assumed by medical sociologists that they were immune to social influences. Research was in the tradition of a sociology *in* medicine, focusing on the achievements of medicine, institutional studies and proposed individualistic explanations of social change: in short, great advances, great men and great ideas. At the level of interaction between the medical practitioner and the sociologist, the sociologist's role was to enhance patient compliance and provide a legitimating story of the rise of the medical profession. This orientation to medicine in sociology was superseded by a change to a sociology *of* medicine (Twaddle 1982). This shift was marked by the publication of Eliot Freidson's *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (1970), Mary Douglas' *Natural Symbols* (1973), Foucault's *Birth of the Clinic* (1973) and Treacher and Wright's (1982) *The Problem of Medical Knowledge*. The thought collective which had been lost since Fleck, Canguilhem, Bachelard, Mannheim and Mills was recovered: medical practice and medical knowledge was a social, cultural and political achievement open to bias and influence and not a privileged epistemological domain separate from society.

This chapter demonstrates Ludwik Fleck's work in the context of this thought collective and details his contribution to it. For Fleck, medical knowledge was a social product (for his essays, see Fleck ([1935a] 1979; Cohen and Schnelle 1985). He was profoundly influenced by the relativistic turn in physics and by reading Niels Bohr on the nature of physics in 1928. Bohr concluded that 'an independent physical reality in the ordinary sense can be ascribed neither to the phenomena nor to the medium of observation' (Fleck [1935b] 1981:240). That is to say, what was observed and the observer exist in relation to one another. The object of enquiry is not distinct from the enquiring subject. Moreover, what physics calls nature is the product of the physicist's laboratory, and Fleck argued that a similar case could be made for medical knowledge. Fleck argues that the view of the world that the individual scientist or medical researcher will have is dependent on the group with whom they are trained, and the society they are socialised into. As mentioned in the intellectual background (above), Fleck was brought up in an academic tradition where the conventionalism of Poincarre and Duhem were dominant; they, along with Bohr and Quine, were all very influential precursors of Einstein's theory of relativity, and from our point of view it was their relativising of what up till then had been thought of as knowledge of 'nature' that shaped the thought collective of the sociology of knowledge and of Fleck.

Fleck and representations

The lesson Fleck took from quantum physics (he had read Ernst Mach the physicist whose work influenced Einstein's development of relativity theory), as well as Neils Bohr and Schrodinger (Schnelle 1986:11), was that we could no longer make the claim to an objective reality as the basis of our knowledge. Rather, what we have is representations of our knowledge of reality. Durkheim, in his work *The Rules of Sociological Method*, had sought to make sociology the study of moral facts – of ideas – and Fleck extended this analysis to encompass the study of scientific ideas.

As Mestrovic (1988) has argued, the turn of the century represented the high-point of *representation* (translating literally as ideas) in European social thought. It informed Gestalt psychology and Freud's work, as well as the Durkheimian school of sociology. To illustrate its meaning, we can best quote Durkheim. In his book *Moral Education*, he states, 'Society is a complex of ideas and sentiments, of ways of seeing and of feeling, a certain intellectual and moral framework distinctive of the entire group' (Durkheim [1925] 1961:128, quoted in Mestrovic 1988:41). Durkheim's project was to overcome the dualism of classical empiricism and apriorism, and the concept of representations allowed him to do this. Representations were both the subjects and the objects of social enquiry. Rather than posit a reality open to investigation by the human subject, Durkheim argued that the two were mutually constitutive. As Fleck was to formulate it:

> Would it not be possible to manage entirely without something fixed? Both thinking and facts are changeable, if only because changes in thinking manifest themselves in changed facts. Conversely, fundamentally new facts can be discovered only through new thinking ([1935a] 1979:50).

The importance of Fleck's work is to provide an empirical case study of this epistemological position. Further, he was to do it in a way that extends the formulations of the Durkheimians. As Fleck wryly noted, the Durkheimians were fine when discussing the representations of primitive peoples, but less able to analyse Western scientific thought from the same perspective:

> All these thinkers trained in sociology and classics, however, no matter how productive their ideas, commit a characteristic error. They exhibit an excessive respect, bordering on pious reverence, for scientific facts (Fleck [1935a] 1979:47).

Fleck set out to show that the knowledge of the natural medical sciences was also a representation, a product of the social.

For Fleck, knowledge of the world is the product of thought styles. By this he meant that all knowledge is possible only on the basis of a tradition of shared assumptions, which, *pace* Popper (1957), do not exist to be challenged but to be supported by scientific investigation. Thus, for Fleck, theories act to both produce the questions we can ask, and predispose the answers we can give. In this, they act as a *gestalt*, circumscribing the possible realities we can perceive, and limiting them. Thought styles do not admit of comparison from an Archimedean point, but are incommensurable, and scientific progress does not occur as a consequence of gradual change but in the usurpation of one style by another. As such, thought styles are about socialisation into the enclave of practitioners, and not through the learning of book knowledge (Harwood 1986), nor through the observation of external 'objective' reality. Fleck argued that what will count as a fact is the product of the thought style into which we are socialised.

That this all sounds familiar and reasonably unproblematic to many of us in the twenty-first century is because it has gained currency under the term 'paradigm' as developed by Kuhn ([1962] 1970). As Kuhn points out in a discussion of his intellectual development, Fleck's work 'anticipates many of my own ideas' (Kuhn [1962] 1970:vii; see also Baldamus 1977). Indeed, had Kuhn acknowledged his indebtedness to Fleck's work, which he read in the German in about 1950, he would have at least saved Fleck from obscurity as well as potentially revolutionised the sociology and social history of medicine. The sociological account of the production of medical knowledge provided by Fleck would have been available as a resource over the last 30 years rather than just the last 10.

Fleck's sociology of medical knowledge

Through the concept of a thought style, Fleck develops a philosophical analysis of science: that the discovery of scientific facts depends not upon the discovery of a pre-existing nature, but the theories we have about that nature (McCullough 1981; Sadegh-Zadeh 1981). He also develops a sociological analysis of science, demonstrating that the discovery of scientific facts depends on non-scientific factors such as religious, political or economic factors. For Fleck, scientific knowledge is collective knowledge, historically located and the product of interactions between competing groups with alternative definitions of reality (Lowy 1988). His concepts of thought styles and the way they operate are illustrated by reference to two apparently unrelated areas of medical knowledge: syphilis and anatomical drawings.

Syphilis

In his study of syphilis, Fleck demonstrates that our understanding of the disease has a history reflecting the political, economic and cultural organisation of society (Fleck [1935a] 1979:1–20). Radically, rather than tracing the history of syphilis as a progressive development out of a dark past, Fleck suggests that even current understandings of it are based on cultural factors. He proposes a historical typology of our knowledge of the condition, all of which is interrelated. Historically, the first understanding, Fleck proposes, is that syphilis is linked to fornication and to the position of the stars, which he calls a *mystical-ethical idea*. Second, syphilis is linked, with other venereal diseases, to its reactions to heavy metals such as mercury. This he identifies as an *empirical-therapeutic notion*. Third, there is a *pathogenic concept*, that syphilis is related to perverted blood. Fourth, there is the idea of a specific cause of syphilis, an *aetiological notion*.

The resolution of the Wasserman reaction – the test for syphilis – which was ‘discovered’ in 1906, provided Fleck with an empirical case study with which to advance the argument that progress in medicine is a social and political event, dependent upon thought collectives, rather than a rational interpretation and utilisation of scientific ‘facts’. The Wassermann reaction was the resolution of these four thought styles and, as Fleck points out, the post-Wasserman understanding of syphilis reflects aspects of each of them. Fleck argues that research into syphilis was motivated by moral outrage in European society about sexual promiscuity and the spread of syphilis on the one hand, and on the other, framed by a political agenda of nation-state rivalry between France and Germany, each seeking to become dominant in the field of biochemical research. Thus social, political and moral factors, binding scientists into a thought collective, both generate research topics and guide their outcome.

Fleck demonstrated that the way in which medicine and its practitioners conceptualised disease depended on their disciplinary-determined culture as well as the wider socio-cultural context within which they worked. Indeed, he wanted to show how bacteriology itself was a social product. He draws attention to two aspects of our thinking about disease and syphilis. The first is that our thinking about illness reflects its origins in nineteenth-century imperial expansion. Thus it is full of military metaphor, with invading micro-organisms doing 'battle' with the body (Fleck [1935a] 1979:59–60). This underlying motif of medicine is a direct reflection of its historical and cultural origins. The second aspect is the role of Christian thought in concepts of disease. Disease is seen as a demon able to infect a person. As Fleck puts it, 'the disease demon haunted the birth of modern medical concepts of infection and forced itself upon researchers irrespective of all rational considerations' (Fleck [1935a] 1979:60). This means that diseases are always moral categories and that they always carry social meaning (see Sontag 1978). They are not morally neutral. Indeed we could say that diseases are normative judgements about what is good, dressed up as facts (Margolis 1976). So what Fleck is suggesting is that all scientific studies depend upon non-scientific elements. These factors are the product of group membership and the participants may be unaware of them.

Anatomical drawings

Fleck provides another example of the operation of thought styles within medical knowledge. In analysing the development of anatomical drawings, he argues these originally had a primitive and symbolic character. In the Middle Ages, in the drawings of Vesalius, they are pervaded with an emotional content. For example, drawings represent the skeleton but at the same time are also symbols of death. Fleck ([1935a] 1979:137) argues that anatomical drawings in the Middle Ages portrayed the world view of that period – they are about religion, death, God's organisation of nature and the place of humans in the cosmos. Anatomical drawings most commonly expressed death and are used to remind people of their mortality. In the modern period, we presume they represent nature, but Fleck argues that, in fact, they reflect modern cultural predispositions. They have two characteristics which are immediately apparent. First, presentations of the body are mechanical. Modern medicine developed at the same time as Descartes was describing the human being in terms of the workings of a clock. People were no longer regarded as whole organisms (vitalism). This image was replaced by a mechanical one complementing the industrial revolution (mechanism). This, Fleck argues, accounts for the highly technical nature of the drawings. Fleck concludes that 'what we find we are faced with in anatomical drawings are ideograms corresponding to current ideas, not the form which is true to nature as we construe it' (Fleck [1935b:246] 1981:246). We do not see better or more clearly, rather our way of seeing changes. Thus the content of anatomical observation has changed according to changes in thought style. The knee joint of today is a mechanical device and has nothing in common with the *genu* of the ancient anatomists, who conceptualised the knee as the site of mercy.

The content of anatomical drawings thus depends on the thought style to which we belong. As Fleck puts it:

> . . . in the last resort what is, and how it is observed therefore depends on our entire culture and its development. It must be assumed that the observation of distinct objects is possible only on the basis of preconceived opinions. An empty mind cannot see at all. There are no observations that are true to nature except those that are true to culture (Fleck [1935a] 1979:247).

Thought styles after Fleck

Thought styles have continued to be influential as a way of analysing scientific and medical knowledge production as well as scientific controversies. In the brief examples that follow, I am not concerned to explore the tensions and problems in these studies but rather just to provide evidence of the heuristic value of the concept of thought style.

The philosopher Ian Hacking has worked extensively on thought styles. For Hacking (1992a:4), they define 'what it is to be objective (truths of certain sorts are just what we obtain by conducting certain sorts of investigations answering to certain standards)' for a scientific group or area of research. That is, they perform both ontological functions (defining the reality that is to be investigated) and epistemological functions (how to study and report on that definition of reality). In this way, scientific thought styles 'become not the uncoverers of objective truth but rather standards of objectivity' (Hacking 1992a:19). Truth and objectivity are the consequences of a specific style, and thus truth and objectivity will vary from style to style. Over time, Hacking argues, a style becomes increasingly secure [and social factors] are decreasingly relevant to its status:

> The style ends as an *autonomous* way of being *objective* about a wide class of facts, armed with its own authority and available as a *neutral tool* for any project or ideology that seeks to deploy it (Hacking 1992b:133, emphasis added).

Clearly there is much to be discussed about Hacking's argument, for example, how does one style come to this position of dominance, and once dominant, how is it freed from social determinants? Historians too have found great utility in utilising the concept of thought style. In his magisterial three-volume study of Western science, Crombie (1994) uses thought styles to marshal his data. Thought styles are based on ideas of nature, of science and the way scientific inquiry should be organised, a triumvirate Crombie refers to as commitments. These commitments 'regulate the problems seen, the questions put to nature and the acceptability of both questions and answers' (Crombie 1988:4).

The historian of biology Maienschein (1988), has documented rival schools of biology in the United States, and in embryology between Germany and the United States (Maienschein 1991a). Under the umbrella of epistemic styles, Maienschein defines 'a biological style [as] characterised by a shared set of problems regarded as appropriate, techniques regarded as useful and approaches regarded as productive' (Maienschein 1988:173), thus allowing her to develop an analysis of a 'Chicago style' of biology developing around 1900. In *Transforming Traditions in American Biology, 1880–1915*, Maienschein (1991b) demonstrates a shift in style to a new way of doing biology from a focus on development to a focus on heredity, and to factors internal rather than external to the organism. This new focus led to epistemological shifts – in the way questions were asked, in how they were to be answered and on what counted as an adequate answer: in short, to a new thought collective. In her work on comparing American and German embryology between 1880 and 1915, Maienschein argues that the American thought style developed as a pragmatic, focused approach while the Germans retained historical, evolutionary perspectives. The Germans 'sought causal mechanical explanations of as many phenomena as possible, guided by strong theories which achieved confirmation when they fit with as much of the available data as possible', while in the American case, the search was for 'definitive facts, as many as possible, which might be quite specific or narrowly based' (Maienschein 1991a:407). The two epistemic styles 'emphasised different goals, processes of investigation and standards of evidence' (Maienschein 1991a:407). As she says in another work on 'epistemological styles', which she adapts to biology: 'a biological style is characterised by a shared set of problems regarded as appropriate, techniques regarded as useful, and approaches regarded as productive' (Maienschein 1988:173). In short, they function as Fleckian thought collectives, creating the conditions for knowledge production, methods of determining facts and methods for determining what counts as adequate knowledge. The difference between thought styles and traditions for Maienschein is that the latter are historically bound, whereas thought styles, as they are in Fleck, can be independent of their historical period, as in his case study of syphilis, and intermingle with each other over time.

Harwood (1993) has similarly identified differences in thought style between German and American genetics in the period 1900–1930. Harwood argues that two different thought styles developed in German genetics, each with different methods, approaches and understandings of genetics. Moreover, these different thought styles are carried out by different social groups. In Mannheim's original formulation of the sociology of knowledge, he argued that membership of specific social groups – classes or generations, for example – led to a shared world view and to ways of seeing, acting and understanding based on the membership of that social group. The group, in short, specifies 'how fruitful thinking can be carried out' (Mannheim 1972:276). Thus science is not based on the 'nature of things' or on 'pure logical possibilities' (Mannheim 1972:267), but on the groups' shared world view. In the same way, Harwood proposes that his book is 'not only [a contribution to] the history of genetics, but to the historiography of science more generally. I hope to persuade others that "style of thought" is a useful analytical (rather than merely descriptive) concept in the history of science' (Harwood 1993:xvii). Hence Harwood argues that in one thought style – which he labels the comprehensives – the social group come from the upper middle classes, see themselves as the carriers of a high German culture, reject the developing industrial society and resist modernisation. The pragmatic thought style, in contrast, is carried by a social group from lower down the social hierarchy. These people are less worried about tradition and have a very different thought style about the role and place of science in the transformation of German culture. In documenting this social basis of the competing views, Harwood demonstrates the presence of a thought style 'when particular ontological and/or epistemological assumptions recur in a variety of scientific domains *and* those assumptions differ from one group to another' (1993:10, emphasis in original).

Fleck's work has also been used in micro-sociological studies of medical practices. For example, Arskey (2008) employs it to explore the contested definitions of Repetitive Strain Disorder; De Carnargo (2002) has developed it in the context of physicians' on-going self-education; Pena (2011) has demonstrated the changes in thought style of renal allograft pathology; while Aronowitz (1998) examines the impact of thought collectives on the classification and diagnosis of conditions as diseases: Lyme's disease, ulcerative colitis, chronic fatigue syndrome and coronary heart disease. Fleck's ideas have also been applied in an ethnographic study of a brain imaging laboratory (Roepstorff 2002). Thus we see that contemporary work reflects Fleck's original concerns with changes in thought collectives over time and in the classification and definition of disease.

Ludwik Fleck is one of the originators of the sociology of medical knowledge. His work disappeared after the war and was 'rediscovered' in the 1970s. In developing a sociology and philosophy of medical practice, Fleck contributed the first ethnographic account of the medical laboratory in his analysis of the Wasserman reaction as a test for syphilis. He also contributed to our understanding of the incommensurability of thought styles, as well as the shifts in thought collectives over time, and continues to be a rich source of inspiration to contemporary historians, sociologists of medicine and sociologists of health and illness. One can only wonder what the impact of his thought would have been on the thought collective of the history, sociology and philosophy of medicine over the last 90 years had it not been lost!

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Chapter 10

Norbert Elias and Erving Goffman: Civilised-Dramaturgical Bodies, Social Status and Health Inequalities

Peter Freund

This chapter explores the relevance of the works of Norbert Elias and Erving Goffman for understanding some connections between 'mindbodies', society, health and well-being. After brief biographical sketches of Elias and Goffman, Elias' work on the civilising process is discussed along with his 'psychosomatics' in which he suggests neuro-hormonal pathways between 'mindbodies' and society. The increasingly internalised forms of social control, characteristic of civilised societies, are embodied in the form of what Elias called the 'habitus'.

Next, an old issue raised by Elias (and, of course, Freud), of civilisation and its discontents, will be considered. These discontents, it will be argued, are, in effect, the result of civilisational pressures or stressors which include emotional, temporal and, most significantly, dramaturgical ones. Here Goffman's work is most relevant. After reviewing some affinities between Elias and Goffman, Goffman's dramaturgical perspective is briefly outlined. It is argued that Goffman's micro-social framework is most useful for understanding civilisational discontents in the form of dramaturgical stress. The relationships between civilisational stressors and socio-economic inequalities are then addressed. The quality and intensity of these discontents are mediated by an actor's location or status in what Elias calls 'figurations'. Social inequalities are expressed in health inequalities. It is concluded that both Elias' and Goffman's work are complementary resources for understanding relationships between modernity and its discontents.

Biographical notes

Norbert Elias

The psychologist, Steven Pinker, in his book on the decline of violence in modern societies, considers Elias to be 'the most important thinker you have never heard of' (2011:590). Born in Breslau, Germany, to Jewish parents in 1897, Elias began his studies, majoring in philosophy and medicine at the University of Breslau. This background is reflected in his focus on relationships between the biological and the social (Hughes 1978). Elias published *The Court Society* in 1933. There, he describes the beginnings of the civilising process in the courts of the absolutist monarchies. His best known work, *The Civilising Process*, was published in German in 1939. He eventually fled from Nazi Germany to Leicester University in the United Kingdom. After retiring, he spent two years at the University of Ghana. He then taught at the University of Amsterdam, where he developed a following. Elias died in Amsterdam in 1990 (van Krieken 2001).

Recognition of Elias' work came late in his life. It was not until the 1960s that the importance of his work was recognised in the Netherlands, Germany and, finally, France. In the late 1970s and 1980s, much of his work became available in English. His work is recognised now, both within and outside the discipline of sociology (for information on Elias, visit www.norberteliasfoundation.nl).

Erving Goffman

Erving Goffman (1922–1982) was born in Canada and received his masters and doctorate at the University of Chicago. He was on the faculty at the University of California at Berkeley from 1958 to 1962 and at the University of Pennsylvania from 1962 till his death (Lemert and Branamon 1997).

Goffman's work is mainly micro-sociological in its focus and ranges from analyses of cultural images of gender (*Gender Advertisements* 1979), discourse analysis (*Forms of Talk* 1981), total institutions (*Asylums* 1961), how actors make sense of the world (*Frame Analysis* 1974), stigma as a social label (*Stigma* 1963), to life as theatre (*The Presentation of Self in Everyday Life* 1959).

While Goffman was an astute ethnographer of everyday life who penetrated social backstages peering behind the scenes, he zealously guarded his own privacy (Shalin 2008). He brilliantly melded theorising with descriptive ethnographic work (Lofland 2000:176). Goffman's work has had an enduring influence not only on sociology but on anthropology and psychology. Goffman was a sociological social psychologist par excellence (for more information about Goffman, consult Lemert and Branamon 1997).

The civilising process

Elias' major work, *The Civilising Process,* was first published in German and consisted of two volumes, *The History of Manners* (1978) and *Power and Civility* (1982). In these volumes, using etiquette books, descriptions of court life and other historical sources, Elias showed changes over the last 500 years in people's behaviour, sensibilities and their emotional make-up: in effect their personalities. He argued that these changes occurred in the context of changing social structures and social relationships which Elias called 'figurations' (1982:231).

In the fifteenth century, conflicts between towns, villages, families and individuals were ubiquitous, not just among knights and warriors, but also among commoners (Elias 1978:200). With the increasing centralisation of political authority, pressures on smaller groups and individuals to live at peace with each other increased, leading to the increasing pacification and domestication of ever larger sectors of the population (Elias 1978:201). As Elias (1978:201) argues, various social structures and relationships demand and generate 'specific standards of emotional control'. Elias thus developed a theory of the emergence of civilised 'mindbodies' over the last 500 years. The civilising process, which had its beginnings in the court societies of the absolutist monarchies, 'trickled down', over time, to the bourgeoisie and eventually to society as a whole.

Elias, much like Freud (1961), argued that with the civilising process, social control shifted from being primarily externally imposed to being internalised, that is self-imposed. One aspect of this self-imposed control was a flattening of our 'affect structure' (emotional make-up) and a stabilisation of emotional expression, characterised by fewer and less intense fluctuations and contrasts. Emotional expression becomes more subdued, less direct, more moderated, and social control becomes more deeply sedimented in individuals (Elias 1978:200).This civilising process is accompanied by change in thresholds of shame and revulsion into which children are socialised – a process which in modern societies is compressed. 'The children have in the space of a few years to attain the advanced level of shame and revulsion that has developed over many centuries' (Elias 1978:140). This compressed socialisation almost always leaves 'scars' (Shilling 2012:172), and a child who does not achieve an appropriate level of emotional control may be labelled as deviant. Thus Elias suggests that what is labelled as deviant, for instance, 'mentally ill', is historically variable.

Another aspect of the civilising process, is the gradual transformation of our sensorium. The use of our sense of smell is de-valued: sniffing food at the table becomes taboo. Children are taught to look but not touch (Elias 1978:203). Smell, touch and taste become less important, whereas sight and hearing, the more distancing senses, become more dominant (Burkitt 1999:51). As Elias (1998:289) observes, that while pleasures of the eyes and ears become richer, more intense and subtle, '[o]ne perceives much and moves little', and modern humans are 'thinking statues'. Elias' metaphors evoke images of people rooted in one place for long periods of time, looking at computer and television screens. The quotidian existence of those Elias labels as 'homo clausus' has implications for discourses on physical and psychological fitness in modern society.

With the emergence of increasingly complex divisions of labour and chains of interconnectedness, there arises the need for time to be rationalised (Elias

1998:265). This time-grid requires the regulation of social, biological and physical processes. This regulation shows itself, in, for example, an official or business person and their complex time schedule of appointments, or a worker who regulates the timing and length of his or her movements (Elias 1982:248). Thus, in a modern society, individuals must develop a highly complex temporal habitus which becomes 'second nature' in order to function in everyday life (Tabboni 2001:9).

Elias avoids problems of biological reductionism by speaking of malleable drives, emotional make-up and affect structures which are capable of being transformed in the contexts of social figurations (Buck-Morss 1978). The concept of a habitus allows 'mindbodies' and the socio-cultural to be bridged. By habitus, according to Mennel and Goudsblom, Elias meant:

> . . . levels of our personality make-up which are not inherent or innate but are very deeply habituated in us, by learning from social experience from birth onward – so deeply habituated, in fact, that they feel 'natural' or inherent even to ourselves (Mennel and Goudsblom 1998:15).

While Elias' use of this concept precedes that of Pierre Bourdieu (1977, 2000), it has been suggested that they are very similar (Shilling 2012:184), with deep-seated conceptual affinities. Both, for instance, emphasise process and utilise a similar triad of concepts as a framework for their analyses: habitus, field/figuration and power. This triad is most useful for understanding the internalised forms of control of which Elias speaks as well as various civilisational discontents. 'Largely unbeknownst to one another, and in an implicit fashion primarily, Elias and Bourdieu complemented each other and pointed sociological inquiry in similar directions' (Bowen et al. 2012:87).

Civilised mindbodies and their discontents

In *Civilisation and Its Discontents*, Freud comments on the source of these discontents:

> Man has, as it were, become a kind of prosthetic god. When he puts on all his auxiliary organs, he is truly magnificent, but these organs have not grown on to him and they still give him trouble at times (1961:38–9).

Such troubles stem from tensions between mindbodies and civilisational socio-cultural demands. (Note that I use mindbodies as one word, as a way of avoiding thinking dualistically about minds and bodies.) One can view Elias' work on the civilising process as a sociological version of Freud's work. Indeed, Elias (1978) acknowledges Freud's influence. Elias examines ways in which controls demanded by civilised existence are internalised and embodied. Like Freud, Elias argues that in civilised societies, socialisation is compressed and often leaves emotional scars which can perturb adult minds and social relationships (Elias 1982:245).

Unlike Freud, Elias focuses on the process through which civilisational controls, expressed in habita, come to be embodied. Most significantly, Elias historicises Freud's work by contextualising social controls in historically changing social figurations and structures (Buck-Morss 1978). Elias does not, as does Freud, assume a fixed biological substrate of instincts but a biology that is open to transformation. For Elias, boundaries between 'instincts' (what Elias called drives) and social conditioning are blurred. Mindbodies embedded in socio-historical contexts are, therefore, more influenced by social experiences and open to the world (Buck-Morss 1978). For instance, in humans, Elias argues, the fight or flight response (Elias knew of W.B. Cannon's work) is capable of greater diversification and refinement than the stereotypical fear or rage (Elias 1991:117–18).

Armoured mindbodies

The habitual inhibition of affect that characterises civilised existence can become so entrenched that the individual becomes incapable of 'uninhibited 'emotional expression and 'particular branches of drives are, as it were anaesthetised in such cases by the specific structure of the social framework in which the child grows up' (Elias 1978:243). Over time, such inhibitions become sedimented in the form of a 'second nature'. Such inhibitions and constraints on emotional expression may contribute to a sense of being alienated from one's body and that of others. As Elias observes:

> The firmer, more comprehensive and uniform restraint of the affects characteristic of this civilisational shift, together with the increased internal compulsions that, more implacably than before, prevent all spontaneous impulses from manifesting themselves motorically in action, without the intervention of control mechanisms – these are what is experienced as the capsule, the invisible wall dividing the 'inner world' of the individual from the 'external world'... What is encapsulated are the restrained instinctual and affective impulses denied direct access to the motor apparatus (1978:258).

It has been suggested that Elias, influenced by Freud, was concerned with the armouring of the body (Falk 1994). The 'invisible affective wall', of which Elias speaks, may express itself physically, and thus 'the barriers of reserve and restraint on feelings become a body armour, frozen into one's movements, gestures, posture and musculature' (Burkitt 1999:52). This notion of armouring is reminiscent of Wilhelm Reich's (1976) concepts of character and body armour: a source of alienation from one's body and those of others. Elias' civilised mindbody is highly individualised and is experienced by the individual as strongly demarcated from its social and natural environments. A high degree of emotional control and self-monitoring is necessary in order to internalise 'finely tuned' social rules (Shilling 2012:201).

The civilising process may also create tensions between social and bodily temporal rhythms. Elias argues that in modern societies, 'animalic cycles' – for instance, eating, sleeping and sexual activity – are regulated 'and patterned in accordance with a differentiated social organisation which compels people up to a point, to discipline their physiological clockwork in terms of a social clockwork' (Elias 1998:261). Thus, work rhythms, for instance, may conflict with bio-rhythms, with social time being out of synchronisation with workers' mindbodies, contributing to stress-related health problems (Shilling 2012:130).

In the same vein as Freud, Elias suggests that the social controls characteristic of modern society can contribute to psycho-somatic disorders. For example, there may be 'a possible connection between the high effectiveness which the monopoly of physical violence have attained in most parliamentary nation states and the high incidence of psycho-somatic disorders' (Elias 2005:99). Elias eschews the idea that aggressive behaviour satisfies some universal need, such as the need for water to satisfy thirst. This behaviour, instead, is seen by Elias as an expression of the automatic fight or flight response. In modern humans, this response may be evoked in situations where they are not able to respond motorically in the way the autonomous branch of their nervous system prepared their mindbodies for. Such conflicts may lead to psycho-somatic disorders (Elias 2005:98), and thus Elias (1980:175) suggests there are relationships 'between the organic structures of excitement and the social structure of events that elicit them'.

Leisure and pleasure balance

As everyday life becomes safer, it also becomes less exciting. Spontaneous pleasures are replaced by careful planning and external conflicts are internalised (Shilling 2012:176). There is a social need for what Elias calls a 'pleasure balance' and for opportunities and places which provide for the possibility of, at least, somewhat satisfying 'instincts' and the need for spontaneity (Tabboni 2001:17). Forms of leisure (Elias and Dunning 1980), or what Mac Andrew and Edgerton (1969) call 'time outs', exist in most societies.

A positive 'pleasure balance' (Elias 1982:246) reduces civilisational pressures by providing opportunities for experiencing liberating sensual and emotional pleasures. 'Living statues' have opportunities to not only move their limbs but relax their 'armoured' mindbodies (Elias and Dunning 1980:40–1). It has been suggested that the most important psycho-biological sources of stress-related problems 'may be that normal resting periods or phases of restitution do not alternate normally with the activation process' (Eriksen and Holger 2002:34). Times and places for leisure (in the broadest sense of the word) offer opportunities for such rest and relaxation (Freund 2011:61).

Car-nage and civilisation

Car accidents, or what might be more accurately described as crashes, are a global public health issue (Freund et al. 2003). In his essay on technisation and civilisation, Elias (1995) looked at car accidents, suggesting technological advances such as motorised transport increased mobility, but have a double edge, in that while on one side they enhanced the power and mobility of the driver, on the other:

> ... they triggered a spurt in the other direction, a move towards de-civilisation. Viewed in terms of the theoretical concept of civilisation, the motor vehicle had two faces (Elias 1995:15).

Fordism, Elias (1995:117) argues, made possible the mass use of cars on the road *and* mass murder. The car 'prosthesis' gives its user 'unalloyed pleasure, but sometimes trouble' (Elias 1995:21). This trouble, argues Elias, is the result of 'de-civilising spurts' which result in car-nage. Thus the problem of car accidents is a 'civilising' problem.

In order to illustrate the psycho-social dimensions of the civilising process, one which involves increasing emotional and self-control, Elias (1978:233–4) used the analogy of different road systems. On the one hand, in the country roads, there is little traffic and the primary danger comes from occasional predators. In such a system, an appropriate habitus includes a subjective and physical readiness to fight or flee: to give free vent to one's emotions. On the other hand, traffic on the main roads of a big city in a modern society demands a quite different moulding of the 'psychological' apparatus, and, hence, a different habitus. There is a constant and complex flow of traffic to be navigated, with many rules, signals, pedestrians, cyclists and automobiles. Self-control and a state of constant vigilance are essential. Even the briefest loss of attention and control can be lethal:

> A constant and highly differentiated regulation of one's own behaviour is needed for the individual to steer his way through traffic. If the strain of such constant self-control of everyday life becomes too much for the individual, this is enough to put himself in mortal danger (Elias 1982:234).

This illustration points to an important issue raised by Elias: the 'technisation' of everyday life in a modern society (Shilling 2012:125). Life in modern societies involves interacting with complex and potentially dangerous technologies. This interaction requires constant focus and sobriety (in the broadest sense of the word).

For Elias, the emphasis is on the lack of individual 'self-steering' as opposed to unsafe vehicles or road conditions. Elias has a tendency to reduce the problem of car accidents to a mismatch between situations and habitus (Elias 1995:30), thus over-individualising the problem and underestimating the role of socio-material and temporal contexts. Given the double-edged nature of auto technology, according to Elias, de-civilising 'spurts' occur even in civilised societies – thus limiting the possibility of accident reduction:

> In not one of the countries was it possible to reduce the number of fatal accidents below a certain figure. In an absolute sense, the number of deaths in motor traffic is still quite considerable. It is certainly considerably greater than the number of people killed by terrorists in these countries (1995:26).

While Elias' work offers some interesting insights into sources of accidents, he has a tendency to underestimate the role that the qualities of the infrastructure and traffic systems play in accidents. Second, there are pressures produced by particular ways of organising access and mobility. Thus in car-centred transport systems, where cars dominate space, and dependence on the automobile for access and mobility is very high, there are systemically produced pressures which demand *constant* vigilance and self-control, a condition of subjectivity that is stressful and not 'natural' (Freund 2004:280) and may contribute to psycho-social overload (Shilling 2012:121). One might argue that a 'tyranny of sobriety' is a feature of such systems (Freund 2004) and contributes to an inability to always maintain an appropriate habitus.

The technisation and rationalisation of everyday life, characteristic of modern societies, are a source of psycho-social stress, partly because of the need to maintain an appropriate temporal and technological habitus. This, along with other civilisational stressors, may contribute to psycho-social overload 'which may adversely affect health and well-being' (Shilling 2012:179). Another significant source of stress in civilised societies is dramaturgical in nature.

Elias and Goffman

In his discussion of the eating of meat, Elias argues that modern societies are characterised by dramaturgical closure:

> Carving itself does not disappear, since the animal must be cut when being eaten. But the distasteful is *removed behind the scenes of social life*. Specialists

> take care of it in the shop or kitchen. It will be seen again and again how characteristic of the whole process that we call civilisation is this movement of segregation, this hiding 'behind the scenes' of what has become distasteful (1978:121).

Repugnance, disgust and other emotions are more easily evoked and the 'distasteful' is concealed. Among the 'distasteful', animalistic activities which are sequestered, are executions, torture, dying, bodily functions (sleeping, giving birth, sexual activities, defecating and urinating, for instance) (Lofland 1975). Thus 'sexuality too is increasingly removed behind the scenes of social life and enclosed in a particular enclave, the nuclear family. Likewise, the relations between the sexes are isolated, placed behind walls of consciousness' (Elias 1978:180). It is also possible to view the family in contemporary society as an enclave or what Goffman might call a backstage region, in which individuals can escape some of the psycho-social demands of waged work (Shilling 2012:182).

As indicated earlier, the civilising process contributes to increased thresholds for shame and disgust. In fact, according to Elias, an increased sensitivity to being shamed and embarrassed was encouraged by early books on manners (Elias 1978:292). This sensitivity was enhanced by the increasing ability of actors to take the role of the other, an ability catalysed by the civilising process (Shilling 2012:171). Scheff (2006:64) observes, '[t]he idea that not only shame but also disgust are major sources of social control suggests a link between Goffman and early Freud and Elias'. According to Kuzmics (1991:10), the civilising process 'amounts to bodily functions, spontaneity and expressions of emotions taking place behind the scenes (Consider here Goffman's distinction between front and backstage)'. These characteristics of the civilising process suggest that dramaturgical work is very important in 'civilised' societies and a potential source of stress. After briefly examining Goffman's dramaturgical perspective, I then turn to looking at the stresses of performing: dramaturgical stress (Freund 1998).

The dramaturgical perspective: Social life as theatre

In *The Presentation of Self in Everyday Life*, Goffman uses metaphors of the theatre to illuminate the workings of social interactions in everyday life. Individual actors or groups utilise dramaturgical strategies which involve, among other things, face and body work, in order to manage the impressions that audiences have of an actor or groups seeking to put on a common front, which Goffman (1959) calls performance teams. Goffman (1959:xi) intends to provide 'a framework that can be applied to any concrete establishment, be it domestic, industrial or commercial'.

The social spaces in which dramaturgical activities of self-presentation occur, may be divided into front and backstage regions (where actors relax, rehearse, step out of character and share secrets). Given the specialised nature of everyday life, the possibility of discrepant roles arises. Such discrepancies can be managed by segregating performances, by scheduling them and by spatially segregating them. This ability to manage one's self-presentation can be short-circuited by structural conditions. As Goffman shows in *Asylums*, the lack of the inmate's or patient's privacy can undermine their ability to 'come across' the way they would like to. The implication of this is that one's social status influences one's ability to manage information. Dramaturgical strategies are means through:

> . . . which individual actors, small groups and institutions and even societies, manage the style in which information is presented and expressed, and the flow of information across the boundaries of their informational preserves. Actors, for instance, seek to delve into the secrets of individuals, groups or institutions while at the same time, protecting personal and team secrets (Freund 1998:269).

An important feature of Goffman's work is his focus on the embodied nature of social interaction and on face and body in self-presentation. This presentation is accomplished through face and body work (Goffman 1963). In doing expressive-impressive activities, actors show such activity posturally and muscularly and by being spatially embedded in social fields (Freund 2011:62). Goffman's primarily micro-social perspective is relevant to understanding the dramaturgical aspects of the civilising process. One of these aspects is dramaturgical stress.

Dramaturgical stress

Elias provides a historical, macro-social framework for many of Goffman's insights into embarrassment and shame as well as other sources of dramaturgical stress (Shilling 2012). Dramaturgical stress may be conceptualised as the stress of presenting oneself socially and of accurately 'reading' one's audiences: the stress of role-playing. Self-presentational activities in modern society require high levels of emotional regulation, involving, among other things, what Hochschild (1983) calls 'emotion work and labour'. In the context of capitalism, she suggests emotions become a commodity.

In the dramaturgical work required to conceal or redefine distressing feelings, new tensions are created which must also be hidden from audiences. Threats to one's ontological security occur when masks 'crack' or threaten to do so. A person who is ontologically insecure may see their 'inner' self as always potentially visible to others and hence feels vulnerable (Freund 1998:283). When masks become more than skin deep and meld with feelings, a short-circuiting of one's ability to be in touch with one's real feelings may lead to the development of what Laing (1965) calls a 'false' self. The civilising process is seen by Elias (1978) as enlarging the psycho-somatic 'spaces' of subjectivity, thus creating a highly reflexive, developed and enlarged 'inner theatre' of the imagination, for rehearsing, reliving and brooding over social encounters and other social experiences. Such 'spaces' are a fertile soil for contributing to the chronic, low-level stress which characterises everyday existence in a civilised society.

It has been suggested in criticisms of Elias, that behaviour in the court societies of the sixteenth century does not describe everyday life under contemporary capitalism (Kuzmics 1991). Yet, as Shilling (2012:182) points out, Elias was quite aware that quotidian existence in contemporary capitalism involved similar forms of emotional and mindbody management and dramaturgical skills. For instance, highly bureaucratised forms of capitalism are most conducive to embarrassing situations and involve complex ceremonies (Kuzmics 1991) and, for many, everyday existence is representational, that is, dramaturgical (Turner 1984).

Dramaturgical stress is also a consequence of living in contemporary capitalist consumer cultures. Tensions, which are gendered, for instance, between commoditised 'ideal' bodies and real, existing ones, abound in American consumer cultures. It is possible to see current patterns of eating disorders as influenced by dramaturgical pressures (Shilling 2012:218). Other psychological problems such as agoraphobia, according to Davidson (2003:71), involve fearful and avoidant behaviour and can be conceptualised as a breakdown in one's ability to use dramaturgical skills and other forms of coping. It is not, she argues, a fear of open spaces but of public social spaces (Davidson 2003:9). In effect, persons with agoraphobia can be seen as suffering from 'stage fright' (Davidson 2003:82). Women who are culturally defined as object, decorative objects, may develop a high level of sensitivity to the other's gaze and hence experience greater dramaturgical stress. What Davidson's study illustrates is that civilisational pressures, such as dramaturgical ones, do not fall equally on all, but are socio-culturally distributed, as are the means for coping with such pressures. The degree and quality of such pressures, as well as their impact on health, varies greatly with an individual's status or position in social figurations or networks and structures.

Civilisational discontents, social and health inequalities

Health inequalities (expressed as differences, for instance, in life expectancy or infant mortality rates) are strongly linked to social class and status. The theoretical bases and empirical evidence for such linkages have been critically and thoroughly reviewed by Cockerham (2007). Despite important differences within psycho-social approaches, most tend to be grounded in versions of stress discourses. Psycho-social approaches assume that neuro-hormonal connections exist between status and health. In effect, what happens, it is theorised, is that repeated, chronic and intense stress can, under certain conditions, neuro-hormonally de-regulate the body (Freund 2011). For instance, Massey (2004) argues that high levels of racial-ethnic segregation and poverty produce high levels of chronic stress. Some studies have found an inverse relationship between social status and the level of stress experienced, and the availability of coping resources (Freund et al. 2003; Cockerham 2007).

Elias has been criticised for glossing over inequalities in his conceptualisation of social figurations and structures. Thus, to view civilisational pressures as simply emanating from interactions in 'complex chains of interconnectedness' is to obscure the social and economic inequalities which are embedded in such chains. For instance, Buck-Morss argues:

> The timing precision of an assembly line is only weakly explained by 'increasing pressures of interconnectedness'. It is a deliberate scientific response to the goal of increased productivity, and hence of increased surplus value experienced by the capitalist as corporate profit and by the worker as corporeal fatigue (1978:193–4).

The social control of mindbodies produces more stress for those in subordinate statuses, as opposed to those in higher statuses. Recent research, contrary to previous popular assumptions, finds that 'non-executive stress' is greater than the stress experienced by executives. Highly demanding work, coupled with little control, may contribute to stress-related health problems (Freund et al. 2003). Elias (1982:329) suggests that existence in 'civilised societies' imposes mounting work and temporal pressures on individuals, as well as creating a chronic sense of insecurity. These pressures and chronic insecurities are socially distributed.

Goffman shows an awareness of certain kinds of micro-social inequalities and their institutional integuments and considers a whole range of problems which arise 'through the coexistence of authority, hierarchy and democratic norms of equality, or organisational forms that reflect them' (Kuzmics 1991:4). He has little to say about social class, for instance. What is missing in Goffman is a macro-social, economic framework, one which Elias provides, at least, the outlines for (Kuzmics 1991:16).

Williams (2001:66) suggests that *Stigma* (1963) is a 'corporeal treatise' which discusses 'the various ways in which the body and the norms regarding its presentation mediate between an individual's social and their self identity'. Stigmas are *labels*, as Goffman (1963) points out, and what is – or is not – stigmatised is culturally, socially and historically variable. He suggests three types of stigma: bodily (for example, a scar), moral (for example, sexual 'deviance') and 'tribal' ('stigmas where, for instance, a whole ethnic and/or 'racial' group, is stigmatised). In modern societies, what Goffman calls 'stigma theories', which legitimate stigmatising individuals or groups, are often grounded in 'scientific' discourses (for example, Nazi racial 'science'), as opposed to religious ones.

The ability to stigmatise and make labels 'stick' involves the exercise of power by one group over another (Link and Phelan 2006:528). In situations where the balance of power is very uneven, argues Mennel (1982:122), those dominated and exploited cannot escape their position. There the process of stigmatisation is very common. While this process varies in quality and intensity, the content remains the same:

> The outsiders are always dirty, morally unreliable and lazy, among other things. That was how in the nineteenth century industrial workers were frequently seen: they were often spoken of as the 'Great Unwashed'. That was and is, how whites often perceive blacks (Mennel 1982:122).

Once a stigma is successfully imposed, it can create stress and tensions for those stigmatised as well as low self-esteem and a lowering of an individual's or groups' life chances (Goffman 1963) through discrimination in housing and employment (Link and Phelan 2006:52).

In modern societies, 'uncivilised' mindbodies, in 'racialised' and colonial forms, are stigmatised. Under colonialism, it was the 'white man's burden' to bring civilisation to the colonies. Of course, the heaviest burden most often fell on the colonial subjects. Such ideologies continue in today's world to function as stigma theories which gloss over the costs to those stigmatised. For instance, Franz Fanon (1963:293), an Algerian psychiatrist, discussed the relationship between 'civilised' social domination and the psycho-somatic well-being of colonial subjects, whose problems were seen by colonial doctors as emanating from 'The Natives' biological makeup. The colonial subject's neuromuscular problems were 'in fact, the postural accompaniment to the native's reticence and the expression in muscular form of his rigidity and his refusal with regard to colonial authority'. The problem did not originate in the native mindbody but in the social figurations and structures of inequality in which the native was located. In this example, the individual could not leave the social spaces in which racist encounters took place and thus he or she somatically expressed a resistance which could not be shown. This form and distribution of muscular tonicity represented a way to armour one's mindbody against colonial authority, thus keeping dominating others and their claims outside one's psychological space.

Foreign, ‘uncivilised’ bodies can be stigmatised for their dress, bodily comportment and by their smell. In a study of Pakistani immigrant women in Canada, Ameeriar (2012) found that while multiculturalism was celebrated in discourses, food and art festivals in everyday life, Pakistani women were pressured to develop a sanitised, civilised habitus in order to gain access to the labour market and citizenship. This habitus required abandoning or at least concealing ‘native’ clothing, bodily comportment and, most significantly, smell.

As Elias argued, the civilising process influences and, in a sense, constructs the sensorium. Bodily odours, particularly intense and ‘strange’ ones, are experienced as distasteful. Civilised bodies are odourless and ‘Canadian’ bodies ‘smell in such a way that odours disappear’ (Ameeriar 2012:516). Immigrant ‘smelly’ bodies are stigmatised, and, to be de-stigmatised, they must be ‘sanitised’ through body and face work as well as other dramaturgical strategies.

To conclude, the psycho-social stressors of civilised quotidian existence, be they temporal, economic, emotional or dramaturgical, as well as resources for coping with them, are distributed by social status and social locations in structures and figurations. These social inequalities are linked to the health inequalities which characterise modern societies.

Conclusion: Civilised and dramaturgical mindbodies and their discontents

Elias’ psycho-somatics views civilisational pressures as contributing to stress-related issues via neuro-hormonal pathways. These pathways can be seen as bridges linking mindbody, social structure and figurations. Many of the discontents are different types of psycho-social stressors: temporal, emotional and dramaturgical, for instance. These may contribute to stress-related disorders.

The socio-cultural contexts of such stress-related disorders are to be found in social figurations and in shifting configurations of power. For example, the centralisation of political authority and the monopolisation of violence are accompanied by the pacification and ‘domestication’ (and its attendant discontents) of increasing sectors of the population.

Embedded in figurations are complexes of status differences – that is, social inequalities. Social locations or positions in such figurations may vary by gender, socio-economic, racial, ethnic and cultural status. Socio-cultural inequalities in social figurations and structures have been linked to health inequalities (Freund et al. 2003).

Health inequalities are expressed as differences in life expectancy, mortality and morbidity rates and differences in various bio-markers (Freund 2011). Studies of both the theoretical and empirical aspects of links between social and health inequalities have been thoroughly reviewed by Cockerham (2007). Such studies also show relationships between status and cortisol blood levels (a stress hormone), with lower status being linked to higher levels of cortisol. These relationships have been explained in terms of contemporary stress discourses, which essentially argue that material stressors (such as hunger and other forms of material deprivation) have decreased in modern societies and been replaced by a host of psycho-social stressors. The psycho-social stressors of 'civilised' existence are, among many, emotional, temporal and dramaturgical in nature, and their impact on mindbodies varies with one's location in shifting networks and in structures of power.

Goffman's dramaturgical perspective is a resource for understanding dramaturgical stress and its contexts and thus, along with Elias' theorising, constitute often complementary resources for studying the psycho-social stressors of modernity. Furthermore, their approaches have the potential to further illuminate relationships between social and health inequalities.

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Chapter 11

Alfred Schutz: The Co-construction of Meaning within Professional–Patient Interaction

Patrick Brown

The point of departure for this chapter, as with Schutz's social theory itself, is the work of Max Weber. It is Weber's understanding of social action, hinging around aspects of subjective meaning, that Schutz has so usefully scrutinised and developed. The first half of the chapter considers key tenets of Schutz's positive critique of Weber, which draws heavily on his critical reading of Husserl's phenomenological philosophy. In his characteristically thorough and specified manner, Schutz denoted various difficulties in Weber's conceptualising of how we make sense of others and how we consider their motives. Within these different reflections upon social action, Schutz stresses the incompleteness of our understanding of others and our heavy reliance on 'taken-for-granted' knowledge that actors accumulate over time. The problems of communication that emerge also prompt us to consider the different forms of knowledge we develop about others and the world around us. Concepts of ideal-types, the natural attitude and the life-world are seen as vital to this analysis. Later sections discuss professional–patient interaction in light of this framework, emphasising the inherent limitations to mutual understanding that Schutz illuminates. Certain important applications of Schutzian frameworks for the analysis of clinical encounters are reviewed.

Biography

Alfred Schutz was born in Vienna in 1899 and fought for the Austrian–Hungarian army in the 1914–1918 war before studying law, economics and sociology at the University of Vienna where, among others, he was influenced by the teaching of Ludwig von Mises. His most important sources of intellectual stimulus were to become Edmund Husserl and Max Weber, alongside French philosopher Henri Bergson. Schutz's classic work *Der sinnhafte Aufbau der socialen Welt*, later translated into English as *The Phenomenology of the*

Social World, sought to harness insights from Husserl and Bergson in reworking Weber's sociological method. Schutz corresponded frequently with Husserl up until the latter's death in 1938. It was in this same year that Schutz, a Jew, left Austria for Paris and then the United States. He worked at the New School for Social Research in New York until his death in 1959. At the New School, he taught and later worked with Thomas Luckmann, who has been influential in further developing phenomenological sociology, partly by completing and publishing some of Schutz's unfinished manuscripts.

Key themes within Schutz's phenomenological sociology

As already suggested, Schutz's phenomenological sociology is a profoundly dialectical synthesis of Weber and Husserl, critically reading and revising one in the light of the other (Tellier 2003). But it was towards sociology, rather than philosophy, that his main work was aimed, and so *The Phenomenology of the Social World* (1967) begins with Weber's theory of action and seeks to reconstruct and reinvigorate this as a systematic basis of sociological enquiry. Following Husserl's edict to go 'back to the things themselves' (cited in Svenaeus 2001:81), Schutz subjects Weberian formulations of subjective meaning to intense levels of scrutiny, uncovering various weaknesses in the process.

Simmelian influences within German-speaking sociology had been successful in postulating that:

> . . . all concrete social phenomena should be traced back to the modes of individual behaviour and that the particular social form of such modes should be understood through detailed description (Schutz 1967:4).

Schutz admired Weber's attempt to pursue precisely such a scheme of research. *Verstehen* was a fundamental concept within this sociological approach, focused as it was on understanding the *subjective meaning* through which individuals 'take account' of the behaviour of others (Weber 1978:30). The attachment of subjective meaning to behaviours is what, for Weber, distinguishes *action* from unintentional conduct – with action existing as the essential subject matter of social science:

> . . . the meaning of particular social phenomena can be interpreted layer by layer as the subjectively intended meaning of human acts. In this way the structure of the social world can be disclosed as the structure of intelligible intentional meanings (Schutz 1967:7).

As precise and coherent as this basis may be, Schutz criticises Weber for the limited epistemological scrutiny to which he exposes the possibility for accessing the meaning of others. While recognising that Weber was not unaware of certain problems in this *Verstehen* sociology, Schutz nevertheless argues that Weber fails to explore the implications of different and limited paths to knowing the other. Schutz (1967:8) goes on to delineate the relatively intimate forms of knowledge we have of proximate others from the '"flatness" and "anonymity"' characteristic of our knowledge of remote others. So, if we consider social action as behaviour which is imbued with meaning in light of the attributed meaning of other individuals, then it is clear that such attributions may involve a whole array of different modes and depths of knowing others. More nuanced understandings of meaning and action are therefore necessary (Schutz 1967:12).

Subjective meaning and specificities of time

Once more reworking Weberian conceptualisations, Schutz (1967:124,134) distinguishes between subjective meaning, as applied to our own behaviours (*meaning establishment*) or as we seek to understand the meaning given by others to their actions (*meaning interpretation*), and *objective meaning* where we interpret and classify behaviours in a manner which disregards the consciousness of the other who acted. Regarding meaning establishment, Schutz develops a more nuanced understanding of this process by drawing on Henri Bergson's phenomenology (for example, Bergson 1913), alongside the work of Husserl (2012), and particular philosophical interrogations of chronology within the lived-experience. For Schutz (1967:12), such a 'philosophically laborious journey' is absolutely necessary to properly get to grips with basic concepts of sociological research.

As one example, Schutz (1967:86) takes Weber's notion of motivation and explains various ways in which it is too simplistic, 'lumping together' various ideas which are better kept separate. For example the *in-order-to motive*, which one holds before a deed is undertaken (towards the future completion of a *project*), is distinguished from the *because-motive*, which one recognises retrospectively. The latter is in turn disaggregated into *pseudo because-motives* where a prospective future outcome is considered to have been the underlying intention for the behaviour, and into *genuine because-motives* where behaviour is attributed to existing or preceding contexts. An example of a pseudo because-motive is where someone visited a doctor 'in order to be relieved from an aching back'. This can be seen as a 'translation' of the in-order-to motive (Schutz 1967:91), quite different to the genuine because-motive, which was that the person felt impaired by an on-going pain and had several options such as taking pain killers, doing exercises or visiting a doctor, of which this last was perceived as potentially the most effective based on earlier experiences. The pseudo because-motive belies a much more complex set of contextual considerations. Yet, even at the time, action motivated towards completion of *the project* does not necessarily reflect on important underlying assumptions (Schutz 1967:192): pain ought to be averted; doctors will not make things worse; and so forth.

One might well question at this stage whether such detail is really necessary; what are the fruits of this 'laborious journey'? In his specific engagement with Weber, these distinctions enable Schutz to describe future-oriented motives as different from meanings, which are attributed retrospectively. Perhaps more importantly, this draws our attention to the nature by which social actions – their future-oriented motivations and meanings attributed *ex post facto* – are importantly and often decisively comprehended and shaped via taken-for-granted assumptions. This requires a quite different consideration of social action from the rational-conscious, traditional or non-rational categories typified by Weber. Instead, we are encouraged to pay attention to ways in which conscious projection and reflection are interwoven with, and bounded by, a *natural attitude* of casual assumptions in our everyday interactions. The influence of this more nuanced conception of action on twentieth-century sociology was vast and is perhaps most popularly apparent in Bourdieu's conception of habitus, by which action is powerfully shaped by certain taken-for-granted dispositions as learnt or inculcated within social fields (see Atkinson 2010).

Inter-subjective meaning and relative proximity

From a Schutzian perspective, taken-for-granted notions thus bear importantly on how we consider the motives and meanings of our own actions, but their relevance is emphasised when we start to consider how we make sense of others. We might go further to say that taken-for-granted notions are inescapable and indispensable in considering and interpreting the others with whom we interact. To go further, still we should add that, when one person communicates with another, some common taken-for-granted schemas (most obviously, language) are necessary, though not sufficient, for this communication to be effective.

The starting point of this analytical trajectory is, of course, to emphasise the impossibility of truly accessing the intended meaning of another person. Schutz, following Bergson's philosophical enquiries into the process of consciousness (1913), stresses that because meaning is 'constituted . . . within the unique stream of consciousness of each individual, *it is essentially inaccessible to every other individual*' (Schutz 1967:99 original emphasis). Instead, we use a range of interpretative tools at our disposal to infer or guess the meaning of others. These tools – which form the basis of everyday inter-subjectivity and interpretative sociology alike – involve the multi-sensory observation of another's body as it moves to create sound, speech, gestures and so on, and the more or less conscious interpretations of these as expressions or indications of this person's intended meaning.

In every day interactions, social actors leave this impossibility of true empathy to one side and presume that they can indeed interpret the other sufficiently well. This is done by the placing of the self in the other person's shoes, or rather 'everything I know about your conscious life is really based on my knowledge of my own lived experiences' (Schutz 1967:106). So the other person is observed, their bodily movements are considered as signifiers of their lived experiences, and we then extrapolate the meaning given to these actions by considering the meaning we would give amidst similar lived experiences. Appropriate interpretation of the other thus requires the categorising of movements as *signs* which renders them intelligible – a smile; a smile through gritted teeth – in terms of what these signify (*significative function*). It may also entail consideration of what this means for this observed person in this context – disdain; frustration; felt need to show politeness – which is the *expressive function* of this sign.

As we peer more deeply into the complexities of what is being achieved in everyday interactions, so do we become more sensitised towards how much is taken-for-granted within these interactions. For example the observer does not focus specifically on interpreting each muscle movement around the mouth to categorise it as a smile, nor does he or she have to specifically reflect on times when he or she has smiled in a similar fashion to recall how he or she felt. Instead, he or she just 'knows' disdain when he or she sees it: 'my intentional gaze is directed right through my perceptions of his bodily movements to his lived experiences lying behind them and signified by them' (Schutz 1967:101). This readiness to infer, to take the other's meaning as readily accessible and in many senses for granted, is the natural attitude of social actors. Under this natural attitude, the actions of many individuals can be seen as drawing upon, being coordinated through, while helping to shape and reproduce, a broader *life-world*. This taken-for-granted 'reality' may be shared by many, forming the basis of wider sociocultural contexts of common-sense understandings and norms (Berger and Luckmann 1967; Schutz 1973:21).

Common stocks-of-knowledge and their influence upon interactions

Alongside a heightened awareness of what is taken-for-granted in interacting with others, through our everyday natural attitude, Schutz also sensitises the sociologist to the extent to which this presumptuous disposition can be problematic. Implicit above are a range of possibilities by which misinterpretation may occur: focusing on a behaviour as meaning-imbued, when it is not carried out consciously by the observed person; categorising a sign as one thing (for example, a forced smile) when it was in fact another (a genuine smile); assuming a sign pertains to the expressive function the observer would typically give by it, whereas it has a quite different meaning for the observed person.

Such breakdowns in interpretation are always possible, though their likelihood is influenced by at least three interrelated factors: the extent to which the taken-for-granted reality of the observed overlaps with that of the observer; the proximity of the observed other; the familiarity of the observed other.

Processes of interpretation involve 'the referral of the unknown to the known, of that which is apprehended in the glance of attention to the schemes of experience' (Schutz 1967:84). Everyday social life necessitates countless such interpretations where the unknown meanings of the other actors are, under the natural attitude, presumed intelligible in taken-for-granted interpretations through existing knowledge. The most basic assumption is that of the consciousness of the other person (Schutz 1967:108), but actors also assume their ability to interpret others through classification of signs into *types* of behaviour and their associated objective meanings which they already 'know'. Where the observer shares many similar schemes of experience with the observed, then such inferences are more likely to be more accurate.

When there is close physical proximity between the two actors, then the observer may also enquire into the subjective meaning of the observed. This enquiry into the other person's meaning can be helpful in refining mutual understanding, though is in turn subject to further problems of interpretation. Nevertheless, where frequent attempts at verification (more explicit or implicit) have taken place over a number of occasions, then this familiarity is likely to facilitate a more accurate interpretation.

Familiarity between two or more people also means that a person seeking to convey his or her meaning, through *expressive acts*, at any one moment has a better grasp of the *stock-of-knowledge* that the observer will draw upon in interpreting. The observed can then seek to speak (or otherwise act) in light of this, to maximise the possibility of effectively conveying meaning. Those being observed by less familiar others will similarly seek to 'pitch' their communicative behaviours appropriately, though this may well be less successful – once again depending on the extent of common experiences, overlapping stocks-of-knowledge and shared working assumptions, and the observed person's accurate assessment of these.

The more or less substantial overlapping of prior experiences – direct experiences of certain events; or knowledge passed on indirectly through parents, teachers and others – and the stock-of-knowledge emerging from these is thus fundamental for inter-subjectivity. The application of this stock-of-knowledge by each actor is usually taken-for-granted and accordingly can be hard to discern. However, the contingencies of these processes become more readily apparent when they break down (Habermas 1987:400): when, for example, one of the persons deliberately challenges the use of common-sense language (Garfinkel 1967:42–4); or when a person lacks an adequate stock-of-knowledge with which to interpret the other.

The fictional example below is of a young boy, Christopher, who would be typified as having an autism-Asperger spectrum condition. He literally carries part of his stock-of-knowledge around in his pocket but is often unable to apply this in a taken-for-granted way:

> I got Siobhan to draw lots of these faces [with different expressions] and then write down next to them exactly what they meant. I kept the piece the piece of paper in my pocket and took it out when I didn't understand what someone was saying. But it was very difficult to decide which of the diagrams was most like the face they were making because people's faces move very quickly (Haddon 2003:3).

Typifications and different levels of anonymity

While in certain cases Christopher is able to use these face drawings to help him interpret the meaning of the other, he is doing this based on relatively abstract and crude *typifications* of what this meaning may be. He often finds it hard to grasp the expressive function of signs which would involve him envisaging the current subjective meaning within the stream of consciousness of the other. Instead, he tends to consider others' actions purely in terms of their objective meaning. But Christopher is by no means unusual in limiting himself to considering the objective meaning of those around him. All social actors do this a great deal of the time. It would be exhausting and impossible to consider the streams-of-consciousness of all those with whom we interact. Instead, our natural attitude often restricts us to relatively straightforward understandings of the objective meaning of others' actions, inferring this through brief observations of behavioural and communicative signs that we categorise and infer from, based on past experiences and learnt typifications. The subjective meaning of the other is therefore often taken-for-granted and not specifically focused upon.

As already suggested, typifications can be relatively crude and abstract – a fearful person – or they can be richer and more nuanced – the fear felt by someone I know well when he visits *that* dentist. The latter inference of objective meaning is still taking much for granted, in terms of the lived experience and subjective meaning of the person encountering the dentist, but it is missing much less than the more basic interpretation. Note that distant others are usually interpreted using more simplistic typifications. This degree of proximity or anonymity is, for Schutz (1967:176–81), a very important basis by which we consider the structure of the social world of those we are researching. He develops a typology of eight increasingly remote modes of considering absent others: from those with whom we have recently interacted and with whom we shall shortly meet again; to coming across an object made by a stranger about whom we know nothing.

More broadly, this typology points towards different formats of social relationships we have with more proximate or distant others. Those who are most absent from us, who we have never observed, are comprehended in the loosest, most anonymous and abstract sense. We may read about or have been told about a person, but we cannot picture his or her or consider his or her other than through a relatively small number of details we have heard about. We relate this limited knowledge to past experiences of supposedly similar others and gradually build, through inference and assumptions, an ideal-type of the person. This understanding of another is very weak and referred to as the *they-relationship* (Schutz 1967:181). Our knowledge of such rather distant others is built purely upon ideal-type inferences about the person or a 'course-of-action' we might presume they would take, using these to construct knowledge of others pertaining to what it is that we want to 'know' about them (Schutz 1967:190).

More concrete than this is the *thou-relationship*. This is where other persons are directly encountered and attention is focused upon them. These persons cease to be mere generalised others – a doctor or patient – and their individual actions and apparently relevant meanings are considered and interpreted. Although another person is encountered through attention to specificities of their being, interpretations may still be based on ideal-types (Schutz 1967:186). The specific actions of the other are noted but they are understood as those of a happy person, or a happy, white, middle class Englishman. Over time, fewer ideal-types are necessary, or indeed useful, as the uniqueness of the individual and his actions are increasingly apprehended (Schutz 1967:186).

Within this face-to-face encounter, the observer of the middle class Englishman may enquire into the meaning of his disposition and thus this interaction gradually develops into the *we-relationship*. This format of interaction, while still potentially drawing upon ideal-types as useful points of reference for interpreting actions – language is the most obvious typification here; inferring blushing as indicating felt embarrassment is another example – is characterised by the interweaving of the actors' streams-of-consciousness. There is a direct reflection upon and explication of each person's understanding of the other's actions, making this form of interaction the most accurate in terms of mutual interpretation and also the most 'concrete' in the *realness* of the experience:

> ... being present while a friend talks is very different from reading his letter. I not only can grasp the objective meaning of his words, but I can hear the tone of his voice and watch his gestures and other bodily movements. But ... there is an additional advantage: I can look into his eyes and ask him what he means. In other words, I can transform direct social observation into direct social relationship (Walsh 1967:xxvii).

Sociological enquiry into professional–patient interaction

These different levels of concreteness of knowledge, which are inversely associated with levels of anonymity, alongside various other aspects of Schutzian phenomenology outlined above, hold significant relevance for one particular form of face-to-face encounter: interactions between patients and professionals in healthcare settings. Various applications of Schutzian theory within these contexts are considered below, but first it is necessary to say a little about the study of these interactions more generally.

Of the many social encounters that take place in relation to health and illness, professional–patient encounters are arguably the most obvious and ubiquitous. From a certain perspective, the typically short, highly ritualised (Goffman 1967) and dyadic nature of these interactions would render them a rather straightforward format to study. Yet, the fore-going subsections provide us with sufficient nuances to suggest otherwise. The complexity of interactions – and of the background knowledge, norms and assumptions on which these depend – may be especially heightened given the institutional settings within which healthcare interactions are embedded. Indeed, over the past 50 years, an increasingly refined sociological understanding has emerged.

An early review of the literature denotes different key features within patient–professional encounters, including their process and content, as well as the various attributes and expectations of the physician and patient (Korsch et al. 1968). Sociological studies in this era were often influenced by early Parsonian approaches, which describe expected duties within the doctor–patient relationship and moreover distinguish between the 'instrumental' and 'expressive' functions of the professional role (Parsons 1951), with the latter oriented towards the management of the psycho-social needs of the patient. In spite of the attention drawn towards this social function and the various contexts which influence it, alongside the hospital ethnographies that importantly informed the analysis, the specifics of interactions between professional and patient are not explicitly focused upon. Instead, systemic understandings are prioritised, comprised of expectations of the mutual roles, responsibilities and capabilities of actors (Parsons 1975). Presumed competencies of the clinician, based on general aptitude, training and clinical experience, alongside professional obligations as a trustee, each contributes to certain dynamics within the professional–patient relationship, not least the 'built-in asymmetry' that is in many senses defining of these interactions (Parsons 1975:276).

In keeping with broader trends in medical sociology, approaches in the late-1960s and 1970s developed a highly critical analytical perspective towards medical professionals (Gabe et al. 1991) – not least in their interactions with patients. While some earlier studies had described different models of professional–patient relationship (Szasz and Hollender 1956), a more critical and social-theoretical medical sociology emerged, which was interested in the underlying power dynamics latent within these schemes of interacting. Parsons' (1975) analyses had emphasised power, yet his work fell increasingly out of favour due to the apparent determinism of its systems-theoretic basis (Gerhardt 1989). The growth of interactionism, drawing on Mead, Cooley and Blumer and assisted into the mainstream by Becker (1963), paid more attention to the co-construction of behaviour and motives within specific interaction contexts.

Interactionism, Becker's (1963) labelling theory and Freidson's (1970) critical account of medical professionals, galvanised the social-constructionist turn in medical sociology, with arguably the most forceful critical out-workings of this approach being directed towards psychiatry (for example, Szasz 1961). This growth of constructionism, the concurrent impact of Goffman's key works (especially 1959), combined with Dahrendorf's (1958) critique of Parsons' functionalist neglect of the individual, led to the usurping of structural-functionalism by symbolic interactionism 'as the leading paradigm within medical sociology' (Gerhardt 1989:80). Interacting individuals, rather than social systems, were to become the predominant concern of sociological research into healthcare.

Applications of Schutz in analysing professional–patient encounters

Structuring effects of taken-for-granted knowledge

Goffman's influence led to an unprecedented interest in unpicking the order and rituals of interactions. Alongside ethnomethodology, his work emphasises the extent to which pre-given norms, rules and assumptions structure the dynamics of dyadic and group interactions. Within this tradition, Heath (1984) explores in highly systematic detail of the timings and techniques of interaction which underpin the exchange of information within the clinical encounter. Here the 'nonvocal actions of the speaker assist if not establish the sequential implications of the utterance with which they occur', compelling the 'recipient' to listen and respond in a certain manner; provided these nonvocal actions are appropriately performed (Heath 1984:262). Such ethnomethodological research illuminates the structuring effect of taken-for-granted roles and is, via Garfinkel's influence, implicitly placing various aspects of Schutzian theory under empirical examination (Gerhardt 1989):

> In order to treat rationally the one-tenth of his situation that, like an iceberg, appears above the water, he must be able to treat the nine tenths that lies below the water as unquestioned and, even more interestingly, as an

> unquestionable background of matters that are demonstrably relevant to his calculations but which appear without being noticed (Garfinkel 1967:172–3, cited in Gerhardt 1989:183).

Not only did Garfinkel point many back towards the writings of Schutz, but the coinciding of Berger and Luckmann's highly influential *The Social Construction of Reality* (1967), with the student uprisings of the late-1960s propelled phenomenology into the emerging 'mainstream' within medical sociology's critical turn (Gerhardt 1989). In contrast to Garfinkel's use of Schutz as an important starting point[1] for empirical examinations into the ways in which taken-for-granted assumptions and common-sense understandings are accomplished and applied in practice, Berger and Luckmann develop a much more theoretically oriented reworking of many of Schutz's key concepts, whereby:

> [t]he reality of everyday life appears already objectified, that is, constituted by an order of objects that have been designated as objects before my appearance on the scene (Berger and Luckmann 1967:35).

Accordingly, various *pre-given* orders of everyday clinical encounters, in terms of interaction norms, the value and technical utility of certain objects, the composition and relative vulnerability of the human body, are fundamental to actors' sense-making activities in conjunction with others. This is true for both professionals constructing meaning towards diagnosis and patients constructing meaning of their illness and what is required of them within treatment. But of course, these two types of actors are not equal within the taken-for-granted rules of sense-making activities, partly due to the content of these rules and partly due to some knowing the rules better than others (Berger and Luckmann 1967:42).

'The social stock of knowledge includes knowledge of my situation and its limits' (Berger and Luckmann 1967:41), and other actors are also aware of these assumptions and 'handle' me accordingly. As acknowledged by Parsons and others, these rules have traditionally ordained the professional as controller of the interaction. While recent reductions in knowledge asymmetry have arguably challenged this control, professionals remain the most familiar with these rules within the interaction and therefore possess further power through this knowledge. Many actions, which in everyday life might be construed by the patient as professionals overstepping their limits (for example gynaecological examinations – see Brown et al. 2011), are prone to being reformulated by the patient as appropriate or normal. Misgivings may or may not occur, but these are often endured and explained away as a result of the patient's own lack of familiarity with the rules.

It may often be the stranger, the migrant patient for example, who experiences greatest vulnerability due to his or her lack of familiarity with hegemonic norms. Bowler (1993) explores the stereotyping of South Asian mothers-to-be applied by UK-based midwives, describing various taken-for-granted assumptions that structure and compromise care-giving. Schutz (1976:96) is quoted in denoting how the stranger 'becomes essentially the [wo]man who has to place in question nearly everything that seems to be unquestionable to the members of the approached group' (Bowler 1993:171). The challenging of the stranger's natural attitude assists in legitimising dominant norms while creating distress for this patient (Andersen 1987).

Constructing the taken-for-granted: Different levels of knowledge concreteness

Within their formulation of a social dialectic, Berger and Luckmann (1967) take a step back and explore the emergence of this objective reality which structures inter-subjectivity. Phenomenology is in this manner interested in the emergence of a person's stock-of-knowledge as well as its influence on interactions and the new knowledge derived from these encounters. On-going clinical experiences, within one encounter and over a series of encounters, are therefore able to be broken down into a series of dialectics, where a prior stock-of-knowledge shapes the interpretative experience of an interaction, thus helping construct a new reality which is then incorporated within the experiential stock-of-knowledge, and which will be drawn upon in the future.

Rooted in this accumulating stock-of-knowledge, social experiences with less than familiar others such as patients or professionals are deciphered through the application of myriad interpretative schemes and ideal-types, which are woven together and constructed into knowledge of the other. A patient therefore gives meaning to a nurse sitting for a time by his or her bedside, employing interpretative schemes regarding the physical signs themselves alongside assumptions about the English National Health Service, typified as understaffed (Brown et al. 2011:289). These different bases of interpretation are related to one another in considering the nurse as fitting the ideal-type of a caring but overstretched professional, thus deemed even more caring due to her busyness. It is of course possible to imagine other possible interpretations, but this patient's past experiences and accumulated stock-of-knowledge help render this reality. In contrast, another patient in the same study interprets a doctor's yawn as indicating the type of a bored and disinterested professional, while the yawn might also conceivably have been understood as indicating hardworking yet overstretched staff.

Thus, an important feature of patients' and professionals' constructed realities within their encounters is shaped by the past and the knowledge accumulated therein. But here another theme within Schutz's work should be invoked to understand how certain forms of previously acquired knowledge are more influential – or deemed 'relevant' (Schutz 1976:250) – than others. The differing concreteness of knowledge, as seen above, involves its relative vividness or flatness in terms of abstraction and anonymity. Abstract ideas and institutions may be able to be described, counted and presented in meticulous detail, but a number of inferential steps are required to make sense of these in light of the actor's own lived experience. In contrast, direct experiences, in their phenomenological richness, are less tentative and more concrete.

Brown and Calnan (2012:37–41) develop this understanding into a three-tiered schema of a differing concreteness of knowledge derived from three types of experiences: second-hand 'mediated knowledge' about remote events, first-hand observations or 'public experiences' and first-hand 'private experiences'. These latter experiences – which are distinguished by their communicative depth and affective dimensions as *we-relationships* (though Schutz seldom acknowledges the role of emotions) – provide the most concrete knowledge. Nevertheless, all three forms of knowledge are relevant, in constructing experiences and a person's stock-of-knowledge and in 'trialectically' influencing one another (Brown and Calnan 2012:37–41).

A vital qualification within this phenomenological framework is that the actor is not a passive sum of his or her experiences but actively applies and constructs knowledge (Brown 2009), bracketing off certain notions which may be unhelpful due to complexity or other difficulties. This pragmatic achievement of the natural attitude is vital within patient experiences in order to minimise anxiety and build trust (Möllering 2006; Brown 2009). Depending on their concreteness, some experiences are more easily bracketed away than others. Abstract media stories are relatively easily overridden by direct experiences. Direct experiences of misdiagnosis or false negative screening results are more problematic but still able to be explained away (Solbjør et al. 2012), so long as mediated knowledge and private-interactive experiences are sufficiently positive to enable these problem-events to be typified as aberrations and thus bracketed-off (Brown 2009).

Lost in translation? Communication amidst divergent life-worlds

Individuals' construction of meaning is made possible by and grounded in their life-world, 'the reality which seems self-evident to men remaining within the natural attitude' (Schutz 1973:3). Accordingly, where two individuals from divergent social contexts interact, then such a 'world in common with others' (Möllering 2006:55) may be problematically deficient. This theme within Schutz's framework has commonly been harnessed to consider the healthcare experiences of patients from minority ethnic backgrounds (for example Andersen 1987; Bowler 1993). The challenges to the stranger's natural attitude have been noted above, but the professional also faces challenges in his or her sense-making of the patient and his or her condition. Schutzian analyses of these settings denote the inevitable resort to 'stereotypes' (Bowler 1993). Indeed, Schutzian frameworks help emphasise that ideal-typical assumptions are innate to all encounters with unfamiliar others but can become problematic when professionals' life-worlds are (seen as) so divergent from those of their patients that problematic typifications impact negatively upon care – for example in terms of limited pain relief offered to South Asian women in labour (Bowler 1993).

Late-modern healthcare contexts require professionals to access the meaningful experiences of service-users in real time but also to envisage their meaningful motivations and actions in the future, as these professionals are increasingly required to manage risk. This is especially the case in mental health services (for example Warner and Gabe 2004), but policy frameworks in a growing number of countries also require health and social care professionals working with children to interpret the meaning that others give to their parenting and assess risk in relation to this.

Veltkamp (2012) explores this latter role within recent policy contexts in the Netherlands, whereby healthcare professionals are increasingly asked to interpret parental action with regard to ensuring child safety and 'quality' parenting more generally. Professionals have limited interaction time with parents and children, hence they must infer a lot about general conditions and actions from infrequent 20 minute encounters. 'We-relationship' encounters may emerge within these contexts, especially with like-minded parents, but these revert into 'they-relationships' when applied towards the more distant future actions of the parent. Thus, typifications are commonly applied, drawing on risk protocols and other encoded professional knowledge but also influenced by relational factors. Those who are from backgrounds which are less familiar to the largely white middle class professionals, or who fail to attend and thus are automatically deemed risky, are conceptualised through increasingly abstract typifications due to a lack of familiarity, a defensive resort to protocol, and/or through the abstraction of the 'case' as it is discussed with colleagues. Such abstracted considerations of these parents provide weaker grounds on which to trust in their parenting, while more familiar and more 'open' parents were typified as unproblematic based on more concrete 'we-relationships'.

This subsection has considered the patient's perspective and that of the professional but thus far has not explicitly brought these together. Effective healthcare outcomes emerge from detailed and accurate interpretation of the other, as facilitated through 'we relationships', which enables adequate and mutually agreeable diagnosis, treatment and cooperation. Patients may feel undermined and disempowered if they are patronised by ill-judged communication by professionals (Coyle 1999), and this in turn may affect their openness and cooperation, which hinders accurate assessment (Brown and Calnan 2012). Non-compliance is, in turn, interpreted as imbued with particular meanings by professionals (Scheid-Cook 1993), who adjust their actions towards the patient in light of these interpretations (Fineman 1991), which may or may not be accurate.

The complexity of this interpersonal communication, in the expressive and significative functions and interpretations of each actor, engenders its quadruple contingency (Brown 2009:393), limitations and a corresponding proneness to severe misunderstandings. This enduring problematic can be seen in heightened form within triadic care relationships such as those existing between professionals, carers and children or adults (of diminished/diminishing capacity). Bruggeman (2013) explores such latter triads in a dementia clinic setting. Multiple motives and meanings become lost in translation, thus constraining possibilities for adequate diagnosis and illness understanding, due to misinterpreted communications, as well as what is said and not said due to (mis)inferred notions of what other actors in the triad want to know.

Summary

The fore-going sections have offered only a brief glimpse into the richness of Schutz's work but nevertheless highlight multiple applications in deconstructing the complex inter-subjectivities which take place when patients and professionals encounter one another. Critics of phenomenology may argue that the attention devoted to the intricacies of these interactions and individual understandings mean that the broader interactive systems, and power dynamics found therein, are correspondingly neglected. Yet, those building on Schutz's work, from Garfinkel to Bourdieu to Berger and Luckmann, offer a range of clear visions of ways in which phenomenological attention to detail can be built up into broader analyses of group dynamics, institutional structures (see especially Möllering 2006) and broader society. The comprehensiveness of these analytical possibilities, from the minutiae to the macro, facilitates research which is sensitive to 'the interactive', power dynamics and the structuring of the most mundane and everyday. This renders Schutz's work theoretically valuable and methodologically rigorous, while always reminding researchers of potential fallacies and taken-for-granted assumptions latent within their own interpretative work as sociologists.

Notes

1. Quéré (2012:307) denotes a 'net continuity in Garfinkel's use of a phenomenological background, despite the fact that there has been an evolution, even a twist, in such a use – his references being more and more to existential phenomenologists (Heidegger, Gurwitsch or Merleau-Ponty) and less and less to Schutz'.

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Chapter 12

Antonio Gramsci and Pierre Bourdieu: ‘Whiteness’ and Indigenous Healthcare

Angela Durey

Race acts as a powerful social and cultural force in countries colonised by Western nations where Indigenous or First Nation peoples often remain disadvantaged across all socio-economic indicators including education, health, employment and housing (Browne 2005; Walters and Saggers 2007). In Australia, Moreton Robinson (2009:xix) describes ‘White Anglo-Australian cultural and racial dominance’ as the ‘invisible omnipresent norm’. It is rarely interrogated or seen as a difference, instead it is the benchmark by which differences from that norm are measured, valued and often ignored. Power relations based on race can reproduce inequalities and discriminate against Indigenous people, yet often remain ‘natural, normal and unmarked’ (Moreton Robinson 2009:183), including in healthcare. Mainstream healthcare delivered to Indigenous people in post-colonial countries is located within a racialised social structure where the ideas, values and practices of the dominant, racial and cultural group are accepted as the norm (Kowal 2008; Moreton Robinson 2009).

This norm is reflected in a biomedical model that focuses mainly on individual rather than social determinants of health, with the prevailing view that the model is objective or impartial (Johnstone and Kanitsaki 2010; McGibbon et al. 2014). Individual determinants are based on the assumption that each physical ailment has a specific cause, producing particular symptoms that can theoretically be cured. This mono-causal model emerged in the nineteenth century with Louis Pasteur’s theory that germs infect organs in the body. The model often conceptualises the body as a machine made up of various parts. If one of its parts is diseased, the biological cause can be isolated and treated (Germov 2002). The focus on the individual also extends to the impact of lifestyle on health, where the individual, rather than social factors, is held responsible if his or her lifestyle increases the risk of disease and early death (White 2002). Biomedicine also adopts the Cartesian belief that the mind and body are separate, with disease viewed in physical rather than psychological terms.

An individual's thoughts, feelings and lived experience of illness are considered unscientific and often dismissed or seen as secondary (Germov 2002; Saggers and Gray 2007). Biomedicine has been critiqued for its reductionist view of disease that negates the role of social and psychological factors in favour of physical causes (Germov 2002). This critique is particularly relevant in the context of Indigenous health, where focusing on individual physical problems overlooks the social determinants of health, including the negative impact of the on-going colonial legacy of inequity and marginalisation of Indigenous peoples, poverty and racism (Saggers and Gray 2007; Ziersch et al. 2011).

This chapter explores how racism, as a social determinant of health, can impact on the provision of mainstream healthcare to Indigenous peoples and detrimentally impact on health outcomes. The chapter draws on Antonio Gramsci and Pierre Bourdieu to explain how the ideas, values and beliefs of the dominant cultural and racial group are accepted as the norm in a post-colonial country like Australia. While neither theorist uses race in their analysis of social relations, their ideas about power help explain how race, as a structuring or organising principle, can reproduce inequity and discrimination. Gramsci and Bourdieu's ideas help to explain how mainstream healthcare delivered to Indigenous people in post-colonial settings can compromise rather than improve health outcomes.

Biography: Antonio Gramsci

Antonio Gramsci (1891–1937) grew up in Sardinia, a disadvantaged agrarian region of southern Italy relative to the wealthy industrial north. His father was imprisoned leaving his mother and seven children struggling in poverty. Gramsci left school early to support the family and was influenced by his brother's radical socialist politics. He returned to school and was awarded a scholarship to study at Turin University during a period of industrialisation where workers were recruited from poorer regions. Gramsci's own experiences of class struggle in the Marxist sense helped shape his understanding of inequity. Gramsci ([1971] 1999) worked within a Marxist paradigm, though he challenged Marx's economic determinist view of social relations by drawing on his own experience and understanding of social inequality.

Writing during the Industrial Revolution in Europe, Karl Marx ([1867] 1999) analysed the political and economic transformation from feudalism to capitalism as a set of social relations between the capitalist or ruling class and the working class or proletariat. Marx identified the inequitable exchange of capital between the capitalist, or owner of the means of production, and the labourer who sells his or her labour in exchange for a wage. Under capitalism, labour power creates a product equivalent to the value of the worker's labour plus the surplus value (Marx [1867] 1999:121). If more hours are worked than the cost of labour to produce the product, a surplus value or profit is created. This surplus value is claimed by the owner of the means of production who exploits the worker by coercing him or her to work longer than necessary to deliver a product and create a surplus, often forcing down wages to increase profit in the process. This inequitable exchange of capital underpins the class struggle (Marx [1867] 1999).

Gramsci moved beyond Marx's economic determinism to examine the spatial as well as socio-economic elements of class, particularly the subordination of disadvantaged regions (the southern 'agrarian bloc' in Italy), to more developed, industrialised ones (the 'northern bloc') (Gramsci [1971] 1999; Gundogan 2008). Gramsci was a socialist, a trade union official, a journalist and a political intellectual (Hall 1986). In 1922, Mussolini's fascist regime gained power and Gramsci became involved in a revolutionary alliance between the workers of the industrial north and the peasants of the agrarian south. He joined the communist party and was arrested in 1926 by the Italian fascist government and imprisoned for 20 years (Gundogan 2008). His main political and social writings occurred from 1910 to 1926 and from 1929 to 1935 while he was in prison. His renowned *Prison Notebooks* (Gramsci [1971] 1999) are a compilation of his letters and his political and ideological thinking while incarcerated. These were smuggled out of prison by his sister-in-law and published posthumously.

Gramsci's theory of hegemony

Gramsci ([1971] 1999) argues that politics and ideology, not economic determinism in the Marxist sense, underpin social practice. He explains ideology as 'any conception of the world, any philosophy which has become a "cultural movement", a "religion", a "faith", any that has produced a form of practical activity or will' (Gramsci [1971] 1999:328). Gramsci ([1971] 1999; Bates 2002) suggests we are ruled not just by force but also by ideas. He explained his theory of hegemony as a relationship of power, where one class or socio-cultural group dominates another through its position of leadership and cultural authority. This hegemonic group uses the state's public institutions (including the government, judiciary and the police) to embody and enforce its ideas, regardless of the ideas and values of the rest of civil society (Forgacs 1988; Gramsci [1971] 1999; Bates 2002). The dominant group balances *coercion*, political force implemented by the state, with *consent*, where civil or 'private' institutions such as the family, trade unions and the church also promote the state's ideas, thereby strengthening its position and gaining the consent of subordinate groups (Forgacs 1988; Gramsci [1971] 1999). The hegemonic group promotes its ideas and values as supporting the 'common good', reflecting 'a deeply held belief that the superior position of the ruling group is legitimate' and that 'the hegemonic group stands for a proper social order in which all men [*sic*] are justly looked after' (Femia 2002:266).

This approach illustrates how hegemony is a relation 'not of domination by means of force, but of consent by means of political and ideological leadership. It is the organisation of consent' (Simon 1982:21). In this process, subordinate groups accept the ideas, values and beliefs espoused by the dominant group as the norm or common sense. In other words, the world view of the dominant class is popularised and integrated into that of subordinate classes (Bates 2002). In this way, dominant groups, aided by social institutions reinforcing their ideas, are able to direct social and political consciousness (Gramsci [1971] 1999; Bates 2002).

Gramsci ([1971] 1999:12) also suggests that an individual's notion of common sense, or the way they perceive the world in which they live, is generally unreflective and uncritical. Subordinate classes are conscious only of the ideology of the dominant class because, axiomatically, the dominant class defines and controls the production of ideas (Williams 1994; Gramsci [1971] 1999). Hegemony describes a form of power and how it is practised. It goes beyond ideas to encompass a 'whole social process' that interlocks 'political, social and cultural forces' that impact on and are reproduced in social practice (Williams 1994:595).

However, a disjuncture between hegemonic ideas and the lived experience of disadvantage among subordinate social groups can lead to counter-hegemony, where norms supporting the interests of the hegemonic group are contested by subordinate groups. These groups may in turn form alliances with other groups and create the potential for structural change (Gramsci [1971] 1999:77–8). Such a disjuncture questions the notion of whose interests the so-called 'common good' are effectively serving.

Pierre Bourdieu explores this idea further with his concepts of structure and agency, arguing that individuals or 'agents' must think reflexively in order to challenge the objective structural reality (Bourdieu and Wacquant 2002:19). Bourdieu explains reflexivity as a pursuit that locates individual knowledge and experience in a social and historic context, and illustrates how the most personal actions belong, not to the individual per se, but to the complete system of social relations that inform such actions (Bourdieu et al. 1991).

Biography: Pierre Bourdieu

Pierre Bourdieu (1930–2002) was a leading social theorist and held a chair of sociology at the prestigious Collège de France in Paris. He grew up in a petit bourgeois family in rural France and began studying philosophy at university before being conscripted to serve in the Franco-Algerian war. It was in the French colony of Algeria that his interest in social science developed, where he later conducted ethnographic research with the Kabyle, a Berber ethnic group (Bourdieu 1970). His critical account of how the symbolism of the Kabyle house was linked to social behaviour, for example gender relations, became highly acclaimed as a structuralist text (see Jenkins 1993; Bourdieu 2004). Structuralism is a term that refers to objective social structures such as gender and class and the meanings attributed to them that determine social practice (Germov 2002). At a later date, Bourdieu (2004; Jenkins 1993) conducted further analysis of his research on the Kabyle that resulted in critiquing the dominant structuralist paradigm in France. He found it inadequate in explaining principles influencing how people actually behave in social contexts rather than how they are supposed to behave. This led Bourdieu (Bourdieu and Wacquant 2002:17) to develop a theory of the relationship between objective structures and their influence on social practice.

Bourdieu's theory of social practice

Bourdieu (2004:73), in his analysis of social relations, argues that social life is not just a 'mechanical reaction' to objective conditions or the summation of individual experiences. Instead, objective structures such as class (or race) inform individual experience and behaviour in social relations that are themselves influenced by the structures or organising principles of a particular 'field' (Bourdieu and Wacquant 2002:17; Bourdieu 2004:73). Bourdieu (Bourdieu and Wacquant 2002:17–19) classifies the world into socially structured spaces or 'fields' of conflict and competition. Examples of fields include the artistic field, the cultural field, the scientific field and the healthcare field. Individuals, depending on the position they occupy in a specific field, define the hierarchy and power relations and struggle either to preserve or change the boundaries of that field.

Conditions within a field produce structures of 'habitus', a 'system of durable, transposable dispositions', or outlooks, that influence how individuals experience and respond to the world around them (Bourdieu 2004:72). 'Field' and 'habitus' function in relation to each other, as individuals engage in this 'space of play' (Bourdieu and Wacquant 2002:17–19). As a structuring mechanism, habitus operates within individuals or agents forming an integral part of their behaviour. It is acquired by organising principles such as class and race that influence the social conditions that shape the individual's lived experience and inform their perceptions and social relations. These dispositions are determined by past social conditions that inform current practice where agents 'reproduce the objective structures of which they are a product' (Bourdieu 2004:72).

While each agent 'wittingly or unwittingly, willy-nilly, is a producer and reproducer of objective meaning' (Bourdieu 2004:79), part of social practice remains unconscious – 'the forgetting of history' – where 'we do not sense this man [*sic*] of the past, because he is inveterate in us; he makes up the unconscious part of ourselves' (Bourdieu 2004:78–9). This 'unconsciousness' is evident in Bourdieu's (2004; Bourdieu and Wacquant 2002:172) notion of 'misrecognition' where, for example, relations of dominance in a particular field are not recognised for what they are, inequitable, but accepted as common sense, the way things are.

This approach evokes Gramsci's (1999:12) view that an individual's perception of the world is generally unreflective. Gramsci argues that subordinate groups who 'spontaneous[ly] consent' to norms in social relations espoused by the dominant group do so because of its position of power and leadership within the social order and its ability to 'coerce' subordinate groups to integrate the dominant world view as the norm. Bourdieu adds to this by suggesting that an individual's habitus produces a common-sense view that is revealed in their social relations where the meaning of practices is understood and taken for granted:

> The system of dispositions – a past which survives in the present and tends to perpetuate itself into the future by making itself present in practices structured according to its principles . . . (Bourdieu 2004:82).

Bourdieu also claims that the dominant group does not consciously reproduce inequity in social relations (Bourdieu and Wacquant 2002). Members of this group do not recognise when their behaviour is inequitable or discriminatory and instead accept it as the norm, thereby reproducing the status quo. Indeed, the axiomatic nature of their hegemonic role ensures that their ideas and practices are not interrogated or made accountable. Subordinate groups' 'doxic' acceptance of the status quo or 'uncontested acceptance of the daily lifeworld' reinforces this position (Bourdieu and Wacquant 2002:73). According to Bourdieu, the established social order can lull the privileged *and* those who are disadvantaged into uncritically accepting ideas constructed by the dominant group as the way things are and ought to be:

> Of all the forms of 'hidden persuasion' the most implacable is the one exerted, quite simply, by the *order of things* (Bourdieu and Wacquant 2002:168, emphasis added).

Indigenous healthcare

The 'order of things' is reflected in the prevailing dominance of the biomedical model that is seen as impartial in its assessment and treatment of disease in individuals despite increasing calls to give more attention to preventing disease and to the social determinants of health (Saggers and Gray 2007; Russell 2013;

McGibbon et al. 2014). Evidence suggests that Indigenous ill-health is often caused by structural factors including the legacy of colonisation and dispossession of Indigenous people from their land and culture, the forced removal of their children, discrimination, poverty and racism (Eades 2000; Browne 2005; Saggers and Gray 2007). The prevalence of racism in Australia has been demonstrated in a study of 312 Indigenous people in Darwin where 70 per cent had experienced interpersonal racism mainly from service providers in workplace and public settings, with one-third experiencing internalised racism and two-thirds acknowledging institutional or systemic racism (Paradies and Cunningham 2009). A recent study in South Australia found that 93 per cent of Indigenous Australians had experienced racism at some stage (Ziersch et al. 2011). Research has found an inverse association between mental and physical health and the racism experienced by Indigenous Australians (Larson et al. 2007; Ziersch et al. 2011), with a strong causal link between interpersonal racism and depression (Paradies and Cunningham 2012).

Racism is explained in various ways. *Structural* or *institutionalised racism* occurs when access to power, goods, services and opportunities is inequitable based on race (Jones 2000). Examples in healthcare include evidence that fewer options for treatment and appropriate care are offered to Indigenous compared to other Australians (Boffa 2008; Coory et al. 2008; Yeates et al. 2009). *Interpersonal racism* has been described as prejudice and discrimination. Prejudice is explained as the holding of different assumptions about the ability, motives and intentions of others based on race. Discrimination is defined as acting differently towards people because of their race. Interpersonal racism can be deliberate or unintentional and includes lack of respect, suspicion or avoidance (Jones 2000). Interpersonal racism has been demonstrated in the communications between Indigenous patients (and their families) and health providers, and generally stems from the providers' lack of awareness of Indigenous culture, and lack of understanding of the Indigenous lived experience (Shahid et al. 2009). *Internalised racism* occurs when those who are discriminated against accept the beliefs, limitations and negative messages about their value and self-worth imposed on them by the dominant racial and cultural group (Jones 2000).

In healthcare delivered to Indigenous people, acknowledging and reflecting on the privileged position of the dominant racial and cultural group is integral to understanding racism and how it is constructed and practised; so it does not remain unconscious (Paradies 2006; Pease 2010). When race or culture are discussed, it is often in terms reserved for the racial and cultural 'other'. In a healthcare setting, the focus is usually on Indigenous disadvantage rather than the impact of Whiteness and its associated privileges (Moreton Robinson 2009; Walter and Butler 2013). According to O'Donoghue (cited in Carson et al. 2007:xxi), racism is 'still deeply embedded in the structure of our society . . . in health, in housing, in education and employment'. While the hegemony of Whiteness and privilege in structures such as education and healthcare are accepted as the norm rather than critiqued and called to account for any inequities, Bourdieu's notion of 'misrecognition' of inequity seems relevant. It illustrates how individuals become acculturated to certain dispositions and ways of thinking and acting that are unreflective and seen as common sense, thereby preserving the established social order and reproducing the hegemonic culture (Acciaioli 1981; Bourdieu 2004).

However, racism has been identified as a key barrier to Indigenous cardiac patients accessing health services and receiving good quality care, thus increasing the risk of further cardiovascular events and negative health outcomes (Artuso et al. 2013). It has also been noted as a factor in Indigenous people's reluctance to access to education, employment and medical care where increased exposure to stress as a result of racism can result in detrimental physiological and psychological effects (AHMAC 2012). Despite the damage racism causes to the health of Indigenous people (Larson et al. 2007), it is often unchallenged and unreported in health services (Johnstone and Kanitsaki 2009). A robust interrogation of such practices has not been forthcoming; instead, health providers often reject the idea that racism is a problem in this context despite evidence indicating otherwise (Johnstone and Kanitsaki 2010). Such practices are not identified as racist but often reframed using other terms that are more socially acceptable, such as communication barriers and a lack of cultural competence evoking another example of Bourdieu's notion of 'misrecognition' (Bourdieu 2004:172; Johnstone and Kanitsaki 2010). In addition, the biomedical model's focus on healthcare as objective, unbiased and value neutral (Johnstone and Kanitsaki 2010), and its attribution of the problem of ill-health to individual rather than social factors, effectively diverts attention from reflection on problems in the healthcare system which detrimentally impact on Indigenous health, thereby reproducing the status quo.

Reflection on practice

Notwithstanding the diversity within and between Indigenous cultures, the habitus of many Indigenous people in post-colonial countries has been shaped by oppression, social disadvantage and the marginalisation of Indigenous culture and knowledge. These now impact on their current experience, health and perceptions of the world (Mitchell 2007). These conditions are reproduced in objective structures such as the healthcare system and continue to shape their habitus. For those who have experienced racism, the result can be a distrust of healthcare services and a reluctance to access them (Shahid et al. 2009).

Health providers whose habitus reflects their dominant position in the healthcare field may not recognise the prejudices or assumptions they may hold about Indigenous people. As part of the hegemonic group, their 'misrecognition' or lack of awareness of such biases can maintain the boundaries of the field, thus continuing to locate the problem of poor health within the individual patient rather than in the provider or healthcare system. The hegemonic boundary is reinforced when organising principles in the healthcare field advocate an impartial approach to health education and practice. The assumption here is that everyone should be treated equally and in the same way. This approach leaves little room for a counter-discourse offering a more complex reality that examines racism in healthcare rather than rendering it invisible (McDermott 2012; McGibbon et al. 2014). McDermott (2012) argues that analysing racism is not an 'optional extra' in medical education but a requirement to understand its negative impacts on Indigenous health. Racism is often 'subtle [and] unintentional' (Paradies and Williams 2008:447), yet its effects can be harmful. American Indian/Alaskan Native youth in the United States currently experiences significant health disparities caused by several factors, including racism and the health providers' lack of competence in responding to cultural differences (Goodkind et al. 2010).

Unless assumptions or biases towards Indigenous people in healthcare are examined for whether they promote or undermine their health, discrimination is set to continue. Research following lung cancer diagnosis shows that survival is worse for Indigenous Australians than other patients and has been attributed to differences in treatment and forms of entrenched inequality that exist at the patient, provider and system level (Coory et al. 2008; Davidson et al. 2012). Current thinking suggests that a new approach is needed to 'how healthcare is developed for and delivered to Indigenous Australians' (Russell 2013:1). An editorial in the *Medical Journal of Australia* asks whether medical specialists make different decisions about appropriate treatment for Indigenous people based on their own assumptions about the socio-economic and cultural circumstances of their patients (Boffa 2008). Similarly, findings from the United States identified unconscious bias in health providers towards underserved populations where negative stereotypes based on race, class and sex influence provider behaviour and clinical decision-making. These biases are found to contribute to on-going disparities in treatment and poorer health outcomes (van Ryn 2002; Burgess et al. 2007).

Bias is also reflected in health providers' assumptions about 'non-compliance' with treatment or medication regimens. These often focus on the Indigenous patient as the problem, with health providers failing to identify factors in their own practice that might compromise care, such as the need to communicate more effectively (Durey et al. 2011). Health providers who focus just on those who are disadvantaged and what they need to do to improve their health can reinforce the invisibility of Whiteness and privilege (Pease 2010). If this occurs, they may not be called to account for practices that compromise the quality of care delivered to Indigenous people, effectively maintaining the boundaries of the healthcare field (Walter et al. 2013). Yet, focusing just on the attitudes and assumptions of individual health providers can overlook discrimination in the healthcare system that, according to Browne (2005:81), reflects attitudes and assumptions that are 'deeply entrenched in dominant culture'. If health providers are not required by the system to examine any assumptions or biases they may have towards Indigenous people that can influence their practice, racism is likely to persist. For this to improve, a counter-hegemonic approach to healthcare is required, where healthcare services and providers not only respond to McDermott's (2012) call for a counter-narrative that reflects on both interpersonal *and* systemic racism in healthcare, but also suggests providers become agents of change to improve Indigenous healthcare. In the United States, an extensive review of the literature to promote healing and restore trust in American Indian/Alaskan Native youth included examining basic assumptions about Indigenous youth in the healthcare system and moving beyond a reliance on Western models of care (Goodkind et al. 2010).

Counter-hegemony

Health providers who critically reflect on the objective, structural reality and organising principles underpinning the healthcare field can become conscious and critical of a healthcare system that discriminates against Indigenous people. These are the individuals who recognise the disjuncture between hegemonic ideas and the lived experience of disadvantage for Indigenous people, and who challenge the status quo and develop counter-hegemonic alliances or partnerships with Indigenous people. Such practices create the potential for structural change. As agents of change, healthcare services and providers can support Indigenous people's experience, challenge the 'uncontested acceptance' of the way things are and question the view that hegemonic ideas and values serve the common good. Reflecting on how the objective reality informs healthcare delivered to Indigenous people shines the lens on the social and collective unconscious embedded in healthcare practice in a post-colonial setting that disadvantages Indigenous people, however unintentionally (Bourdieu and Wacquant 2002). In other words, examining and questioning concepts of Whiteness and privilege underpinning mainstream healthcare can identify how it discriminates against Indigenous people, the organising principles informing health providers' dispositions (habitus), their position in the healthcare field and whether it maintains the boundaries of the field or contests the status quo.

While programmes have proliferated in recent years to deliver mainstream healthcare to Indigenous people that is anti-discriminatory and respectful of cultural differences, evidence of their effectiveness in changing behaviour and improving practice is inconclusive (Downing et al. 2011). Most programmes follow a cultural awareness model, where participants learn about 'Indigenous culture', but fail to examine the healthcare system itself, therefore reproducing the 'very chasm it attempts to bridge' (Downing et al. 2011:9). Programmes that offer superficial responses to the problem of discriminatory healthcare to Indigenous people can reinforce a depoliticised view of how individuals from the non-hegemonic culture are 'othered' within the context of post-colonisation (Sakamoto 2007). In contrast, programmes that theorise notions of power in post-colonial countries and interrogate notions of Whiteness and privilege at systemic and interpersonal levels can facilitate a 'self-reflexive grappling with racism and colonialism' and offer a counter-hegemonic, more robust response to the issue (Sakamoto 2007; Pon 2009:60). Focusing on how the ubiquity of hegemony in healthcare practice lulls health providers into accepting the status quo can also serve as a wake-up call on the importance of reflexive practice in healthcare.

Gramsci and Bourdieu's theories in the indigenous healthcare context

A key limitation to both Bourdieu's and Gramsci's social theories is their lack of focus on race. Nonetheless, their perspectives on power can be transposed effectively to healthcare settings in post-colonial contexts and provide a framework to understand the role of race in discrimination against Indigenous people. Both theorists illustrate how inequitable power relations between different social groups are constructed and practised to benefit some groups and disadvantage others. Gramsci's theory of hegemony highlights how the ideas, values and practices of the dominant racial and cultural group are normalised through its cultural authority and leadership and through the coercive powers it uses to organise the consent of subordinate groups to accept its worldview. Bourdieu's notion of 'habitus' and 'field' adds another perspective to understanding the issue of healthcare delivered to Indigenous people by exploring the relationship between objective structures such as race and social practice.

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Part III

The Mid-Twentieth-Century Theorists

Chapter 13

Talcott Parsons: His Legacy and the Sociology of Health and Illness

Evan Willis

There is little doubt that Talcott Parsons is *a* major figure in the development of the sociology of health and illness. Whether he is the major figure in the sense of being the founder has been the subject of hotly contested debate. Now that several decades have passed, it is possible to assess his legacy and lasting importance to this field of sociology. This chapter argues that although his writings are reflective of the times in which he wrote, and these times have long since passed, his core ideas remain central to the sociological sub-specialty – whether it is called the sociology of health and illness or medical sociology.

Biography

Talcott Parsons (1902–1979) was an American sociologist, who spent most of his career at Harvard University in Boston where he was a member of faculty from 1927 to 1973. According to Hamilton (1983:32–5), Parsons took his BA at Amherst College in 1924 majoring in biology, sociology and philosophy. Postgraduate studies followed at the London School of Economics, where he met his future wife and fellow American student, Helen Bancroft Walker, with whom he had three children. After a year in London, Parsons moved to Heidelberg in Germany, arriving only a few years after the death of Max Weber. He later translated several important books of Weber's into English, including the seminal *Protestant Ethic and the Spirit of Capitalism* in 1930. Parsons studied with Max's brother Alfred and took a doctorate in sociology and economics, before returning to the United States in 1926. He soon took up a post at Harvard, first in economics, then in sociology, which he occupied for the rest of a career in which he wrote more than 150 books and articles: a productivity probably since unmatched by any sociologist. Later in his career, Parsons underwent training in psychoanalysis and qualified as a lay practitioner. He died in 1979 from a stroke while giving a series of lectures in Munich.

Parsons' sociology

While this chapter deals primarily with the contribution of Parsons to the field of health sociology, it is necessary to start with his general approach to sociology. Parsons is without doubt one of the most important, if contentious, figures in the development of the discipline of sociology. In the United States, he may well be the most important figure. His voluminous writings have had an enormous impact. In many ways, he gave sociology its sense of lineage by bringing the work of Max Weber into the English speaking world to take his place along with Marx and Durkheim as the 'holy trilogy' of classical sociology. As Holton and Turner (1986:3–4) argue:

> ...the importance of Parsons' work is that it attempted to outline in an unambiguous manner a map of the social. This comprised both the defining of boundaries between 'society' and organic life, and the internal exploration of social relations between culture, personality and social structure. Parsons' sociology can be seen as a quest for the sociological paradigm.

Holton and Turner (1986:6) go on to argue that:

> ...in almost every area of modern sociology, he made some important and lasting contribution. It is therefore impossible to work in modern sociology without confronting and coming to terms with Parsons' legacy.

So, Parsons' contribution was not only to the sociology of health, which is the subject of this chapter, but in what most regard as his major works (Parsons 1937, 1951a, 1964, 1969, 1978) to a multitude of other areas including religion, economics, work, law, the family and theory itself. These broad and diverse interests seem to have sprung from a variety of other writers, certainly Weber appears to have been central. Beyond that, however, it is difficult to pin down a tradition or school that he followed. He read and studied widely, especially in biology, philosophy, anthropology and theology, developing his own approach as his views matured.

From such a vast body of writing, it is difficult to extract major themes in his writing. Holton and Turner (1986:12), in their enthusiastic review of his work, argue there are three dimensions to his sociology: 'the theory of action, the Hobbesian problem of social order and the structural-functionalist perspective on social systems'. Parsons' aim was to develop a general sociological theory for the study of society. This he called action theory; an analytical scheme that was voluntaristic in nature, and arguing that actors play an active, and not only adaptive, role. These actors, Parsons (1937) argued, live in a social world where there is a structural disjunction between the actual and the desirable (and between the desirable and the desired). Social action has to be seen as tension-oriented to reduce such a disjunction. So, although, according to Sciortino (2007), Parsons' theories themselves underwent structural change as he constantly revised and changed his argument, language and perceptions, over a career spanning 50 years, the key intellectual puzzle throughout this time was:

> ... to explain how the existence of a set of (analytically) autonomous actors requires the functioning of an unintentionally generated (and sustained) social structure.... The theoretical direction of Parsons' effort has in fact been quite stable: in all his phases, Parsons argued that the solution to problems of social order has to be looked for in the existence and functions of the normative elements of social life (Sciortino 2007:112–3).

Parsons sought a general outline of a system of social action, as one of four sub-systems, the others being culture, personality and behaviour (see Parsons, especially 1937). In this way, he sought to provide a unified social science approach spanning a number of disciplines, including biology, that were centrally focused on a unitary theory of social action.

So, Parsons' theoretical contribution was to analyse the structure and function of various elements in society that together make possible the functioning of the overall social system, thus answering the central sociological question of how is social order possible? His ideas were developed into the general theoretical system known as structural-functionalism, of which he was the key contributor. Preceded by Émile Durkheim and succeeded by Robert Merton, Parsons laid the foundation for this influential approach to studying society – such that he has been described by Outhwaite (2005:212) as the 'midwife of modern sociology'. Indeed, Holton and Turner (1986:13) go so far as to argue that his contribution to sociological theory has been more powerful than that of Marx, Weber or Durkheim. At least for the United States, it is possible to argue that Parsonian sociology was the dominant paradigm for the discipline for much of the twentieth century.

Yet, although he has been regarded by many as the twentieth century's most influential American sociologist, Parsons' work has remained controversial and the subject of many criticisms (for a detailed treatment, see Turner 1986). The vast corpus of work, the dense and abstruse language and the shifting of positions over a long career, all make the work difficult to access and permit different interpretations. Robertson and Turner (1991) indeed have a chapter on how to read Parsons. In recent years, for example, there has been an awareness that Parsons' translation and interpretation of the work of Max Weber is only one such reading, and there has been a call to 'deParsonise Weber' (Cohen et al. 1975, see reply by Parsons 1976 and rejoinder by Pope et al. 1977). Cohen et al. argue that Parsons over-emphasised Weber's focus on the normative aspects of social action as the basis for collective integration to the detriment of non-normative structures of dominance.

The criticisms of Parsons' work are many and varied. To make sense of them requires a treatise much longer than this chapter and is a difficult task for a non-American outsider. It requires an understanding of the historical context in which he was writing in the United States, in particular. Parsons' work spanned the rise of fascism in Europe, the upheaval of the Second World War, followed by the cold war and McCarthyism and then the political upheavals of the 1960s. Actually, Hamilton recounts that Parsons was himself investigated by McCarthy committees – mainly on account of speaking out vigorously against accusations levelled at colleagues. Indeed, the 'image of Parsons as a defender of human rights sits uneasily with the stereotype of "reactionary functionalist" as he is so often portrayed' (Hamilton 1983:45).

What there are however, are several lines of critique. Some flow from the underlying assumptions of a philosophical nature. There are those who are opposed, for instance, to his emphasis on consensus rather than coercion and conflict. For example, C. Wright Mills (2008) and others, have argued that conflict is endemic to social life rather than the result of poor role performance. Other lines of criticism have referred to the conservative nature of his work (see Hamilton 1983), although this conservatism is in the original sense of conserving what is already in place and thus supportive of the existing status quo rather than favouring one particular political system over another. Although no systematic empirical research has been conducted for this chapter, it seems that (at least outside the United States) in most sociology units of study, as Margaret Sargent and colleagues (1994:64) put it, 'Parsons is dug up and reburied each year'. That is, Parsons is acknowledged as formative and important to the development of the discipline, criticised extensively and then passed over. Other criticisms are concerned with changes to the character of healthcare itself. As White (2002:107–8) has argued, 'Parsons' characterisation of the medical profession has not fared well with the passage of time'. To name a few changes, White goes on to outline how the medical profession is not the unitary occupational body it was in Parsons' time but is now heavily fissured, the rise of complementary and alternative medicine was not anticipated and universalistic criteria are no longer generally applied.

The outcome of all this is that, in an overall sense of Parsons' general works, at least outside the United States, the impression gained is that there is not a Parsonian tradition of any note. In the US context, the torch has been borne by able ex-students such as Renée Fox (1979, 1996), Uta Gerhardt (2002, 2007) and some others, as represented in the publication of an edited collection of papers given at a conference to mark the 100 anniversary of his birth in 2002 (Fox et al. 2005). Indeed, in her intellectual biography of his work, Gerhardt (2002:ix) begins her preface by arguing that Parsons 'may be one of the truly tragic figures in the history of sociology of the twentieth century'.

Gerhardt (2002:ix) goes on to give several reasons for this, among them:

> Although he struggled all his life to make sociological theory more concrete when it went beyond mere description of apparent social facts, he was charged to remain unable to incorporate reflexivity into social thought. Although he aimed vigorously to account for the dynamics of meaning orientation in the increasingly pluralist modern society, he was accused of mechanistic systems thinking fitting a hermeneutic Brave New World.... Although he remained a Weberian all his life, subsequent to his encounter with Max Weber's genius during work on his doctoral dissertation, he had to defend himself against attempts, by younger colleagues, to rescue Weber (and also Durkheim) from the prongs of an allegedly false Parsonian interpretation.

But, it his work in health sociology that is primarily the focus of this chapter, and to that issue I now turn.

Parsons and the sociology of health and illness

This author's experience of many years in Australia and several other countries is that the works of Parsons are covered in an early lecture in the sociology of health or medical sociology almost everywhere. While there is often a sense of the 'dug up and re-buried' phenomenon about it, the Parsonian characterisation of the *social* nature of the illness experience is still considered sufficiently relevant for our students. Should Parsons therefore be considered the 'founder' of that specialisation of sociology whether it is known as medical sociology, the sociology of health and illness (the name used in this chapter) or some other title? Certainly, he is a founder, but should he be accorded the pre-eminent position as the parent or perhaps the father of the discipline? Answering that question is the focus of the remainder of the chapter.

First though, what other contenders might there be for the title of founder or parent? Certainly, the other major theoretical traditions of sociology examine the effects of the organisation of society on people's health. From each there developed insights which still today form some of the key underpinning ideas that drive the sociology of health. From Durkheim, in his classic work on S*uicide* (1951), we have at least two key insights, arguably still as relevant today as they were in his time. One is that there is a separate and distinct social/sociological level of analysis of even the most supremely individual act of taking one's own life so that, as Durkheim showed, an account of suicide only at the level of the psychology of the individual is inadequate. The second is that humans do better in groups! That is to say, for Durkheim, the extent of social bonds and the level of integration into society are likely to significantly influence, if not determine, the likelihood of suicide. Although one category from Durkheim's typology of suicides is the exception (altruistic or over-integration as in the case of the Kamikaze pilots), generally speaking, as Durkheim first showed, it is the more integrated who are less likely to take their own lives. By extension, those who are more integrated into society, and have strong social bonds, tend to be healthier.

Within the Marxian tradition, the possible contender is Engels, whose landmark work *The Condition of the English Working Class* (first published in 1845 and translated into English in 1885), made the connection, central to the sociology of health and illness, of the relationship between social structure and health. Indeed, Engels argued that the nature of the material conditions under which people live their lives effects their health and well-being and that the life chances of an individual, healthwise, improve the further up the social scale (for Engels and Marxists since, the class) the person is located. Much of the sociology of health and illness, including the whole social determinants paradigm, derives from this central insight (see White 2002).

The central work of Parsons on health is in his seminal book *The Social System* (1951a), where he outlines the 'Sick Role'. In his conception of this role, illness is understood in a dual fashion as 'not merely a state of the organism and/or personality but comes to be an institutionalised role' (Parsons 1978:81). This is to say the state of being sick is not to do with the person themselves but the role they come to occupy in a social context. In other words, illness can be understood as a social process.

For Parsons, illness can be understood as a form of deviance in the sense of being a threat to the social order and functioning of society. To cope with this threat to its existence, societies develop social mechanisms that regulate and control threats arising from the fact that individuals get sick and eventually die. The health system, as part of the general social system, can therefore be thought of, according to Parsons, as an institution of social control to legitimate (that is decide actual from feigned illness) and manage the threat. The aim is to provide a societal mechanism whereby (most) individuals can return to the effective performance of their social roles. This is not to imply anything pejorative about being an institution of social control; in primitive societies, the social control institutions of medicine, religion and the law are fused (often in the role of the Medicine man). In modern societies, these two social roles are separated into the professions of law, the clergy and medicine, although similar debates continue about whether individuals are 'mad' (that is sick) or 'bad'.

But, why did Parsons choose the health system and the doctor–patient dyad as the smallest unit of analysis for the social system generally – especially when a sociological specialty in health did not exist at the time? Collyer (2012:81–9), in her seminal book on the development of health sociology, has suggested two reasons may have been the availability of research money (especially from the National Institutes of Mental Health) on one hand, and that health system issues were being extensively discussed by the government on the other. These two factors may have influenced Parsons to concentrate on this area. Alternatively, as Turner (1986:120) appears to argue, the choice of the Sick Role by Parsons was relatively incidental, for it was more about his main task of illustrating his general theory of social action than it was specifically about health.

As is well known, the Sick Role has two rights and two responsibilities. On the rights side, individuals are not blamed for the state they find themselves in and are temporarily exempt from role responsibilities, be it domestic responsibilities, to submitting a university essay after the due date, to taking sick leave from paid employment. But it is only conditional legitimation. The two responsibilities are to seek out technically competent help with the sickness and comply with the recommendations of the experts. As Parsons (1964:332) argues:

> . . . to be sick was not only to be in a biological state which suggested remedial measures, but required exemptions from obligations, conditional legitimation, and motivation to accept therapeutic help. It could thus in part at least be classified as a type of deviant behaviour which was socially characterised in a kind of role.

What the Sick Role is, in fact, as Turner (1986:120) argues, is a role-set or dyadic social system of the doctor–patient relationship, spelt out in terms of Parsons' (1951a:48–50) well known normative behavioural prescriptions, the patterned variables. For instance, the doctor should show *affective neutrality*, that is, not become emotionally involved with the patient. They should be *universalistic*, that is, practice without reference to the patient's class, gender, ethnicity, age and so on. They should show *functional specificity*, to ensure their contact is confined to health matters. Finally, doctors should show an *orientation to collective norms*, in that both doctor and patient should be committed to ending their purpose and time relationship. From this dyad, Parsons (1951b:436–7) developed an account of the professions and their normative behaviour according to these patterned variables.

For Parsons, the professions are important to the stability of society, and the medical profession especially so. They are, as Kevin White (2002:104–5) has argued, an important part of the answer to the classic sociological question of what 'holds society together' in the face of the individualism, egotism and self-interest of modern society. In that sense, Parsons was attempting (as Durkheim had done before him), to develop a distinct sociological level of analysis in contrast to the economists' view that the social world is driven by the market-oriented, utilitarian pursuit of self-interest. Instead, the professions perform the key social function of stabilising the social system known as society.

Criticisms of Parsons

The concept of the Sick Role and the role of the medical profession have been subject to a great deal of criticism that need not be rehearsed in detail here (for further critique, see Morgan 1985:47–52; Turner 1986:121–4). In summary, these critiques include the notions that most illness never reaches the doctor; that the model is medico-centric when it is the patient role being outlined more than the Sick Role; that it assumes a model of the ideal patient who is totally compliant; that it fits acute rather than chronic illness; and that it cannot account for conditions such as pregnancy.

However, as Morgan (1985:48) points out, many of the criticisms of the Sick Role fail to realise that what Parsons outlined was an 'ideal-typical exaggeration of empirical reality' of what should happen. It was meant as an analytical example of his general theory, rather than describe all the variations in the conceptions of the role by patient and therapist. To the frequent criticism that his conception of the Sick Role could not account for instances of chronic illness, Parsons (1975) later responded that while the goal of complete recovery is not achievable, nonetheless, the condition may be managed so that the patient is able to return to as normal as possible a pattern of functioning in their social roles.

Of Parsons' account of the professions, the critique is more trenchant. Even Turner (1986:119), in his overwhelmingly sympathetic analysis of Parsons' work, admits it may be 'obsolete'. A substantial body of work, including the author's own (Willis 1989), argues that the professions have to be understood in terms of power as they pursue self-interested strategies of social closure aimed at the maintenance of autonomy, and ultimately income and status rewards. As White (2002:105–6) argues:

> Parsons' structural functionalism can easily be portrayed as a celebration of America in the 1950s and his eulogisation of the medical profession is part of this. His argument may be seen as medico-centric and biased on behalf of the doctor ensuring patient compliance.

Yet, for all the criticism of Parsons' formulation of the Sick Role, as Morgan (1985:52) points out, there has been little offered in the way of viable alternatives with which to analyse the illness experience. So, while the Sick Role is still frequently referred to, its use is mainly as what Shilling (2002:625) calls a 'negative referent' rather than a relevant conceptual tool today. Its importance to health sociology, as Herzlich (1973:9) argues, is as a historically adequate account of normative expectations around illness in the middle of the twentieth century. What makes it obsolete, as Bury (1997:106) suggests, is the rise of marketisation and patient empowerment. Doctors today ply their trade in a very different social and economic context.

For Freidson (1970:239) however, Parsons' theory was insufficiently sociological. Freidson portrayed medicine as a moral enterprise with the right to create illness as an official social role. Freidson makes a distinction between disease and illness and identifies in his typology sociological types of illness according to the imputed legitimacy and seriousness of the condition. Epilepsy, for example, may be a serious deviation and a stigmatised condition. A cold, in contrast, may be a minor deviation which is conditionally legitimate. This appeared to provide the platform for an alternative, more sociological approach to illness and health which eclipsed the Parsonian paradigm from the 1960s.

Yet, many writers, among them Turner (1986:109), have argued that to see Parsons' contribution to the field only in terms of the Sick Role is too narrow. There are other contributions as well. One is outlined by Turner (1986:109), who goes on to argue 'one might suggest that what Durkheim did for the sacred, Parsons did for health, namely to locate the dynamics of health and diseases at the centre of the social fabric of society'. Parsons developed a sociological understanding of health and disease, providing the conceptual basis for the social model of disease as a counterpoint to the medical model of disease. His view was that illness could be understood as a social process, as an interruption of the 'capacity for the effective performance of valued tasks' (Parsons 1964:262). Not only was his insight that it was social and not only biological (or perhaps social *as well as* biological depending on one's stance on the debate about the nature of reality in general and medical reality in particular); but also that it could be understood as a process and not just an event. By seeing illness and health as something occurring over time, its social nature could be understood; that is, the way the illness experience is effected by social processes and factors. It also becomes possible to study the pathway as well as the aftermath of the encounter with a health professional. Sociologists of health and illness generally (as any textbook in the field demonstrates), have gone on to articulate the 'stock in trade' of health sociology – which is to show how the standard sociological sources of social variation such as class, gender, ethnicity, place, sexual orientation, able-bodiedness and so on can affect the illness experience. So, Parsons' work provides the basis for a research agenda of understanding and developing answers to the question of how illness mediates social relations.

The Parsonian legacy

So, where does that leave the work of Parsons in the second decade of the twenty-first century? Which of his insights are lasting and which simply reflective of the times in which he wrote?

One of the ways of answering this question of legacy is empirically. If a conceptual framework is seen as being of contemporary rather than historical relevance, it will still be in use today. Or to ask it another way; in the publication output of contemporary health sociologists, as represented by mainstream academic medical sociology journals, what proportion use what might broadly be called a Parsonian framework? Fortunately, the research to answer this question has been conducted by Fran Collyer (2013a, 2013b) as part of her investigations into the sociology of medical sociology. In the first, (2013a), Collyer does a citation-context analysis of journal articles from the sociology of health and medicine, in Australia, the United Kingdom and the United States of America, revealing the top 21, most-cited authors in the field. Across the three lists, Parsons appears only in the US list, and then as far down as number 20 (Collyer 2013a:10). From this empirical study, we can see the work of Parsons is no longer actively cited – except to a limited degree in the United States.

In her other paper, Collyer (2013b) conducts a context-content analysis of some 670 papers from mainstream sociology journals from the 1960s to 2011, to consider, at least in the Australian context, what theoretical frameworks are utilised in the sociology of health and medicine. Although the overall numbers are not large, she shows that in the 1960s, functionalism as a theoretical framework (with Parsons the main contributor and not including Durkheim), was the conceptual basis for 44 per cent of articles surveyed. By the 2000s there were none. So functionalism, (and by implication the conceptual basis provided by Parsons), at least in the Australian context, has declined absolutely. Regrettably, as far as is known, comparable data is not available for the United States, or for other countries.

But citations are only one measure of the legacy. Another is the importance of the ideas in forming the basis of the discipline – especially for those scholars who continue to work broadly speaking within that theoretical tradition. In 1996, the editors of *SocHealth*, the electronic newsletter of the Health Sociology section of The Australian Sociological Association, published a virtual conference on the legacy of Parsons (Ezzy and Willis 1996). Renée Fox, who had been a student of Parsons (as well as a family friend), was invited to pen a piece on the legacy of her mentor for contemporary medical sociology. Several colleagues responded and Fox then wrote a rejoinder.

Her aim, in the short paper that forms the centrepiece of this virtual conference, is to:

> . . . enlarge knowledge of the range of his work in this area, to rectify some of the erroneous assumptions about his characterisation of the Sick Role, to challenge persistent assertions about the conservative and static nature of his action theory, and to demonstrate the creatively original and penetrating way in which his angle of vision continues to illuminate matters of basic and of transcendent importance that are integral to medical sociology (Fox 1996:2).

Parsons would have been very interested in the changes to medical care in the United States since his death, Fox (1996:2) argues, and keen to examine all the changes that have occurred, because '[i]n my view, the theoretical grid that he provided offers an insight-provoking means for launching an analysis of these happenings'.

Fox (1996:2) goes on to elaborate several elements of Parsons' 'angle of vision' on health matters. First, how he was concerned with the moral and metaphysical questions that surround illness and the implications of the exemption from responsibility for having fallen ill conferred upon patients by the Sick Role. Second, Fox points to the issue of uncertainty in the medical setting as being a major theme of Parsons' work, and as being both theoretically and empirically amenable to sociological analysis; something she has worked on extensively herself (for example Fox 1959):

> . . . the theme of uncertainty was an important leitmotif in Parsons' approach to medicine, not only with regard to the situation of the patient, but that of the physician as well. He was keenly aware that no matter how advanced the science and technology of medicine, and the proficiency of its practitioners may be, its capacity to effectively deal with illness, accident, and suffering, to account for their causes and predict their outcome, and to ward off death is inherently fraught with uncertainty and limitation (Fox 1996:2).

Third,

> . . . he also recognised the paradoxical fact that while medical scientific progress can reduce extant areas of uncertainty and limitation, it also identifies previously held misconceptions, uncovers fresh areas of ignorance, raises new questions, and brings in its wake side effects and iatrogenic harms that did not exist before (Fox 1996:2).

Fourth, Fox argues:

> . . . Parsons was interested in the patterned ways of handling uncertainty and limitation that physicians learn through their medical education, socialisation, and practice, and in the implications of these shared ways of coping for their professional equanimity and performance.

So, Fox, along with a few others, most notably Gerhardt, have 'kept the Parsonian flame burning'. Others work within the broad tradition, significantly influenced by Parsons' ideas. One interesting line of development of his work is an emphasis on the psychoanalytical aspects. As Gerhardt (20032) points out, Parsons based his notion of the Sick Role – partially at least – on the social theory of Freud, and later in life trained as a lay psychoanalyst. This theme in his work has been taken up by Ezzy (1996), and especially by Lupton (1996, 1997). Lupton (1997:562) argues that for Parsons, 'psychoanalytic theory was central to analysing the social aspects of the medical encounter'. His work provided the basis for later writers such as Karl Figlio (1987) who have employed psychoanalytic theory effectively in theorising healthcare. Lupton (1997:577) concludes that:

> . . . without some degree of understanding of the psycho-dynamic processes involved, sociologists of medicine and health will be unable fully to analyse the continuing complexities of the doctor-patient relationship, the medical encounter and the illness experience.

In this regard, Gerhardt (1989) identifies two models of illness in Parsons' work. One is the structural/incapacity model where the focus is on illness resulting from role-related strain, with therapy conceived in terms of the rights/duties of the Sick Role. The other is a deviance/psycho-dynamic model, which is a more psychoanalytic model. Here, illness is due to the breakthrough of repressed dependency needs, and therapy is pursued through the unconscious dynamics/psychotherapeutics of the doctor–patient role. Gerhardt claims Parsons' critics have mistakenly taken the structural/incapacity model as his model of illness as deviance, when in fact they have missed the latter model.

Another writer is the Canadian Arthur Frank (especially 1991a, 1991b, 1995), whose corpus of work is very much in the Parsonian tradition identified by Fox in at least two senses: the moral and metaphysical questions that surround illness, and the management of uncertainty and limitation on the part of both practitioner and patient. An underlying project to Frank's work appears to be to reformulate some of Parsons' ideas to reflect changes to healthcare. In his 1991 paper, Frank begins to revise the notion of the Sick Role towards more of a health role, as well as demonstrate links from Parsons' work to more contemporary theoretical perspectives such as post-modernism. As he reflects:

> Parsons could not foresee how actively people would invest in the health role or how investable the image of health would become. At Parsons' memorial session at the *American Sociological Association* meetings in 1979, I could not have imagined a world of video aerobics (a word not found in my 1980 dictionary), lycra as athletic wear, much less as street clothing, or liposuction. Where will it end? (Frank 1991b:213).

In 2013, some 35 years later, the health world has been transformed further, especially as the impact of the Human Genome Project begins to be felt (see Willis 2013).

Nonetheless, even here, as Shilling (2002) has argued, Parsons' analysis of the cultural values underpinning Western society (for example the work ethic, instrumental rationality) is highly pertinent to contemporary understandings of health in anticipating the proactive, vigilant approach to health and body-maintenance and the growth of the well-informed consumer of healthcare.

Conclusion

There is considerable agreement that the works of Talcott Parsons remain important to the field of health sociology (see, for example, Lupton 1997; Williams 2005; Varul 2010). Even the fact of significant critique does not lessen the importance of the ideas, as Eakin (1996:4) argues:

> Rather than being evidence of its inadequacy, the existence of so much 'critique' is testimony to the Sick Role's theoretical vitality. Although indisputably central to the genesis of a sociological interpretation of health, Parsons' formulation is not frequently invoked in present-day scholarship. The sociological principles embedded in the Sick Role, however, have enduring contemporary relevance.

So finally, what ideas in particular remain important? In the view of this author, the most enduring are those around the power difference between patients and practitioners in the therapeutic relationship, which translates directly as vulnerability and the management of uncertainty. This is experienced in a number of ways: the existence of threatening symptoms, the wait for assistance, negotiating the health bureaucracy to gain appropriate treatment, the need to submit to bodily inspection, the high potential for intimacy and the breaching of social taboos around bodies. In this context, social regulation to protect the vulnerable patient is appropriate. The doctor's normative role remains to act only in the best interests of the patient, and apply the highest standards of scientific knowledge and technical competence. In return, they are granted unlimited access to the patient's body and biography and an 'exclusiveness of trust'. The power differential remains at the heart of the healthcare dyad. The rich Parsonian legacy continues to direct both conceptual and research focus in this direction.

As a result, Parsons arguably qualifies for the title of the parent of the sociology of health and illness. Many of his ideas are at the core of our sub-discipline, and the study of his works remains a useful exercise for the insights they yield. There were, of course, precursors to Parsons, who delineated a distinctly social and sociological framework for understanding health and the illnesses that are the human condition. But, arguably, it is appropriate to designate the sub-specialty of the sociology of health and illness as having originated properly in 1951 with the publication of the landmark Parsonian book *The Social System*. In it, he laid out the framework that sociologists have been engaging with ever since.

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Chapter 14

Robert Merton: Occupational Roles, Social Status and Health Inequalities

Johannes Siegrist

Although Robert Merton identified with the emerging sub-discipline of medical sociology less strongly than Talcott Parsons, his influence on this field was significant. Importantly, with his emphasis on social role and social status as basic sociological categories; with his discussion of the concepts of reference group, relative deprivation and social opportunity structure; and with his theory of deviant behaviour as an adaptive response of people with low socio-economic status to structural tensions between societal goals and restricted opportunities, Merton inspired ground-breaking research on social inequalities in health. From his perspective, health was a form of deviant behaviour, and indicators of social status – specifically, occupational position and education – were analysed as significant predictors of unequal health. Several criticisms have been raised against Merton's sociological orientation, but more recent theoretical developments illustrate the fertility of Merton's seminal contributions to the field of health and medical sociology.

Biography

Robert K. Merton was born on 5 July 1910 in Philadelphia, Pennsylvania, as the son of Jewish parents who immigrated from eastern Europe. Despite the fact that he grew up in modest economic circumstances, Merton was able to start his studies in sociology at Temple University in Philadelphia before he received a fellowship of Harvard University for graduate work in sociology. At Harvard, he took advantage of studying with distinguished professors, in particular Pitirim Sorokin – the director of the newly founded Department of Sociology – Lawrence Henderson and Talcott Parsons, who introduced him to classical European sociology, and specifically to the work of Émile Durkheim (Crothers 1987). While his main interest at that time was in the sociology of science, where he completed his dissertation on *Science, Technology and Society in Seventeenth Century England* (Merton 1938a), Merton became increasingly involved in theoretical work, not least in an attempt to overcome Sorokin's historical approach to sociology on the one hand and Parsons' focus on a general sociological theory on the other (see below Merton's middle-range theory). His essay on 'Social Structure and Anomie' (Merton 1938b) is probably the most influential result of this early stage of theoretical reasoning.

In 1941, Merton became an assistant professor at Columbia University, New York, and subsequently promoted to associate professor (1944), full professor (1947) and departmental chair (1961). As a special distinction, he was appointed 'University Professor' in 1974, reflecting his long-standing merits at Columbia University as well as his growing recognition in the international scientific community. Together with Paul Lazarsfeld, Merton promoted the department to one of the world's leading sociological research institutions in the 1950s and 1960s, in close conjunction with the university's Bureau of Applied Social Research. Over decades, Merton continued to contribute to sociological theory and research by an impressive series of elegant articles. He died at the age of 92 on 23 February 2003, in New York.

It is not easy to trace Merton's theoretical development in post-war American sociology and explain the rapidly growing influence of his work. Starting with a critical appraisal of functionalism, as applied in cultural anthropology, Merton disregarded universal functions of societal life. Rather, he restricted the notion of functionalism to a heuristic device to be applied to certain types of sociological interpretation, such as the function of social control in the medical profession or the function of reward in scientific communities (Sztompka 1986:126–43). Importantly, as early as in the first edition of his landmark book *Social Theory and Social Structure* (Merton 1968, first edition 1949), Merton emphasised the primary role of structural analysis in sociological theory. In Durkheim's terms, he conceptualised society as a distinct reality patterned by social structures. 'By structure is meant that organised set of social relationships in which members of the society or group are variously implicated' (Merton 1968:216). A few years later, Merton clarified the notion of social structure by introducing the concepts of role-set and status-set as basic forms of interdependence in society and by emphasising the role of opportunities and constraints exerted by a particular social structure on an individual's behavioural choices (Merton 1968). Although these analytical innovations are described below, it is of interest to note that Merton, as distinct from Parsons, never aimed at developing a comprehensive theory of social structure and individual behaviour. Rather, he exemplified the analytical value of his proposed concepts in essays and empirical studies on selected sociological topics, such as deviant behaviour (Merton 1938b), socialisation into professional roles (for example, *The Student Physician* 1957) or processes of 'self-fulfilling prophecy' (Merton 1948).

Why did Merton nevertheless become one of the most influential sociologists in twentieth-century sociology (as documented, for instance, by Sztompka

1986; Crothers 1987; Clark et al. 1990)? A convincing answer points to the fact that Merton played a crucial role in transforming American sociology from a loosely organised area of scientific enquiry into a conceptually distinct discipline that advanced knowledge through theoretical activity and systematic empirical analysis. Sociology is considered a nomological enquiry, aimed at the discovery of patterns or regularities of social life through the development of testable 'middle-range theories' (Merton 1968). These theories apply to limited areas of social behaviour, social organisation and social change. By producing cumulative valid knowledge on limited areas, they are part of a gradual process 'evolving, not suddenly revealing, a progressively more general conceptual scheme that is adequate to consolidate groups of special theories' (Merton 1968:51). Merton's own seminal propositions of middle-range theories, his elaboration of a scientific methodology of the social sciences, his strong links with empirical research as well as the important strategic role of sociological training at Columbia University provided a rather unique source of influence on the formation of American – and Western – sociology over several decades.

Apart from his many theoretical and empirical contributions to sociology, Merton was an expert in rather distant fields of scholarship, most impressively in the history of science. With his broad range of scientific and cultural knowledge, with his elegant style of writing (as documented in numerous essays), he must be considered an eminent intellectual authority.

While Merton did not claim to be a medical sociologist, he nevertheless enriched the evolving sub-discipline of medical sociology in several regards. This will be addressed in the next section, with a special focus on the significance of social status and social role for human health. The last section discusses more recent theoretical and empirical scientific developments of research on the social determinants of health, pointing to promising extensions of Merton's theoretical notions as well as to critical appraisals of his approach.

Theoretical significance to medical sociology

Although intertwined, Merton's main theoretical contributions to health and medial sociology are best summarised in three parts, elaborating, first, the notions of social status, social role, role-set and status-set; second, his discussion of reference groups, relative deprivation and social opportunity structure; and third, the concept of deviant behaviour resulting from a mismatch between cultural goals and institutionalised means (anomie).

Social status, social role, role-set and status-set

In *Social Theory and Social Structure*, Merton acknowledged that Ralph Linton introduced the twin concepts of social status and social role to the field of sociological theory: 'By status Linton meant a position in a social system occupied by designated individuals; by role, the behavioural enacting of the patterned expectations attributed to that position' (Merton 1968:422). As a fundamental principle, every social structure is characterised by a differentiation of social statuses and related social roles. Merton builds on Linton's notion that 'each person in society inevitably occupies multiple statuses and that, for each of these statuses, there is an associated role' (Merton 1968:422). However, in his critical extension of Linton, Merton asserts that 'a particular social status involves not a single associated role, but an array of associated roles' (Merton 1968:423). To identify this complexity, Merton introduces the terms role-set and status-set. A role-set defines the range of expectations addressed by different reference groups to the holder of a single social role, such as the medical student whose behaviour differs in response to the specific expectations from teachers, other students, patients or other health professionals. While coping with different expectations may give rise to conflicts within the role-set, this situation is further complicated by the fact that an individual person occupies several social statuses at the same time and that she or he moves through a sequence of statuses over the life course. Thus, being exposed to a status-set is likely to increase the experience of inter-role conflicts, and it is an important task of sociology to identify the social mechanisms that reduce – or fail to reduce – these conflicts and tensions.

Merton has identified several such mechanisms, for instance, by pointing to the reduction of complexity by according primacy to a person's most influential social role, or by emphasising the importance of social support provided by members holding the same social status (Merton 1968:425–33). It is not by chance that Merton illustrates the first of these arguments by discussing an occupational role, the teacher of a public school. Meeting the expectations of parents of his pupils has higher priority than meeting expectations of an organisation which is only loosely connected to the school, because parents can sanction the teacher's deviant behaviour. As the occupational status holds primary significance to the teacher, he or she can prioritise the way of coping with divergent role expectations according to their relevance. Although Merton does not introduce the notion of 'master status' in this context, it is clear that occupational positions provide the principal 'statuses into which individuals move by virtue of their own achievements' (Merton 1968:436). The centrality of occupational status and role becomes evident from further theoretical notions, the concepts of reference group, relative deprivation and opportunity structure, as well as the interpretation of social anomie.

Reference group, relative deprivation and opportunity structure

Members of a role-set are considered a reference group if the occupant of a status refers his or her behaviour to the norms and values of this group. One of the core functions of this reference is social comparison. Comparing one's own behaviour with that of a reference group is essential for self-evaluation. Social comparison processes occur most often with reference groups of the same or of a similar social status. Congruent expectations of one's status with a relevant reference group may thus reduce conflicts and tensions, but opposite reactions result from unfavourable social comparison. If one's own situation is evaluated as inferior to the situation of the reference group to which one's aspirations and expectations are directed, feelings of relative deprivation emerge.

Importantly, the experience of relative deprivation is not confined to social comparisons with reference groups of the same or similar social status. In fact, Merton devoted two large chapters of *Social Theory and Social Structure* to wider applications of reference group theory where subjective evaluations are linked to socio-structural conditions (Merton 1968:279–440). According to him, research has to focus on:

> . . . evaluations of institutions or externalised judgments – for example, where comparison with others leads . . . to the judgment that the social system militates against any close correspondence between individual merit and social reward (Merton 1968:294).

Socio-structural conditions act as external constraints against individual choices where the chances of realising a desired goal depend on the person's location in the vertical social structure. The vertical social structure distinguishes status positions according to access to core resources, such as authority, power, influence and prestige. Therefore, the social opportunity structure affects people's unequal life chances – a term that Merton explicitly borrowed from Max Weber in this context (Merton 1968:230). The social opportunity structure gives rise to people's experiences of their relative deprivation, and these experiences are often aggravated by a process termed 'accumulation of disadvantage' (Merton 1976:124). For instance, social disadvantage in early life may result in poor educational and occupational outcomes later on, accruing to people holding a low socio-economic status. In this context, Merton's influential notion of deviance and social anomie deserves attention.

Social structure and anomie

Chapter six of Merton's classic book, carrying this title, is probably the most famous of his writings. It aims at explaining the occurrence of deviant behaviour in a sociological rather than psychological perspective by analysing structural tensions between a society's basic cultural goals ('the things worth striving for'), and the opportunity structure, providing institutionalised means to meet these goals (Merton 1968:187). Merton illustrates these structural tensions with reference to his contemporary American culture with its emphasis on wealth as a symbol of success and on recurrent high personal ambition as a prerequisite of social and economic success. This 'American dream' of unrestricted opportunities of social upward mobility sharply contrasts with the real life chances of lower socio-economic population groups. According to Merton, deviant behaviour emerges as a way of adaptation to these structural tensions by the frustrated, socially excluded population groups. Social anomie erupts into a social system if socially excluded groups increasingly adopt recurrent deviant behaviours as a way of compensating their disadvantage. In this regard, Merton distinguishes two types of adaptive reactions, innovation and retreatism.

'Innovation' describes an illegitimate adaptation (deviant behaviour) to a situation where 'goals are held to transcend class lines . . . yet the actual social organisation is such that there exist class differentials in accessibility of the goals' (Merton 1968:200). Here, deviant behaviour departs from institutional norms, aiming at a reduction of emotional tensions among socially deprived people who still adhere to the society's basic cultural goals. The strain of experiencing 'the gulf between merit, effort and reward' (Merton 1968:203) may precipitate the likelihood of conducting criminal acts or of becoming addicted to gambling.

Merton's analysis of innovation as a form of social deviance was elaborated in more detail in the second edition of his main book. Here, in a new chapter, he addresses forms of departure from regulatory norms other than criminal acts: 'For example, a distinct theoretical advance was effected by Parsons' conception that illness is . . . to be defined as a form of deviant behaviour' (Merton 1968:235–6). To my knowledge, this is the first time that Merton links his theory to health outcomes, although, as mentioned, the social determinants of health were beyond the scope of his analysis.

'Retreatism' is a second type of adaptation which occurs if people are no longer capable of sharing the cultural norms, but fail to cope actively with the fact that access to institutional means has been rejected. Among these people, 'defeatism, quietism and resignation are manifested in escape mechanisms' (Merton 1968:207). Merton mentions 'psychotics' and 'autists' as examples of this type of adaptation. Again, his reflections on this topic in the second edition add more clarity to this subject. Here, retreatism is discussed in terms of apathy, melancholy, or anhedonia, a typical pattern of depressed mood following the loss of a major social role or a highly valued goal in life.

Summary and evaluation

Merton's elaborations of the core sociological terms of social status and social role; his emphasis on occupation as a dominant form of achieved social status in modern societies; his analysis of the significance of reference groups and related experiences of relative deprivation; and his link of these latter experiences to macro-structural aspects of unequal opportunities and accumulated disadvantage (giving eventual rise to deviant behaviours); provide a promising theoretical background for the analysis of a crucial aspect of people's life chances, that is, their health and life expectancy. While Merton explicitly contributed to the emerging field of sociology of medicine, by studying the process of professional socialisation of physicians, he did not fertilise his theoretical innovations by applying them to empirical work in the field of sociology in medicine, the analysis of social determinants of health and disease. This task has been carried out by a subsequent generation of social scientists and epidemiologists in the United States and Europe, who began to study the social determinants of health in the 1960s and 1970s, using several of Merton's concepts in more or less elaborated ways.

It is important to note that one of Merton's former students, Peter Blau, together with Otis Duncan, developed a detailed analysis of the American occupational structure (Blau and Duncan 1967), revealing social inequalities of status acquisition in this influential Western society. Furthermore, as an extension of Merton's discussion of status, Lenski's analysis of status crystallisation and status inconsistency (Lenski 1954) was relevant for studies linking this latter notion to elevated risks of stress-related diseases (see below). Educational attainment, an indicator of the main channel towards achieved social status in modern societies, discussed repeatedly by Merton, was introduced as a main explanatory variable in one of the first epidemiological investigations on social inequalities in health (Hinkle et al. 1968). Furthermore, Merton's concept of relative deprivation was instrumental in advancing explanations of the 'social gradient of health' (see below). These are just a few remarks on Merton's direct and indirect influence on an emerging field of scientific enquiry, the study of social inequalities in health. However, in this field of enquiry, several criticisms of Merton's theoretical contributions also became apparent. These will be briefly discussed in the final part of the chapter, following the next section that deals with more recent theoretical and empirical scientific developments of research in this important area of medical sociology.

Social inequalities in health

This section considers research on social inequalities in health with reference to four Mertonian notions: first, social status as the core element of social stratification in modern societies; second, relative deprivation as a relevant outcome of social comparison; third, accumulation of disadvantage as a useful concept in life course research on health inequalities; and finally, the contribution of occupational roles to the explanation of health inequalities.

Social status and health: Cumulative evidence

American society during and after the Second World War served as a model in Merton's analysis of social stratification with its core elements of educational attainment, occupational status and income. For many social scientists, this 'meritocratic triad' was the leading paradigm for analysing social stratification in modern Western societies, and it certainly dominated research on social inequalities in health during the second half of the twentieth century. Therefore, it is not surprising that numerous epidemiological studies in North America and Europe used one of these indicators, or a combination of them, to document the social determinants of health. Among the pioneering studies were Hollingshead and Redlich's (1958) study on social class and mental illness; Hinkle et al.'s (1968) analysis of educational level as a predictor of coronary heart disease; Antonovsky's (1967) review paper on social class, life expectancy and overall mortality; Kitagawa and Hauser's (1973) analysis of administrative data on socio-economic differentials in mortality in the United States; and, in England, the first Whitehall study of occupational status and coronary heart disease among civil servants (by Marmot et al. 1978).

In essence, these and many later studies revealed an inverse relationship between social status (as measured by one or several indicators of socio-economic position) and risk of morbidity or mortality: the lower one's standing in the social hierarchy, the poorer one's health. This 'social gradient' of health was confirmed for all modern societies where respective research has been performed, irrespective of their healthcare or welfare system, and irrespective of their level of wealth, economic performance or socio-cultural tradition. Social inequalities in health were documented for men and women, for different age groups and for a large number of chronic disease conditions. These inequalities are substantial, because mean differences in life expectancy between those at the top and at the bottom of the social stratification system are anywhere from four to ten years (Lynch and Kaplan 2000; Marmot 2004; Mackenbach et al. 2008; Lahelma 2010).

Despite the relevance of its results, this research has largely lacked a theoretical foundation, for it mainly describes statistical associations. There have been several attempts to integrate the different components of social stratification into a more comprehensive analysis of pathways and inter-relationships. For instance, changes of status over time, both intra- and inter-generational, or structural conflicts by inconsistent combinations of status components (status incongruence) are explored (Bruhn et al. 1966). Moreover, four alternative explanations of the observed associations have been proposed in an influential British publication, the *Black Report* (Townsend and Davidson 1982): artefact, social selection, materialist/structural and cultural/behavioural. While the first two explanations found little support in later research, the remaining approaches have continued to influence scientific enquiry. According to the materialist explanation, education, occupational class, income and wealth determine material living conditions resulting in an unequal distribution of health across populations, whereas the cultural explanation maintains that health inequalities result from health-damaging behaviours that are differentially shaped across the socio-economic strata. However, more recently, these mainstream explanatory frameworks have been extended and differentiated, and some can be linked to Merton's theoretical work.

Relative deprivation

Evidence of the social gradient of morbidity and mortality has provoked the question of why those second to the top of the social hierarchy suffer from poorer health than those at the top. Obviously, material explanations cannot account for this difference. Rather, psychosocial processes with relevance to the social gradient of health need to be considered. One such process concerns the appraisal of status differentiation. People striving for status acquisition, maintenance or improvement compare their own situation with those of others. If they dispose of relevant resources and capabilities equal or superior to those of significant others, they experience favourable social comparison. Otherwise, feelings of relative deprivation trigger emotions of anxiety, anger, frustration or disappointment and act as powerful stressors in everyday life, impairing mental and physical health in the long run (Henry and Stephens 1977). More recent research on health inequalities therefore focuses on those resources and capabilities that matter for the experience of relative deprivation, such as skills acquired through education, as well as opportunities to belong to supportive social networks, of having control over one's life and of experiencing social recognition and reward (Marmot and Wilkinson 2006; Siegrist and Marmot 2006). By these extensions, the materialist explanation of unequal health has been supplemented by psychosocial processes acting as stressors or protective factors in human health and disease.

Aggregated disadvantage

With the advent of life course epidemiology (Kuh and Ben-Shlomo 2005), impressive new study findings, mostly derived from birth cohort studies, have enriched the explanation of health inequalities in adult life by identifying trajectories of aggregated disadvantage from birth to mid-life. These trajectories are triggered by the adverse material, psychosocial and behavioural circumstances of mothers during pregnancy and early childhood. Together with critical conditions of parenting, they affect children's physical and mental health as well as their cognitive and emotional development. These disadvantages in early life may result in a social patterning of educational attainments. Low levels of education, in turn, are often followed by exposure to unemployment or adverse working conditions, thus contributing to an accumulated burden of stressful conditions over the life course. In summary, different direct and indirect pathways influence adult health, operating via social chains of risk or via biological or psychological chains of risk (Power and Kuh 2006).

There is no space to document the rich empirical material illustrating the heuristic value of the notion of accumulated disadvantage in explaining social inequalities in health (Kuh and Ben Shlomo 2004), or to discuss its more recent application to research on ageing in advanced societies (Dannefer 2003). Yet, one should keep in mind that this research opens a unique window of opportunity for sociology to become involved in trans-disciplinary research. Life course epidemiology demonstrates the intimate links between the social, psychological and biological dimensions of human life, and it is likely these links can be more successfully disentangled by combining the scientific effort of related disciplines. In particular, research on epigenetics addressing 'gene x environment' interactions holds some promise.

Occupational roles and health inequalities

Given the centrality of work and employment in adult life, the material and psychosocial aspects of work and their effects on unequal health received special attention in recent research in health and medical sociology. In discussing the limited access of members of the lower classes to America's opportunity structure, Merton shed some early light on this topic (Merton 1968). Substantial empirical and theoretical work evolved during the 1980s and 1990s from cohort studies of employed populations that were mainly conducted in Europe. The British Whitehall II study of male and female civil servants (Marmot et al. 1991) and the French Gazel study of public employees (Goldberg et al. 2007) are prominent examples, specifically so because they advance the study of sociological models explaining the contribution of adverse working conditions to health inequalities. Two such models have received special attention, 'demand-control' and 'effort-reward imbalance'. The demand-control (or job strain) model identifies stressful work in terms of job task profiles defined by high psychological demands and a low degree of control or decision latitude (Karasek and Theorell 1990). Stressful experience resulting from this exposure is due to limited experience of personal control and self-efficacy in combination with continued high work pressure. 'Effort-reward imbalance' was developed as a complementary model with a primary focus on the work contract and the principle of social reciprocity lying at its core (Siegrist 1996). Rewards received in response to effort include a salary or wage, career opportunities (promotion, job security) and social recognition. Failed reciprocity (high effort in combination with low reward) occurs frequently in modern working life and generates strong negative emotions and associated stress responses.

Both models have been shown to follow a social gradient (where lower occupational status groups are more often exposed to stressful conditions, see Wahrendorf et al. 2013) and are associated with elevated relative risks of a broad spectrum of mental and physical disorders (Schnall et al. 2009). These studies have been conducted in many European countries, in the United States, Canada, Japan and in several rapidly developing countries including China. Importantly, there is evidence that stressful work in terms of these models to some extent mediates the association of occupational position with unequal health. Additional studies document a moderating role, where the strength of effects exerted by stressful work on health is magnified among socially deprived groups (Hoven and Siegrist 2013).

In summary – in addition to unemployment, precarious employment and exposure to physical and chemical hazards – a stressful psychosocial work environment contributes to the explanation of health inequalities in adult life. In the frame of Merton's theory of social anomie, stress-related disorders can be interpreted as a third type of critical adaptive response to the strains resulting from structural discrepancies between shared socio-cultural goals and limited opportunities of successful striving, complementing deviant forms of innovation and retreatism.

Critique and concluding remarks

Merton's work with relevance to health and medical sociology has been criticised in several ways. Three critical arguments are briefly discussed here. In line with a neo-structural Marxist approach, it is argued that Merton fails to integrate his middle-range theories into a conclusive macro-structural explanatory framework that takes into account fundamental class conflicts (Crothers 1987:142–55). Although Merton made several references to Marx' writings, he did not endorse his main arguments (Sztompka 1986:26). While it is obvious that the concept of status-based social stratification is embedded in larger societal structures, the conflicts and dynamics arising from these structures are not adequately captured in the conventional notion of status-based social stratification. Some recent advances address these shortcomings. For instance, the classification of occupations by Erikson and Goldthorpe (1993) tries to integrate aspects of power and influence at work. Another pathway towards a macro-structural analysis of health inequalities is suggested by Phelan and Link's (2013) theory of fundamental causes of disease. Their basic proposition maintains that this theory should focus on those material and psychosocial resources that are vital to maintaining a health advantage. Clearly, this comes close to, but extends the materialist explanation.

A second critique of Merton concerns the lack of analysis of agency as an essential complementary element in any sociological analysis of social structure, at least with regard to modern societies. Anthony Giddens claims that 'we need to give intensive thought to the notion of structure, as well as theorising the intentionality and knowledgeability of agents' (Giddens 1990:105). It is this latter aspect which is absent in Merton's work, and this is why, according to Giddens, Merton's analysis falls short of capturing the specificity of modern society: 'Modern social systems are in substantial part constituted by regular importation of knowledge used to alter the circumstances of system reproduction' (Giddens 1990:106). Thus, by restricting the analysis of social action to the agent's responses to pre-defined role-related expectations, Merton's theoretical approach fails to incorporate this reflexive dimension of human agency.

A third criticism of Merton, raised most explicitly by Blalock, is the lack of consideration of 'the linkage between micro and macro levels of analysis . . . separating out the effects of individual level variables . . . from those of the social context' (Blalock 1990:393). This critique is supported by Blau, who maintains that despite Durkheim's substantial influence on Merton 'much of his analysis is on the micro level' (Blau 1990:153). Advanced statistical techniques of multi-level analysis have been available for several years, and these allow hierarchical-level modelling. In fact, many recent studies on social inequalities in health apply these procedures to disentangle contextual effects on health from the compositional effects of individual-level characteristics. For instance, indicators of an adverse socio-economic neighbourhood, income distribution or community-level social segregation have been shown to act as contextual effects of health inequalities (Berkman and Kawachi 2000). Supported by methodological advances and new empirical evidence, structural analysis in medical sociology must be considered one of the promising areas of future enquiry.

Today, theorising in medical sociology offers a broad spectrum of approaches (for example, Collyer 2012; Cockerham 2013). It is certainly not accurate to claim that most of them are inspired, in direct or indirect ways, by the substantial work provided by Merton. However, with his many innovative theoretical concepts, presented in an elegant and concise style and embedded in a consistent methodological framework, Merton has had a distinct impact on theoretical and empirical research in the field of health and medical sociology.

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Chapter 15

George Libman Engel: The Biopsychosocial Model and the Construction of Medical Practice

Marilys Guillemin and Emma Barnard

Pick up most medical practice textbooks published in recent decades and the term ‘biopsychosocial’ is prominent. Over this period, medical curricula internationally have been structured around the teaching of the biopsychosocial model, involving an integration of the biological, psychological and social (Neghme 1985; Suchman 2005). In a survey of 54 medical schools in 1997–1999, Waldstein et al. (2001) found that 80 to 93 per cent used the conceptualisation and/or measurement of psychosocial factors in their curricula. The biopsychosocial approach is an attempt to redress the traditional model of biomedicine, with its predominant focus on pathophysiology and biological approaches to disease, and its lack of a comprehensive inclusion of the social and psychological aspects of health and illness.

In this chapter, we begin by examining the key proponent of the biopsychosocial model, George Engel, and the development of the model. This is situated in a historical context of the medical professions and medical practice of the late 1970s. We describe the biopsychosocial model and its purported application to research, medical education and clinical practice. Like other conceptual approaches in medical practice, the biopsychosocial model has both benefits and challenges. Among its benefits are its focus on patients’ stories and experiences, as well as its acknowledgement of the complexities of medical practice and the intricacies of doctor–patient engagement. On the other hand, the biopsychosocial model has been heavily critiqued both as a model and for the difficulties presented when applying it in actual practice. These issues are discussed in detail in relation to Engel’s model.

Biography

The biopsychosocial model is usually associated with George Libman Engel, although others claim to have named it prior to Engel. George Engel was born in 1913 to an affluent Manhattan family, firmly rooted in medicine. His uncle Emmanuel (Manny) was an acclaimed physician-scientist. Engel and his twin brother Frank trained in medicine at Johns Hopkins University Medical School during the 1930s. At this time, the medical curriculum at Johns Hopkins reflected the 'clinician-scientist' programme that had been introduced earlier in the century. Engel worked at Mt. Sinai Hospital in New York City during his internship where Manny held a senior medical appointment. He was later introduced to psychosomatic medicine and psychiatry by way of clinical appointments at the University of Cincinnati and the University of Rochester Medical School; Engel retained joint appointments in medicine and psychiatry. Engel pioneered the delivery of biopsychosocial medical curricula to undergraduate students until his retirement in 1983 (Shorter 2005).

At Cincinnati, Engel became a reluctant convert to psychiatric research via the influence of his psychiatrist colleague John Romano, who was a devotee of psychoanalysis. Here Engel began to accept connections between the psychological dynamics of the mind and biological forces of the body that were demonstrated in his research findings (Cohen and Clark 2010). Engel's research at Rochester focused on the psychosomatic aspects of gastrointestinal disorders, particularly ulcerative colitis. This led to the development of his integrative model of health and illness in 1951 and detailed further in his 1960 publication: 'A Unified Concept of Health and Disease'. Between 1949 and 1955, Engel completed psychoanalytic training with Franz Alexander's Chicago Institute for Psychoanalysis, and 'thus Engel the internist came to have his feet firmly planted in American psychoanalysis' (Shorter 2005:4).

The seminal paper that came to be associated with the biopsychosocial model was titled 'The Need for a New Medical Model: A Challenge for Biomedicine' and was published in the highly reputable journal *Science* in 1977. It is noteworthy that when Engel published this paper in 1977, he was 64 years old and a celebrated clinician, researcher and educator. The publication was a culmination of many years of clinical practice and education of medical students and graduates.

What is the biopsychosocial model?

The biopsychosocial model of health, as conceptualised by Engel (1977), recognised that illness and ill-health are influenced by a person's biological, psychological and social attributes, and that health is best understood as an integrated combination of all of these components (Engel 1977; Nicassio and Smith 1995; Sperry 2006). This is compared with singular biomedical understandings of illness and ill-health which describe patients in terms of disease and exclude psychological and social aspects of a person (Feinstein 1987). As Wade and Halligan (2004) state, biomedicine makes three assumptions: first, that there is a single underlying cause for an illness; second, that this single cause is due to pathology; and third, that by removing the disease there will be a return to health. There is evidence to disprove all three assumptions (Wade and Halligan 2004). Biomedicine operates by discovering the pathology rather than trying to understand the illness. In contrast, Engel advocated for the biopsychosocial as a scientific, inclusive framework that could be applied to better understand and deal with 'the human side of illness and patient care' (Engel 1978:169).

The model, as described by Engel (1977), was predicated on systems theory and utilised a hierarchy of natural systems as its framework. In this context, the system comprised a number of levels of organisation, beginning with the sub-atomic particle, to the single cell, through to the nervous system and the person. This hierarchy represented the physical and biological elements of the model and comprised the lower half of the whole structure. The centre of the model consisted of the person (that is, experience and behaviour), which then extended through a number of levels including the two-person (that is, the dyad), family, community and ultimately to the biosphere. This upper-half represented the psychosocial or higher order levels of organisation in the natural hierarchy (Engel 1982). The central tenet of the biopsychosocial model was that each level, from sub-atomic particle through to biosphere can be examined and understood as a single element, in relation to its neighbours (and their neighbours) on the hierarchy, or in the context of the entire system.

Engel's writing during the 1960s explored what the social entailed in more detail than his later papers, which focused on defining and defending the biopsychosocial model and its application to teaching, research and clinical practice. In 'A Unified Concept of Health and Disease' (1960), Engel discussed specifically some of the social consequences of experiencing disease, which necessitate people making social and psychological adjustments to life with, or after, illness. Using the example of active tuberculosis, Engel (1960) demonstrated that a diagnosis in one person has social consequences for the family unit, potentially manifesting as infection, disruption and extra burdens and/or deprivations depending on the disease progression and how the family responds to the initial infection. Engel also emphatically stated that traditional medical attitudes where the concept of disease is restricted only to what can be recognised or understood by physicians is misguided, as 'disease cannot be defined on the basis of the *function* of physicians, which is a social and institutional phenomenon' (1960:52). Engel believed strongly that the term 'pathological' was relative and set by convention, be it medical, scientific or social.

Engel's philosophic treatise, 'Is Grief a Disease?' (1961b), asked the reader to consider grief not as it was understood at the time (as a syndrome), but as if it were a disease, caused by a biological organism. The symptoms of grief are physical (sleep disturbance, pain and discomfort, anorexia); psychological (sadness, guilt, shame, feelings of loss, emptiness, hopelessness); and social (loss of interest in usual activities and associates, impairment of work performance). Defining further the 'unified concept of disease', Engel argued that the cause, effect and resolution to a period of grief are not dissimilar to the trajectory of an illness or disease caused by a biological organism. In a letter to the editor in 1961, written in response to criticism of 'Is Grief a Disease?', Engel described health and disease as 'complex bio-psycho-socio-cultural phenomenon' (Engel 1961b:427) and described this phenomenon as 'social and cultural processes within their own right' (Engel 1961:429). This prompted one commentator to suggest that 'Engel viewed the social domain of the model as encompassing cultural, spiritual, and other broader issues' (Smith 2002:310).

Although Engel is most strongly associated with the biopsychosocial model, others have suggested the approach dated well before Engel. An implicit biopsychosocial model has 'always been apparent to physicians' (Shorter 2005:2) as far back as Hippocrates, in that a patient's physical, emotional and mental states and their broader social circumstances all contribute to the pathogenesis of illness and ill-health. Although Engel has been associated with the biopsychosocial model since his key publication in 1977, Engel denied coining the phrase (Fiscella 2005:410). Roy Grinker (1964) is recognised as having used the term 'biopsychosocial' as early as 1954. Grinker was an acclaimed American neurologist and psychiatrist. Grinker was a prolific psychiatric scholar and researcher, and much of his work focused on the impact of war trauma on soldiers (Grinker 1983). His use of the 'biopsychosocial' appears in publications during the 1960s (Grinker 1965), prior to Engel's seminal papers published in 1977 and 1980. Grinker has been described as the 'unrecognised founder of the biopsychosocial model and its major advocate within psychiatry' (Ghaemi 2010:37). Grinker's concept of the biopsychosocial was underpinned by biological systems theory, which in his view was an antidote to reductionist paradigms within psychiatry more broadly, and one that he regarded as unscientific (Ghaemi 2009). The biopsychosocial model, as articulated by Engel and published in *Science* in 1977, was the culmination of Engel's thinking of the model from systems theory, although he would extend it to medical education and clinical practice (Engel 1978, 1980).

Historical context of the biopsychosocial model

It is important to acknowledge the historical context in which the biopsychosocial model appeared, as well as the psychoanalytic and philosophical imperatives that influenced its development. It is well documented that the Western world in the 1960s and 1970s were decades of great social change and upheaval; this was reflected in health policy, debate and technical developments within medicine more generally. Notably, the women's health movement and consumer health movement galvanised much of this change.

The biopsychosocial model developed at a time where medicine, rooted in a traditional biomedical context, was being forced to recognise that factors contributing to health existed beyond the biomedical. As acute diseases such as polio were being eradicated by vaccination, behavioural risk factors and 'lifestyle' factors were becoming recognised as increasingly important in addressing a new burden of chronic disease. As part of the New Public Health movement that had developed over the course of the twentieth century, health policy on a global scale began to reflect concepts that were central to the biopsychosocial model. Canada's *Lalonde Report* (1974), the *Report of the US Surgeon General* (1979) and the *Report of the Expert Committee into Health Inequality* (known as the *Black Report*) in the United Kingdom (1980), emphasised that social, economic and environmental influences and behavioural approaches were central to improving population health and well-being. In Australia (and elsewhere), preventive health strategies continue to emphasise concepts that have arisen from the biopsychosocial model (Australian National Preventive Health Agency 2013:26).

At the same time that Engel was advocating the biopsychosocial model, medicine and medical science were experiencing an era of unprecedented technological innovation. From the 1950s to the 1970s, medical therapies such as pharmacological interventions and diagnostic and surgical techniques developed rapidly (Baum 2008). Within psychiatry, Engel's chosen specialisation, there were parallel fundamental shifts. As a discipline, psychiatry has been regarded in the latter half of the twentieth century as being held 'hostage to mind-body problem(s), buffeted back and forth between psychological and physical definitions of its object and its techniques' (Porter 1997:523). During the 1980s, the essential focus of psychiatry shifted from the clinically based model to a research-based medical model, and research investigators replaced clinicians as the most influential voices in the profession (Wilson 1993). Pharmacological advances in treating mental illness were encouraging an about-turn away from behavioural science approaches in mainstream psychiatry, and were occurring at exactly the time when Engel's famed article was published in *Science*: 'The timing of his 1977 article coincided with a resurgent medical reductionism that was largely unopposed, and, in particular, was effecting a radical revision of psychiatry' (Epstein and Borrell-Carrió 2005:428). For Engel, this period meant that it was more important and relevant than ever for medicine to address and improve its 'explicit attention to humanness' (Engel 1997:522). Despite the growth of pharmacological interventions during this time, it was becoming clear that pharmacotherapy alone was inadequate to treat illness and ill-health (Shorter 2005). For Engel, the biopsychosocial model offered a potential bridge to address psychiatry's philosophical and clinical problems.

Benefits of the biopsychosocial model

For Engel and other proponents, the biopsychosocial model offered a number of benefits, both as a philosophy and an approach to clinical practice (and research). As Borell-Carrió et al. (2004:576) noted:

> The biopsychosocial model is both a philosophy of clinical care and a practical clinical guide. Philosophically, it is a way of understanding how suffering, disease and illness are affected by multiple levels of organisation, from the societal to the molecular. At the practical level, it is a way of understanding the patient's subjective experience as an essential contributor to accurate diagnosis, health outcomes, and humane care.

This emphasis on the patient's experience was key to the biopsychosocial model's focus on clinical communication skills to establish effective therapeutic relationships between clinician and patient.

For Engel, the biopsychosocial model was a model based on a hierarchy of natural systems and influenced by general systems theory. Applied to medicine, systems theory and the biopsychosocial model moved beyond long-held ideas in psychiatry and medicine about Cartesian dualism and provided a conceptual approach to address the shortcomings Engel saw as inherent in singular biomedical approaches of medicine. Engel believed that the biopsychosocial model had very broad applications, in medical education and teaching, research and in clinical practice. 'The proposed biopsychosocial model provides a blueprint for research, a framework for teaching, and a design for action in the real world of healthcare' (Engel 1977:136). This was an ambitious vision and was to become problematic in its application.

In addition to psychiatry, the biopsychosocial model has been applied in other medical specialities, including family medicine (Downing 2012), primary care (van Dijk-de Vries et al. 2012; Segal et al. 2013), addiction (Fischer et al. 2007; Samenow 2010; Buckner et al. 2013), mental health (McKay et al. 2012), occupational therapy (Mosey 1974) and pain studies (Saariaho et al. 2012), to name a few. Intuitively, the psychosocial nature of these fields is suited to the biopsychosocial framework because they recognise complexity, patients' stories and the human side of illness and patient care (Engel 1978). According to Seaburn (2005), Engel created a 'map of human experience' with the biopsychosocial model that had as much utility for physicians as it did for therapists.

Critiques of the biopsychosocial model

Much of the critical literature addressing the biopsychosocial model has been indelibly influenced by the model's origins in psychiatry, where it has been the subject of much contestation. A detailed analysis of these issues is beyond the scope of this chapter. However, in short, much of the debate and critique is centred around the philosophical nature of the biopsychosocial model and its implications with regard to psychiatry as a discipline and its relationship to medicine (see Pilgrim 2002; Ghaemi 2006, 2010). Indeed, McLaren (1998) suggested that the biopsychosocial model was so flawed that it should be abandoned in psychiatry, and new models developed.

The most common critique of the biopsychosocial model has been its inability to be applied in practice. Seaburn (2005:397) suggested: 'If the strength of the biopsychosocial model is its capacity to help us "see" more clearly, perhaps its greatest limitation is that it doesn't tell us exactly what to "do" with what we see'. Engel envisioned the biopsychosocial model as a panacea for the conceptual failings he saw inherent in teaching medical students, and research and clinical practice. However, Engel's vision has not explicitly translated into the practical applications demanded by these domains. The biopsychosocial model in itself does not address resourcing issues (David and Holloway 2005), is not testable, is too general, has no obvious methodology and its application in research has been minimal (Smith et al. 2013). For Herman (2005), the biopsychosocial model is not easily taught, is missing a diagnostic system to facilitate its use in clinical practice, is difficult for clinicians to apply, particularly in stressful situations, and is time-consuming. Engel envisaged that the model be taught holistically, but in practice it has been interpreted and taught in two parts: as the 'bio' and the 'psychosocial'. Engel rejected the notion of it being a split model, as proposed by Herman (2005), and advocated that it be conceptualised and taught as a whole, because dualism as much as reductionism can mitigate the potential to collaborate effectively with other disciplines (Engel 1982).

Others have argued that contemporary medicine has become so complex that no one model can adequately serve its needs. As Kontos (2011:515) noted: 'If the biopsychosocial (or any other) model is analogous to a Swiss army knife, what medicine needs instead is a tool box filled with different and dedicated tools suited for specific tasks'. However, the biopsychosocial model also faced more fundamental conceptual critiques, including from sociologists such as Armstrong (1987). In his critique, Armstrong (1987) argued that in the biopsychosocial model, social science is not truly integrated but remains subservient to the biomedical paradigm. Armstrong claimed that within the biopsychosocial model, biomedical dominance remains unchallenged without any real reconstruction of medical knowledge and the ways that illness is understood. Armstrong advocated for a more critical examination of biomedicine, together with a new, multifaceted construction of illness.

It is noteworthy that other than Armstrong's critique there has been little direct critique of the biopsychosocial model from sociologists and other social scientists. However, there exists a strong critical literature around biomedicine and biomedical approaches to medical practice. The most notable of these critics includes Ivan Illich, who published *Medical Nemesis* in 1976 as a scathing attack on Western biomedicine, medical therapies and what he called 'clinical iatrogenesis' or therapeutic side effects. There has also been considerable scholarly work exploring critical approaches towards biomedicine during the second half of the twentieth century. These approaches originate from social movements (class, race, gender), the development of new social theories (emotion, disability and embodiment), and the growth of lay knowledge and user/consumer movements, together with critical approaches to science and technologies (Lupton 2012). Within the sociology of health and illness there is a vast literature that offers a strong and significant critique of biomedicine and biomedical approaches; these include the ways that we understand and experience our bodies, understandings of health and illness, our interactions with medical practitioners and examinations of the systems of medical governance. Furthermore, there has been the significant work of Michel Foucault and his influence on scholars such as Nikolas Rose who have examined the ways that biomedicine has reshaped our lives and medical practice. Rose's work includes *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty First Century* (2007), where he examines the transformative effects of biomedicine on doctors, on consumers and on medicine itself. These social analyses have served to provide a critical perspective of the power of biomedicine and its effects.

Multiple interpretations of the social in the biopsychosocial model

What is meant by the social within the biopsychosocial model remains ambiguous; 'the social' is open to multiple interpretations and applications. In his support for the biopsychosocial model, Engel emphasised the importance of the doctor–patient relationship and the value of interviewing patients and clinical skills (Spike 2007). This interpretation of the social is undoubtedly important. However, beyond this it is not clear how the biopsychosocial model comprehensively addresses other micro-level issues, such as how medical and healthcare practitioners more broadly understand their roles and professional identities; the importance of the meso level of organisations and institutions for medical practice; and the effects on practice of the macro levels of social structures, healthcare systems and healthcare policy.

According to the biopsychosocial model, everything listed above the two-person (that is, the dyad) level on the hierarchy is considered *social*. Clearly, Engel et al. (1957) valued the social and the importance of teaching *psychological* and *social* aspects of human biology. However, the focus Engel devoted to the 'bio' and the 'psycho' in his writing comes at the expense of the 'social'. Engel (1982) touched on the social component of the model in the context of examining illness solely within a biomedical framework. This approach to illness, he argued 'excludes from scientific attention the patient and the rest of the social hierarchy' (Engel 1982:803). Shorter (2005) argued that Engel (1977) innovatively shifted the *social* from the patient's social context (that is, the doctorpatient relationship) to the role of the healthcare system itself in engendering and relieving illness. However, this shift to macro social structures remained underdeveloped.

Stein (2005) has argued that the biopsychosocial model is not singular, but plural, both in theory and practice; it is as much a cultural phenomenon as it is a scientific theory. Adler (2009) argued that the biopsychosocial model is still relevant, and defended its legitimacy in medical research and undergraduate and postgraduate medical teaching programmes, whereby each 'somatic' physician must incorporate their own integrated version of the biopsychosocial model into practice. For Smith et al. (2013), empiricising the biopsychosocial model through instilling evidence-based methods can bring it into the scientific domain, thereby unlocking its utility. Kontos (2011) suggested that the biopsychosocial model can be improved by acknowledging complexity, since no one model can be effective at either the micro or macro level in contemporary medicine.

The biopsychosocial model has been taken up and reconstructed into different yet related approaches, such as patient-, person- or relationship-centred care; what these have in common is a shift of emphasis from biology and the pathophysiology of medicine to a greater focus on the patient and social relations. Of prominence is the patient-centred model of care. Although this approach has been used over the last 30 years, it is most commonly attributed to the work of McWhinney (1985). Mead and Bower (2000) reviewed the literature on patient-centredness and extended McWhinney's initial factors to five key dimensions. The first of these is a biopsychosocial perspective, but they emphasise patient illness and the experience of being ill, and the broad range of difficulties for which patients seek help, and not just disease. The second dimension is the 'patient as person' and understanding the person's experience of illness; the third dimension is the sharing of power and responsibility in the doctor–patient relationship, taking into account social issues of power and control; the fourth dimension focuses on the therapeutic alliance between doctor and patient, including cognitive and affective factors in the doctor–patient relationship that influence not just the relationship but therapeutic outcomes. The final dimension is the 'doctor as person' which recognises the influence of the personal qualities of the doctor and not just their technical skills and knowledge. The patient-centred model has been developed primarily within general practice; however, medical specialities such as oncology and paediatrics have adopted it (Mead and Bower 2000). In the patient-centred model, the social has been extended beyond listening to the patient and developing clinical communication skills of the doctor to enhance the doctor–patient interaction. In patient-centred care, a more sophisticated model is proposed taking into account both the doctor and the patient as social beings, as well as the important sociological power relations as they play out in the therapeutic relationship.

Others have also developed the notion of the social in the biopsychosocial model. Candib (2005) urged us to remember that the social in the biopsychosocial model involves both the doctor and the patient, and importantly, the social context of the interaction. Seaburn (2005) extended Candib's notion of the social in the biopsychosocial model; in addition to a focus on the patient's experience of illness, Seaburn goes beyond the micro level to the meso and macro levels. Seaburn (2005) advocated for dialogue and collaboration and improved communication between all healthcare professionals involved, as well as patients and family members. This is a plea for inter-professional dialogue in collaboration with patients and families. This extension beyond doctor and patient acknowledges the social roles of professions and inter-professional power relations. Furthermore, Seaburn supports integrated healthcare delivery systems that 'respect the union of mind, body, and relationships' (Seaburn 2005:398). This is an explicit acknowledgement that the biopsychosocial model needs to take into account the macro structures of healthcare. Scherger (2005) supported this last point and agreed that the problem is with the acute healthcare model and its time pressures and resource allocation issues, advocating for a new way of delivering healthcare.

These broader aspects of the social have been taken into account by other models of healthcare, such as relationship-centred care developed by Tresolini and the Pew-Fetzer Task Force (1994) in the United States. Relationship-centred care builds on the biopsychosocial model and patient-centred care through the prism of the nursing profession; as the name implies, the focus is on relationships. The dimensions of relationship-centred care include the practitioner–patient relationship, the practitioner–practitioner relationship and the relationships of both practitioners and patients in the communities they inhabit. This model of care explicitly recognises the multiple communities involved and 'the need to understand the broad social, political, cultural, economic, and political determinants of health; and recognise and act in accordance with the values, norms, social and health concerns of the community' (Pew Health Professions Commission and Tresolini 1994:27). Importantly, in relationship-centred care there is acknowledgement that these relationships exist within social systems and structures that mutually shape healthcare practices and outcomes. Following its US origins, there has been considerable uptake of relationship-centred care, often in aged care or community settings, in a number of countries including Canada, the United Kingdom and Australia.

Conclusion

Since Engel's seminal publication in 1977, the biopsychosocial model has continued to prevail in medical curricula internationally. We suggest that this prevalence in medical curricula is an acknowledgement of the model's recognition of the limitations of the biomedical model, as well as its focus on pathophysiology and biological explanations of disease. The biopsychosocial model was an attempt to redress this and incorporate the psychosocial in medical practice and medical education. The emphasis of the biopsychosocial model, as proposed by Engel, was on the patient experience and ensuring that medical practice incorporates the appropriate listening and clinical communication skills to fully hear and relate to patient experiences. As Engel noted, 'successful application of the biopsychosocial model in clinical medicine is 100 per cent dependent upon the clinician's facility with interviewing' (2005:378). Although communication skills between doctors and patients are clearly important, the social extends far beyond these specific interactions.

Critics of the biopsychosocial model have primarily focused on its clinical application and the practical difficulties of its implementation. In examining the social in the biopsychosocial, it is important to examine both what is said about the social, as well as what is left unsaid, or remains ambiguous. By limiting the focus of the social to the doctor–patient relationship, other important micro-level relations are not considered; these include social relations between healthcare practitioners and between healthcare practitioners and families. In addition, there is no consideration of the doctors and practitioners themselves as social beings, both as individuals and as operating within professional groups and communities. This limited conception of the social also fails to recognise the role of professions, healthcare institutions, patient support groups or consumer advocate groups, and the myriad of other social relations that exist at the meso level. There is a lack of acknowledgement of the significant impact of healthcare systems, structures and policies at the macro level that have both direct and indirect impact on healthcare practice. Importantly, the social power relations inherent in medical practice are largely ignored within the biopsychosocial model.

To address these limitations of the biopsychosocial model, other models of care have been proposed. Notably, these include patient- and relationship-centred care that directly acknowledge the biopsychosocial model as part of their foundations. It is interesting that critiques of the biopsychosocial model, as well as its subsequent iterations, have come primarily from clinicians. With a few notable exceptions, there has been relatively little critique of the biopsychosocial model from sociologists and other social scientists. A sociological critique offers us the ability to question the unchallenged assumptions of the biopsychosocial model and its various iterations, both as conceptual frameworks as well as their application in medical education and medical practice.

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Chapter 16

Harold Garfinkel: Lessons on Emergent Behaviours in Complex Organisations

Peter Nugus and Jeffrey Braithwaite

In founding the research approach known as ethnomethodology, Harold Garfinkel contributed ground-breaking logic and strategies to illuminate the way people jointly construct and make sense of everyday social situations. The prevalence at the time of the search for over-arching theories to predict human behaviour underscores the novelty of Garfinkel's principles and methods, such as his famous 'breaching experiments'. Although Garfinkel himself was suspicious of grand theorising, this chapter argues for closer conceptual attention to the shared but hidden meanings that are implicit in social interactions, which are laboriously maintained in interaction, and which make 'society' work. Sociology has marginalised social action theories and ethnographic research. Coupling Garfinkel's methods for analysing 'real-life' situations with social action theories, such as symbolic interactionism, actor-network theory and recent incarnations of complexity theory, help guide transferable lessons from empirical research into the way workers co-construct and manage their changing environments in complex organisations.

Biography

Harold Garfinkel (1917–2011) was a sociologist associated with founding the research approach known as ethnomethodology, grounded in the methods people use to orient themselves to shared situations in order to be able to jointly accomplish shared tasks and shared meaning. Garfinkel was raised in Newark, New Jersey, to a father who had a business dealing in furniture. Following early studies in accounting, Garfinkel committed himself to volunteering in social and community service organisations, which fired his sociological imagination. He eventually enrolled in a master's degree in sociology at the University of North Carolina. While undertaking war service, where he was a trainer at an army base, initially in Florida, Garfinkel met his lifelong partner, Arlene Steinback, who survived him. After the war, Garfinkel undertook a doctoral degree at Harvard. Although Garfinkel would ultimately be distinguished by a more empirical than structural approach to understanding social relations, he was strongly influenced by Talcott Parsons (1902–1979) while at Harvard. Garfinkel's work also showed influence of and engagement with Alfred Schütz's (1899–1959) work on the mutually informing processes of cognition and behaviour. Garfinkel taught briefly at Princeton University, amid a cohort of leading social and behavioural scientists. Subsequent positions at Ohio State University and the University of California Los Angeles (UCLA) realised research on team leadership, jury work and suicide. Garfinkel would remain at UCLA for the rest of his life, following retirement, as an emeritus professor.

Garfinkel's path

Early on, Garfinkel forged an unusual path – unusual for the time, that is. He wanted to ground enquiry in empirical study of everyday situations and question taken-for-granted norms about the way social relations between people were ordered. Just how predictable was social action? Contextually, Talcott Parsons' imperative to lay out the normative relations necessary to hold families and societies together was prevalent at the time. Garfinkel's approach is distinguishable from this, seeking to base social research on actors' everyday reasoning and methods for ordering those situations. He saw this as complementary, rather than oppositional, to Parsons' search for an objective and over-arching explanatory framework for social life (Garfinkel 1967:chapter 4).

A key to Garfinkel's contribution was to bridge theory and practice in presenting methodology not merely as systematic ways to collect and analyse data, but as ordinary ways of using and creating situations and contexts – even if the maintenance and creation of shared practices was not the intention of the participants. For this reason, Garfinkel urged students and scholars to document multiple examples of improvised behaviour used in different situations, such as in analysing conversational practices in detail (Heritage 1984). A range of such studies appear in his most well-known book, *Studies in Ethnomethodology* (1967). This includes how jurors deliberate and how an inter-sexed person illuminated the constructed character of gender roles by passing as a female even though, unbeknown to others, that person was born male (Garfinkel 1967). Such studies were intended to capture the quality of 'reflexivity' in social situations which comes from the active role played by context in shaping action, which is itself remade and redefined by action (Heritage 1984). According to Garfinkel, a social situation – evident through interactive talk among mutually engaged participants – contains the elements to document the production and management of order and sense-making, and is unique to that situation (Rawls 2008).

Real, emergent social situations were thus important for Garfinkel, and from a methodological viewpoint, this focus was unusual and imaginative at the time. He saw that accounting for what one does as idiosyncratic to the circumstances, contexts and needs of the participants and as necessary and constitutive to social order – that is, cooperative activity. This approach is fundamentally sociological, because without the need to act in concert with others there is no need to account for one's behaviour. Consider one of his exemplars. There is mutual understanding among actors as to how they orient themselves to the new situation of being a juror. They are brought together for the purpose (to determine under direction a case) and adjust to each other over time as they get into the trial in mutually accommodative ways. Another example Garfinkel uses is the disarmingly simple activity (on the surface) of standing in a queue, awaiting service. Although standing in a line may appear spontaneous and random, it is a recognisable event that gains recursive meaning for both participants and onlookers by associating the actions with the context and the behaviours (or practices) of the participants who produce the action (Garfinkel 1967:chapter 7).

According to Garfinkel, people order their relations with each other on the basis of shared procedures for problem-solving and shared knowledge that are generally hidden away. We know this familiarly as 'common sense'. People don't draw attention to this; they just mobilise it in a constant stream of talk. Garfinkel and a generation of language-based social researchers documented in great detail patterns in the use of classic phrases which show hidden evidence of shared but complex assumptions. These include phrases such as 'you know', 'anyone can see that' and 'etcetera' (Sacks et al. 1974; Schegloff 1986; Heritage and Maynard 2006). Until Garfinkel, these remained in the realm of the taken for granted, and no one had called them to attention, let alone analysed their occurrences, use and purpose.

The 'breaching experiments' are perhaps the most well-known features of Garfinkel's work and were ground-breaking and insightful at the time. Even now, decades later, they provoke thoughtful reflections on common social representations. Breaching was conducted by Garfinkel himself and in student assignments. Breaking roles – such as acting like a polite stranger at one's family dinner table – provoked startling reactions, showing how tightly bound the need for accountability is in even the most mundane of activities (Garfinkel 2002). The purpose of these natural-anchored experiments was to show the underlying assumptions on which people rely on in everyday routines that make society work. In the remainder of this chapter, we review the approach attributed to Garfinkel – ethnomethodology – and discuss it in relation to theoretical and empirical sociology.

Ethnomethodology: Making sense and order of the world

'Ethnomethodology' is a composite term from the ancient Greek *ethnos* (meaning 'people from various ethnic and racial groups') and methodology (in most dictionaries, 'systematic, analytic activities'). It is the study of methods people use to make sense and order of their social world (Garfinkel 1967, 2002). What makes ethnomethodology unique is that it involves treating seriously people's own knowledge, rather than sociologists' theorisations, of how participants order their relations with others as part of the setting that enables the setting to be ordered (Garfinkel 2002). The term was introduced by Garfinkel in describing the common-sense ways and shared reasoning through which, as mentioned, jurors weigh evidence and understand and adjudicate the roles and reliability of various actors in the setting (Garfinkel 1967:chapter 4). That is to say, through the implicitly agreed methods of reasoning that participants bring to a shared situation, participants bring order to that situation. While local orders exist, people can only become jurors, for example, because of common cognitive rationalities that manifest and persist in society. These develop outside of the local situations and are tacitly imported into the situation.

Despite its name, ethnomethodology is not represented by a particular method or set of methods per se. It is a research approach broadly devoted to analysing what people do, say and see in real situations. This implies the use of detailed, nuanced observations and the careful documentation of those observations (Garfinkel 2002). As Garfinkel (2002:6) puts it:

> The objective of . . . [social research] . . . is to discover the things that persons in particular situations do, the methods they use, to create the patterned orderliness of social life . . . [Whatever research method is used, it] must preserve the details of local order production 'over its course' for the analyst.

Ethnomethodology is the study of the methods, approaches and tactics people use to create a social situation. Garfinkel gives priority to participants' own methods over sociological explanations, reflecting his inclination to merge theory and practice (Garfinkel 2002). Garfinkel conducted and promoted – and demonstrated how to conduct – such research. He showed the pain-staking and endless work involved in maintaining social orderliness in which people share a common sense of what a situation entailed and the roles of participants – themselves, and others – in those situations (Heritage 1984). Shared assumptions and shared but methodical ways of problem-solving – evident in phrases people mobilise in ordinary discourse with others, such as 'you know' or 'ok, right', or 'get it?' – are, for Garfinkel, the foundation of society.

The challenge for sociology

Garfinkel challenged the prevailing sociological view that behaviour could be predicted by identifying the rules of behaviour. Instead, he showed how rules need to be interpreted to match everyday situations (Dingwall 1981; Heritage 1984). Methodologically, this was a call to move from abstract rules in middle range or grand social theory to become immersed in the world created in the moment-to-moment activities of people and the situations they co-construct. The problem this presents sociologists is how to do the craft of detailed observations and to document the myriad of day-to-day activities, from the mundane to the unusual and, in particular, how to use knowledge of particular situations after analysis to make broader sense of the world.

Garfinkel's suspicion of over-arching theories notwithstanding (Heritage 1984), we can see a path forward. The various situations that provide fodder for limitless ethnomethodological studies share common social characteristics – they are recursive phenomena. There is, therefore, commonality in such situations that can be discerned at a more abstract level than the phenomena themselves (Goffman 1959). The means by which people influence each other are found in inter-connected webs of iterative interaction and meaning-exchange. Actor's shared procedures for making sense of the world and shared knowledge are cornerstones of Garfinkel's account of the way people make their way in the world. Sense can be made of practical knowledge and its application through understanding common processes by which people learn, accept, challenge and amend shared meanings in interaction. The empirical implications are that we can examine *in situ* shared sense-making systems without assuming causality or presuming firm predictability. In the following two sections, respectively, we deploy complexity theory as a framework for understanding Garfinkel's account of shared assumptions and then examine symbolic interactionism – focused on interrelationships and their effects – as guiding an empirical programme of research in his spirit.

Complex organisation

Garfinkel's work has enormous implications for analysing complex organisations. One particularly complex type, which we research (for example, Braithwaite et al. 2005; Nugus et al. 2009; Nugus and Braithwaite 2010; Nugus et al. 2010; Ranmuthugala et al. 2011), is hospitals, which feature a high degree of specialisation, social and professional manoeuvrings, and differentiation of function. Increasing specialisation and differentiation is a priority of modernity (Beck 1992). The increasingly textured understanding of organisational complexity comes through appreciating them as complex adaptive systems (CASs). Here, organisational, social, political and cultural behaviours are seen as emerging from networks of mutually influencing components (actors, technologies, artefacts) whose boundaries have various degrees or openness (or porousness) and can comprise and be nested in other systems, hierarchically and heterarchically (Braithwaite et al. 2013). In terms of its characteristics as a whole system, a CAS can be considered 'an entity composed of many different parts that are interconnected in a way that gives the whole capabilities that the parts don't have on their own' (Letiche 2008:127). Individual parts are recursively interactive and are adaptive, adjusting over time, and responding to changes and demands of the environment (Urry 2003). CAS's emphasis on the *connectedness* and *mutual influence* of various interactive components aligns with shared understandings and reasoning processes that ethnomethodology seeks to expose.

Far less empirical attention has been paid to the implications of complex organisation for what work needs to be done by those who work in complex organisations. This points to the need for a mutually beneficial union of complexity theory and ethnomethodology. A foundational insight from sociology generally and complexity theory specifically is that actors are parts of interdependent webs of activities. Research from the perspectives of symbolic interactionism, for example, have exposed the mutual influence between systems, parts of systems and actors (Barnes 2001; Nugus 2008). From an actor-network perspective, effects of interactions among people and between people and material objects, for instance, follow from an *assemblage* of influences rather than a single, central causal mechanism (Law 2008). The terms of interaction are set by broader social structures in ways often unbeknown to actors (Katovich and Maines 2003). In interaction, actors negotiate the definition of the situation as they reflect and amend social structures which influence them and to which they also contribute (Vryan et al. 2003). Garfinkel's breaching experiments, or the empirical search for ruptures in definitions of the situation, provide opportunities to identify shared understandings in collaborative work in complex organisations like hospitals, for example.

Garfinkel and healthcare

The importance of local and shared knowledge and competence in healthcare is well established in ethnomethodology. Four of the eight chapters in *Studies in Ethnomethodology* discuss matters relating to healthcare, particularly mental healthcare (Garfinkel 1967). The most prominent direct inheritance of Garfinkel's approach is in conversational analysis. Developed mainly by Harvey Sacks (1935–1975) and Emanuel Schegloff (1937-), conversation analysis involves the detailed study of recorded talk-in-interaction to understand routine shared understandings negotiated in interaction (Sacks et al. 1974; Heritage 1984; Schegloff 1986). A major contribution to understanding doctor–patient interactions in healthcare has been an edited volume by John Heritage and Douglas W. Maynard (2006) entitled *Communication in Medical Care*. Research focusing on relations between health workers in different occupations, on gestural interactions and on information systems in healthcare, is growing (for example, Heath 1986; Atkinson 1995; Greatbatch et al. 2001). However, most ethnomethodological studies in healthcare have focused on verbal interaction between doctors and patients (for example, Frankel 1990; Ten Have 1995; Heritage and Maynard 2006; Heritage 2010).

So original was Garfinkel's emphasis on the relationship between collective activity and social ordering that it is difficult to see where his influence in health research begins and ends (Allen 2004). His handprint is evident in much healthcare research on dynamic ordering in interaction, even where he is not directly referenced. With different degrees of emphasis, much ethnographic healthcare research aligns with the spirit of understanding the mundane accomplishment of shared expertise even though it might not be called ethnomethodological (for example, Gerson and Star 1986; Sudnow 1967). There is enormous scope for continued empirical research on collaborative work in complex organisations because such organisations inevitably require and feature *coordination* among different and specialised services. Events and influences across and within sub-systems and systems of health services require staff to coordinate activities. This is captured in Strauss et al.'s (1985) long-standing and evocative notion of the 'patient trajectory' which concerns the active role staff play in navigating structural influences on their work to treat patients and transfer their care to other staff or services. Much of this work is unpredictable and ill-fitting with pre-conceived guidelines (Gerson and Star 1986). Such coordination work has also been conceived as 'boundary work' across structured roles, occupations and organisations in healthcare (Allen 2000). What complicates such work and makes it all the more fitting for ethnomethodological research is that tasks in a complex organisation rely on staff members who are semi-autonomous and have their own goals, interests, tasks and problems to resolve (Allen et al. 2004). Such studies reflect the ethnomethodological impulse to document the way work and care activities are organised, maintained and distributed in ways that make collective sense to participants.

Structures in interaction: An empirical path forward

Revisiting – or visiting for sociological newcomers – Garfinkel's work serves as an opportunity to call for more sociologists to honour sociology's foundational contributions to understanding how individuals organise their collective lives, as well as how order emerges from everyday talk and behaviours of interacting actors and their artefacts. The theory of symbolic interactionism came out of and owes more than a nodding allegiance to social psychology as well as sociological thinking. It was largely abandoned by the discipline of psychology in the rush to join the prestige of quantification in the 1950s. This abandonment was probably also related to a sense of insecurity in which psychology sought to show itself as a 'real science'. Sociology picked up symbolic interactionism, and it became a showcase for much of what is good in the sociological imagination. Disciplinary boundaries are, of course, constructions, and overlap is inevitable between researchers who call themselves social psychologists and sociologists. The prestige of quantification has also seen the marginalisation of interactionism in sociology – the archetypal poster-child discipline uniquely badged as the study of relations between people.

Sociologists have largely under-recognised and under-utilised the capacity of so-called micro-sociological theories that underpin ethnography – based on understanding the shared enactment of cultural meaning systems – and that might provide an over-arching logic for ethnomethodological studies, to account for structural influences on everyday work in complex organisations. This is despite the fact that the value of ethnography has been in showing how broader influences, such as policies, culture and organisational processes, are made real in interaction (Katovich and Maines 2003; Nugus 2008). Indeed, it is only in interaction that such influence becomes apparent (Mills 1940). The assumption that such theories and methods are useful only for illuminating one-on-one interaction and local cultures limits the capacity of social theory to contribute to understanding the common social dynamics Garfinkel's methods can show and have shown, especially in his hands and those of his most artful successors.

Conclusion

One might argue that tightening the relationship between social theory and methods amenable to ethnomethodology contravenes Garfinkel's spirited suspicion of theory. We argue that this depends on the level of abstraction to which one is willing to attend, and at which one defines theory. Garfinkel argued that reliance on retrospective accounts of social order impedes understanding of actors' methods. We believe this to be the case for models that represent an *a priori* explanation for behaviour or that aim to predict human behaviour, too. We have defined theory more abstractly, to capture more general principles of human interdependence. This is the spirit of theories of human interaction such as symbolic interactionism, complexity theory and actor-network theory, which transcend particular contexts. Indeed, Garfinkel's work relies on common methods of reasoning, however differently they are applied to particular situations. The extent to which one agrees or disagrees with this reasoning depends on the extent to which one sees the role of the sociologist to account for particular social situations, seeking broader conceptual frameworks, or solely to describe members' sense-making of shared situations.

Garfinkel sowed seeds for understanding the dynamics of mutual influence among people which have been germinating for decades. The prestige of quantification has made ethnographic research relatively marginal in sociology. Yet, we know that social structures are evident and manifest in interaction.

Networks of effects are inseparable from day-to-day interaction and are created in interaction (Law 2008; Mol 2008). The term 'microsociology' – as a descriptor for qualitative empirical social research – is a self-contradiction because of the inherent and inseparable manifestation of social structure in interaction. Complex organisations show tight, structured and ordered 'communities of practice' (Ranmuthugala et al. 2011), or 'tribes' of those in particular occupations, for example (Braithwaite and Westbrook 2005; Nugus et al. 2010). Individuals in particular occupations can move across the world or nation and find that they have more in common than different in the beliefs and behaviours they share, despite the difference of setting (Nugus et al. 2014). We can draw on Garfinkel's work to defend ethnographic research against the prevalent assumption that qualitative research lacks transferability, as well as redress to some extent the poor record of sociologists in arguing for the structuralist credentials of ethnography. After all, ethnography makes available to researchers shared worlds in the making. That is perhaps the defining contribution of Garfinkel to the sociological research enterprise.

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Chapter 17

Margaret Stacey: The Sociology of Health and Healing

Hannah Bradby

Margaret (Meg) Stacey (1922–2004) played key roles in establishing sociology as a university-based discipline in Britain and in developing a sociology of medicine, health and illness as a distinct specialism. This chapter outlines her biography and career, during which she helped to consolidate a sociology of health and illness that attends to inequality of various forms, offers critical perspectives on orthodox medicine through a comparative approach and that is committed to theoretical and empirical development. Her interests in the gendered division of labour, her feminist commitment, and a concern to address suffering, are considered in assessing her influence on the discipline.

Biography

Stacey, who was born Margaret Petrie in London in 1922 (Finch 2004), graduated with first-class honours in sociology from the London School of Economics in 1943, which was unusual in her cohort of sociologists whose training was usually in other, older disciplines (Frankenburg 2004:13). She studied alongside Klaus Moser who had been interned as a resident alien when he arrived in the United Kingdom from Berlin with his parents in 1936 (Frankenburg 2004:12). Having served as a Labour Officer in the Royal Ordnance Factory (UK government munitions manufacture), she married Frank Stacey while he was on leave from military service. Her husband's work as a political scientist took the couple first to Oxford University, where Margaret was employed as a tutor until 1951, and then to Swansea University (now University of Wales), where she looked after her growing family of five children, as well as writing up field work undertaken in Banbury which would become *Tradition and Change* (Stacey 1960). In 1961, Stacey, widely known as Meg, was a founding member of the Sociology Department at Swansea University, where by 1970 she was promoted to Senior Lecturer, before being seconded as Director of the Medical Sociology Research Centre (Oleson 2004). Her son's need for foot surgery in infancy at a time when parents were not welcome in paediatric wards, prompted Stacey to establish the Association for the Welfare of Children in Hospital (Murcott 2004) and serve on the Welsh Hospital Board.

In 1974, the Stacey household moved to the Midlands as Frank Stacey joined Nottingham University, and Meg Stacey was appointed as the first woman professor at the University of Warwick, where she chaired the Department of Sociology until 1979. Frank's death in 1977 left the book that he had been writing on ombudsmen incomplete, which Meg saw through to publication (Stacey 1978). From 1976 to 1984, Meg served as a lay member of the Privy Council of the General Medical Council and the first ever sociologist member. She also sat on the education, the disciplinary and the health committees (Stacey 1992a). In 1981, she was elected president of the British Sociological Association (BSA). From 1985, Meg Stacey chaired the Graduate School of Interdisciplinary Studies and the Nursing Policy Studies Centre which she had established (Anon 2004) at the University of Warwick. She retired in 1989 but did not stop work, taking on the presidency of the British Association for the Advancement of Science in 1990 and continuing to publish. Her work was honoured with an international conference in 1999 held at the University of Warwick, the proceedings of which were published as an edited collection (Bendelow et al. 2002).

In retirement, Stacey devoted time to Buddhism and international human rights with the women's peace organisation, Women in Black. Stacey's death in 2004 was marked by obituaries in the national press (Anon 2004; Finch 2004; Murcott 2004), as well as professional newsletters (Frankenburg 2004; Murcott et al. 2004; Oleson 2004), noting her attachment to her sister, her descendants and her companion Jennifer Lorch.

Academic context

Stacey's publishing career (which totalled 14 books (Murcott 2004) and many papers) started with a widely cited community study of Banbury (Stacey 1960), subsequently followed up with a re-study of the same area more than a decade later (Stacey et al. 1975). These Banbury studies trace the development of a rural market town with a strong sense of its nineteenth-century role as a trading centre between Birmingham and Oxford, through post-Second World War industrial, social and political change. Stacey's broad sociological interests informed the studies' attention to employment, political affiliations, religion, family structures and consumer behaviour, using various survey, mapping and interview-based methods to build up a detailed picture of the interrelated aspects of a changing urban community. The theoretical preoccupations of Stacey's later work in health, illness and medicine, which she developed during her university appointments at Swansea and Warwick, are detectable in the interest in gender, in structures and in people's interpretations of those structures.

The establishment of the British National Health Service (NHS) in 1948 was a key aspect of rebuilding a new social contract between citizen and state after the devastation of the Second World War. Stacey's commitment to promoting equality and humanity in the NHS played out at a time when 'expenditure of the British government upon research in all aspects of the health service has been greatly increased' (Stacey 1976b:1). Stacey's interest in medicine's institutionalisation and the development of critical approaches to interrogate its practice, was initiated at a time of significant social change, where resources were being devoted to expanding service provision and where idealism and conservatism were in strong contention. Her focus on the developing NHS (Stacey 1976a), new sociological understandings of medicine (Currer and Stacey 1986a), changes to the practice and the profession of medicine (Stacey 1992a, 1992b) was constructively critical and hopeful of building a better health service. Stacey's personal qualities of supportive warmth and determination are referred to by sociological and medical colleagues, to explain how she managed to sustain a critique that effected institutional change as well as support individuals (Irvine 2005).

From the social administrative and public policy preoccupations of the Banbury studies, a more sociological voice with a particular focus on health and medicine emerged from the 1970s onwards. Colleagues date Stacey's interest in the sociology of health to her son's foot surgery in Wales and describe her 'walking in her son's footsteps to develop the sociology of healing' (Alderson 2004:11). Stacey begins to make the argument that sociological methods have much to offer the study of health service provision, which is, at least initially, conceived as largely co-terminus with the NHS, both methodologically and theoretically (Stacey 1976a:1). In an edited collection, which coincides with a significant reorganisation of the NHS from its original post-Second World War inception, Stacey develops a critique of the emergent discourse around 'healthcare consumers'. She argues that patients should not be seen as consumers since healthcare provision should neither be modelled as an industry nor as a predominantly economic activity. Furthermore, patients, far from being consumers of health services, can equally be seen as producers of the 'elusive and abstract good: health' (Stacey 1976b:194). Stacey points out that patients are work objects, as much as they are consumers of health services, offering as they do their bodies or minds for intervention. The contradiction of being simultaneously a consumer of, and the work object for, health services suggests the inadequacies of an industrial model of healthcare for Stacey (1976c:195). She points out that even in the most depersonalising of medical settings, patients seek strategies to assert individuality and independence (Goffman 1976), citing findings from studies of general practice to contradict the idea of passivity among patients (Stimson and Webb 1975). Stacey laments the lack of a sociological terminology that could allow solidarity and relatedness to be analysed across different settings, for instance, between patients and pupils, or between patients and healthcare workers (Stacey 1976c:199). While the notion of 'patient as consumer' appeared to fill an ideological gap at a time when patients were conceived of in entirely passive terms, Stacey sees the limits of the consumer rhetoric (Stacey 1976c:198). Stacey wants a concept that sees a patient as a social actor and acknowledges the economic implications of that role; allows the idea of the patient as a work object for others; and permits the conceptualisation of such relationships as exploitative (involving power inequalities and suffering) as well as potentially consensual (Stacey 1976c:200). In her later writing, she still had not found an ideal alternative to the term 'consumer', so instead contended herself with defining the patient as 'an actor in the healthcare enterprise rather than a passive recipient of care' (Stacey 1988:6).

Stacey's ambition for the fast developing field of medical sociology continued to grow and began to encompass a comparative approach that extended significantly beyond medical systems of healing (Currer and Stacey 1986b). As a means of putting a contemporaneously dominant system of healthcare into perspective, Currer and Stacey advocate the recognition of 'concepts derived from other cosmologies or other modes of healing, and also from earlier formulations of medicine itself' (Currer and Stacey 1986b:1). In seeking to draw attention to the variation over time and space in how health and illness are conceptualised, Currer and Stacey (1986a) offer an edited collection that seeks to make anthropological, sociological and historical dimensions of analysis relevant to healthcare practitioners and planners. In a review of conceptualisations of health and illness, Stacey sets out an ambitious programme of research that would conceptualise specialist healers in terms of the structure of their society, understanding their work in terms of the division of labour, mode of production, class and the gender order (Stacey 1986:9). Examining other work on how social position interacts with experience, Stacey is interested in whether universal and fundamental concepts of health and illness can be detected across cultures, times and healthcare organisations. Her ambition for the developing sociological field, as potentially productive of theory that could synthesise variation across time, space and social order, is developed in subsequent work which sets out a sociology of health and healing (Stacey 1988). This choice of title was a manifesto to avoid a more limited sociology of medicine, putting medicine in its place as one of a number of competing healing systems. While the term 'medical sociology' persists, the idea of a sociology of health and illness (rather than of disease and medicine) has taken hold. Since 1979 the journal *Sociology of Health and Illness* has published papers that reflect the broader version of this field although perhaps not, as Stacey might have hoped, consistently encompassing anthropological and historical approaches.

Stacey was unusual as a British practising sociologist of the second half of the twentieth century, in having read sociology at university, since it was available in only a few institutions prior to the Second World War. Before she could find employment that built on her academic studies, she did a year of war service, as did her husband, and at this time Stacey campaigned against the imprisonment of enemy aliens which she later said was informed by her encounter with Claus Moser (Frankenburg 2004:12). The experience of working in a society that was defending itself in war and then remaking itself in peace, doubtless influenced her vision of a sociology that was empirically and theoretically engaged with the potential of the social world for progressive political change. During the 1960s, additional university departments of sociology were established, a development in which Stacey participated at Swansea, and during which time the boundaries with social anthropology were in contention. The demographic and theoretical discipline that Stacey studied at the London School of Economics and which had informed her studies of Banbury, was developing participatory and narrative research methods that resembled ethnography as well as grappling with the feminist challenge (Frankenburg 2004). Opening sociology up to greater interdisciplinary influence makes sense in terms of Stacey's interest in gender and comparative methods.

Stacey's role as a pioneer of the sociology of health and illness can be seen in her 1988 book, which was based on lectures at the universities of Warwick and Swansea. She gives extended treatment to the sociology of care, of the pharmaceutical industry and of reproductive technologies, among other topics, all of which proved to be fertile areas of research and critique in subsequent decades. In addition to defining the discipline through her own publishing, Stacey played a role in establishing the BSA Medical Sociology Group, which, soon after its inception in the early 1970s, became the biggest single study group in the BSA. This group, with its annual conference, newsletter and own study groups, has been a forum for the development of the discipline, in the United Kingdom and more widely.

Overall contribution

Margaret Stacey was a key figure in establishing sociology as an academic discipline with a wide purview, employing a range of methods to interrogate theoretical and empirical questions and included a vigorous interrogation of medicine, health and healing. While her contribution was not limited to health and illness, Stacey had a substantial input to conceptualising a sociological approach to the practice of medicine as a healing system, with an interest in its regulation and its effects beyond the clinic.

One of Stacey's contributions to the theoretical development of the sociology of health, illness and medicine was to insist on keeping in play a range of variables, in seeking to capture the complexity of the social world. She did not allow any single variable to dominate, keeping the sense of a delicate balance, even when this presented contradictions. Stacey insisted on an appraisal of the gendered division of labour, which brought unpaid and low-paid work into view together with the disproportionate likelihood of such work being done by women. She was interested in the range of people engaged with health-work and in disrupting the monopoly of paid specialists as experts in healing. She treated biomedicine as a social construction, albeit a powerful one, which could be seen as operating in parallel with alternative systems of belief and practice. In opening up debates about what constituted efficacious or appropriate care, Stacey saw suffering as an unavoidable aspect of what she called 'the biological base' of 'birth, mating, ageing and death' (Stacey 1988:3) with which sociology had failed to engage, due to a fear of biological reductionism. Her contribution did not lie in the construction of elegant grand theory, so much as in bringing together feminism with a critical approach to the socio-economics of healthcare provision and organisation which sought to use all the sociological approaches available. In defining a broad and open theoretical approach, which excluded little, Stacey helped to open up the field for methodologists, practitioners and theorists alike where a range of questions could be pursued. The lively success of the field of health sociology is partly due to the uptake of sociological approaches by healthcare practitioners, managers and service users. The appeal of sociological methods for researchers with a background in, for instance, nursing, public health or physiotherapy has informed an interrogation of therapeutics, diagnosis, healthcare funding, organisation and commissioning, among other topics. While this expansion of research activity has been accompanied by some sociological disparagement of a lack of theoretical acuity, it nonetheless represents a welcome widening of access to sociological concepts and methods. Having practice at the heart of a developing sociology of health and illness was, for Stacey, entirely appropriate, and she (with Hilary Homans), refers to the 'many cross-threads in theory and methodology' as contributing to a cooperative and constructive scholarly community which is 'open to the lessons and approaches of others' and so able to avoid 'a sterile and unthinking conformism' (Stacey and Homans 1978:294).

Feminism

A consistent manifesto for Stacey was feminism. She asserted that the social order depends on a social construction of gender which is not natural in any sense, but which is subject to the consequences of high technology. Crucially, she pointed to the way that the gender order had been over-looked and urged sociologists to get to grips with it (Stacey 1985).

Stacey notes the effect that women's historical exclusion from the public domain, perpetuated by nineteenth-century theories of society ignoring the domestic sphere, has had on the configuration of social structures in general and the configuration of healthcare in particular. Her book entitled *Women, Power and Politics* (written jointly with Marion Price) was a celebration of the 200 years since women as a class began to strive for independence as persons and exercise power 'as individuals in their own right', a right which men gained through the processes of industrial capitalism (Stacey and Price 1981:13). The book inverts the question of why gender inequality persists in disadvantaging women, to celebrate the enormous gains British women made in the five decades since the gaining of suffrage. Stacey's political convictions of the centrality of gendered inequality to an understanding of healthcare are worked through with full acknowledgement of the bodily inequalities engendered by reproduction and child-rearing and without denying the significance of socio-economic class. Stacey's feminism never descends into gender-tribalism, indeed she acknowledges men's contributions as well as their sins. Stacey's father first drew her attention to the need for 'a radical re-division of labour in the private domain as well as in the public' (Stacey and Price 1981:vii). Stacey notes the 'delicate nature of women's struggle for liberation' compared with workers' struggle, 'given the intimate nature of social relations with bed-mate and children', and observing (almost regretfully) that feminists will 'inevitably have to find a place for men in its new order' (Stacey and Price 1981:12). Reference to her father, to her own experience of infertility (Stacey 1985) and of ageing (Stacey 1989), suggests that the personal was indeed political for Stacey, as appropriate for someone who lived through the blossoming of identity politics in the 1960s, but such scarce reference meant that her own situation never dominated her analysis. A willingness to connect personal troubles, as well as the celebration of personal joys, with public politics is evident in the way that Stacey brought feminist conviction to mainstream scholarship. It is also evident in the public service she rendered both on the General Medical Council (Stacey 1992) and, after retiring, with the international women's peace network 'Women in Black' (http://www.womeninblack.org/).

One aspect of Stacey's efforts to live out feminist convictions was to reflect on the gendered nature of written language, to be explicit about meaning and to promote the use of inclusive language. Describing her own alienation from what she describes as the 'masculinist mode' of writing, Stacey uses 'us' (rather than 'them') to refer to women and notes that 'we' means 'you, the readers, and me', further extending this to mean 'people in our society, all of whom are on a journey of discovery' (Stacey 1988:xiiv). For a contemporary reader, such a discussion might seem whimsical, but is best read as part of a more general attempt to render sociology alert to gender without making this its only focus. Such has been the success of feminist critiques of gendered linguistic forms that avoiding exclusively male pronouns as universal indicators of humanity is nowadays almost routine in many spheres. For Stacey, this was part of a wider project of inclusive methodology and theory that covered all the 'actors in the division of labour in healthcare, be they trained or untrained, paid or unpaid' with the hope that findings would inform reform of that division of labour 'for the better well-being of the population' (Stacey 1988:14).

Stacey's concern to avoid 'othering' womankind was linked to wider concerns of inclusivity, expressing as she does the need to 'avoid ethnocentricity' and to take other cultures seriously on their own terms (Stacey 1988). This commitment was played out in her support of doctoral students who worked with other cultures, both as minorities in Britain (Currer 1986) and elsewhere (Lewando-Hundt 1988).

Suffering

In 1978, Stacey (and Hilary Homans) suggested that the sociology of health and illness should continue to concern itself with the problems of domination and subordination and of suffering. The social relations of health and illness are proposed as unusual compared to other types of social relations because of the role that suffering inevitably plays. In the analysis of suffering, their paper asserts that the sociology of health and illness can contribute insights to general sociology as well as to the more applied task of informing policy (Stacey and Homans 1978). Theoretical, methodological and substantive contributions that sociologists of health and illness have made to a more general sociology have proved to be a key feature of the development of the discipline (Bradby 2012), and one to which this volume attests.

Two decades later in 1999, at a conference convened in her honour, Stacey reflected that her lifetime's work could all be seen as turning on the question of suffering, 'particularly the suffering which we human beings inflict on one another, individually or collectively'. Starting with the studies of children in hospital (Stacey et al. 1970) and her recognition of the lack of mechanisms for promoting children's welfare within the hospital system, via work on regulating medicine, to peace advocacy with *Women in Black*, Stacey attended to suffering. In bearing witness to humanity's suffering Stacey's work offers a critique of the ways that various institutions do not. In the edited collection of papers, arising from the conference entitled 'Intended and unintended suffering', she urged her successors to take up 'the challenge of examining the health aspects of the causes and consequences of violent conflicts' (Stacey 2002:281). Social science research has continued to explore social suffering conceptualised as the 'collective and individual human suffering associated with life conditions shaped by powerful social forces' (Kleinman et al. 1997) in terms of philosophical underpinnings (Wilkinson 2005) and practical implications (Bradby and Hundt

2010). The legacy of Stacey's work is clearly visible in the on-going reforms to medical education from the United Kingdom's General Medical Council (GMC) (see http://www.gmc-uk.org/education/undergraduate/tomorrows_doctors.asp) and the debates around what Stacey termed the 'new professionalism' (Stacey 1992a). Stacey questioned whether the GMC had 'the stomach for serious reform', and her doubts that 'radical change' could be effected in the face of the GMC's characteristic 'minimalism and complacency' (Irvine 2005) foreshadowed Dame Janet Smith's findings in her report on the Shipman Inquiry (Smith 2005). The ramifications of how contemporary medical culture determines the values and the management of clinical care can be seen in the urgent discussions of the public's trust and professional compassion in healthcare, following the public investigation of disproportionately high mortality rates at the Mid Staffordshire NHS Foundation (Francis 2013). This research agenda is far from exhausted.

Other agendas

Stacey's legacy was not confined to the agenda around suffering in healthcare settings and beyond, in that she anticipated other theoretical and empirical developments in sociology. For instance, as president of the British Association for the Advancement of Science, Stacey presented a programme promoting a constructive social science perspective on the development and use of new reproductive technologies (Statham 1994:409). Her insistence that birth is as much a social as a biological moment and that the social dimension of reproductive technologies must be researched and discussed has been borne out ever since, with research and public debate around the implications of IVF (in vitro fertilisation), ICSI (intracytoplasmic sperm injection) and surrogacy, to name but a few. Stacey's feminist commitment to inclusive practice can be seen in the development of intersectional approaches (Yuval-Davies 2006) which aspire to analyse the dimension of racism and othering around ethnicity and culture, alongside a gendered perspective, although these have not been much taken up in studies of health and illness.

Conclusion

Stacey's contribution to theoretical developments in the sociology of health, illness and medicine has helped to create a discipline in which theoretical and methodological progress and innovation has been possible. Her published work, influenced by her political commitments that found expression in both activism and public service, contributed to her advocacy for a progressive, inclusive, just and humane sociological project. Sociological analyses interrogating medical power, like feminist analyses of gendered power, have been widely taken up over past decades, suggesting that they have extensive explanatory appeal. While innovative at the time, ideas that are widely adopted can come to seem like common sense from a contemporary perspective. While committed to a theoretically informed sociology, and the use of empirical work to inform progressive reform, Stacey did not promote her own theoretical interests as unique. Her identity seemed to lie in a commitment to feminism, justice and human rights. Therefore perhaps her legacy has greater visibility in action and reform in disciplines such as medicine and nursing, rather than in sociological theoretical schemata.

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Chapter 18

Erving Goffman: The Moral Career of Stigma and Mental Illness

Bernice A. Pescosolido

Observing patients and providers at St. Elizabeth's Hospital in Washington DC, Goffman began the development of his basic concepts about how culturally and socially defined 'difference' shapes the status, roles, rewards and penalties of mental illness. His first set of articles and the book *Asylums* offered an overall analysis of the organisations that deal with the positive or negative reorientation of the self as monk, naval officer or physician in the first case, and mental patient, prisoner or labour camp worker in the second. Goffman outlines the pathways, rhythms, social processes and accommodations possible in the moral career of individuals who enter these organisations. And, he considers the critical role of context in shaping entrances, processes and outcomes. The follow-up, *Stigma*, focused directly on the aftermath of occupying a negatively valued status, where Goffman elaborated the many types, dynamics and effects of the devaluation of identities marked by social circumstances as damaged. In this chapter, the basic framework of Goffman's ideas about the (1) organisational and community processes affecting identity that follow from mental hospitalisation, and (2) stigma that attaches and often remains after socially devalued labels are attached to mental illness are presented.

Only those specifics that are still relevant in contemporary society, where long-term hospitalisation is rare, will be discussed. Yet the insights that remain relevant are many and remarkably durable. Though, even as Goffman himself was 'uninvolved' in the public discussion, his work became a centrepiece of the social and political movement to deinstitutionalise the treatment of mental illness in the United States and across the globe (Grob 1994:272). How ironic, then, that many of the sociological phenomena that he observed continue to describe the social psychological ramifications of being diagnosed with mental illness. His work on how providers, families, patients and even strangers together enact the treatment of mental illness and the longer-term ramifications on social life hold a central place in the understanding of stigmatised illnesses, writ large, laying the groundwork for later theoretical and empirical investigations from obesity to HIV/AIDS.

The intellectual history

Freund (in chapter 10 of this volume) provides a brief biographic history for Goffman; there is no need to repeat it here. Rather, the relationship of his ideas to his research positions puts the work in context and provides a platform for understanding the germination of his theorising. Unlike the present-day US National Institute of Mental Health (NIMH), the NIMH of the early post-Second World War period was one in which the general development of social science theory was supported. As Goffman noted in the Preface to *Asylums*, John Clausen, founding director of the Laboratory of Socio-environmental Studies at NIMH, provided logistical, fiscal and intellectual support, encouraging Goffman 'to look at the hospital with sociology in mind, not junior psychiatry' (Goffman 1961:xi).

In his time in the Lab, specifically from fall of 1954 to the end of 1957, Goffman had done some 'brief studies', as he called them (1961:ix), at the NIH Clinical Center. But it was the year-long ethnography (1955–1956) at St. Elizabeth's Hospital, the enormous federal psychiatric hospital in Washington DC housing thousands of 'mental patients', that provided the data for his early articles (for example, Goffman 1959) and for the two books that followed (Goffman 1961, 1963). While Goffman did not limit his observation to mental illness or even illness (for example, the subtitle of the 1961 book is *Essays on the Social Situation of Mental Patients and Other Inmates*), his theoretical insights on identity were sharpened by employing the common sociological concept of 'deviance', a concept central to the labelling theory of mental illness that was to come later (Scheff 1966). But they also may have been fuelled by personal life experiences. Goffman's first wife, Angelica Choate, was diagnosed with serious mental illness and committed suicide in 1964 (Fine and Manning 2003).

Earlier, Goffman had laid out his thesis about individual action, public reaction and identity in *The Presentation of Self in Everyday Life* (1959). But training his sociological lens on mental hospitals, prisons, convents and the military provided an organisational focal point to sharpen his views of identity, interaction and context under extreme conditions. While Goffman supplemented his original observations by weaving in cases from other contemporary research (for example, Biderman's 1960 *Sociometry* piece on police interrogation; Stouffer's 1945 classic, (1949) *The American Soldier*) and even from literature (for example, Hulme's 1956 biographical book, *A Nun's Story*; Melville's 1850 novel, *White Jacket*) in the sociological style of the day, Goffman's real contribution comes from ethnographic insights.

Yet, there are contentious debates about the nature of Goffman's contributions and his intellectual influences. The prominent German medical sociologist Uta Gerhardt (2003:14) argues that Georg Simmel's ideas, cited in

Goffman's early writings but absent in his later ones, led Goffman to hold a common view of the 'basic forms of social order'. This observation is in line with Fine and Manning's (2003) conclusion that Goffman never directly engaged other theorists in discussion. Yet, clear influences of early anthropological, sociological and psychoanalytic theory are evident in his work, especially those of his mentor at the University of Chicago, Everett C Hughes (Burns 2002).

The seminal statement

In his essay 'The Insanity of Place', Goffman (1969:357) summed up and laid out his assessment of the major form of treatment of the day, long-term hospitalisation:

> Patients recover more often than not, at least temporarily, but this seems in spite of the mental hospital, not because of it. Upon examination, many of these establishments have proven to be hopeless storage dumps trimmed in psychiatric paper. They have served to remove the patient from the scene of his symptomatic behaviour, which in itself can be constructive, but this function has been performed by fences, not doctors. And the price that the patient has had to pay for this service has been considerable: dislocation from civic life, alienation from loved ones who arranged the commitment, mortification due to hospital regimentation and surveillance, permanent post-hospital stigmatisation. This has been not merely a bad deal; it has been a grotesque one.

This statement came after the publication of his two major works on mental illness and its treatment in the United States prior to deinstitutionalisation. While he acknowledged some of the changes that occurred by the end of the 1960s (for example, tightened involuntary commitment laws, a shift to community-based care), Goffman remained steadfast in his conclusion that the situation of mental illness raised critical social issues of identity, place and social interaction for individuals, families or providers that were neither understood nor considered even as the dominant logic on the nature and societal response to mental illness was shifting.

To this day, Goffman's fundamental insights on the nature of treatment continue to spark discussion and recommendations across the societal landscape. Perhaps this is because he 'put a face on the sociological subject', as Denzin (2003:128) claims, or as Scheff points out, shattered 'the calm surface of everyday life ... [proposing] not a political/economic revolution but a revolution in culture' (2003:61). For those diagnosed or treated in the mental health system, there are frequent mentions of how Goffman's work transformed their understanding of their experiences, helping to give rise to the notion of the 'consumer' (in Australia, *Our Consumer Movement;* in Germany, *The Runaway-House;* in Hungary, *Voice of Soul; Mind Freedom International),* coalition (for example, the National Alliance for the Mentally Ill in the United States) and 'psychiatric survivors' movements (for example, *World Network of Users and Survivors of Psychiatry;* see McLean 1995; Morrison 2005 on histories) and most recently to 'mad studies' (LeFrancois et al. 2013).

For psychiatrists, Byrne (1997) reminds us that while stigma existed long before psychiatry, the profession has done little to reduce stereotyping and prejudice, and sometimes added to it (for example, the schizophregenic or 'refrigerator' mother theory of mental illness, particularly for schizophrenia and autism). Only in recent history has psychiatry taken on this topic wholeheartedly, led by Norman Sartorius, who in 1993 as president of the World Psychiatric Association, chose stigma as the focus on the global meeting. There have always been 'radical' mental health providers at the forefront of efforts to improve and change (for example, RD Laing, Thomas Szasz). As Crossley (2006) documents for the 'anti-psychiatry movement' in the United Kingdom, psychiatrists were often on the frontlines of the challenge to traditional psychiatry, finding support from social scientists and other groups.

Yet, as a profession, the quest for the best diagnostic scheme among warring factions (the Emil Kraeplin's vs Sigmund Freud's followers) was the significant pressing social and professional issue of the nineteenth and twentieth centuries, and even today (for example, DSM-5 vs. RDoC debate, Insel 2013).

Today professional, private and public efforts to reduce stigma vary tremendously cross-nationally. The UK and New Zealand governments heavily fund national reduction initiatives *(Time to Change; Like Minds, Like Mine)*, but the United States relies almost entirely on private efforts for stigma change (though see SAMSHA's efforts as an exception), while research funding focuses increasingly on the molecular level and away from community-based issues.

The Basics – *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates (1961)*

Goffman's fundamental concern in *Asylums* lay in understanding meaning and identity, which Freund (chapter 10, this volume) correctly characterises as his focus. Yet, it was the constricted structural roles of those in 'total institutions' that enabled him to see how even such restricted situations allow for, even require, the establishment of meaning, both 'reasonable' and 'normal' as he notes (see Table 18.1). Goffman saw the primary role of structural contexts where 'an organisation can therefore be viewed as a place for generating assumptions about identity' (1961:186). Thus, Goffman may not have embraced the national or historical sweep of the institution of medicine that others, like Foucault (1988) for example, did, yet he understood the inevitable

Table 18.1 Goffman's typologies in *Asylums* (1961) and *Stigma* (1963)

Phenomenon	**Types**	**Examples**
Total Institutions	Established for those labelled in capable and harmless	Nursing homes, orphanages, poor houses
	Established for those labelled incapable and an unintentional threat	TB sanitaria, mental hospitals
	Established to protect the community from 'intentional' dangers and threats	Jails, P.O.W. camps, concentration camps
	Established to pursue an instrumental task	Army barracks, boarding schools, work camps
	Established as retreats and training stations	Monasteries, convents
Inmate Responses to Mortification and Reorganisation Efforts	Situational withdrawal	Curtailment in social involvement
	Intransigent line	Challenging the institution with flagrant refusal to cooperate
	Colonisation	Acceptance of institutional conditions as preferable to those outside with satisfaction from procurement of inside resources
	Conversion	Adoption of institution view of self with corresponding behaviours to be the 'perfect' inmate, patient, soldier to identifying with the staff and acting in their behalf
	'Playing it Cool'	Opportunistic use of all other strategies to maximise physical and psychological damage to self
Types of Stigma	Abominations of the body	Physical deformities
	Blemishes of individual character	Mental Illness, Alcoholism, Obesity, Criminality, Homosexuality
	Tribal stigma	Race, Religion, National Identities
Public Knowledge of Stigma (recognition)	Discredited	An obvious 'mark' that is easily perceived or already known
	Discreditable	Concealable 'mark'

Table 18.1 (Continued)

Phenomenon	**Types**	**Examples**
Coping with Stigma	Acceptance with isolation	Withdrawal from society, accompanied by bitterness, sadness
	Acceptance with actions	Incorporation into identity, e.g., Advocacy, Support Groups
	Passing	Attempt to normalise or hide stigmatising condition
	Correction	Addressing to negate, e.g.,Treatment
	Compensation	Performing normal tasks in a different/extraordinary way, e.g., Special Olympics
	Hostile bravado	Flaunting, usually with a component of anger, e.g., protest
	Victimhood	Seeking secondary gains, e.g., sympathy and roles release
	Blessing in disguise	Attaching special meaning, e.g., gift

connection of culture and structure of the personal and the public. As he noted on the 'two-sided' concept of careers:

> One side is linked to internal matters held dearly and closely, such as image of self and felt identity; the other side concerns official position, jural relations, and style of life, and is part of a publicly accessible institutional complex (Goffman 1961:127).

Thus, like those structural identity theorists who followed (for example, Stryker and Burke 2000), it was the 'structure of the self' (1961:xiii) that Goffman sought to understand. Fundamentally, *Asylums* is about the power of social institutions to shape the life chances and lifestyles of individuals who live and work in 'total institutions'. These institutions 'are encompassing to a degree discontinuously greater than the ones next in line ... symbolised by the barrier to social intercourse to the outside and to departure that is often built right into the physical plant' (Goffman 1961:4). Yet, their influence extends far beyond their walls, moulding both patient and provider, jailor and jailed, novice and veteran, when or if they are allowed to re-enter the community. While Goffman often reminded us that it is social *interaction* through which the structure of the self is formed, he also clearly stated that his sensibilities lay squarely with the 'inmates', as he called them, with the goal of learning about their subjective experiences (Goffman 1961:xii).

In *Asylums,* Goffman sought to define, describe and understand the moral career which is 'composed of progressive changes that occur in the beliefs that he has concerning himself and significant others' (1961:14). A total institution does not aim to 'support' an individual's identity; rather, the goal is to 'constitute it'. Radically, Goffman saw the self not as a property of the person but of the 'prevailing social arrangements' and in particular, in total institutions, of the social control system that routinely compels both the individual and others to act. While the situation is fundamentally different for those who enter a total organisation voluntarily (for example, those who enlist in the military, medical school) versus those who are 'sentenced' to it (for example, those who are drafted, involuntarily hospitalised, sent to jail; Pescosolido 1986), social experiences are likely similar, if less intense in role assimilation. The process begins with a challenge to the self, ultimately reconstituting it, to one degree or another, in line with the organisation's aims. The *mortification of the self* in total institutions is achieved through clear lines of interaction between the few staff and the many inmates and through 'stripping' the physical symbols of the outside world (for example, clothing, hair styles, possessions). Once completed, the *privilege system* offers the foundation for the reorganisation of the self through house rules, rewarding those who follow them and punishing transgressions.

These structures and processes result in narrow and hostile stereotypes whereby, for example, patients come to see themselves as 'inferior, weak, blameworthy, and guilty' (Goffman 1961:7), though the staff hold the power to lessen stigma by offering a 'clean bill of health' (1961:73) upon discharge. Further, because the strategies, or what Goffman called 'secondary accommodations', to the status of 'mental patient' tend to be varied and flexibly employed (Table 18.1), he believed that neither the breaking down nor the rebuilding process could have lasting effects. Yet, he also noted that an individual's 'social position on the outside will never again be quite what it was prior to entrance', since 'the total institution bestows an unfavourable status' (Goffman 1961:72) where stigmatisation produces 'a cool reception in the wider world' (1961:73). Institutional psychiatry, with involuntary admission and lengthy treatment, translated into alienation from society both by and for the individual who receives treatment:

> Once he has a record of having been in a mental hospital, the public at large, both formally, in terms of employment restrictions, and informally, in terms of day-to-day social treatment, considers him to be set apart; they place a stigma on him (Goffman 1961:355).

It was this phenomena, the prejudice and discrimination that followed from both the label and the hospitalisation experience, which his next book explicated.

The Basics – *Stigma: Notes on the Management of Spoiled Identity (1963)*

In *Stigma*, Goffman provided the now standard definition of the concept, an accounting of basic types, and the theoretical fundamentals widely used in research and practice (Hinshaw 2006; Scambler 2011; Pescosolido 2013). Stigma is a 'mark' that signals to others that an individual possesses an attribute which reduces them from 'whole and usual' to 'tainted and discounted' (Goffman 1963:3). As he notes (1963:5, chapter 1):

> ...an individual who might have been received easily in social intercourse possesses a trait that can obtrude upon itself attention and turn those of us whom he meets away from him, breaking the claim that his other attributes have on us. He possesses a stigma, an undesired differentness from what we had anticipated.... By definition, of course, we believe that the person with a stigma is not quite human. On this assumption we exercise a varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances.

The central issue or question that follows is *acceptance* (Goffman 1963:13):

> Those who have dealings with him fail to accord him the respect and regard which the uncontaminated aspects of his social identity have led them to anticipate extending, and have led him to anticipate receiving; he echoes this denial by finding some of his own attributes warrant it.

Stigma, then, is fundamentally a social phenomenon rooted in social relationships and shaped by the culture and structure of society. While arising from an attribute marking difference, stigma can only be enacted in social interaction and is typified by exclusion from key participation in society. Individuals who face stigma are disqualified from full social citizenship.

As in *Asylums,* Goffman focused on a wide range of identities, rejecting the notion of status as an imprecise and overly broad concept. He considered the situation of being an orphan, facing hearing impairment or a wide spectrum of disabilities, engaging in criminal behaviour and holding identities from prostitute to revolutionary, in addition to having a mental illness. He saw the nature and effects of stigma not as static but as having an ebb and flow in concert with other aspects of an individual's 'moral career' and the larger societal context.

Goffman distinguished different types of stigma that categorised both the 'differences' that societies separate out, the influence of public knowledge and the various responses that individuals can take (Table 18.1). Importantly, the issue of disclosure becomes critical for those who have a concealable stigma and whose coping strategy is 'passing' (1963:84ff). However, individuals could expect support from two groups of individuals in society – others that share the stigma and the 'wise', those who do not bear the mark but are nonetheless sympathetic and including (1963:26).

In sum, difference can create a 'spoiled identity' that has ramifications for prejudice, discrimination and ultimately both lifestyle and life chances.

The continuing relevance of Goffman's ideas on mental illness

Sociological attention to stigma has been uneven (Pescosolido and Martin 2007). It nearly disappeared from research entirely in the late 1980s; however, a resurgence at the end of the twentieth century marked renewed sociological attention and greater collaboration with other social scientists and other disciplines, including psychiatry (Pescosolido 2013). In fact, this resurgence found voice in the United States' first Surgeon General's *Report on Mental Illness*. By the time of that publication, the new wave of research had documented that psychiatry's claims of the 'dissipation' of stigma were unequivocally wrong (Martin et al. 2000; Link and Phelan 2001), not only in the United States but in other Western nations (Crisp et al. 2000; Jorm 2000; Angermeyer and Dietrich 2006). The evidence clearly showed the continued existence of stigma and its impact on the lives of people with mental illness, on their families, and on the lower levels of support for research, treatment facilities and providers, and programmatic efforts (Pescosolido 2013).

Perhaps most damning are recent studies documenting the morbidity and premature mortality levels for those diagnosed with mental illness. In the United Kingdom, individuals with serious mental illness (SMI) are at a greater risk for mortality from cardiovascular disease, a risk not attributable to medications or smoking (Osborn et al. 2007). In Sweden, 'excess deaths' were attributed to suicide for men and cardiovascular disease for women (Osby et al. 2000). Further, individuals with SMI in the United States experience poorer medical care (for example, lower rates of cardiovascular procedures, substandard diabetes care, Desai et al. 2002; Druss et al. 2002). All in all, years of life lost are estimated to be, on average, 20 years for men and 15 years for women (Thornicroft 2011).

In fact, in some areas, the data reveal that the social and cultural climate appeared to have worsened (for example, assessments of dangerousness, Phelan et al. 2000). This led the Surgeon General to declare stigma as the 'greatest obstacle' to the recovery of persons with mental illness and to follow-up with the *President's New Freedom Commission on Mental Health* (2003). Other nations, notably Australia and New Zealand, seemed to be ahead in their research and programmatic efforts, and during this time, the United Kingdom formulated its national efforts (see special issue of the *British Journal of Psychiatry,* April 2013, for a recent report on progress).

Goffman's legacy has found a wider voice across a range of medical and behavioural issues, including HIV/AIDS (Pryor et al. 1999; Bos et al. 2008), obesity (Hebl and Mannix 2003), sexual orientation (Herek 2009), smoking (Link and Phelan 2009) and autism (Mak and Kowk 2010). Finally, while there has been more cross-fertilisation across substantive and theoretical traditions in understanding the advances in Goffman's concept, a promising route to further advances remains in taking stock and integrating insights across disciplines.

Where from here?

With Goffman's foundation intact, both theoretical developments and empirical research since his time have built a foundation to elaborate the social processes underlying stigma, helping to define the path to a new generation of research. Figure 18.1 provides the graphical representation of a modem, transdisciplinary approach that starts with Goffman's notion that understanding stigma requires a language of social relationships. However, it acknowledges the role of *complexity* that Nobel Laureate Elinor Ostrom (2009), a social scientist herself, argued that we must acknowledge and build into our research. The notion of complexity should not be confused with the idea that social life is complicated; sociologists have always known that. Rather, it acknowledges that large, interacting systems are at work in any social process. Thus, as Figure 18.1 indicates, individuals do not come to social interaction devoid of psychological issues of affect and motivation; they have a history (or lack thereof) of lived experiences with mental health problems or with the lived experiences of others; they also live in contexts in which organisations, media and larger cultures structure normative expectations for stigma. Labelling theory, social network theory, the limited capacity model of media influence, the social psychology of prejudice and discrimination, and theories of the welfare state, all have the potential to contribute to an understanding of the complex web of expectations and structure, shaping what individuals in a particular social time and a particular social place see as 'different', 'undesirable' or 'dangerous' (Pescosolido et al. 2008).

In sum, while Goffman's contributions remain the fundamental base and continued reference point for stigma (Keusch et al. 2006), they have been complemented by other lines of research. Current theory and research have fleshed out the subtle and not-so subtle nature of stigma (Dovidio et al. 2000) and its current levels at the national (Martin et al. 2000; Pescosolido et al. 2008) and global levels (Pescosolido 2013; Pescosolido et al. 2013). More recent research has looked to change (Pescosolido et al. 2010) and the effect of stigmatising context on stigmatising experiences and the use of treatment (Mojtabai 2010; Evans-Lacko et al. 2011). Importantly, the issue of power has become more visible in understanding the roots of stigma, its relationship to population health and the potential for change (Link and Phelan 2001; Stuart et al. 2012; Evans-Lacko et al. 2013; Hatzenbuehler et al. 2013; Pescosolido et al. 2013).

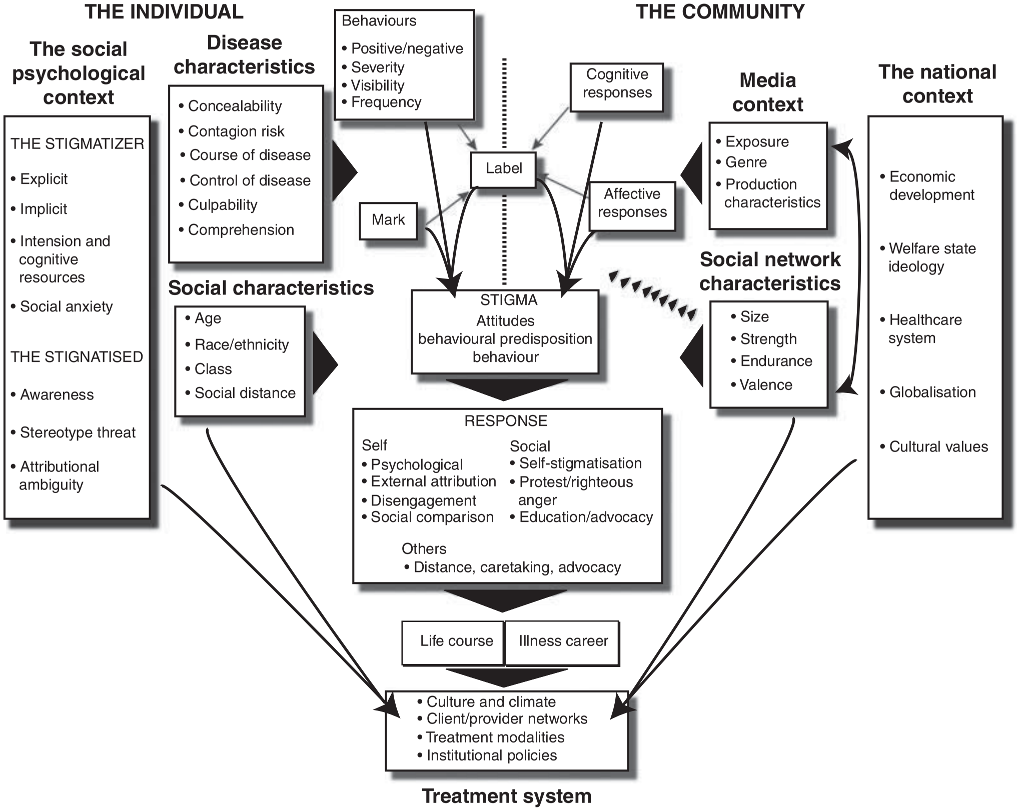

Figure 18.1 Framework Integrating Normative Influences on Stigma (FINIS) Model

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It is important to continue to monitor levels of stigma for individuals, organisations and societies, especially since claims of change are made by those who do not study culture. Yet, it is time to return to some of Goffman's basic ideas, all the while going beyond them, collecting data that benefit from our contemporary toolbox of ideas and approaches. We have the intellectual tools to provide a scientific foundation for efforts to decrease stigma. To date, few efforts do so (see the United States' *Bring Change 2 Mind* as an exception). However, as Figure 18.1 indicates, and sociologists know so well, unintended consequences can arise from a focus on one small part of a complex social system. Just as research advances the need to become more sophisticated, so too do policy and programme efforts to reduce prejudice and discrimination towards mental illness. Sociologists, even in their role as basic researchers like Goffman, can have an immense impact on institutional social change.

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Chapter 19

Eliot Freidson: Sociological Narratives of Professionalism and Modern Medicine

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Theoretical analyses in sociological specialist areas such as health and illness are believed to be led by theorising from mainstream sociological thinking. However, in some cases the reverse is evident, such as in the sociology of professionalism, where considerable debate has focused on the changing position of medicine and doctors, which has been characterised by some scholars as the archetype of professionalism. There have been a multitude of theoretical perspectives informing sociological analysis of this topic, but one of the most influential has been the writings of Eliot Freidson, who has been described (Bosk 2006:637) as 'a founding figure in medical sociology'. This chapter will focus on discussion of some of Freidson's key concepts which appeared in his earlier work, such as professional autonomy (Freidson 1970, 1975), and more latterly, re-stratification, and in his more recent writings, where Freidson (2001) argued that professionalism is an ideal type of organisation of work (or what he termed 'a third logic'), where the professional acts as a mediator presiding over the interests of the state or corporate agencies and serving the needs of the public and demands of patients. Freidson was not without his critics (Coburn 2006), and the chapter will examine the merits of some of these critiques. It will also draw on empirical evidence mainly from the National Health Service (NHS), in England, to examine if concepts such as professional autonomy and discretion, re-stratification and trust are salient in sociological explanations of the current position of medicine.

Biography

Eliot Freidson was born in 1923, brought up on the East Coast of the United States by his immigrant parents, and in between serving time in the Army during the 1940s, studied at the University of Chicago. Freidson was one of a number of eminent sociologists (including Erving Goffman, Howard Becker and Fred Davis) who studied at the University of Chicago and whose research focused on work and occupations (Bosk 2006). His analytical insights, at least in his earlier work, are believed to have been influenced by the work of Everett Hughes, the Chicago-trained interactionist (Halpern and Anspach 1993). However, for much of his academic life (1961 until retirement: he died in 2005), Freidson was based at New York University, where he wrote (mainly single authored) a series of seminal books about medicine and professionalism, beginning in the 1970s (Freidson 1970, 1975). These, Coburn (2006:433) suggests, had considerable influence:

> Freidson set the stage for the study of the power of medicine in the latter half of the 20th century and many of his critics were captured by the concept of professional power and medical dominance.

Contextualising Freidson's sociological perspective

There are a number of general comments about Freidson's perspective which need to be made before a more detailed analysis of professionalism is discussed. First, Freidson's analysis was primarily carried out in the context of a neo-liberal health system found in the United States, where healthcare is predominantly privately funded and provided and the emphasis is on consumer choice and market competition, with the role of the State in the provision of health and welfare being minimal. The implication of this for the medical profession appears to be greater professional freedom due to lack of constraints on both economic and clinical autonomy (Elston 1991), but without the shelter or protection provided by the state (as in the NHS in the United Kingdom) from the unpredictabilities and volatilities of the marketplace and a potentially litigatious patient population.

Second, Freidson's earlier analysis of professional dominance not only focused on the institution of medical professionalism but embraced the structure and nature of the doctor–patient relationship, which he portrayed as a conflict or *clash of perspectives* between their distinctly different worlds. The emphasis on negotiation and bargaining in this analysis appeared to reflect the influence of the interactionist perspective, although this was located within a structural context (Halpern and Anspach 1993). The diverse perspectives of the doctor and patient were reflected in the lay referral system, a typology constructed by Freidson (1975:294), which suggested that the degree of fit between the lay and medical cultures could account for variation in the rates of use of official, professional medical services. This stood in marked contrast to the Parsonian depiction of the doctor–patient relationship characterised by harmony, consensus and a passive, deferential patient (Freidson 1975:321). The approach of Parsons reflected a more general, normative, sociological perspective which took for granted the professions as central to the social organisation of liberal democratic societies. Thus, Parsons' (1951) analysis focused on the 'core' traits of a profession, such as their possession of an 'expert' body of knowledge and a professional code of ethics along with an altruistic service orientation/collectivity orientation.

Third, Freidson considered the social organisation of illness, and the relationship between illness and deviance, showing that some physical, *chronic illnesses* or conditions might be seen as deviant and stigmatising and are constructed by societal reactions or labels rather than intentional rule breaking. Once again this stands in marked contrast to the Parsonian sick role with its focus on *acute illness*.

Finally, there is the general question of how to characterise Freidson's work from a sociological point of view. It has been described as Neo-Weberian (Dent 2006; Nettleton 2013:184), in that Freidson (1970) rejected the functionalist idea of the medical profession emerging naturally out of the division of labour because of its superior skills and knowledge and ability to perform vital functions in industrial society. In contrast to this functionalist explanation, Freidson's (1970) analysis focuses on the way professional groups have sought to secure their market position through monopoly over the supply of service provision. Thus the rise of the medical profession is seen as a political struggle between different interest groups for higher status and prestige and a more favourable market position and market closure. In the *Profession of Medicine* (1975), Freidson also, as Bosk (2006) points out, raises the question previously posed by Weber about the increasing dominance of technical rationality and professional expertise and the impact of this development on the influence of the public on decision-making in democratic society. In his later work, Freidson (2001) depicts professionalism as an ideal type which is juxtaposed against the Weberian ideal type of bureaucracy.

Freidson's sociological position, however, might be viewed as more eclectic in that it emphasises, through both theoretical analysis and empirical research, conflict, sometimes overt conflict, as opposed to consensus, although this conflict is not analysed in terms of social class or gender relations. Certainly, as Coburn (2006) points out, the social closure theorists, with which Freidson's work was associated, put greater emphasis on the strategies used for gaining and maintaining closure with less attention paid to the contexts within which these took place. Freidson's approach also might be described as a form of a structural pluralism (Alford 1975), where the professional acts as a mediator presiding over the interests of the state and serving the needs of the public and demands of patients. The benefits of such a role, according to Freidson (2001), are the engendering of trust and confidence in public services and a reduction in the costs of governmental action and control. However, Freidson's pluralistic approach is distinctly different to other explanatory frameworks (Light

2010), which adopt a pluralistic approach where the medical profession and its dominance are not the major focus but considered alongside other interests in healthcare, including the state, the drug and private industry and patient groups as they struggle for power and resources in the medical marketplace with each interest varying in their influence over time.

The popularity of Freidson's approach appeared to reflect the general movement at the time, at least in the United Kingdom, towards a more 'critical' sociology which emerged at both the micro and macro levels (Gabe and Calnan 2009). His critique focused mainly at the latter level and formed part of the shift in the sociological portrayal of modern medicine away from a more benign form of social control towards a more oppressive agent of social control which was either seen in terms of serving and sustaining the interests of a powerful and unaccountable professional group (Freidson 1975), or serving wider class interests (Navarro 1976; Johnson 1977). Freidson's work was firmly based in the sociology *of* medicine as opposed to a sociology *in* medicine, and as Halpern and Anspach (1993:281) point out:

> Freidson elaborates the implications of professional power for the quality and character of medical services ... The result is medical sociology that raises public-interest questions while keeping both feet in medical sociology.

Professionalism as form of occupational control

The predominant narrative of the Parsonian approach, in common with those who also took a more normative approach (Carr-Saunders and Wilson 1933), was one where the professions perform their role using their expert knowledge in the community's interest, and the altruistic and service orientation of the profession protects the community from exploitation. In repayment for performing this special and valuable role, the medical profession and other professions are accorded higher status and given greater financial rewards than other occupational groups.

There is a second and contrasting narrative on professionalism, which portrays professionalism as a form of occupational control and highlights the self-interested as opposed to altruistic motives of the medical profession. It might be divided between those who see the medical profession as working on behalf of other, more powerful interests (McKinlay 1977), and those who adopt a more pluralist approach and see medicine as working on its own behalf.

The former is illustrated by a Marxist approach, or at least one strand of it, where the medical profession acts as an agent of social control, either as part of the ruling class in capitalist societies or because it constitutes a separate class and serves the interests of the latter (Navarro 1988). This coercive role might be exemplified through controlling access to work, or through the use of a biomedical ideology which translates social and economic causes into individualised illness experienced by patients. However, Freidson's approach (at least in his earlier work) falls into the second category, in that professionalism can be characterised as a process of political struggle between groups intent on achieving higher status. Here, Freidson's theory of power seems to be based on the process of social closure where medicine is an *exclusionary* form of market closure based upon credentialism. The rise of the medical profession occurred as a result of an historically specific process involving a power conflict and thus the focus was on explaining why medicine was so successful in attaining professional status compared with other occupations. The key to this, at least for Freidson (1975), was through attaining and maintaining autonomy, as he argued that the most strategic distinction between occupation and profession lies in legitimate, organised autonomy from other occupations, clients, the state and industry:

> Where we find one occupation with organised autonomy in a division of labour, it dominates the others. Immune from legitimate regulation or evaluation by other occupations, it can itself legitimately evaluate and order the work of others. By its position in the division of labour we can designate it as a dominant profession . . . (Freidson 1975:369).

According to writers like Freidson (1970), a profession is distinct from other occupations in that it has been given the right to control its own work. The recognition of professional status is a licence of functional autonomy, secured from the state by political action, giving the profession the exclusive right to control access to, and organisation of, the tasks that constitute its work. The right of autonomy is usually granted through state patronage. It is not an intrinsic quality of an occupation, making it superior to competing groups, but expert knowledge and other attributes are used by these groups as ideological ammunition for attaining the powerful position of professional status. Freidson (1975) argued that by using the ideology of professionalism, such as laying claim to having exclusive access to a body of knowledge, or having a training course which covers the appropriate length of time, occupational groups gain the position 'profession' within a given social structure and gain control over the division of labour. For example, Freidson (1975:57) suggested that one of the reasons nursing's professionalising strategy proved problematic was that much of what they were taught was specified by doctors, making evident their lack of autonomy (Morgan et al. 1985).

Clearly, another key difference between nursing and the then male-dominated medicine was in the gender division of labour, although nursing's professionalising project and pursuit of social closure were also hampered by not having exclusive access to an abstract and specialist body of knowledge (Witz 1992). In contrast, medicine successfully tied itself to science, which according to Larson (1978) aided the development of its monopoly in the medical marketplace. Science was valuable as it could be standardised and uniform and thus reproduced though training and education, but it was also specialist and so could enhance closure by creating a distance and autonomy from the patient and other competing groups. Medical practice and its knowledge base in the nineteenth century has been described as characterised by 'widespread disorder and uncertainty' (Collyer 2010:89), although scientific discoveries in the late nineteenth century – including the increasing use of anaesthesia along with the successes of the public health movement – may have enhanced the credibility of the medical profession by convincing the public of the superior medical commodities it could offer. However, the use of science, and in particular the germ theory of disease, was invaluable in other ways:

> For example, the adoption of the germ theory of disease by medical practitioners led to a shift away from patient-centred medicine towards a system which reduced patient involvement and created greater patient dependence, which in turn increased professional autonomy (Morgan et al. 1985:117).

The end of the golden age of professional medical power?

The re-conceptualisation of the nature and development of medical power by Freidson and other scholars enabled sociological analysis to focus not just on why the professionalising project of medicine was so successful, but also the extent to which, by the 1970s, its power was beginning to decline (Elston 1991:58). It has been argued (Willis 2006:422) that the golden age of medical dominance lasted for about 40 years from the 1930s until the 1970s. Thus, beginning with literature from the United States in the 1980s, debates in the sociology of professionalism focused on the extent to which the golden age of doctoring was over and medical power and authority in decline, or that medicine has, in the face of recent challenges, managed to retain its overall dominance (Kelleher et al. 2006). Those who advocated the wane of medical power highlighted the threats generated through the impact of the processes of deprofessionalisation, proletarianisation, corporatisation and bureaucratisation. This analysis was predominantly derived from the experience of the United States.

The Neo-Weberian concept of deprofessionalisation, as conceived by the American sociologist Marie Haug (1973), suggested the knowledge gap and the level of uncertainty between doctor and the public had been reduced, thus limiting the ability of doctors to maintain their clinical autonomy. This is claimed to have occurred through increasing computerisation and bureaucratic regulation which made expert knowledge and opinion more visible and open to challenge and scrutiny. This technological assault on medicine's knowledge base was complemented by the rise of the so-called articulate, information-rich consumer, in that the public and patients were no longer blindly trusting in their doctor. Patients, according to this argument, had been transformed into assertive and knowledgeable consumers, actively shopping around for their healthcare, and trust now had to be earned by doctors rather than assumed. The demands of the consumer were enriched by access to health knowledge through the media and the internet (Nettleton et al. 2005).

The challenge of deprofessionalisation was believed to stem primarily from the patient and the public, but the Marxist notion of proletarianisation was essentially top-down. The de-skilling of medicine and the loss of clinical, economic and political autonomy were believed to be due to the ceding of power to managers. The increasing marketisation of medicine under corporate capitalism (McKinlay and Arches 1985) involved doctors increasingly becoming employees of corporate companies. Many US doctors worked in hospitals/Health Maintenance Organisations paid for through pre-payment plans with third-party payers whose interests stood over and above those of individual doctors.

A more recent formulation of this thesis by McKinlay and Marceau (2002) substituted 'corporatisation' for 'proletarianisation' in recognition of the growing significance of corporate provision, with doctors working for large-scale, hierarchical bureaucratic organisations (and because of hostility to the equation of doctors with 'wage slaves' which was detracting from the explanatory power of the underlying thesis). Eight related factors were identified by these authors as contributing to the demise of the medical profession. Six of these were described as external, and therefore outside the control and influence of the medical profession. These were: the changing nature of the state and the loss of its support; the increasing control of the content of doctors' work; globalisation and the information revolution; the increasing threat from other healthcare workers, which, for example, blurred the boundaries between medicine and nursing; the epidemiological transition, and the shift from cure to care and the increase in chronic illness; and finally, the changing nature of the doctor–patient relationship and the decline in public trust. These six external factors were complemented, according to McKinlay and Marceau (2002), by two internal factors in the United States which might be under the control of the medical profession. These were an oversupply of doctors (which weakened their market position) and the fragmentation and therefore weakening of the doctors' union and its influence due to increasing specialisation and the inclusion of related occupations with relevant expertise.

The explanatory power of both the concepts of corporatisation and deprofessionalisation were subsequently questioned. Some scholars contested the value of corporatisation, in that class-based interests of doctors were seen to be at variance with, and not aligned to, those of the proletariat. Doubts about the value of the explanatory power of the concept of deprofessionalisation were also raised, as it was argued that the knowledge gap between medicine and the public is actually widening rather than diminishing due, in part, to the increasing emphasis on specialisation in biomedical discourse (Elston and Gabe 2013). It has also been suggested that the impact of the Internet (Nettleton et al. 2005) has been exaggerated in terms of patient empowerment, its democratic importance and the reconfiguration of the patient–clinician relationship. Nettleton et al. (2005) characterise the Internet as contingent and embedded, focusing on its routine/mundane use in the context of peoples' everyday lives. This approach stresses concordance between medical and lay criteria in terms of what constitutes 'good-quality' information, and recognises that people do not necessarily want to become empowered or experts, but seek to 'enrich' their consultations with healthcare professionals.

Alternative and contrasting sociological accounts of the professionalising strategies of medicine have shown how, at least at the elite or macro level, it has been able to respond or anticipate possible challenges, changes and threats, and sometimes use opportunities to maintain or even enhance its autonomy and control. For example, Freidson (1994) portrayed the current period as an uncomfortable moment of readjustment or re-professionalisation rather than deprofessionalisation or proletarianisation. He put forward a theory of professional re-stratification, that is, a process of increasing division between the rank-and-file 'doctor practitioners' and the 'knowledge' (research) and 'administrative' medical elites. Freidson (1994) argued that while the power base may have shifted within the profession towards these elite groups, the profession itself is still dominant. For example, the elite practitioners and medical researchers play a central role in developing the clinical protocols and guidelines being used by the rank-and-file practitioners, and the increasing number of medical doctors taking on managerial roles (poachers turned gamekeepers) suggests that doctors may be taking back the professions' monitoring and regulatory roles:

> When one elite formulates the standards, another elite directs and controls, and other professionals perform the work, something important has happened to the organisation of the profession as a body and to the relations between its members which may have serious implications for its corporate character in the future (Freidson 1994:143).

An alternative explanation from Harrison (2009) and Harrison and Ahmad (2002), who write about professional power in the NHS in England, suggests some agreement with Freidson that medicine's power – at least at the macro level – has been maintained through the power of biomedical ideology (Harrison 2009). However, paradoxically, the reductionism and individualism inherent in the biomedical discourse are congruent with managerial ideology, enabling medical work to be commodified and more easily controlled. Hence, according to this argument (Harrison 2009), the dominance of biomedical discourse might put professional autonomy and freedom under threat.

Coburn et al.'s (1997) Marxist response to Freidson's explanation also emphasises the influence of managerialism on professional power, but argues more strongly that it has undermined the profession as a whole through state co-option of medical organisations and elites, and thus medical power and professional dominance might become subordinate to capitalism. The authors argue that medical institutions are being used by external forces, such as the state, to constrain their own members and implement policies over which they have no control:

> Relative to the re-stratification argument, there is considerable evidence to indicate not only that medical dominance is being eroded, but that at least some of this erosion is being channelled through external constraints or controls over key medical organisations and over medical elites generally. While there is merit in the notion that strategic elites within medicine are attempting to preserve (a lesser degree of) power through making minimal concessions, our view is that medical institutions are being used, co-opted, by external forces into constraining their own members (Coburn et al. 1997:21).

Professionalism as an ideal type of organisation of work

Earlier, the two narratives of professionalism were contrasted with one another as the first emphasised the altruistic and service ethos of the medical profession, and the other the more self-interested values of an occupational group intent on attaining and maintaining high levels of power, status, income and job satisfaction. Freidson's earlier work fell squarely into the second narrative, which is clearly illustrated by Bosk (2006:644), who states:

> The concluding paragraphs of the *Profession of Medicine* invoke an image of a group of professionals isolated from the community that they exist to serve, blinded by self-delusion and deceit, and whose actions create a new, oppressive 'tyranny' while always claiming to serve the public good.

Freidson's analysis, as summed up by Bosk (2006), depicts doctors as moral entrepreneurs attempting to extend and expand their territorial jurisdiction. Bosk (2006) also suggests that Freidson's approach provides the basis for the development of the key concept of medicalisation, which others have since built upon.

In contrast, in Freidson's last book, *Professionalism: The Third Logic* (2001), the first of these narratives of professionalism appears to be privileged as healthcare is portrayed as provided by well-intentioned and expert professionals. Freidson argues for professionalism as an ideal type which contrasts with alternative ideal types of organisation of work, such as bureaucracy or the free market:

> The two most general ideas underlying professionalism ... the belief that certain work is so specialised as to be inaccessible to those lacking the required training and experience, and the belief that it cannot be standardised, rationalised or ... commodified (Freidson 2001:17).

Thus, for Freidson, medical professionals require discretionary specialisation and occupational control over their work to fend off the dangers of managerialism and consumerism:

> The ideal – typical ideology of professionalism is concerned with justifying the privileged position of the institutions of an occupation in a political economy as well as the authority and status of its members. To do so it must neutralise or at least effectively counter the opposing ideologies which provide the rationale for the control over work by the market on the one hand, and by bureaucracy on the other. I shall call the ideology of the market control consumerism, that of bureaucratic control, managerialism (Freidson 2001:106).

Thus, social closure is important (at least in the US healthcare market), as it forms boundaries and provides a refuge or social shelter from the dual pressures of consumerism and managerialism:

> ...within which a formal body of knowledge and skill can develop, be nourished, practised, refined and expanded (Freidson 2001:202).

Bosk (2006) sees Freidson's new position as a dynamic response to a changing social and political context, whereby doctors are portrayed as a group with the moral authority to champion the public interest, and the public reciprocate by trusting medicine to be committed to their interests. This view stands in contrast to Freidson's earlier work of 1975, where medical doctors were 'moral entrepreneurs' and there was a clash of perspectives between the world views of doctors and patients.

The value of this third logic, at least in terms of the professions' ability to protect the public interest, has been contested by Horowitz (2013). In this ethnographic study of the work of medical boards in the United States, which are legislated to control who can practice medicine, Horowitz explored the ways medical boards frame their discussions and the conditions under which public members can participate effectively in decision-making processes. She argues that Freidson and others have placed too much emphasis on the way consumerism and managerialism are challenging the medical profession and suggests it is social closure that has hampered the medical profession. This is because the restricted lens of medical discourse limits their capacity to take account of the public interest, and this leads to increases in patient complaints and media-fuelled medical scandals:

> ... social closure has institutionalised a medical discourse that has inhibited intergroup communication and discourages broadening the range of participants engaged in deciding the public good. The decision making process is going to be truncated when the parties involved fail to take each others perspectives, and such a process is going to back fire, as evidenced by the proliferation of patients' complaints, malpractice suits and bad press besetting the medical profession (Horowitz 2013:173).

These doubts about the values of the medical profession in the United States are more strongly articulated by Larson (2003:461):

> ... the richest profession in the world has worried very little, through its official representatives, about the collective value of health which it purports to serve. Practicing in the only developed country without national insurance, it has contributed to costs that are, on average, double those of other developed countries, with public health results and indicators equal or inferior to theirs.

The explanatory power of Freidson's key concepts

What of the explanatory value of the key concepts developed by Freidson? Freidson (1975) provided, at least in his earlier work, a general conceptualisation of professional dominance and autonomy which other authors have taken further to provide a framework which delineates the different dimensions of these more general concepts. For example, according to Elston (1991), 'professional dominance' appeared to be underpinned by the concept of professional autonomy which has clinical, economic and political dimensions, and which vary in importance in different health systems. Clinical autonomy is defined as the right of the medical profession to set standards and evaluate clinical performance; political autonomy is the right to make policy decisions as the legitimate experts on health and medicine; and economic autonomy is the right to determine levels of personal remuneration or the level of resources available for work (Elston 1991:6). Evetts (2002), however, drew attention to what she saw as a distinction between an 'ideal-type' of professional autonomy, where professional decision-making is determined solely by the best interests of the individual client/patient, and professional *discretion*, which she sees as more reflective of modern professional organisational contexts. Specifically, she (Evetts 2002:345) states:

> . . . professional discretion enables workers to assess and evaluate cases and conditions, and to assert their professional judgement regarding advice, performance and treatment. To exercise discretion, however, requires the professional to make decisions and recommendations that take all factors and requirements into account. These factors and requirements will include organisational, economic, social, political and bureaucratic conditions and constraints. Thus, professional decisions will not be based solely on the needs of individual clients, but on clients' needs in the wider corporate, organisational and economic context.

Freidson's (1975) earlier work was informed both by theory and empirical research and he did provide more concrete examples of the social conditions and circumstances where the achievement of professional development and the attainment of professional autonomy might be both successful and problematic (Coburn 2006). For example, Freidson's (1975) analytical approach attempted to link the structure of work settings with medical performance and practice, distinguishing work settings according to 'the degree to which they are amenable to lay or colleague control' (Freidson 1975:107). He argues that colleague-dependent practice – which is reliant on referral of patients from clinicians – will lead to greater adherence to professional standards than lay-dependent practice which relies on its income, at least in the US health system, from lay demand. Thus, these latter forms of practice will be more likely to be influenced by lay judgements and criteria which, according to Freidson (1975), is sometimes at odds and in conflict with clinical perspectives.

Some empirical work has taken this analysis further, but in the context of the predominantly tax-funded, English NHS. This work suggests that the work setting can encourage or discourage the attainment or reinforcement of professional autonomy, and which either promotes or inhibits progress towards achieving status as or within a profession. For example, medical professionals who organise and run open-access hospital accident and emergency departments in the NHS in England have, in the past, attempted to define their work in terms of a hospital clinical specialism and tried to control the type of patient they see and the nature of their workload. This might be seen as an attempt to reinforce professional autonomy: although such a strategy has proved problematic for this branch of medicine in terms of their professional development (see Calnan 1982). This is due mainly to the structural features of this medical setting where the patient workload is generic as opposed to specialist, and patients have direct access to the service rather than being referred through a general practitioner (GP) gatekeeper who can control or ration demand. General practice in England could be characterised, like hospital accident emergency departments, as client dependent, which limits their professional development (at least in its earlier days). However, of late, its professionalising strategies have been more successful and this, it is claimed, has been due, at least in part, to its ability to create organisational barriers and further social distance from patients through, for example, working in large-scale partnerships with appointment systems, limited home visiting and out-of-hours contact and triage systems provided by practice nurses (Calnan and Gabe 1991).

There is evidence from empirical research carried out in the primary-care sector of the English NHS that the concept of re-stratification has some explanatory power. However, as Calnan and Gabe (2009) state, a distinction needs to be made between horizontal stratification and vertical stratification at the micro level:

> . . . the increasingly complex division of labour in general practice with GPs delegating routine tasks to nurses, the limited managerial control at the PCT[1] level, an increasing division between the traditionalists and entrepreneurs and between the paternalists and egalitarians and salaried GPs, who are more interested in a work life balance, suggest that re-stratification is taking place. Much of this appears to reflect a type of horizontal stratification at the micro-level, but there is also evidence of vertical stratification between those GPs involved as clinical leads or in managerial roles in the PCTs or are responsible for the QOF[2] in their practices and thus have more influence and those who are not involved with these activities (Calnan and Gabe 2009:72).

Freidson's (2001) emphasis on trust in his recent account of professionalism parallels other, but distinctly different, sociological arguments, which suggest there is an emergence or re-emergence of trust in sociological theories of occupational development and control, as well as an appeal to the discourse of professionalism. Previous critical analysis of professionalism depicted occupations as driven primarily by self-interest and the need for power, status and material wealth rather than altruism. Trust was used as a means for duping or coercing the public into believing in the superior product of scientific medicine and thus enhancing the professionalising project. More recent theories have reconnected trust and professionalism through a renewed interest in risk and the challenges posed by a possible decline in public trust. For example, as Evetts suggests (2006), the current appeal to professionalism for occupations has markedly different implications from the more traditional type of occupational control which medicine exemplified over 50 years ago. The appeal to professionalism most often includes the substitution of organisational for professional values, accountability replacing trust, and autonomy being constrained and controlled:

> Professionalism and trust become important once again because trust is perceived to be in serious decline (Evetts 2006:525).

Other sociological accounts of the link between trust and professionalism have shown how the medical profession used the development of external regulation (such as guidelines) to reinforce their professional position. Calnan and Rowe (2008), for example, argue that these new tools of bureaucratic regulation – which are signifiers of quality – are actively used by doctors to build trustful relations with colleagues. These performance indicators or quality standards are being used as 'public proofs' of quality of their services under conditions of tighter control and regulation. They are also taken up by patients and perceived as prerequisites for self-determined decisions and trustworthy relations. The traditional 'embodied' professionalism is transformed into a 'disembodied' professionalism founded on information. Thus, as Kuhlmann (2006) argues, new patterns of building trust are emerging rather than declining.

New forms of medical professionalism?

There has also been a related sociological debate about the extent to which organisational changes - manifested in new forms of governance and accountability -have spawned new forms of medical professionalism. Kuhlmann (2008) argues that there is increasing evidence of new forms of professionalism emerging which are distinctly different from earlier forms as professionalism becomes more diverse and context dependent. An example of this is provided by Checkland (2004), who suggests that a new type of GP in the NHS may have emerged, like 'street-level bureaucrats', who mediate between external, bureaucratic pressures to adhere to clinical guidelines and the professional practice of everyday patient care based on experiential, individualised knowledge. Another example is the emergence of doctors as 'public service entrepreneurs', who adopt the values of the market to meet the needs of the patients but are not driven by a profit motive. This might be seen as an alternative type of professionalism within medicine that features both self-interest and altruism (Calnan and Gabe 2009) and thus integrates both forms of sociological narrative discussed in previous sections.

In contrast, there are those who have suggested that the influence of these organisational changes on the medical profession, manifested in new forms of governance and accountability, have been exaggerated. For example some writers continue to characterise medical professionals, in more traditional terms, as having a significant degree of autonomy over their work (Willis 2006; Timmermans 2008). Such autonomy enables the medical profession to resist any enforced change and use it to enhance their social position. Certainly, this conclusion seems to be reflected in empirical evidence. For example, a recent study (Spyridonidis and Calnan 2011) shows a lack of use and acceptance of forms of clinical governance, such as NICE guidelines, in the NHS in England. This resistance to top-down governance is a recurring theme in clinicians' accounts which reflect the profession's traditional concerns about the importance of clinical freedom and discretion. Both GPs and hospital doctors adopt strategies to avoid top-down modes of control, such as NICE[3] guidelines, which they perceive as unacceptable restrictions on their professional right to clinical judgement and self-regulation. This is illustrated by the following quotes from doctors in the NHS in England:

> I do not like too prescriptive sets of guidelines, because you want to have flexibility. I am doing it for 40 years now. With most things I have a rough idea where I am going so I don't need guidelines to tell me how to treat patients, this is my job (general practitioner).
>
> Changes that are introduced are not always popular with everybody and GPs like hospital consultants are very precious about how they want to practice with their clinical freedoms (general practitioner) (Spyridonidis and Calnan 2011:402).

Yet, other evidence from studies in primary care in the NHS suggests an increasing acceptance of the need for professional scrutiny and accountability among the rank and file (McDonald et al. 2009). This apparent inconsistency in findings might reflect the differential impact of external pressures on different forms of professional discretion. Despite the attention given to the concept of professional discretion, there appears to be a lack of discussion and analysis, suggesting the need for a closer examination of the concept and its constituent dimensions (Cheraghi-Sohi and Calnan 2013).

Other writers have suggested that the concept of 'new professionalism' is too simplistic since there are aspects of continuity as well as of change within the medical profession (Evetts 2006). It has been argued that the contemporary workplace has placed increased pressure on professionals to be flexible and construct multiple occupational identities. For example, doctors in England (such as GPs) have needed to adopt or construct multiple identities to embrace being both 'professionals' and 'business owners' (Spyridonidis and Calnan 2011).

Conclusion

This chapter has focused on theoretical and empirical analysis in the sociology of professionalism in the case of medicine. One of the key theorists in this field over the last 30 or so years has been Eliot Freidson, and the analysis has therefore primarily discussed and assessed some of his key concepts. It is evident that Freidson's work has contributed to a series of questions about the changing position of professional medicine. In the era of the golden age of medicine, the key to understanding how medicine was so successful at attaining and maintaining status and power was through the concept of professional autonomy. In the more recent era, where the debate has focused on the so-called decline in the social status and power of scientific medicine, Freidson's concepts of re-stratification and the third logic of the ideal type of professionalism have shown how the medical profession has responded to external pressures and challenges.

Two types of narrative on professionalism have been prevalent in sociological analysis, portraying professionalism either as a form of occupational control and highlighting the self-interested motives of medicine, as opposed to the narrative focusing on the altruistic motives of the medical profession working in the interests of their patients and the public. Both narratives are evident in Freidson's writings. In his earlier work, the focus on occupational control and social closure reflected the self-interested nature of medical professionalism, and in his later writings this form of organisation of the division of labour was seen as essential to not only protecting the medical profession but also the public, with the public-spirited medical profession now working in the interest of the public.

Certainly, much of Freidson's work is focused on the private market system of healthcare in the United States, where economic incentives and clinical practice are more overtly linked. However, globalisation and the increasing adoption of neo-liberal concepts of choice and market competition into policies for publicly funded systems of healthcare (Pollock and Price 2011), where doctors are employed by or contracted to the state (such as in the NHS in England), suggest that the dual narratives of professionalism will become increasing prevalent. Alternatively, with the increasing emphasis on de-regulation and devolution, and with health systems within countries becoming more pluralistic, meta-sociological narratives of medical professionalism may have less explanatory power and occupational practice may be better understood in terms of the influence of local organisational contexts and circumstances.

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Notes

1. Primary Care Trusts (PCTs) were formed in 2002 as NHS organisations in England and Wales became responsible for improving the health of the community, developing

primary and community health services and commissioning secondary services within their geographical boundaries for populations of approximately 100,000 to 300,000. However, recently (2012), they have been abolished and replaced by clinical commissioning groups.

2. The Quality and Outcomes Framework (QOF) was a General Medical Services contract initially introduced in 2004 in the NHS in England and Wales. This was a prescriptive, but optional, pay-for-performance scheme which linked GP incomes to evidence-based practice (see Cheraghi-Sohi and Calnan, 2013, for further details).
3. NICE (National Institute for Health and Care Excellence) regulates the provision of new drugs within the English NHS on cost-effectiveness grounds and provides evidence-based clinical guidelines for health authorities and clinicians.

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Chapter 20

Ivan Illich and Irving Kenneth Zola: Disabling Medicalisation

Joseph E. Davis

Medicalisation has been one of medical sociology's most important concepts. It has been studied by a wide variety of scholars and has generated a rich literature, complete with an extensive array of case studies and historiography. Much of this work has been directed to exploring the process by which medical definitions and treatments are applied to behaviours, minds and bodies in areas not previously defined or treated as medical matters. Deviant behaviour, reproductive matters and borderland medical conditions have often been the focus of research. More recent efforts to extend medicalisation theory have aimed to capture additional features of the ever-more complex interweaving of health and medicine into everyday life. We seem to be living under a 'regime of total health' (Armstrong 1993) and a medicine without limits.

This chapter revisits and explicates the critical perspective of two of the pioneer theorists, Ivan Illich and Irving Kenneth Zola. Though quite different and with seemingly little influence on each other, their critiques of health and the limits of medicine overlap in many important respects. While widely read in earlier years and offering a valuable contribution to social theory in health, illness and medicine, their work is now neglected. Both continue to be cited in the medicalisation literature, to be sure, but the references are to isolated points rather than the larger perspective. In fact, the perspective, when engaged, is often dismissed as being anti-medicine, extremist and empirically inadequate. There certainly are problems and they can be acknowledged. Illich himself did so and wrote papers in which he amended and updated some of what he had said about medicine and professionalism (for example, Illich 1986, 1995). But what is of enduring value in their work does not hinge on these problems and could be the basis for a far more robust research agenda. What Illich and Zola offer is a perspective that directs our attention to the deep cultural and institutional roots of the problem of limits, and 'against its more publicised benefits' (Illich 1976:4) sensitises us to what is lost – disabled – by the relentless growth of medicine and the sacralisation of health.

Biographies

The personal background of both of these thinkers is crucial for understanding their outlook.

Ivan Illich (1926–2002) was born in Vienna into a family of minor nobility with Jewish, Dalmatian and Catholic roots. Forced to leave Austria in 1941, his family moved to Italy. In subsequent years, Illich studied natural science in Florence and philosophy and theology at the Gregorian University in Rome. He received a doctorate in the philosophy of history at the University of Salzburg, where he also developed a strong interest in the medieval understanding of suffering. In 1951, following his ordination to the Catholic priesthood, Illich came to the United States to do postdoctoral research at Princeton and was assigned to serve as assistant pastor of an Irish-Puerto Rican parish in the Washington Heights section of New York. These were the years of the Great Migration of Puerto Ricans to New York. Illich quickly learned Spanish, travelled and immersed himself in Puerto Rican culture and initiated a wide variety of pastoral projects that were marked by a great respect for indigenous traditions and for the resources of ordinary people to cope with the vicissitudes of their lives (Fitzpatrick 2002).

Following on his innovations in New York, Illich was appointed vice-rector of the Catholic University of Puerto Rico in 1956. In 1961, he moved to Cuernavaca, Mexico, where he co-founded the Centro Intercultural de Documentación (CIDOC), a research centre that offered courses for missionaries. It was there that Illich initiated a series of carefully focused intellectual conversations with leading scholars on ‘Institutional Alternatives in a Technological Society’ and published a stream of books on specific institutions, including medicine. Following troubles with the Church, he resigned from active ministry in 1969 (he remained a priest). He continued to run CIDOC until he closed it in 1976. Thereafter, Illich, who had become an international celebrity, adopted a lower profile. Still, he continued to write extensively and travel, leading seminars, lecturing and splitting his time between Cuernavaca and academic appointments at universities in Germany and the United States. He was diagnosed with cancer in 1983 (Corley 2002), but refusing the advice of doctors to be treated with sedatives, which would have ended his work, he administered his own medication and continued on. He died in 2002.

Irving Zola (1935–1994) was born to immigrant parents and grew up amidst a large, extended family in Dorchester, a poor inner-city suburb of Boston and then in slightly more affluent Mattapan. His youth, otherwise stable and secure, was interrupted by two traumatic medical incidents, polio at the age of 15 and a major car accident at 20. Both involved a year’s confinement and left him permanently wearing a long brace on one leg and a reinforced back support, and using a cane. According to Zola (1983a), experiences with these personal experiences left a lasting impression that he self-consciously drew upon in his work – a reflexive approach he called ‘socioautobiography’. His early experiences and later reflections on his disability made him sceptical of authorities deciding what constituted the best interests of someone else, awakened a concern with the ‘validation’ of persons (Zola 1991a:3) and fostered an identification with ‘the stigmatised, the outsider, the oppressed’ (1983a:16).

Zola received an elite education, first at Boston Latin and then at Harvard (during the heyday of the Social Relations Department), receiving a BA and, in 1962, a doctorate in sociology. After a one-year postdoctoral fellowship, he accepted an appointment in the Sociology Department at Brandeis, where he spent the rest of his career. In the late 1960s, he helped co-found Greenhouse, a counselling collective, rooted in humanistic psychology and an egalitarian ethic. During a research stay at Het Dorp, a community for the severely disabled in the Netherlands, chronicled in his book *Missing Pieces* (1982), Zola confronted his own disability and thereafter began to write on disability and its implications in society. In 1977, he worked to create, and direct for many years in the 1980s, The Boston Self Help Center, a grassroots organisation for people with chronic illnesses and disabilities. He was also a founding member of the Society of Disability Studies and the first editor of *Disability Studies Quarterly*. He died, at age 59, in 1994.

Perspective

Neither Ivan Illich nor Irving Zola is easy to categorise as a social theorist. Both combined, in different ways, elements of genealogical, phenomenological, symbolic interactionist and political economy perspectives, with a deeply humanistic orientation. Illich early described his writings as each ‘an effort . . . to question the nature of some certainty’, some unexamined axiom, such as ‘health’, which serves as a pillar of contemporary society (1970:11). Zola, in his own way, saw his work as an act of resistance to new modes of social engineering, which draw upon technology and an ‘aura of objectivity’ (1975:84) to normalise cultural – ‘healthist’ – ideals that are inimical to the disadvantaged and the proper freedom of everyone. Together, they shared a focus on the importance of language and story, processes of subjectification, the limits of technology and expert systems and the unintended but very real threat of medicalisation to human dignity. What sets their work apart is the social vision they exemplify.

Illich frames the genesis of *Medical Nemesis*, his famous critique of medicine and a ‘medicalised culture’, as another in a series of examinations of modern institutions and the service economy. In part it is that, continuing a line of analysis he first explored in his reflections on the way the Church had institutionalised the priesthood (Illich 1967), and also in three small volumes prior to *Medical Nemesis*. These books, all of which appeared in many translations, were *Deschooling Society* (1971), on the problem compulsory education creates for learning; *Tools for Conviviality* (1973), on the ethics of assessing technological development; and *Energy and Equity* (1974), on the effects of intensive energy use on social relations. Each of these volumes, and then *Medical Nemesis,* which was first published in 1975,[1] works out two critical ideas about the social impact of institutions in industrial societies. These ideas are 'paradoxical counterproductivity' and 'radical monopoly'.

Illich analyses modern institutions as a type of 'tool', 'planned and engineered instrumentalities' (1973:22) that are self-propelled by a powerful logic of rationalised, impersonal efficiency and self-justified in the name of optimising human welfare and controlling nature. Institutions, like all tools, can be beneficial, 'productive' for practical self-reliance and mutual self-care, but only within certain parameters of size and intensity. Tools and human goods require a careful balancing that in industrialised societies has become radically skewed. The issue is not the dominance of instrumental rationality, as critiqued by Max Weber, but a powerful confusion of institutional means for proper human ends (Depuy 2002:194). Unchecked by any larger, cultural configuration of human goods, professionals and expert systems increasingly monopolise all aspects of life, not only defining what people need but controlling their satisfaction. Under these conditions, society is progressively rearranged for the sake of the institutions, which become counterproductive, 'paradoxically tak[ing] away from society those things the institution was designed to provide' (Illich 1976:213). Schools become inimical to learning, medicine to health, development to helping the poor and so on.

While counterproductivity creates a wide variety of negative consequences, from environmental pollution to unsafe food to traffic congestion to 'sick-making' hospitals, these externalities are not the main issue. In fact, according to Illich, too much emphasis on this type of counterproductivity can easily confuse people as to what is really at stake. What makes large modern institutions defeat their intended purposes is the way in which bureaucratic systems and professional services displace and degrade freedom and independence. As 'radical monopolies', they do not simply corner the market like commercial monopolies but colonise the very life-world. They impose a society-wide reconfiguration of human goods – learning, health, care – as commodities and appropriate the capacities of people to do or make things on their own. What is most at stake with counterproductivity is the way it reshapes subjectivity and the social environment.

The path to Zola's writing on medicalisation is different, less systematic and more incremental. He began his career as a student of deviance and his early work explored how non-conformists and the vulnerable view the world. These studies led him to embrace the emerging 'societal reaction' or 'labelling' perspective on deviance (Zola 1983a:12). This school conceptualised deviance as a label, variably affixed to behaviour by social groups rather than a natural property of the behaviour itself. A step towards this de-naturalising of boundaries with respect to health and illness had already been taken in the functionalist analysis of Talcott Parsons, Zola's teacher at Harvard. Parsons theorised illness as a form of deviance. Illness, like crime, he argued, is a failure to conform to culturally specific normative role performances and is disruptive to society. Like crime, it is a problem of social control, and the doctor is a control agent who regulates entry to the sick role and 'exposes the deviant to re-integrative forces' (Parsons 1951:313). Re-integration in industrial society, however, does not involve punishment, as with crime or sin, but treatment, which, Parsons (1958) argued, generally has positive effects for individuals and society.

Zola's empirical studies in medicine and the influence of the writings of Hans Selye, René Dubos and others led him further towards a de-naturalised perspective on illness (1966, 1983a:135), while his work on labelling and then disability led to a less optimistic and more political view of medical social control. What constitutes 'symptoms' and receives medical attention, he argued, is highly variable, new diseases are continually created and there is no natural limit on what social or personal problems, deviance or difference, might be found to have health consequences (Zola 1970:689). This fluidity and expansibility constitutes an important reason to be wary of the formal power of medicine to monopolise 'illness' and its treatment, as well as of the growing social valuation of health (Zola and Miller 1973:169). Lines between normality and pathology, like other deviance distinctions, involve a moral dimension and do not merely arise from empirically derived facts. The extension of medicine is not some inevitable triumph of science or humanitarianism but a contingent historical, political and cultural process, mediated by elites who are backed by the legal power of the state. We cannot, he argued, assume that the impacts of medicalisation on social organisation, self-care and the vulnerable will be benign. In the mode of recent rights movements, they must be critically explored.

Disabling medicalisation

In his only joint publication with Illich, a small volume of essays written with three other co-authors, Zola employs the phrase 'disabling medicalisation' (1977). The words disable, disabling and disability appear throughout Illich and Zola's writing, and 'disabling' is a perfectly apposite term to capture their shared concern with the consequences of the far-reaching process of medicalisation. What makes medicalisation an issue of profound public importance, they argue, is precisely what in human life it insidiously and thoroughly disables.

Limits to medicine

Medicalisation, for both Illich and Zola, concerns the appropriate limits on the growing influence of medicine. Medicine's traditional field was a domain more or less defined in terms of treating illnesses and the circumscribed symptoms and needs of patients. Since the early modern period, medicine has also served a wider, social function, particularly in public health. So its extension beyond the bounds of treating illness is not unprecedented. However, especially in the post-war period, the issue of limits has gained urgency as medicine has rapidly expanded into virtually every aspect of life, leaving less and less outside the scope of 'health' and 'illness' and nothing in principle exempt. The bounds that had once contained medicine are progressively disappearing.

Illich and Zola do not share the same theory of the causes of medicalisation or its effects, but their accounts have important overlaps. Illich, despite the implications of his own analysis, has a tendency to speak of medicine in equivalent terms with other major institutions of society. Zola, on the other hand, sees medicalisation as a uniquely powerful process, and medicine as expanding and displacing other institutions of social control. Consequently, Zola gives more attention to the roots of medicalisation. Illich has more and broader things to say about its consequences.

Medical control

The earliest critiques of medicalisation, such as in the writings of Thomas Szasz, concentrated on the growing social role of psychiatry and the self-aggrandisement of doctors to greater social influence. Against such claims, Zola argued that the domain expansion of medicine is not limited to or the result of something amiss in the field of psychiatry, nor does it reflect the political power of doctors or 'any professional "imperialism" ' on their part (1972:487). Rather, the mandate of all of medicine is growing, along with its jurisdiction as an institution of social control, because, in part, science has displaced the influence of the more traditional institutions of religion, as source of truth, and law, as source of authority (Zola 1977:46, 1983b:58). A critical driver of medicalisation, he argued, is a cultural void that science, including medical science, helped to create (Zola 1977:46).

For Zola, however, there is nothing inevitable about the wholesale expansion of medicine. It does not reflect any corresponding growth in demonstrated curative capacity. On the contrary, the boundaries of medicine are expanding because of the extraordinary and growing popular preoccupation with health. In part due to medicine, health is no longer 'merely the means to some larger end but the end in itself, no longer one of the essential pillars of the good life but the very definition of what is the good life' (Zola 1977:51). This new 'health', synonymous with the 'greatest possible achievement and satisfaction' in all spheres of life (1973:169), is an almost infinitely expansible category, both practically and symbolically. It is not, for example, limited by illness, which Zola emphasises; it is a fluid, open-ended category. The vast reservoir of bodily discomforts, ageing effects and psychic struggles found in the general population can and are being recast as 'symptoms', 'diseases' and 'disorders', while medicalised prevention – 'indictments of "unhealthy" life activities' – and risk factor correlations extend medicine ever deeper into daily life and ceaselessly reinforce the 'belief in the omnipresence of disorder' (1972:498). At the same time, as one can invariably feel, look or function better, the potential cosmetic/enhancement uses of medical procedures and technologies will grow in lockstep with our technical capacities. Moreover, as a kind of master language, this 'health' can be made relevant, as explanation or justification, to virtually any problem or feature of the practice of life.

Further, Zola argues, the eager embrace of medicalisation is rooted in the cultural appeal of medicine's mode of expert intervention. This appeal has several dimensions, he argues, but most important is the myth of moral neutrality. Medicine describes itself as objective and value-neutral, speaking a technical language of fact and findings, and carried on in the interest of each individual's own good. The myth is rhetorically persuasive because the cloak of science makes it appear that medicine is never taking any controversial stances with respect to the good. The myth is powerful because it dovetails perfectly with the ever-expanding mechanisms of bureaucratic order and expert control, which require just such discourses of objectivity and beneficence. For Zola, like Illich (see below), medicalisation expresses the modern technological and bureaucratic imperative and the deep reliance on experts that it generates.

For Zola, illness, disorder and the like are, by definition, a form of deviance. The ceaseless extension of the regime of 'health', then to ever-more social problems and aspects of daily life can only increase the forms that deviance can take and the control measures necessary to address them. Social control enforces a standard. Consequently, it is directly and, far more commonly, indirectly coercive. Medical social control, Zola argues, is no exception, whether or not it can be judged to be more humane than a past practice or alternative possibility in a given case. Medical control is simply a different strategy for securing order and conformity, with its own particular dynamics and consequences, intended and unintended.

Iatrogenesis

For Illich, medicine has gone awry because it has turned healthcare into an engineering programme, a 'service', designed on the industrial mode of production and using technical means and seeking technical effects. Like other modern institutions, medicine has become a radical monopoly. It not only defines what constitutes sickness, what ill-health merits recognition and what shall be done, but also restructures the whole social environment and mystifies and expropriates lay control and coping abilities. Medicine, like other large-scale institutions, generates this dependency and the characteristic counterproductivity. In the medical case, Illich calls this counterproductivity 'iatrogenesis', from the Greek for caused or having its origins in physicians. In *Medical Nemesis*, he does allow that iatrogenesis might contribute to well-being. However, following the work of Dubos, Thomas McKeown, and other research produced in the 1950s and 1960s (1976:13), Illich argues that only a small percentage of the modern decline in the disease burden or rise in life expectancy has anything to do with professional medicine. The taxonomy he elaborates of medicine's iatrogenic effects concerns harm to health, which he defines not as a physical property but in terms of self-care.

Illich's taxonomy has three levels, each more significant than the one before. At the first level is 'clinical iatrogenesis', a category which includes the sort of medically inflicted conditions – treatment side-effects, human errors, malpractice – that are commonly classified and discussed within medicine itself under the rubric of 'iatrogenesis'. It is an old problem, Illich argues, that growing specialisation, technological dependence and other changes are exacerbating. While certainly significant, he devotes only a short chapter in *Medical Nemesis* and very little in his other writing to this kind of damage. It is quite secondary to his main concerns and, as he stressed in a 1975 speech to British physicians, talking about it can mislead people into thinking that this is the 'issue which makes the iatrogenic impact of medicine important' (Illich 1975:79).

The key concern for Illich is in the second, and especially third levels of iatrogenesis, neither of which involves any negative judgement of medical effectiveness. The second he calls 'social iatrogenesis'. Here his concern is with the wide-ranging effects of medicalisation on social life, structure, behaviour and ritual. These effects involve expropriations. Increasingly shifting care to specialised institutions like hospitals, for instance, has a dramatic impact on social space, such that the home becomes inhospitable to birth and to those who are sick, or infirm, or handicapped (Illich 1976:41). '[D]ying at home becomes socially inconceivable', Illich writes, while daily life is so rearranged that 'ageing at home becomes increasingly more painful rather than more beautiful' (1975:80). As life is medicalised, social control and moral authority, diagnosis and classification, economic resources, available remedies and other powers are structurally appropriated by medicine. The future is mortgaged to pay for a 'mirage of health' (Dubos' term) and people are left, on their own or in their primary groups, captive to endless medical supervision, impotent to manage their bodies and their affairs.

Finally, and of even more insidious impact is cultural or symbolic iatrogenesis. This form of health-denial is an effect of the modern 'war against all suffering' (Illich 1976:127) and its impact on the sufferer. Cultures have traditionally provided individuals with the means to interpret and find meaning in 'inevitable and often irremediable' experiences of 'pain and impairment, decline, and death' (1976:127–8). There existed culturally mediated arts of suffering and dying that nurtured self-reliance and understanding. 'Medical civilisation', by contrast, Illich argues, undermines such cultural programmes, turning pain, disease, disability and dying into technical problems and depriving people of meaningful expressions for their anguish (1976:131,170).

Disabling dependence

For both Illich and Zola, medicalisation constitutes a threat to the human person. It has corrosive effects on human dignity, disabling important aspects of personal and social life, especially for the most vulnerable. The measure for these effects, the ground for their critiques, is a normative picture of the human good that places a pre-eminent ethical value on self-governing activity. For Illich, the key criteria for accessing our tools, their productivity or counterproductivity, is whether they serve or undermine 'individual freedom realised in personal interdependence' (1973:11). He defines health itself as the 'autonomous power to cope' (1976:207), an autonomy rooted not in some disembodied individualism but in 'self-care' and non-technical and unmanaged relations within a cultural community. Zola, most directly in his writing on disability, also emphasises the freedom to control one's own care within a nexus of 'mutual aid' and sensitivity to the social sources of suffering. This requires people retaining, as far as possible, the tools to cope with their own lives, express their own values and to help others in non-objectified relations, attending to the whole person and the cultural representations of persons in the wider social milieu.

'Against health'

In their critique of medicalisation, Illich and Zola might both be characterised as 'against health', to borrow a provocative phrase from an interview with Illich (1992b). The 'health' they stand against is not any state of genuine well-being but a particular ideology, a healthism, promoted by medicine and increasingly abroad in the wider, medicalised society. The ideology of 'health' described by Illich and Zola is an overweening value, an end in itself stripped from any larger context of a well-lived life. It is conceptualised as a kind of commodity that can be engineered, creating and stoking the illusion that the existential realities of pain, suffering, ageing and death can be eliminated. This health, a false image of perpetual youthfulness and psychic serenity, demeans those who do not measure up and reinforces the tendency to isolate them and decrease their social visibility (Zola 1983b:51). It drives people to keep turning to medicine even when medicine has nothing worthwhile to offer. And, as internalised, it leads to a kind of self-alienation – the body perceived as a machine, the self experienced as an abstract system.

The 'health' they stand against is also an unavowed moral language. Both Illich and Zola argue that talk of health and illness is infused with value assumptions. They do not suggest that this is improper. Labelling a state of affairs an 'illness' is to label it undesirable and, most of the time, to create an imperative to act, to be 'medically-treated-changed' (Zola 1977:65). Health and illness are not neutral terms but invariably draw on cultural symbols and values, indicating what is 'normal, proper, or desirable' (Illich 1976:45). In social arenas, they function as what philosophers call 'thick ethical concepts'. A descriptive and an evaluative component coexist in the same term and cannot be separated (Putnam 2002). The problem arises in the denial of this inescapable evaluative component by the claim to value-free objectivity. This denial obfuscates the prescriptive, moral dimension and exempts it from evaluation. Values imposed by 'supposedly morally neutral and objective experts' (Zola 1972:487) speaking a language of science and beneficence are very difficult to recognise or challenge. Extending this language through medicalisation extends hidden value judgements to more and more areas of life. Principled, moral questions, such as what freedom people have for themselves and their bodies are not addressed but 'shunted aside' (Zola 1972:500).

Further, the 'health' they stand against often constitutes an adaptation to destructive social arrangements. The medical model, Zola argues, reduces problems to individual pathologies, their solutions to therapy. Health defined in these individualistic terms cuts off the social analysis of troubles and blinds us to wider social responses and responsibilities. It contributes to perpetuating inequality and enforcing invidious norms. It also becomes, in Illich's words, 'but a device to convince those who are sick and tired of society that it is they who are ill, impotent, and in need of technical repair' (1976:9). With medicalisation, health takes on an increasingly important symbolic function. It provides the inducements and the justifications, eases the tensions and disables resistance, to features of life in industrial society that harm and diminish people, particularly the poor and the weak.

Meaning and suffering

A 'health' built on illusions undermines the capacity of people, individually and collectively, to deal with human weakness, vulnerability and pain. The most significant effect of modern medicine and its export to developing countries, Illich argues, is the way in which it disables cultural models of pain and suffering and then prevents new ones from arising. Pain and impairment have both an incommunicable and referential character, and raise fundamental questions of theodicy: why must I suffer? 'Why does this kind of evil exist, and why does it strike me?' (1976:142). Traditional cultural frameworks make pain 'tolerable by integrating it into a meaningful setting', by 'interpreting its necessity' (1976:134). These frameworks fit suffering into a larger story that is 'cosmic and mythic, not individual and technical' (1976:149) and provide 'words, cries, and gestures' (1976:144) to express anguish. They provide concrete models of suffering and virtue – the saints, the Buddha and so on – and show how to integrate 'the grammar and technique, the myths and examples' into a repertoire, a 'craft of suffering well' (1976:145). And, thereby, these frameworks not only equip sufferers to ethically respond and cope with their reality but enable compassion and connect sufferers and their incommunicable experience to a larger community of those who have suffered.

Medicalisation, Illich argues, defeats all of these cultural functions. Pain, redefined in almost exclusively physical terms, in terms of an entity that medicine can 'kill', is degraded to a list of complaints. Social context and other forms of suffering – such as 'grief, sorrow, anguish, shame, and guilt' (1976:139) – long included in the nonmedical word 'pain', are stripped away and rendered both less visible and less real. The extension of life is pursued heedlessly for its own sake, also stripped of any larger framework that would allow people to accept and face their reality. In this important sense, the war on suffering that drives medicalisation disables culture itself. The larger role of sufferer is eviscerated, leaving merely the 'patient', a technocratic subject whose malfunction the system is aimed to relieve. In addition to language and story, traditional cultures had healing practices, such as an ameliorative pharmacopeia of psychoactive substances, which were integrated with the symbolic and performative. Medicalisation deprives culture of this integration, promoting management by technique, now monopolised by professionals, while reinforcing the decay of the others. Under these conditions of privatised struggle, people come to see it as reasonable 'to flee pain rather than to face it, even at the cost of giving up intense aliveness' (Illich 1976:152).

Zola shares the concern with the social origins of suffering and the need to respect the nature of pain and struggle (1992:11). Drawing on the labelling perspective as well as feminist and other rights movements, he raises questions of 'voice', naming and other social representations of suffering (1993), the implicit devaluing of sufferers through the projection of 'healthist' expectations, and discrimination and the refusal to accommodate difference. Expert opinion, to give one example, which medicalisation extends, can certainly be a valuable perspective. But, Zola argues, it can also control who speaks for sufferers as well as what can be said about pain and suffering. He illustrates with personal experiences, such as being told by a doctor that a test, which Zola had undergone twice before, is 'easy' and 'doesn't hurt', yet Zola has found extremely difficult, both physically and psychologically (1992:13). The issue with expert control here is not mere insensitivity. It is claims to knowledge and the power to define what is real that can effectively silence the voice of those who suffer, limiting or denying the needs they can express or the meanings they have available to give to their experience. This disabling, he argues, creates suffering, limits access to resources and alienates people from their own personal and bodily knowledge and sense of self-efficacy.

The priority of (restoring) vernacular life

For both Illich and Zola the disabling of self-efficacy is the most significant consequence of medicalisation, and so its restoration must be the central strategy of resistance. Illich often uses the word 'vernacular', which in its Latin use means 'homespun' or 'homemade', as 'opposed to what was obtained in formal exchange' (1981:57). He speaks of 'vernacular culture' to designate the grounded space of the everyday in which most people, most of the time, have lived their life. It is constituted by customs, understandings, and a sensibility rooted in and emergent from ordinary local interaction, as people go about their affairs and exercise their own agency and determination to 'fend for themselves' (Illich 1971:3) and 'find their own way' (Illich 1976:214). The model of the vernacular, for Illich, is life in more traditional societies, historical and contemporary, but the ideal he has in mind is not indexed to a world, real or imagined, that we have lost. Rather, the 'vernacular' celebrates the capacities of ordinary people, their awareness and acceptance of limitations and their will to struggle and overcome. It is a conception of human freedom and efficacy that Illich uses as a standard against which the aims, logic and hierarchies of expert systems can be evaluated.

For Illich, extending the reach of expert systems like modern medicine extends the undermining of the freedom and self-efficacy of vernacular life. This is the primary meaning of his famous opening sentence of *Medical Nemesis*: 'The medical establishment has become a major threat to health' (1976:3). Genuine health involves self-efficacy in the vernacular context of mutual support, ritual and meaning-making. Health, in this sense, is inconsistent with isolation and dependence. But the counterproductivity of medicine also means that an expert system or profession can never be the direction to turn in addressing the problem. The way forward must include a reinvigoration of vernacular life and culture, a judicious use of technology, and a return of much care to ordinary people and their communities. Much of modern medicine is actually compatible with this project, Illich argues, if equally distributed and organised to serve human freedom (1976:220). Because less in the professional grip, it may be that non-Western and developing societies are in a position to strike a better balance.

Zola does not speak in terms of the vernacular, but he has many similar ideas. Medicalisation, for Zola, undermines mutual aid and self care. He too stresses the need to demystify medicine, and to draw boundaries to its influence and exercise that protect people's values and everyday life. He is sensitive to the objectifying and dehumanising aspects of an overly technical approach, insisting that care is a profoundly human activity and must enable and validate the sufferer not increase dependence. In his writing on disability, he highlights the work of the independent living movement and its emphasis on the freedom of persons to control their own environment. In agreement with Illich, he believes many helpful procedures, including tasks like catheterisation, can be self-taught, and much care can be returned to ordinary people and without medical supervision. People, he emphasises, must be informed and they must be allowed to take risks and fail. 'An environment or device that prevents any kind of risk produces not a real life', he writes, 'but a mirage of one. There is human dignity in risk. There can be dehumanising indignity in safety' (Zola 1983c:353). In many areas, therefore, the way forward must be to decentralise, de-specialise, and simplify a vast array of 'medical services' that are currently regarded as the sole province of professionals (Zola 1991b:309). Like Illich, the answer to medicalisation is political, not professional.

Strengths and limitations

In the sociology of health, illness, and medicine, the work of Illich and Zola has been neglected. As noted at the outset, both Illich and Zola continue to be cited in the literature but in a narrow context (for example, Lupton 2012; Nettleton 2013). There is a great deal of writing on Illich, even an *International Journal of Illich Studies*, but not much any more with respect to medicine. One can still find references to *Medical Nemesis*, though the main section, on cultural iatrogenesis, the most original and important of his concepts, gets little (positive) attention. Similarly, Zola's writing, outside of disability studies, gets cursory attention and his concern with medicalisation is seldom placed in the context of his other writing. Moreover, both, and especially Illich, are often misread.

In 'The Crisis of Medicine or the Crisis of Anti-medicine?' a published version of an earlier lecture, Michel Foucault frames his remarks explicitly with reference to *Medical Nemesis*, the early British version of which had recently appeared. He ([1976] 2004:12) chides the book as a 'radical and bucolic rejection of medicine in favour of a non-technical reconciliation with nature'. For Foucault, anti-medicine makes no sense, for 'what is diabolical about the present situation is that whenever we want to refer to a realm outside medicine we find that it has already been medicalised' ([1976] 2004:14). In other words, to use Illich's terms, the vernacular has disappeared, so that any attempt to escape medicalisation will always bring one back, willy-nilly, to medical knowledge. Although for differing reasons, others have similarly castigated Illich's work as being anti-medicine and anarchist and at least some of Zola's positions as anti-medicine and 'extremist' (for example, Hedgecoe 1998).

There is certainly some basis for characterising Illich, especially, and Zola as anti-medicine. Both freely used polemical language and challenged professional medicine on a wide range of issues. They took a dim view of its accomplishments, worried about its growing power, were sceptical of its humanitarian claims for itself, questioned whose interests it served, emphasised that it operated as a moral enterprise that punished deviance and helped maintain unjust order, charged it with robbing people of their self-efficacy, and held it responsible for losing sight of patients as persons. And that is not a complete list. They often painted with a broad brush and on a thin evidentiary canvas. There are undeniable limitations. But characterising Illich and Zola as anti-medicine misses the deep point of their work. The polemical nature of their writing notwithstanding, neither is against medicine, medical science, or medical technology.

The study of medicalisation began with a particular emphasis on deviant behaviours, like child abuse and school misbehaviour, and natural life processes, like childbirth and ageing. Subsequently, research turned to considering the expansion of medicine into a wider range of problems of living, like shyness and perfectionism, as well as enhancement issues, such as the use of Ritalin for test taking. Over the years, the extensive body of research under this rubric has tended to concentrate on controversial cases – cases that did not seem obviously medical – and to evaluate them within a range of concerns about the individualising and depoliticising dynamic of the medical model, the power of medicine, and the monopoly of the medical profession over the technologies of intervention (Davis 2010). More recently, there have been efforts to extend medicalisation theory to include related and new developments. Biomedicalisation theory, for instance, is an effort to capture new techno-scientific and commercial changes, including concerns with risk and surveillance (Clarke et al. 2003). Similarly, a range of other concepts have been offered, such as 'geneticisation' (Lippman 1992), 'healthicisation' (Conrad 1992), 'disease mongering' (Moynihan et al. 2002), and 'pharmaceuticalisation' (Abraham 2010) to identify features of the increasingly complex web of biomanagement that extends well beyond the boundaries of medicine and ever further into everyday life and the bodies of individuals.

Illich observed this changing terrain and modified his assessment in his writing after *Medical Nemesis*. Writing in the mid-1980s, for instance, he argued that while health concerns continue to rise, the 'relative importance of the medical establishment within the health sector' has declined (Illich 1986:1325). Or in the mid-1990s, he noted that the medical has become increasingly interwoven with larger systems of social and bodily management. 'Food, drugs, genes, stress, age, air, AIDS, or anomie', he wrote, 'are no longer medical but systemic issues' (1995:1652). Borders between institutions that had once seemed clear had become fluid and fuzzy. Zola too saw these developments. But the changing role of medicine didn't alter the force of their critique because their purpose was not to blindly attack medicine or the profession but to analyse and evaluate the cultural and institutional conditions under which the 'health society', to borrow Ilona Kickbusch's later and useful term, was emerging. The declining relative importance of medicine proper within this society, where 'health is everywhere' (Kickbusch 2007:151), does not change the main lines of their analysis and if anything intensifies the central concerns they expressed.

What Illich and Zola offer for a sociology of health and illness is a broader, more cultural and humanistic framework of analysis. Each element of their critique opens new avenues of exploration, paths towards essential but hard questions, and alternative models to those in which the medical-health-industrial complex operates. The framework is not anti-medicine. Foucault is right, that makes no sense, but not because medical knowledge is ubiquitous. Medical knowledge is not the problem. The problem is the proper ordering of human goods. What Illich and Zola show us is that more is at stake here than questions of equitable distribution, or medical error, or consumer protection, though, of course, all of these are important. What is at stake is, to quote Zola, 'what is or will become of man', that is, the human person (1972:502).

The health society is a vast engineering experiment where each person, now construed as a 'life', is asked to willingly adopt a managerial rationality and construe, monitor and manipulate their bodies according to ever-shifting techniques and the ministrations of experts (Illich 1992a). This is the 'risk society', as described by Ulrich Beck (1992) and Anthony Giddens (1990), a society constituted by interactions with abstract systems and expert knowledge and lived under a 'regime of total health' (Armstrong 1993). It is constituted, as any number of theorists have shown, by new subjectivities characterised by greater reflexivity, activism, and expertise, and by changed relations to the body, health, technology and medical authorities (for example, Chrysanthou 2002; Rose 2007; Mol 2008; Milewa 2009). What becomes of human life and human dignity under this regime? That is the larger question towards which Ivan Illich and Irving Kenneth Zola lead. Gaining a critical distance on contemporary certainties, such as health, is the first step to even asking the question. And exploring answers must begin by investigating what other fundamental human goods are in the balance. Not just what is enabled but also what is disabled in vernacular life, including, most radically, meaning in suffering.

Notes

1. The London publisher Calder and Boyers first published a much shorter, working paper version of *Medical Nemesis: The Expropriation of Health* in January 1975. The

following year, the longer text, which included revisions made in response to reactions to the working paper, was published in New York by Pantheon Books under the same name. The US version was then released in England by Marion Boyers under a different name: *Limits to Medicine: Medical Nemesis, the Expropriation of Health* (1976).

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Chapter 21

Michel Foucault: Governmentality, Health Policy and the Governance of Childhood Obesity

Julie Henderson

This chapter addresses the work of Michel Foucault and the theory of governmentality. The chapter commences with a discussion of the underlying assumptions of a Foucaultian approach to social theory, focusing upon the role of discourse and the relationship between knowledge and power. It then outlines the concept of governmentality in relation to liberal democracy and identifies the manner in which later theorists have explored neo-liberalism as a governmental rationality. Neo-liberalism is discussed in relation to three aspects of governance: the relationship between the market and state; between the state and health professionals; and ideas of citizenship and personal responsibility for health and well-being. The chapter concludes with a case study in which Foucaultian theory is applied to childhood obesity. Discussion concerns the emergence of childhood obesity as a political problem, policy solutions and parental responses to policy. The limitation of Foucaultian theory will also be addressed.

Biography

Michel Foucault (1926–1984) was a French philosopher who held the Chair in History of Systems of Thought at the College de France from 1971 until his death from AIDS in 1984. He had a privileged childhood, being the son of a surgeon working in private practice. His family were nominally Catholic and much of his secondary education was undertaken in Collège Saint-Stanislas, a strict Jesuit college where he excelled at history and philosophy. His relationship with his father was reported as being difficult and in 1946 he rejected his father's wishes that he become a surgeon and studied philosophy at the École Normale Supérieure.

Much of Foucault's theoretical work was concerned with histories of the medical and social sciences, focusing on the impact of these knowledges upon disadvantaged and marginalised groups. His early work was influenced by both existentialism and Marxism; however, growing political uncertainty in France which culminated in civil unrest and general strikes in May 1968 contributed to disillusionment with traditional critical theories among some members of the French intelligentsia, including Foucault. These events are viewed as contributing to Foucault's understanding of power as associated with knowledge rather than capital, and as productive rather than repressive (Ransom 1997). A second factor that influenced the direction of his work was his sexuality, which led to political activism on behalf of homosexuals and other marginalised groups and to a theoretical interest in the development of medical and psychological systems of thinking in discourse about sexuality and strategies for managing people who fall outside the norm (Stanford Encyclopaedia of Philosophy 2013).

Foucault's theoretical framework

Foucault's work can be understood as post-structuralist insofar as he is interested in how language mediates our understanding of the world. The underlying assumption of post-structuralism is that social reality is constituted in language: language orders and shapes our social reality through providing representations of that social reality (Tonkiss 1998). The focus of study from this perspective is upon language, texts and representations. This is encompassed in the idea of a discourse, which can be understood as an expert system of language 'which draws on a particular terminology and encodes specific forms of knowledge' (Tonkiss 1998:248). For Foucault, we understand the social world through discourse. Our understanding of ourselves is also mediated by language and by discourse about what it means to be human. As such, discourse can be understood as creating and locating us as subjects (Weedon 1987).

Foucault is concerned with the manner in which discourse constructs people and the power evident in such knowledges. In his own words, 'my objective has been to create a history of the different modes by which, in our culture, human beings are made subjects' (Foucault cited in Rabinow 1984:7). The means by which this occurs is through the development of scientific and professional knowledges about the body, psyche and what it means to be human which 'objectify subjectivity'. These knowledges classify and divide populations through establishing normative standards for bodily performance and presentation. They are tied to power through 'hierarchical observation, normalising judgment, and their combination in ... the examination' (Foucault 1984:188). The development of knowledges about a population enables the creation of standards of normality by which to judge the individual. The judgement process is institutionalised in the examination, which makes the individual a case that can then be 'judged, measured and compared with others' (Foucault 1977:191). The process of categorisation allows the identification of those failing to meet normative standards and precipitates their management in time and space, either through segregation or rehabilitation via the creation of structures and practices to manipulate, shape and train them (Hewitt 1991).

Power also operates for Foucault, however, through subjectification, which is concerned with the 'way a human being turns him or herself into a subject' (Foucault cited in Rabinow 1984:11). Foucault argues for a process of self-formation that is mediated by exposure to discourse and incorporation of those knowledges into a concept of self, resulting in self-regulation in response to professional and scientific knowledges. As such, power, for Foucault (1981), is not a repressive force held by one group over another but rather a productive force that operates through the knowledges which create people as disciplined subjects.

Governmentality

Of interest to Foucault in his later work was the analysis of knowledges about how to govern, and the subjectivities or ideas about citizenship that these encompass. For Foucault (1979:7), governmentality is concerned with the 'art of government': with 'knowledges of how to rule but also with . . . the organised practices through which we are governed and through which we govern ourselves' (Dean 1999:18). Gordon (1991) argues that governmentality has two aspects: the technical aspect or 'the will to govern' reflected in the principles and goals that guide peoples' behaviour and manifested in the practices that regulate behaviour (Gordon 1991), and knowledges about 'the reasons, justifications, means and ends of rule' (Rose 1993:288). Miller and Rose (1990) describe this as the *mentality* of rule. For Rose (1996:42), it has a moral aspect in that it is concerned with the allocation of responsibility for the tasks of governance, but also an epistemological aspect in that these ideas 'embody particular conceptions of the objects to be governed'.

For Foucault, the focus of governance from the nineteenth century has been upon the protection of the population through the 'materiality of power operating on the very bodies of individuals' (Foucault 1980:55). The dominant model of governance or governmental rationality operating from this time in Western countries has been liberalism. The central discovery of liberalism for Foucault was that it was possible to govern too much. He states:

> . . . it seems to me that, at that very moment it became apparent that if one governed too much one did not govern at all – that one provoked results contrary to those one desired (Foucault 1989:261).

The defining discipline of liberalism is economics (Foucault 1979). Dean (1999) argues that the state from this point was required to be economical both fiscally and in use of power. Classical liberalism for Foucault can be understood as a means of reconciling a free market economy with the exercise of political power through protecting the market from the state (Burchell 1993). This approach provides a means of confronting conflicting needs – those of the rights and interests of citizens with the need to exercise power (Rose 1996). The criterion for successful government is how it maintains the 'free' conduct of individuals while ensuring they exercise a 'well-regulated and "responsibilised" liberty' (Barry et al. 1996:8). This is achieved through indirect means through the creation of knowledges about citizens, through what Foucault calls 'biopower'.

Foucault (1981:143) defines biopower as the techniques of power that bring 'life and its mechanisms into the realm of explicit calculation . . . [making] knowledge-power an agent of transformation of human life'. This occurs across two 'registers' – the technico-political or bio-political register which identifies knowledges and techniques for actively controlling the population, and the anatomico-metaphysical register which is concerned with the development of knowledges that discipline the body through constructing the individual in a particular manner (Foucault 1977:1981). The technico-political register operates at a population level and is reflected in statistical knowledges such as health data that identify regularities within the birth, death and morbidity rates of the population and enable service planning. The anatomico-metaphysical register operates at the level of the individual and is evident in knowledges which establish norms for presentation of the body and for behaviour. The development of the human sciences resulted in society becoming the object of scientific observation. 'Human behaviour became . . . a problem to be analysed and resolved' . . . [leading to behaviour becoming bound up] with 'mechanisms of power' (Foucault 1988:106). The establishment of normative standards creates the conditions for the development of the forms of self-mastery and self-regulation necessary to successfully govern free and civilised citizens (Rose 1996). The role of the state, therefore, is to create the conditions for a form of personal autonomy and citizenship which incorporates responsibility for oneself and for dependent others through adoption of these norms.

Neo-liberalism as a governmental rationality

A number of more recent theorists, such as Nikolas Rose and Mitchell Dean, have applied the concept of governmentality to current governmental rationalities to identify the features of what Rose calls advanced liberalism and others call neo-liberalism. While classical liberalism was concerned with protecting the free market from the state, neo-liberalism involves the state actively creating the conditions for the operation of the free market (Burchell 1993). Neo-liberalism redefines the problem of government from the anti-social effects of the market to the anti-competitive effects of society, contributing to a reaffirmation of the separation of the market from the state (Gordon 1991:42). As with classical liberalism, economics is the defining discipline of effective governance and human behaviour is viewed as capable of being judged and understood within the context of economic theory. This understanding is reflected in a changing relationship between the state and free market; the state and professions; and state and citizens.

In relation to the market, many of the functions previously performed by the state have either been privatised or become the responsibility of semi-governmental authorities, while many publically owned and publically operated services have adopted managerial techniques from the private sector. This trend is evident in Western countries but has also spread to other countries (Collyer and White 2011). Neo-liberalism has been associated with the application of ideas and strategies from the private sector to public healthcare delivery in the form of New Public Management. As a consequence of the adoption of New Public Management techniques in the public health sector, health services in Western countries have experienced service amalgamations; closures and relocation; earlier patient discharge and shorter admissions; increasing workloads arising from the management of more acute patients; and the shifting of the burden of care to the family and carers (Hancock 1999; Leicht et al. 2009). A second strategy involves increasing reliance upon private provision of health services. In the community sector this is evident in growing use of general practice and non-governmental organisations to provide health services in many countries, including Australia, the United Kingdom and New Zealand, and is associated with tendering for service provision, with success dependent upon the extent to which the tendering organisations match government objectives (Hughes et al. 2011; Henderson et al. 2013). A third strategy involves greater use of semi-governmental authorities (such as professional regulatory bodies) to regulate aspects of service provision. For Rose (1996:56), this is evident in the 'quango-isation of the state', resulting in the decentralisation of regulatory functions to quasi-governmental agencies.

The application of market principles to healthcare delivery also changes the relationship between the state and health professionals, leading to greater indirect management of professional practice. The adoption of managerial techniques from the private sector results in the subjection of health professionals to demands to achieve efficiencies and provide quality services with fewer resources (Leicht et al. 2009), while being responsive to the needs of the users or consumers of the service. Osborne (1997:185) argues that healthcare delivery is being permeated by 'responsibilisation' which manifests in pressure upon health managers to be financially responsible for running health services as businesses. This is evident in the establishment of efficiency criteria and performance management procedures in many Western countries (Tousijn 2006:471). Efficiency is determined through the measurement of health outcomes (Teghtsoonian 2009). Osborne (1997:185) associates neo-liberalism with the construction of variables for measuring healthcare delivery 'in the form of targets relating to finance, pharmaceuticals, recovery rates, operations, patients, waiting-lists and so forth'. Collection of data pertaining to health outcomes provides a means of meeting information needs for policy-making; for managing patients and healthcare programmes; for coordinating care across sectors; evaluating the outcomes of care; and educating healthcare professionals (Reid 1999). All subject health professionals to targets established by agencies external to that profession (Dent and Whitehead 2002).

Neo-liberalism is also associated with a reconstruction of the users of health services as consumers able to make informed choices between competing services provided by the market. This conception challenges the traditional relationship between the expert practitioner and patient (Fournier 2000; Lane 2006). Tousijn (2006:471–2) identifies three consequences of consumerism: greater patient expectations for information and involvement in decision-making around treatment; the growth of consumer groups; and the development of mechanisms for incorporation of consumers into the management structures of healthcare organisations. Fournier (2000) argues that health policy, which promotes informed consumption of health services, contributes to demand for responsiveness to consumer needs. This is evident in the subjection of health professions to consumer demands and the redefinition and measurement of quality care in relation to consumer needs.

A third aspect of change refers to the changing relationship between state and citizens of that state. Clarke (2005) argues that neo-liberalism is premised upon active citizens undertaking responsibility for their health and well-being through management of lifestyle, thereby reducing reliance upon governmental supports. This form of governance is based on mutual obligation. The state has an obligation to provide the 'conditions of the good life', and the public to exercise 'active responsible citizenship' (Rose 2000:1398). Citizens are required to exercise free choice (Higgs 1998), but they must also 'assume responsibility for these activities, both for carrying them out and, of course for their outcomes' (Burchell 1993:276).

Planning for the future is one of the hallmarks of responsibilised citizenship (Rose 1996). O'Malley (1996) associates the responsibilised citizenship with a form of 'prudentialism', where the individual becomes responsible for the preservation of their own health and welfare, effectively privatising social functions previously performed by the state. The individual is required to protect the future through managing risks in the present via assessment of risk and adoption of practices to maintain security (Murphy 2000:293). This is particularly evident in relation to maintenance of health. Preservation of good health becomes one of the obligations of citizenship. The right to health is reconstructed as the responsibility for 'accepting and adopting the imperatives issuing both from the state and other health-related agencies concerning the maintenance and protection of good health' to prevent placing a burden on the healthcare system (Petersen and Lupton 1996:65). ' "Good" citizens control their bodies according to "The Good" choice promoted by government . . . while those who don't "conform" are subject to an increased level of surveillance' (Rawlins 2008:138). These judgements create divisions based upon a capacity to manage risk between '*active citizens*', who accept responsibility for managing lifestyle risk, and ' "*targeted populations*" . . . who require interventions' (Dean 1999:167, emphasis in original).

Rose (2001) describes this imperative as the 'will to health', whereby every citizen is required to become a partner in, and accept responsibility for, a project to better their own health and well-being. Far from being an enterprise solely of the state, the 'will to health' has been capitalised on by a range of private enterprises, including pharmaceutical, food, and leisure and sports industries, but also a range of non-government organisations, pressure groups and self-help associations (Rose 2001). And, far from being encumbered by this responsibility for health betterment, individuals might see this as a new-found freedom; one which they, themselves, are 'empowered' to undertake.

Responsibility for health and well-being extends beyond the individual, however, to family members. Murphy (2000) argues for a trend towards the development of policies targeted at children that emphasise what children will 'become' rather than what they currently are. Parents are responsibilised through extending familial responsibilities beyond the provision of care in the present to the protection of their children's future health and well-being via the promotion of healthy behaviours and the development of a healthy lifestyle. Governance of children for future responsibilities involves greater monitoring of these children. The primary responsibility for ensuring that children become good citizens lies with parents, and in particular mothers (Lister 2006). Children are also often positioned, in policy, as vulnerable consumers who must be protected in their own interests and the long-term interests of the wider community (Colls and Evans 2008). Murphy (2000:297) associates the vulnerability of children with moral accountability on the part of parents to prevent the 'consequences of risky behaviour'. As such, good parenting is viewed as maximising both the physical and psychological health and well-being of children, with mothers who fail to do this falling short of expectations for good parenting. Some authors (Kokkonen 2009; Vander Schee 2009) note a public association between nutrition and a judgement of adequate parenting. This is particularly evident with parents of obese children who are presented as over-indulgent and as failing to establish proper boundaries (Kokkonen 2009).

The discussion below explores how Foucault and the concept of governmentality can be applied to the issue of childhood obesity and policy responses to it. The concept of governmentality has been identified as particularly pertinent to issues of obesity as it enables an analysis which extends beyond the medicalisation of obesity to the manner in which the individual self-regulates nutrition and exercise in light of medical discourse (Evans and Colls 2009). Discussion focuses upon three issues: the emergence of a discourse of childhood obesity as a social and political issue; policy responses to childhood obesity; and literature which addresses personal and parental responses to child obesity policies. The chapter concludes with an assessment of the limitations of a Foucaultian approach to the issue of childhood obesity.

Governing childhood obesity

Constructing an epidemic

Foucault is interested in the manner in which social issues become problematised and the circumstances that allow an issue to be viewed as a problem at any given time. Childhood obesity is a problem which is receiving increasing interest, in part due to a perceived obesity epidemic. Obesity is presented in the media and academic literature as an 'epidemic' with long-term health and economic ramifications arising from the burden of chronic disease (Boero 2007; Mitchell and McTigue 2007). That this is a recent trend is attested by Moffat (2010), who in a search of Medline[1] from 1980 to 2007 for articles about childhood obesity found that two-thirds of the articles were published after 2000. Mitchell and McTigue (2007) argue that the framing of body weight as an epidemic has its roots in a World Health Organization report published in 1998 titled *Obesity: Preventing and Managing the Global Epidemic*. This was developed in response to the efforts of, and in conjunction with, a number of NGOs such as the International Association for the Study of Obesity and the International Obesity Task Force; both acting as moral entrepreneurs in placing childhood obesity onto the political agenda (Moffat 2010).

The media has a major role in creating a moral panic around obesity (Campos et al.2006). Much of the reporting of obesity is alarmist and uncritically accepts the framing of obesity as an epidemic, preventing the presentation of alternate views (Boero 2013). Obesity is frequently presented as a biomedical problem. Lawrence (2004:57) argues that the reporting of obesity can be analysed in terms of 'individualising' and 'systemic frames', where individualising frames 'limit the causes of a problem to particular individuals' and systemic frames assign 'responsibility to government, business and larger social forces'. Obesity is frequently identified in the media as a problem of discipline, albeit self- or parental discipline (Henderson et al. 2009). The individualisation of obesity in the media has been enhanced by media coverage which presents social problems as human interest stories, which turn 'a complex set of phenomena into a morality tale' ignoring the impact of social context (Saguy and Almeling

2008:59). The medicalisation of obesity in the media has resulted in the association of obesity with biological and behavioural factors (such as genetics or poor food choices), which warrant medicalised solutions in the form of medication or bariatric surgery (Lawrence 2004; Boero 2007). Childhood obesity is frequently presented in the media as a failure of parents, school and society (Saguy and Almeling 2008). It is constructed as a problem in which children are positioned on the one hand as agents who can apply pressure upon parents through 'pester power' for fast food, and on the other as 'innocents' who need to be protected from the marketplace activities (Henderson et al. 2009). The solution to this problem is most frequently found in parental responsibility for food consumption (Henderson et al. 2009).

For Mitchell and McTigue (2007:394), the designation of obesity as an 'epidemic' has rhetorical significance beyond the epidemiological reality of increasing obesity rates. As a metaphor the concept of epidemic is associated with chaos, shame and blame, particularly with respect to children (Moffat 2010). Through the association of obesity with more traditional epidemics, obesity is redefined as a medical condition (Boero 2007; Moffat 2010). Boero (2007:42) identifies obesity as a 'post-modern epidemic', as it is unevenly medicalised and has no clear pathological basis. Additionally, the risk of becoming obese is held in common rather than being associated with an identified group lending itself to a form of prudentialism through self-management of weight to prevent this risk. The designation of obesity as a risk factor for chronic illness creates an additional moral imperative for self-management, due to use of scarce health resources and the growing economic burden posed by the provision of these services. As such, the management of obesity shifts away from management of populations to the individual, marking a transformation in the focus of public health thinking (Boero 2007). Moreover, obesity becomes a problem of the individual to be addressed as 'a matter of common concern' for the public good (Mitchell and McTigue 2007:394).

The central means for categorising body weight is through the use of the body mass index (BMI). BMI is a function of weight and height and is used to designate people as normal weight (BMI of 18.5–25), overweight (BMI of 25–30) or obese (BMI over 30). Increase in BMI is generally associated with higher morbidity and mortality rates, with individuals with a BMI over 25 assumed to be less healthy than those in a normal weight range. This perspective has been challenged by Campos et al., who argue there is little evidence that BMI alone is associated with greater risk of morbidity and mortality except for individuals with a BMI above 35 (Saguy and Almeling 2008). Body build and level of cardiovascular fitness may be a greater predictor of morbidity and mortally than BMI alone (Campos et al. 2006). Use of BMI is particularly problematic for children, as it must be considered in relation to age and measured in relation to average growth rates for that age. The use of BMI in this context fails to account for differences in developmental rates, making it an unreliable indicator of future morbidity (Evans and Colls 2009). Despite this, BMI is widely used. For Evans and Colls (2009), the capacity of BMI to provide a numerical measure of weight can be understood as a technique of biopower which operates at both a population and an individual level. The measurement of BMI can be a technique to survey the population, to identify geographical populations at risk and to establish quantifiable policy goals. At the level of the individual it is used to discipline the body through establishing norms of bodily presentation.

Policy responses to childhood obesity

Policy responses to childhood obesity are frequently framed around the concept of obesity as an epidemic. In the United States, the concept of an 'obesity epidemic' was grounded in the release of *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity* in 2000 (Mitchell and McTigue 2007). This report identified 'overweight and obesity ... [as having] reached nationwide epidemic proportions' (cited in Mitchell and McTigue 2007:394). Public health policy also often references the health and economic consequences of an obesity epidemic. The Australian Department of Health and Ageing, in a report entitled *Healthy Weight 2008,* states, for example, that:

> Obesity is now seen as a major epidemic .... The problem is of enormous health, social and economic concern because overweight and obesity cause a wide range of debilitating and life threatening conditions (cited in Alexander and Coveney 2013).

The solutions to childhood obesity operate at both a population and an individual level. Children hold an ambiguous position in current political thinking (Such and Walker 2005; Colls and Evans 2008). The responsibilities of citizenship are extended to children through greater participation in governance and through education in 'good' food choices (Rawlins 2008). Conversely, children are often positioned in policy as vulnerable consumers who must be protected in their own interests necessitating government intervention (Colls and Evans 2008). Policy responses to childhood obesity often adopt strategies which educate and monitor children and their parents and ensure political solutions involving regulation of the market (Henderson et al. 2009). Brescoll et al. (2008), in survey research of US Federal policy-makers found there was little political will to adopt strategies which regulate the market through banning activities such as fast food advertising. Favoured options include nutritional labelling and nutrition education: strategies which promote personal responsibility for food consumption and funding for biomedical research into the causes of childhood obesity. Similar trends are evident in Australia. Federal policy focuses at one level on the development of guidelines for healthy eating and activity; education of health professionals, teachers and childcare workers about health food choices; and the development of curricula for primary and secondary schools about healthy eating; on the other, it focuses on mandatory childhood health checks (Commonwealth of Australia 2003; Department of Health and Ageing 2007). Thus the strategy promotes education for self-management as well as surveillance, reflecting a tension between the construction of children as 'active citizens' or as a vulnerable population.

Public health policy often frames childhood obesity as an issue that can be resolved through good parenting. This is associated with consumption. In Australia the *Clinical Management Guidelines for the Management of Overweight and Obesity in Children and Adolescents* associates the consumption of high-density foods with 'parental monitoring of food choice' (NHMRC 2003:35). Alternately, it can be viewed as a function of physical activity. Alexander and Coveney (2013) note that the Canadian *Family Guide to Physical Activity* advises parents to:

> . . . work with your children to encourage healthy behaviours by setting some physical activity ground rules. Encourage your children to play outside and try to be an active role model yourself. Usually active parents will have active kids.

Disciplining parents? The impact of discourse about childhood obesity

A final aspect of the debate is the manner in which the development of discourses of parental responsibility for nutrition and obesity impact parents who are the subject of these debates. Authors identify the pressures placed upon parents to provide good nutrition for children (Murphy 2000, 2003; Vander Schee 2009). Monitoring of nutrition begins in the pre-natal period with restrictions upon alcohol consumption, foods that may be contaminated with listeria, and excessive weight gain during pregnancy (Fox et al. 2009), and continues through infant-feeding practices through to monitoring of nutrition within schools. The primary target for these concerns is mothers (Robson 2005). For Murphy (2003), mothers are subject to 'biologico-moral discourse', which equates good feeding practices with good mothering, enabling the intrusion of the public sphere into the privacy of the family. Good mothering is associated with health consciousness, the establishment and maintenance of rules and boundaries and with the investment of time in teaching good eating habits (Kokkonen 2009).

A moral imperative to provide good nutrition is enforced by practices which survey children. Programmes which promote surveillance of children and through children of parenting include BMI screening of school children in the United Kingdom and in many states in the United States (Evans and Colls 2009; Vander Schee 2009). These programmes may disproportionately impact families who are economically vulnerable or lack other forms of capital. As a result of these programmes, some population groups may be identified as more likely to be overweight than others and identified as being 'at risk' and in need of intervention to meet the 'norm' (Vander Schee 2009).

Limitations of a Foucaultian approach

There are a number of strengths in applying governmentality as a theoretical frame for exploring the governance of childhood obesity. Policy responses can be understood within the context of a governmental rationality which promotes individualised over public solutions to health problems and in which the reduction of the risk factors for chronic illness is viewed as protecting limited healthcare resources. Further, a focus upon the subjectivities created in these policies enables examination of the manner in which policy is both productive and repressive for the parents and children subjected to it. Despite this, there are limitations to using this theoretical perspective to explore discourse around childhood obesity. For critical theorists, this perspective is limited due to a failure to address the impact of structural inequalities arising from class and gender upon parental capacity to respond to policy imperatives. While a Foucaultian perspective enables critique of representations of good parenting and the impact of failure to meet parental norms, it does not explore the extent to which those who fail to meet the norms are women belonging to marginalised groups. For Vander Schee (2009:560), a privileging of a responsibilised and active citizenship separates the lives of subjects 'from the broader socio-cultural factors which shape their world', enabling the viewing of obesity as evidence of individual character deficits rather than structural inequalities (Townend 2009). For Robson (2005:221), the dominant standards of 'good mothering' ignore the 'material and cultural resources and constraints' in which mothering occurs. Younger, poorer and single mothers frequently have to negotiate norms of good mothering with limited financial and material resources and limited cultural capital (Baker 2009). As such, condemnation of parenting may fall disproportionally upon these groups.

A second critique focuses upon issues of agency. Crossley (1996:99) describes a tension between a theoretical conception of the body as 'lived' and active and the body as acted upon, with Foucault associated with the group of theorists who argue that discourse is 'inscribed' on the body. For some, this is viewed as evidence that Foucault regards the body as passive. For Crossley (1996), Foucault views the body as both active and acted upon. He argues that the body is 'invested by power': that people can act upon their body but 'under specific conditions, by virtue of specific techniques to a more or less stipulated and specific end' (1996:108). This can be seen in the childhood obesity debate in programmes which 'empower' parents and children to make the healthy choice, effectively channelling agency towards desired ends (Warin 2011).

Conclusion

This chapter has outlined the features of a Foucaultian approach to governance. Governance for Foucault is informed by governmental rationalities or knowledges which prescribe what effective governance is and delineate the role of those being governed. Later theorists draw upon governmentality to outline the features of neo-liberalism. The features include reduced state provision of services; indirect management of the health professions through performance criteria and greater responsiveness to consumer concerns; as well as increasing personal responsibility for health and well-being. The chapter concludes with a case study of the childhood obesity debate which demonstrates the extent to which the problem has been defined in both policy and the public imagination as an issue of individual and parental responsibility contributing to individualised policy solutions.

Notes

1. Medline is a database containing medical and health academic articles.

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Chapter 22

Niklas Luhmann: Social Systems Theory and the Translation of Public Health Research

Samantha Meyer, Barry Gibson and Paul Ward

For some, Niklas Luhmann's social theory is 'the best description and analysis of contemporary society presently available', and yet 'the majority of people – not only the wider public, but also in academic circles – have apparently failed to notice this' (Moeller 2012:3). Over his lifetime Luhmann produced over 75 books and 500 articles (Borch 2011), although he is probably best known for his scholarly work on the sociology of trust and risk (Luhmann 1979, 1988, 2000, 2005) and systems theory (Luhmann 1982, 1995). Given his wide-ranging and voluminous outputs, it is therefore highly unlikely that we will be able to provide a completely adequate introduction to his work in this short chapter. It is with this in mind that we would direct readers to some of the useful texts that introduce Luhmann (King and Thornhill 2003, 2006; Moeller 2006; King 2009; Borch 2011). In addition, it is worth pointing out that Luhmann's own lectures introducing systems theory have now been published and are presented in a very accessible format, clearly demarcating his theory of society from other approaches in sociology (Luhmann 2013). For many of those working with his theory, an exciting development has been the recent publication of *Theory of Society Volume 1: Cultural Memory in the Present* (Luhmann 2012).

Following a biography of Luhmann, this chapter briefly covers relevant aspects of Luhmann's systems theory, including the notions of system differentiation, communication, polycontexture and structural coupling. We then present a case study to demonstrate the utility of his work in understanding why public health research is difficult to disseminate into policy and practice, particularly in non-health sectors. As we discuss, the nature of social systems as 'closed' monocontextures renders communication between systems difficult. Drawing on the notion of structural coupling, we put forward potential solutions to the absence of communication between systems and discuss potential implications for public and population health.

Biography and background

Niklas Luhmann was born in Germany in Lünberg on 8 December 1927. He grew up in Nazi Germany and, as Moeller (2012:121) states, '[as] was practically mandatory at the time, he became a member of the Hitler-Jugend, the fascist youth organisation, at an early age'. Luhmann was later conscripted into the German army as a solider and sent to the front in 1944 where he was captured by American soldiers. At this time he became interested in law after witnessing violations of the Geneva Convention during his time as a prisoner of war (Moeller 2012). Luhmann did not follow an administrative career however, and for various reasons began to study sociology at Harvard University between 1960 and 1961. It was here that he met Talcott Parsons and was introduced to systems theory. Over the next five years Luhmann returned to Germany, and after getting his PhD and writing a number of books, became full professor in Bielefeld in 1969.

The main influences during Luhmann's early career were Descartes, Husserl and Schütz. Later he was heavily influenced by Parsons. When he set out his research programme in 1969 to construct a 'theory of society', he rather famously stated it would take 30 years to complete and would cost nothing. He then set about to produce this theory of society. The beginning of the process involved a now famous controversial debate between Luhmann and Jürgen Habermas, a debate that demonstrated two very different approaches to understanding society. Habermas wanted to critique society and normatively reorder it to become more just, fair and equal. Luhmann sought to describe society accurately. These, as you can see, are two very different projects (Moeller 2012).

Luhmann's theoretical framework

Luhmann went on to develop a theory that conceived society as being composed of communication and nothing more. In doing so, he dispensed with the idea that society was composed of human beings. Although this might seem controversial it is important to realise that for him human beings *were* dispensable to society. Although there would be no communication without human beings, Luhmann argued that they are just not central to the principal dynamics of society. This of course makes him a radical anti-humanist (King 2009). For Luhmann, sociology, if it was to achieve its ambition as a science of society, ought to be able to adequately describe society, including its principal dynamics. For Luhmann, these dynamics were to be found in social systems.

Stepping aside from questions associated with the ontology of social systems, Luhmann simply stated that there are systems, these being of three typologies:

interactions, organisations and societies. His principal task became explaining what these were and how they worked (Luhmann 1995). His theory is difficult to grasp since he dispenses with 'old' sociological concepts and borrows concepts and ideas from a range of approaches outside of sociology. So, for example, he drew on the calculus of Spencer-Brown (1969) in the *Laws of Form*, the theoretical biology of Maturana and Varela (1980, 1987) and their concept of autopoiesis alongside Koselleck's (1998) conceptual history.

From this brief introduction it should be clear that the over-arching tradition that Luhmann was working within was that of systems theory. More specifically, his theory was developed out of what is known as the 'second-order' turn in cybernetic systems theory. In this perspective the old idea of systems as wholes made from parts is jettisoned in favour of the idea that systems are primarily distinguished through the distinction between a system and its environment. Luhmann's systems theory, then, is primarily about the distinction between a system and environment. He views environments as being overly complex, and systems function as a way to reduce the complexity of their environment. Within each system (for example, health) are even still smaller units, or sub-systems, which reduce complexity even more (for example, dentistry, primary care, emergency care). He uses the term 'boundaries' to represent social differentiation and system formation: the differentiation of society and formation of internal and external systems. Were it not for the divisions between systems, the societies would be too complex to maintain organisation. Internal systems exhibit a greater deal of order because they have fewer possibilities (less variation in understanding) than their environment (Luhmann 1979). The system has its representation of the world and reduces the world's complexity in order to be able to meaningfully orient itself to this, by structuring the possibilities of its own experiences and actions through the agreement of the system's members (Luhmann 1979). The inner order of a system helps to stabilise an extremely complex environment by organising a less complex system order that is better suited to human capacities for action (Luhmann 1988).

In order for a system to emerge it must be able to demarcate itself from its environment by observing *what the system is* and *what is its environment*. But the system cannot observe the whole universe; indeed, it must generate and select *what is the 'relevant' environment,* and in doing so the system is said to *produce its environment as its environment*. In this way the system is both internal and external to itself. It might seem strange to talk of systems being able to observe – a reification almost. But nonetheless, in Luhmann's approach this is what they do. Understanding his view that there are systems out there in our environment that are watching us and which we do not have direct access to is a fundamental step in grasping just how radical his theory is and the ensuing implications for public health research and policy, if indeed we want our research (undertaken and communicated in the scientific system) to impact on policy (communication undertaken in government). It is this radical Luhmann that we, among others (King 2009; Moeller 2012), would like you to grasp in this short chapter.

In public health, we often hear the cries of 'why don't policy-makers listen to our research findings', which is the bedrock for the emerging field of implementation science and translational research. Luhmann's social systems theory and noted distinction between systems and their environment is instructive in terms of providing an explanation for why policy-makers do not (or cannot) listen. For Luhmann, society is composed of separate sub-systems, all of which are operationally closed from each other but nonetheless interact in a myriad of complex ways (Luhmann 1995, 2002, 2012, 2013). If we understand society as a global system, then all systems within society depend on and mutually interact with all other systems and sub-systems. However, systems are differentiated by the form and semantics of communication both within and outside. Resultantly, as we discuss below, despite mutual interaction, the different semantics within systems can have implications for communication between systems. In Luhmann's view, our research is being communicated within and by the scientific system, whereas we want to influence varying systems responsible for public policy.

Luhmann's theory also draws on the concept of polycontexture (Günther 2004). This idea has enabled Luhmann to propose a detailed theory of social differentiation but to develop his approach in very particular ways (Luhmann 2002). As we have seen, societies are divided into systems that perform specific functions. Each functional system is monocontextural; it views the world through a singular, two-sided code, and therefore generates a singular view of reality. This singular view cannot be connected with the view of other functional systems. Society then is composed of fundamentally different 'non-congruent' views on reality (Borch 2011:90). As we shall see this has important implications for those working within public and population health.

Luhmann's systems theory allows us to understand how systems are differentiated, and therefore why communication is problematic. However, his discussion of the notion of structural coupling is a potential solution for future research transfer. Structural coupling builds on his premise that despite the boundaries existing within and across social systems, ultimately they mutually interact and are mutually inter-dependent (Luhmann 1997; Van Assche and Verschraegen 2008). The notion of structural coupling works precisely because the functions of these systems are different, while working towards a common goal. At a later point in this chapter we discuss how structural coupling can be used to facilitate public health researchers and policy-makers to work alongside one another to address the wider determinants of health.

Public and population health in a polycontextural society

Public health deals with searching for effective means of securing health and preventing disease in the population. It involves defining disease, measuring their occurrence and seeking effective interventions. Evidence of public health initiatives can be traced back to BCE 3000 (the introduction of sanitation facilities) and examples of what we now refer to as public health have since been documented globally (see Tulchinsky and Varavikova 2009, for a list of historical markers). Historically, public health has followed the traditions of epidemiology, preventative medicine and community health. Prior to the final years of the twentieth century, the focus of public health practice involved sanitation and hygiene, with a focus on ensuring that individuals were living in conditions that promoted health and reduced exposure to communicable diseases. The focus of public health in the past two decades has dramatically shifted, following the recognition of the relationship between health and social and economic development (Baum 2008; Tulchinsky and Varavikova 2009). Alongside this shift is a focus on population, rather than individual health. The population health perspective recognises the importance of the social determinants of health; that is, the factors that affect health such as housing, poverty and employment status. This perspective is focused on improving population health by working alongside sectors external to epidemiology and the medical sector. The role of health promotion and primary healthcare for public and population health is now widely recognised, as are the social or non-medical determinants of health (Lavis 2002). Health promotion is the process of enabling people to increase control over and improve their health, and involves both primary healthcare (for example, education programmes to reduce cardiovascular risk) and working to address the social determinants of health (for example, poverty reduction). The process within The World Health Organisation (2009), starting from the *Declaration of the Alma Ata* (1978) and the *Ottawa Charter for Health Promotion* (1986) has shifted the emphasis of conventional medicine towards an incorporation of primary healthcare and health promotion.

Australian public health policy has recently been reoriented towards illness prevention and health promotion (National Health Priority Action Council 2006; National Preventative Health Taskforce 2008; Department of Health and Ageing 2009; National Health and Hospitals Reform Commission 2009). This is partly a response to the social and financial pressures from the increasing prevalence of a range of major chronic illnesses and an ageing demographic. It is also a response to the recognition of the importance of the social determinants of health and the need to focus on 'Closing the Gap' in health between advantaged and disadvantaged groups in society (Marmot and Wilkinson 2006; Commission on Social Determinants of Health 2008; National Preventative

Health Taskforce 2008). The focus on promoting health and preventing illness for the most vulnerable groups in society is central to contemporary global agreements such as the *Jakarta Declaration* (WHO 1997) and the *Bangkok Charter for Health Promotion* (WHO 2005). In addition, in Australia, the *National Health and Hospitals Reform Commission* (2009) recommended a key reform goal as 'Tackling major access and equity issues that affect health outcomes for people now', which is also supported by the Council of Australian Governments (COAG 2008).

Public health research is increasingly recognised as a provision for evidence-based outputs regarding the upstream factors (prevention) affecting health, namely the social determinants of health. Most recently, the *Nairobi Call to Action* (2009) has listed urgent health promotion responsibilities, which include building and more centrally applying knowledge. However, the majority of health and related policy development, as well as healthcare finances, remain directed towards acute care and focus on downstream factors (treatment), rather than prevention (Ollila 2011). The evidence-base for policy-related approaches to health promotion over the past four decades is underutilised (Lomas 2007). This problem is evident in the research transfer literature, whereby despite producing extremely important research findings (at least, important within public health), they are not taken up (or selected) by policy-makers (Petticrew et al. 2004; Whitehead et al. 2004). A major challenge for health promoters is presenting stronger evidence to convince policy-makers to address the wider determinants of health (McMichael and Butler 2007).

Luhmann's social systems theory provides an explanation for difficulties in research translation. Public health functions to prevent ill health and promote positive health in the population through the modification of pathogenic environments. However, public health, we are told, operates across a number of different systems rather than constituting a specific system in its own right (Pelikan 2007). It therefore manifests itself on a polycontextural reality, though is regarded as a monocontexture. However, the recognition that population health is affected by social determinants requires public health as a system to cross system boundaries and communicate with social systems understood to impact health (for example, public housing). This is all achieved by public health practitioners (in their various guises) acting as 'go betweens' or knowledge brokers within and across different function systems and introducing an intensive referencing of public health. It is like trying to navigate your way in a new and unfamiliar country with a different language and set of cultural codes – public health practitioners and policy-makers need a guide to each other's social system.

Pelikan (2007) notes an important paradox, now well established in public health circles, that the cost of clinical medicine, including the expense of research, delivers relatively poor results compared to public health medicine

(McKeown 1976). Yet public health is at a specific disadvantage compared to the medical system. The medical system operates on diseases in the specific bodies of individuals. This contrasts to the abstract goals of public health to avoid future illness in populations (Pelikan 2007). This means clinical medicine can promise to save the lives of individuals as opposed to public health, which can only promise to decrease the risk of disease in future populations. Medicine can rely on the clinical sciences. It is argued that public health can only employ social interventions into the social conditions of disease, unlike clinical medicine which can rely on technical and marketable goods directed at individuals (Pelikan 2007). The implications of promoting health and preventing illness are more difficult to measure than clinical outcomes and this has implications for how public health research and practice are viewed in terms of their relevance to healthcare. Furthermore, the advantage for medical practice is rooted in power relations between biomedicine and other disciplines. The medical profession since the latter half of the twentieth century has been denoted as a profession of power and authority (Conrad 1992). Conrad discusses the notion of social control, arguing there are certain medical conditions that physicians lay claim to (Conrad 1992) and that ‘the greatest social control power comes from having the authority to define certain behaviours, persons and things’ (Conrad and Schneider 1980:8). This has implications for the treatment or prevention of certain medical conditions outside of the medical jurisdiction. (Williams and Gabe’s chapter on Peter Conrad and medicalisation, in this volume, will be of interest to readers seeking a more thorough discussion of the medical profession and issues of power, surveillance and social control.)

Polycontexturality and the ‘Realities’ of population health practice in Australia

Our goal in the following section is to demonstrate the potential for communication between systems. In order to achieve this we present a case study which discusses how public health might cross system boundaries. Our discussion is rooted in the argument that public health as a system is regarded as a monocontexture; it has specific views on the reality of what is, forms and constructs ‘health’. However, within public health, health is constructed as something that exists beyond the ‘boundaries’ within which it is situated. The environment external to the public health system, and subsequent systems within that environment, are observed to shape health – health therefore exists within a polycontextural reality. In the following case study we explore the extent to which public health can span other systems. A recent approach taken in South Australia (SA) to address the social determinants of health demonstrates the reality of integrating public health into the policy agendas of many sectors. Drawing on Luhmann’s systems theory, and discussions of the reality of a polycontextural society, we approach and discuss why policy does not often engage with evidence-based research on prevention.

'Health in All Policies'

It has long been recognised by individuals working in the health sector that the primary means for affecting change in the social determinants of health are outside the realm and control of the health sector (Williams and Broderick 2010; Ollila 2011). This recognition has led to a call for policy, across government sectors, to incorporate health in all policies. For example, city planners are called to consider walkability, green space and appropriate lighting in housing developments to make safer, more active communities. This approach to addressing the social determinants of health is the fundamental principle guiding a recent policy development in SA referred to as *Health in All Policies* (Kickbusch and Buckett 2010). The policy suggests that policy decisions in all sectors (housing, environment, economy) will, and do, influence health. Accordingly, across all sectors 'health' should be a priority (Puska 2007).

The above use of the word 'priority' was done so purposely – it is the very nature of those in health promotion, and rightfully so, to view health as a priority – it is what we do, what we live, our logic and our language. It is one of the reasons why Pelikan (2007) is quite accurate to describe public health as a social movement. Indeed, the language used to discuss the social determinants of health has changed over the past four decades and key concepts (inequity, inequality, health promotion) in public health differ according to the sector within which they are spoken (policy, research) (Lavis 2002). Consequently, approaching policy-makers and asking them to prioritise health in a non-health-focused sector is problematic and has been regarded as 'health imperialism' (Glouberman 2001). The key issue to implementing *Health in All Policies* is to develop strategies designed to have impact on the social determinants of health that are understood and accepted by other policy domains, sectors of government and the community as well. However, in doing so, it must be recognised, and thus part of the strategy, that the social determinants of health or population health agendas are not central to every monocontexture and therefore unlikely that integrating health will be a priority (Williams and Broderick 2010). As a way of overcoming this, the SA government explored policy options that contribute to the goals of non-health sectors while also improving population health (Kickbusch and Buckett 2010). The result was a commitment to a *Health in All Policies* approach (Lawless et al. 2012), the aim of which was to get the health sector to work alongside all sectors and agencies to identify how policy impacts health (Kickbusch et al. 2008). This approach is based on the premise that public policies in all sectors influence the determinants of health and it is therefore necessary to look at the ways to make public policy positive for population health. Central to this initiative is effectively communicating with policy sectors about how health is constructed by non-medical determinants and how policies and interventions can be amended to address them (Ollila 2011).

Health in All Policies acknowledges the need for policy options to benefit all sectors – if health is to be integrated into all policies, other sectors need to mutually benefit. However, in order for this to occur, it must also be recognised that the lack of engagement between public health researchers and policy-makers may result from ineffective communication. Both sectors emanate from different discourses, or what Luhmann refers to as 'closed systems'. The language (semantics) used in each of these sectors is unique, prohibiting understanding regarding the central aims of the individual sectors. Each individual system uses a specific language and logic and way of achieving their desired outcomes. Consequently, one system cannot be controlled or steered directly by a different system – policy-makers cannot be steered by the logic, language and desired outcomes of public health researchers. The SA model of *Health in All Policies* has been predicated on the notion of effective communication between systems. In theory, discussions with other sectors should focus on the mutual benefit of healthy political agendas. SA Health has been mindful of the dangers of dominating partnerships and consequently taken a collaborative approach (Lawless et al. 2012).

The case study and extant literature on inter-professional collaboration leads us to question how communication between varying discourses might be mediated and made more effective (Palmeri 2004). The idea of the polycontextural society becomes relevant when approaching the lack of communication between public health researchers and policy-makers. Functional systems, being monocontextural, view the world differently. Teubner (2000) suggests that in a polycontextural reality, the interaction between systems becomes the site of a multiplicity of different 'discursive' projects from a number of different social realities. For example, the incorporation of a community centre in a new subdivision plan may be understood by the health sector as a space for community programmes to increase physical activity, social inclusion and social cohesion. The benefits for population health are foreseeable. However, in order for the community centre to be built, the sectors responsible for zoning and housing developments need to see the potential benefits. The role of the public health sector is then to demonstrate that the inclusion of a community centre will also serve the interests of other systems involved. In this example, developers may see a community centre as a feature that is likely to sell more homes. The result is mutual benefit – more houses are sold (beneficial for developers) *and* the community is more inclusive (beneficial for the health sector). In this respect, integrating health into housing policies does not produce simply a health priority. The following section moves on to discuss approaches to addressing system differentiation through what Luhmann refers to as structural coupling.

Structural coupling: Addressing miscommunication in a polycontextural reality

The preceding case study highlights the need for a guide to navigate social systems to facilitate and promote communication between systems. Evaluation to date suggests that *Health in All Policies* is a promising means of moving the agenda from policy rhetoric to policy action. However, it remains difficult to measure the process of *Health in All Policies* (Greaves and Bialystok 2011; Storm et al. 2013) and consequently to determine the extent to which initiatives such as *Health in All Policies* will impact population health. This case study provides a vehicle for discussing the application of Luhmann's social systems theory. Luhmann's framework allows us to better understand how the introduction of a health code throughout different systems can result in complex interactions that in turn produce differential effects. As noted, despite the boundaries that exist within and across social systems, ultimately they mutually interact and are mutually inter-dependent. Herein lies the solution that Luhmann refers to as 'structural coupling' (Luhmann 1997; Van Assche and Verschraegen 2008). This is clearly identified in the use of biomedical research and the translation into practice in hospitals – structural coupling is formed between a university (research) and healthcare (the hospital). The notion of structural coupling works precisely because the functions of these systems are different, while working towards a common goal – a university, for instance, establishes a structural coupling between the healthcare and the scientific system by simultaneously making decisions in the world of scientific research and the world of healthcare. The problem with public health research and the integration into policy is that the communication between systems is not yet coordinated – structural coupling does not exist. Ollila (2011:14) suggests that one strategy to facilitate what we are referring to as 'coupling' is to place an emphasis on systematic cooperation of the health sectors with other sectors: 'In contrast to the health strategy, the health sector does not stress its own aims and objectives, but advances the health aims through its systematic approach to cooperation'.

Van Assche uses the following example in his discussion of structural coupling within planning which can be understood in relation to healthcare:

> A planning firm not only makes economic decisions concerning payments and future profits, it also makes aesthetic decisions about design, legal decisions about zoning plans and political decisions about how to react to other political decisions. The structural couplings made by organisations (such as planning firms) do not destroy the operative autonomy of the coupled systems, because what is economically profitable, aesthetically pleasing or legally correct will still be determined by reference to the recursive network of economic, aesthetic or legal communications, respectively. *Yet, the couplings represent a possibility to coordinate different processes*

> *of communication . . . and to influence the conditions of the operations of other function systems* (Van Assche and Verschraegen 2008:274, emphasis added).

In the same sense, within the realm of health, communication needs to be coordinated so that all systems see the benefit. With regard to *Health in All Policies*, at present, very little of what is offered by public health researchers is incorporated into the decisions of policy-makers. What is successfully translated are the interests of health economists, powerful interest groups such as the *Australian Medical Association* and scientifically based research. The coupling that exists between those systems and policy has been developed and thus translation occurs.

An alternative perspective is offered by Austrian philosopher Ludwig Wittgenstein, whose work also identifies a pragmatic solution to difficulties in communication. Wittgenstein proposes that consideration needs to be given to the contextual detail in which language is used – the premise being:

> . . . there is no formal system of the rules of language that accounts for every use of a word or phrase. Rather, words and phrases acquire particular meaning in particular situations, and language evolves as our use of it changes (Greenhalgh et al. 2011:543).

Wittgenstein's work (2009:26) is of relevance to the case of research translation in that he regards the 'active use' of language as what is meaningful to study in social action (Greenhalgh et al. 2011). It is only when there is concurrence in the language used between and within other systems that engagement between systems becomes possible.

Both Luhmann's notion of structural coupling and Wittgenstein's discussions of communication can be facilitated by what, albeit abstract, Teubner refers to as 'contracts'. Contracts can be used to bind together often conflicting fields of action. The contract is a 'conflictual relation between colliding discourses, language games, systems, textualities, projects, trajectories' (Teubner 2000:405). Teubner (2000) suggests that contracts between systems have to take into account the plurality of discourses. The contract is used to exploit the desires and energies of the partners, for the purpose of achieving the contractual end.

Teubner (2000, 2007) claims contracts produce an obligation for the simultaneous transformation of these discourses towards achieving very different projects. To address the issue of mis- or poor communication, the contract is inter-discursive, whereby it facilitates communication between structures, albeit their use of competing or diverse discourses. This is a productive use of the idea of polycontexturality, whereby a contract can serve several purposes and a common goal is achieved (Teubner 2000, 2007). The notion of the contract is an example of what Teubner refers to as 'ultracyclical linkages' (Teubner

2011). The contract sets into motion an 'ultracyclical movement between different social systems' (Teubner 2000:409), whereby the system boundaries are transcended as social systems translate their 'languages' into each other as a means of making use of each other.

An example of the success of *Health in All Policies* (HiAP), and the role of structural coupling in facilitating communication between sectors, can be found in Canada. The National Collaborating Centre for Healthy Public Policy (Quebec 2010) recently produced a document on healthy food policy that introduces the need for a multi-sectoral approach to influencing individuals to make healthy food choices. In line with HiAP, they recognise economic, environmental and social factors that influence access to healthy food. As such, all sectors involved within food systems (production, transport, distribution, marketing) must be governed by 'Healthy Food Policies'. In order to facilitate this process, the institute has introduced Food Policy Councils (FPCs) which are made up of stakeholders from across the food system. Their role is to look at the operations of the food systems and provide policy recommendations on how to improve the system (National Collaborating Centre for Health Public Policy 2011). In this sense, the FPCs attempt to act as a mode of communication between sectors or monocontextures. Although they do note challenges for the stakeholders in navigating organisational structure, they have seen many successes stem from such agendas (see examples of specific initiative from across Canada at National Collaborating Centre for Health Public Policy 2011).

Concluding comments

Luhmann's social systems theory provides a foundation from which to understand the problematic communication between competing sectors. Additionally, from a social systems theory approach, we understand that structural coupling and the use of inter-discursive contracts may be a means of developing policy which works in favour of cross-sector agendas. Despite the value of Luhmann, Wittgenstein and Teubner's theoretical positions in understanding and approaching this issue, social theory remains abstract and the way in which one might broach the issue is obscured. A way forward is to operationalise their ideas and identify strategies for coupling.

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Chapter 23

Jürgen Habermas: Health and Healing Across the Lifeworld–System Divide

Graham Scambler

The German critical theorist Jürgen Habermas inherited the mantle of spokesperson for the 'Frankfurt School' from its founders Horkheimer and Adorno via an impressive tranche of scholars and activists, including the likes of Herbert Marcuse. He has played the classic role of the engaged intellectual. He has developed a distinctive philosophical sociology and 'theory of communicative action' encompassing structural, cultural and personal change through the transition to modernity; he has regularly entered the public arena to exchange views and to debate; and he has endeavoured to intervene in politics and policy-making, recently on the future of Europe. This chapter begins by putting his life's work into the context of time and place. The middle sections are committed to (1) a discussion of his early work, notably on the structural transformation of the public sphere and crises of legitimation; (2) a critical exegesis of his later philosophy and sociology of modernity, culminating in the 'de-coupling' of lifeworld and system that underpins his theory of communicative action; and (3) an examination of the extension of his theory of communicative action to accommodate a 'discourse ethics' and deliberative democracy. The remainder of the chapter spells out the relevance of this extensive body of work to issues of health and healing. Examples are given of how Habermas' studies have already made a significant impact on the sociology of health and healthcare, and the chapter concludes with a consideration of potentials yet to be realised.

Intellectual biography

It is easier to contend that Jürgen Habermas' career falls into phases than it is to discern those phases. In his biography at the turn of the century, Matustik (2001) outlines three such periods: 'liberation to restoration' (1945–1959); 'incubation to revolt' (1960–1969); and 'revision to hope and back again' (1970–2000). Habermas, who was born in 1929 and raised by a father with Nazi sympathies, was 15 when Nazi Germany was defeated and for Matustik his birthday on 15th May marked an existential rupture: he and his teenage peers began, slowly and haltingly, to take stock and to look *forwards* to cultural renewal. He was in the Hitler youth and had been sent to man the Western defences. The 'liberation' *compelled* reflexivity: his pre-given world was for the first time subject to interrogation. The reality of Auschwitz seeped through. In his *gymnasium* studies he began to read Marx, Engels and the dramas of Sartre. He went on to study at universities in Gottingen, Bonn and Zurich, encountering Heidegger, Lukacs and the philosophical works of Sartre and de Beauvoir. His PhD dissertation at Bonn University was on Schelling. Habermas attended the Freud lectures and discovered Marcuse's early essays, becoming Adorno's 'first assistant' in the same year. There he became familiar not only with the work of Adorno and Horkheimer but also that of Bloch, Benjamin, Durkheim, Marx, Parsons and Weber. Having established himself as a philosopher, Habermas was now versed also in European sociology. His heady involvement in the anti-nuclear movement and the interpretation of Marx alienated him from Horkheimer however, and he left Frankfurt in 1958 for a fresh start with Abendroth at Marburg.

In 1962 Habermas was named Extraordinary Professor of Philosophy in Heidelberg; but two years later he was back in Frankfurt, succeeding Horkheimer as professor of philosophy and sociology. This was the decade of Marcuse's growing influence and of student rebellion (*One Dimensional Man* was published in English in 1964 and *Repressive Tolerance* in 1965). Habermas was heavily involved in public meetings, and in Hannover on 9th June 1967, during a session with student leader, Rudi Dutschke, he warned against student *actionism*, or 'Left Fascism'. During 1968, the climatic year of student revolt (during which Frankfurt's Sociology Department was occupied by students and Adorno called in the police), he published his 'Five Theses on the Direction and Aims of the Student Movement', distancing himself, alongside Adorno, from Marcuse's siding with the students.

In 1971, Habermas left Frankfurt to co-direct the Max Planck Institute in Starnberg. At the close of the decade (1979) Marcuse died in Starnberg after visiting Habermas, and Dutschke died too (Habermas giving the eulogy). In 1980 Habermas received the Adorno Prize in Frankfurt, and in 1982 he returned there as professor of philosophy and sociology. His first lecture was on the roles of science and politics, critical to the student movement, and he went on to defend non-violent civil disobedience. In 1989 the Berlin Wall came down, followed in 1990 by the unification of East and West Germany. Although Habermas retired in 1994, he continued to speak out. Indeed, in the years since the turn of the century, which takes us beyond Matustick's account, he has not only publicly debated events like the Gulf War, 9/11, the invasions of Iraq and Afghanistan and the travails of the Eurozone, but turned his academic attention to issues of post-national constitutionality and governance, not least in Europe. But it is time now to put flesh on the skeleton of his career to engage with his impressive body of theory.

An unfolding project of modernity

Early work

Excellent exegeses of Habermas' work are available, which allows us to focus here on those major texts of salience to the sociology of health and healing (McCarthy 1978; Rehg 1994; Outhwaite 1996). The first thing to note is that Habermas did not share the post-war gloom of his Frankfurt mentors, Horkheimer and Adorno (Horkheimer and Adorno 1982). He rejected their equation between rationality and what Weber characterised as *Zweckrationalitat* or 'instrumental rationality'. Instrumental rationality, in his later work *system* or *strategic rationality*, refers to the form of rationality that governs means-to-ends. He was later to contrast this with *lifeworld* or *communicative rationality*, which refers to rationality oriented to common understanding and consensus. Critically, communicative rationality also embraces exposing and reflecting on the 'hidden' assumptions behind our world views, including the norms they embody, and subjecting them to inspection and interrogation. Instrumental rationality, he maintained, simply took these hidden assumptions for granted.

His first major book was *The Structural Transformation of the Public Sphere*, published in German in 1962 (and which arose out of an 'Habilitation' thesis which failed to satisfy Adorno but was supported by Abendroth) (Habermas 1989). It was a dissertation that hinted at a way out of the gloomy predicaments and prognostications that characterised *Dialectic of Enlightenment*. In it Habermas traces the origins of 'public opinion' back to the bourgeois public sphere emergent in eighteenth-century Europe. It was in this period, he argues, that a literate bourgeois public started to become 'politicised', debate contemporary issues and question those in authority. The clubs, coffeehouses and salons that opened from the early 1700s onwards afforded succour and support to an increasingly free press, resulting in a critical forum 'in which gentlemen independent of the court and other political institutions could get together on a basis of relative equality and discuss the great events of the day' (Outhwaite 1996:8). This *ideal* of the rational, informed discussion of public policy was to run 'like a red thread' through Habermas' life works.

Habermas was aware that this European prototype of the 'public use of reason' was compromised from the start, not least by class and gender. He also noted early tendencies towards commercialisation, going on to argue that the public sphere of the lifeworld was subsequently to undergo a rapid transformation or 're-feudalisation'. The principle of critical publicity became progressively diluted with the expansion of the role of the state, culminating in 'welfare statism', and the emergence of large private businesses and of the mass media. While once the press *informed*, or mediated, the reasoning process, it later came to *form* it. The political process also changed, a cleavage opening up between party activists and passive electorates. Public opinion was no longer an enabling or constraining source of critical judgement but a socio-psychological variable to be manipulated. In brief, the public sphere was 'smothered through colonisation by instrumental reason' (Beilharz 1995:57). In some ways, this seems reminiscent of *Dialectic of Enlightenment*, but Habermas remains more cautious and less pessimistic than his Frankfurt mentors.

During the 1960s, Habermas published four further books in Germany. *On the Logic of the Social Sciences* provided an innovative and critical survey of the methods used in the social sciences in the mid-1960s (Habermas 1990b). *Theory and Practice* was a collection of pieces on the relationship of theory and practice in the social sciences (Habermas 1986), incorporating an early attempt to critically appropriate Marxism that featured the distinction between 'work' or 'labour' and 'interaction'. Marx, Habermas claimed, had failed to make this distinction and had as a result neglected interaction; the consequence of this was a reduction of communicative action to instrumental action. This encouraged a 'mechanistic' interpretation of the relationship between the forces and relations of production that undermined it as an explanatory theory and as a theory of human liberation. Habermas (1986:169) writes:

> ... to set free the technical forces of production ... is not identical with the development of moral relationships in an interaction free of domination ... *Liberation from hunger and misery* does not necessarily converge with *liberation from servitude and degradation*; for there is no automatic developmental relation between labour and interaction.

Towards a Rational Society was published in Germany in 1968 and dealt, aptly enough, with student politics among other issues (Habermas 1986a). The distinction between labour and interaction again featured, as did the neglect of the latter. Habermas also bemoaned the 'scientisation of politics', whereby putatively scientific resolutions were advocated for conflicts of value. Students, he hoped, might contest this 'technocratic background ideology' of depoliticisation.

Knowledge and Human Interests, another product of 1968, offered a synthesis of previous reflections (Habermas 1986b). He picked up on an earlier claim that the historical generation of knowledge is:

> ... structured by universal and a priori 'cognitive interests' that are features of the human 'species being', essential characteristics of human life. These cognitive interests ... are transcendental 'knowledge-constitutive' interests that guide the search for knowledge. They are fundamental and invariant orientations to knowledge and action that are rooted in the universal

> conditions and circumstances of the evolution of the human species, understood as a process of 'self-formation' (Scott 1995:231).

The conceptual distinction between work or labour and interaction remains central here, but is augmented by a third form of action, 'domination'. A threefold categorisation emerges. First, the *empirical-analytic* sciences are governed by a technical concern with the prediction and control of objectified processes: 'the facts relevant to the empirical sciences are first constituted through an a priori interest in the behavioural system of instrumental action' (Habermas 1986b:109). Second, the *historical-hermeneutic* sciences are governed by a practical interest in human understanding. And finally, the *critical-dialectical* sciences, like psychoanalysis and the critique of ideology, are oriented to emancipation from domination. It was a categorisation that Habermas was later to question on the grounds of circularity: social theory must provide the grounds for a theory of knowledge, while this theory of knowledge must itself provide the foundations for social theory.

'Problems of Legitimation in Late Capitalism', translated as *Legitimation Crisis* (Habermas 1976), was an analysis of capitalism within the Marxist fold, but one that suggested that, unlike liberal capitalism, late capitalism was susceptible to a multiplicity of possible crises. The state, he argued, attempts to 'iron out' the peaks and troughs of the business cycle and to contain the opposition between wage labour and capital in pursuit of 'a partial class compromise'. But this state intervention carries risks. The potential economic crises faced in late capitalism that are 'managed' by the state are not thereby expelled from the social system but merely displaced into other spheres.

State intervention courts a crisis of legitimation in that it leaves the state responsible for managing the economy. According to Habermas, an authentic legitimation of late capitalism is not possible because of the continuing existence of its class structure. Even in times of growth – that is, in the absence of crisis – the fundamental contradiction between the social processes of production and the private appropriation and use of the product remains. The system is geared not to 'generalisable interests' but to the private goals of profit maximisation.

A legitimation crisis arises out of a crisis of motivation, or 'a discrepancy between the need for motives declared by the state, the educational system and the occupational system on the one hand, and the motivation supplied by the socio-cultural system on the other' (Habermas 1976:74–5). A motivation crisis occurs when changes in the socio-cultural system are such that its 'output' becomes dysfunctional for the state and the system of social labour. The motivations central for late capitalism are (a) the mass loyalty associated with formal or parliamentary democracy, and (b) family and career orientations suitable for status competition (respectively, 'civil and familial-vocational privatism').

The last volume to be mentioned in this section is *Communication and the Evolution of Society*, published in Germany in 1976 (Habermas 1991). This is a wide-ranging collection covering work on language and speech acts, psychological and moral development and social evolution. These are all themes to which Habermas returned, so they are revisited in the next part of this chapter.

Theory of communicative action

Only select core themes of the two-volume *Theory of Communicative Action*, published in Germany in 1981 (Habermas 1984, 1987), can be summarised here. One criterion of selection is their salience for later critical theoretic contributions to the sociology of health and healthcare. They are the reconstruction of the Enlightenment project by means of a theory of communicative action; a social theory of evolution; the uncoupling of system and lifeworld; and system and lifeworld rationalisation.

A reconstructed Enlightenment project/theory of communicative action

At a growing pace through the 1970s and afterwards, Habermas was committed to refashioning the ideas behind the European Enlightenment. He rejected Weber's concepts of rationality and rationalisation as overly restrictive and insufficiently abstract. By contrast, he espoused the universality of reason. His defence of the notion of universal reason involves a formal or procedural concept of rationality owing much to the linguistic turn in Anglo-Saxon philosophy in the twentieth century. Reason, he argued, issues not from the subject–object relations of philosophies of consciousness, but from the subject–subject relations of communicative action. People's use of language implies a common endeavour to attain consensus in a context in which all participants are free to contribute and have equal opportunities to do so. Language use, in short, presupposes a commitment to an *ideal speech situation* in which discourse can reach its full potential. It is a claim that recognises no historical limitations. The idea of rationally motivated shared understanding – and rational motivation implies a total lack of compulsion or manipulation – is, Habermas maintains, built into the very reproduction of social life. The symbolic reproduction of social life is based on the 'counterfactual' ideal of the ideal speech situation, which is characterised by 'communicative symmetry' and a compulsion-free consensus (see Scambler 1996). This concept of communicative action is bound up with Austin's (1962) notion of speech acts, to which we return later.

A theory of social evolution

Evolution for Habermas is a learning process for the human species. He even draws parallels between personal and social learning. We have seen that he contests relativism by arguing that the canons of rationality, or the modes of reaching warranted conclusion, are the same everywhere. This allows individuals and cultures to be located on scales of evolutionary development using 'cognitive adequacy' as the criterion. He cites Piaget's discernment of stages of cognitive development in children; and in a similar vein he proposes three stages of cultural development or evolution: the 'mythical' (as found in primitive societies), the 'religious-metaphysical' (as found in traditional societies) and the 'post-conventional' (as found in modern societies). Primitive cultures were dominated by myth and were typically 'closed' and refractory to change: the institutional arrangements for public engagement were lacking. Rationality was expanded with the spread of religions like Buddhism, Hinduism, Islam and Christianity that contributed the rationalisation of culture. Modern capitalism, Habermas contends, is characterised by post-conventional cognitive domains and forms of social organisation. He is far from uncritical of capitalism; he does see gains in the potential for human enlightenment.

The uncoupling of system and lifeworld

The lifeworld does not admit of easy definition. It cannot be 'known' since it is the vehicle of all knowing. We cannot step beyond its borders. However, as Sitton (1996:169) states:

> ... although the lifeworld *as a whole* (my emphasis) can never be placed in question, elements of the lifeworld can be and are placed in doubt. In these cases, the element is 'thematised', made subject to argument as the participants attempt to re-establish their mutual definition of the situation, a prerequisite for successful cooperation.

The lifeworld can be reproduced through communicative action but *not* through instrumental or 'strategic' action. The lifeworld is for Habermas the medium or symbolic space within which culture, social integration and personality are nurtured and reproduced.

The system addresses material rather than symbolic reproduction. It is characterised by strategic rather than communicative action. In a manner reminiscent of Parsons, Habermas argues that societal differentiation has delivered four 'sub-systems': the *economy*, the *state* (comprising the system), and the *public sphere* and the *private sphere* (comprising the lifeworld). We have witnessed an uncoupling of system and lifeworld in modernity. These four sub-systems are interdependent. The economy produces *money*, the state *power*, the public sphere *influence* and the private sphere *commitment*. In the words of Crook et al. (1992:28):

> ... the economy relies on the state to establish such legal economic institutions as private property and contract, on the public lifeworld to influence

consumption patterns, and on the private lifeworld to provide a committed labour force, and itself sends money into each other sub-system.

System and lifeworld rationalisation

The capacities of the four sub-systems are not equivalent. With social differentiation has come a separation or de-coupling of lifeworld and system, with the latter coming to dominate the former. Habermas writes in this context of the *colonisation of the lifeworld* by the system. Drawing on Marx and Weber, he claims that the lifeworld has become bureaucratised and commercialised. This means that the possibilities for communicative action have become attenuated as people's dealings with each other have grown increasingly strategic or instrumental. System rationalisation, in short, has outstripped lifeworld rationalisation (the impact of this macro-change on meso- and micro-interaction is addressed later). Occidental rationalisation has been 'selective'. Unlike Weber or Horkheimer and Adorno, however, Habermas neither sees this as inevitable nor irreversible. Rationalisation in the West is contingent. The 'logic' of development allows for what he calls a rationalisation of the lifeworld, namely an extension of the scope for communicative action and communicative rationality. In other words, lifeworld *de-colonisation* is possible. Even Habermas finds optimism hard to come by, but he does suggest that the most likely agents of lifeworld rationalisation are what in Europe are called 'new social movements' (as opposed to 'old' class-based movements); he shows particular faith in the women's movement.

Discourse ethics and deliberative democracy

Habermas' (1990a, 1993, 1996) discourse ethics represents a continuation or deepening of his theory of communicative action. A 'principle of universalisation' implicit in Mead's notion of 'ideal role-taking' lies at its core. Every valid norm, the argument runs, has to fulfil the following condition: '*all* affected can accept the consequences and the side effects its *general* observance can be anticipated to have for the satisfaction of *everyone's* interests (and these consequences are preferred to those of known alternative positions for regulation)' (Habermas 1990a:65). This principle should be distinguished from the 'principle of discourse ethics', which states that 'only those norms can claim to be valid that meet (or could meet) with the approval of all affected in their capacity *as participants in a practical discourse*' (Habermas 1990a:66). The principle of universalisation concerns 'moral' questions of 'justice' and 'solidarity', which allow for formal universal resolution; the principle of discourse ethics concerns 'ethical' questions of the 'good life', which can only be addressed in the context of substantive forms of life, cultures or individual aspirations or projects.

Discourse ethics privileges moral questions; and justice and solidarity are necessarily related to communicative action. Justice refers to the 'subjective freedom of inalienable individuality', and solidarity to the well-being of those who participate in the same lifeworld community (Habermas 1990a:200). According to Habermas, morality cannot underpin the rights of the individual without simultaneously underpinning the well-being of his or her community. If discourse ethics grounds morality, however, *it does not resolve substantive issues*.

Just as Habermas' theory of communicative action 'suggests' a discourse ethics, so the latter suggests a concept of deliberative democracy. This comes down to the idea that the legitimacy of political authority can only be accomplished via public participation in deliberation and decision-making (there is an 'internal relation' between the rule of law and popular sovereignty). Habermas seeks to go beyond both classical liberalism and communitarianism, both of which privilege the moral over the legal, by arguing that morality and law stand in a 'complementary relation', and moreover that the core human rights enshrined in legal orders are essentially legal, not moral, rights. The state polices such rights, but its legitimacy in doing so derives from the public use of reason (as articulated in a 'vibrant' civil society and public sphere). In his more recent pronouncements on the increasingly global or post-national world we inhabit, Habermas advocates a transnational form of republicanism, writing – at least before the current crisis within the 'Eurozone' and the emergence of what Beck (2013) calls a 'German Europe' – of the potential for a 'republican Europe' (Eriksen and Weigard 2003). It is in this context that he has regularly engaged in analyses of world events such as 9/11 and the subsequent invasions of Iraq and Afghanistan. One further work should be mentioned – *The Future of Human Nature* (Habermas 2003). Based on three talks, this deals with advances in genetics and genetic interventions and their implications for identity-formation and the self-understanding of the species. Human nature, he maintains, is no longer 'given'; we are becoming part of it, just as we have become part of the planet we live on; and we are only now beginning to fathom what this might mean.

Health and healing

Given the breadth and depth of his philosophical and sociological enquiries and interventions over many years, it is perhaps surprising that medical sociologists have made relatively little use of Habermas' studies. Maybe this neglect is in part due to his silence on health and healthcare (if not on welfare regimes) and the inaccessibility of his writings (Scambler 2001). Within the confines of this chapter it will be necessary to be selective, and I have opted for a threefold focus. The first discussion revolves around the doctor–patient encounter and draws on Habermas' macro- and micro-theories; the second switches attention to healthcare systems; and the third revisits the concepts of civil society and the public sphere in relation to health policy and reform.

Doctor–patient interaction

An early attempt to apply the theories of Habermas to doctor–patient interaction focused on pregnancy and childbirth (Scambler 1987). It was suggested that obstetricians in Britain, the United States and elsewhere were from the 1970s on unwitting agents of lifeworld colonisation. Notwithstanding evidence to the contrary, they had come to believe that a good or safe birth was one occurring in hospital and utilising the latest technology; and they transmitted this conviction to mothers-to-be. In Mischler's (1984) terminology, the 'voice of medicine' trumped the 'voice of the lifeworld'. In a later, more general contribution, this analysis was extended to more routine consultations with generalists (Scambler and Britten 2001). What are the nuts and bolts of this thesis?

C. Wright Mills (1959) famously proclaimed that 'personal troubles' must be understood in terms of social structures. Waitzkin (1989:221) elaborates on this theme: 'structures of society help generate the specific social context in which patients and doctors find themselves'. Habermas' 'formal pragmatics' (arising out of Austin's (1962) analysis of speech acts) is pertinent at this point. Austin distinguished between 'locutionary' speech acts (that is, saying *something*), 'illocutionary' speech acts (that is, to act *in* saying something: 'I promise . . . '), and 'perlocutionary' speech acts (that is, to bring about something *through* saying something) (Habermas 1984:288–9). Communicative action, for Habermas, is linguistically mediated interaction in which all speakers pursue illocutionary aims to reach an agreement that will support a 'consensual coordination of individually pursued plans of action'. Strategic action, on the other hand, occurs when at least one speaker aims to produce perlocutionary effects on his or her hearers. Perlocutionary effects ensue 'whenever a speaker acts with an orientation to success and thereby instrumentalises speech acts for purposes that are contingently related to the meaning of what is said' (Habermas 1984:289). Communicative action is oriented to consensus; strategic action to success.

A sentence or two of elaboration is necessary here. Simple requests or demands are illocutionary acts with which the speaker 'openly' purses his or her aim of influencing the hearer/s, and with which a power claim may be associated. The speaker pursues illocutionary aims unreservedly, but nonetheless acts with an orientation to success. Habermas refers to this as *open strategic action*. When speakers employ speech acts for perlocutionary purposes, this is called 'concealed strategic action'. With both of these, the potential for the binding (or bonding) force of good reasons remains unexploited. This potential is only realised in communicative action, when illocutionary acts express 'criticisable validity claims' (concerning truth, appropriateness and sincerity). What Habermas calls 'communication pathologies' arise when there is confusion between actions oriented to understanding and consensus and actions oriented to success. Instances of concealed strategic action might involve either *conscious deception* or *unconscious deception*. In cases of the former at least one of the participants acts with an orientation to success, but allows the other/s to assume that all the conditions for communicative action are being met. This is a form of manipulation. With unconscious deception, however, at least one of the participants is deceiving him or herself about the fact that he or she is acting with an orientation to success and is only 'keeping up the appearance of communicative action' (Habermas 1984:332).

The relevance of this formal pragmatics for a sociology of doctor–patient interaction is evident. The old-style paternalistic doctor ('I'm the doctor, I know best') is engaging in open strategic action. As this style has become progressively less acceptable in routine or non-emergency consultations, Habermas' analysis of concealed strategic action has grown in salience. As we have seen, this embraces conscious deception or manipulation, as when a doctor deploys abstruse terminology to intimidate a patient, and unconscious deception or systematically distorted communication, as when neither doctor nor patient is aware that strategic rather than communicative action prevails. The notion of systematically distorted communication allows for doctors (not uncommonly) or patients (more rarely) to act with an orientation to success, not understanding, *but yet sincerely and in good faith*. It is a notion particularly useful when considering the impact of system rationalisation/colonisation on one-to-one encounters.

Healthcare systems and lifeworld colonisation

While the post-war period of 'organised', Fordist or welfare statist capitalism was characterised by state engagement in healthcare, the present phase of financial, post-Fordist or post-welfare statist capitalism is epitomised by the involvement of private or for-profit providers of healthcare services. Some have documented a ubiquitous or global neo-liberal assault on welfarism; others have cited the failure of Clinton's plan to reform US healthcare in the early 1990s or the obstacles facing 'Obamacare' at the time of writing; while others have focused on the privatisation of the National Health Service (NHS) in England and Wales.

To pick up on the last of these, there have been a series of NHS reforms since Thatcher's time in office (that is, post-1979), many of which have promoted private sector involvement in what from 1948–1979 had been close to a public sector monopoly. These reforms (neo-liberal mark I – Thatcher and Major, 1979–1997; II – Blair and Brown, 1997–2010; and III – Cameron/Clegg (2010–) have grown more ambitious and radical over the last generation. They have also privileged *policy-based evidence* over *evidence-based policy*. Major's introduction of the Private Finance Initiative (PFI) in 1992 delegated the building of new hospital and other healthcare facilities to the private sector, who then leased them back to the NHS, often at exorbitant rates on the back of 20–30 year deals. The advantage to government was that the rebuilding programme did not appear on its books. This has proved a predictably expensive way of getting new buildings 'on the cheap'. New Labour pursued this same tactic with a vengeance. At the time of writing healthcare authorities are experiencing crippling indebtedness.

The Cameron-led coalition government post-2010, however, has delivered a full-frontal assault on the NHS via a Health and Social Care Act, passed in 2012. Health authorities already over-stretched by PFIs and committed to making savings from 2011–2014 under a New Labour initiative dating back to 2009, now faced challenges from acquisitive, for-profit businesses. This Act marked a radical re-commodification of healthcare in England. Scott-Samuel's (2012) predictions are already coming to pass:

- the NHS will become a publicly funded budget and a brand name for a subcontracting operation for competing private organisations, subject to European competition laws which will allow private companies to predominate over other – third party – providers;
- the post-credit crash NHS has a more-or-less fixed budget, so services of 'low clinical priority' will cease to be free;
- this will lead to a market for health insurance, affordable for the affluent, which will drive up costs (administrative, fees, private profits); and
- personal health budgets will lead to personal charges as commissioning groups will operate on an individual basis in order to be compatible with the insurance companies (*no more population-based polling of risk*).

Both the lobbying against the de-commodification of healthcare in the United States and the re-commodification of the NHS can be cast as examples of the colonisation of the lifeworld by the system. Scambler's (2012) thesis that financial capitalism has witnessed the emergence of a new *class/command dynamic* in Britain illustrates this. He contends that in financial capitalism those comprising the largely transnational financial and business elites hold greater sway over the more national political elite than was the case in the post-war period. In short, class actors (representing sub-system of the economy) 'buy' more 'power' than hitherto from command actors (representing the sub-system of the state), and are thus able to force policy changes like the re-commodification of the NHS. Evidence-based policy is transmuted into policy-based evidence in the process.

Civil society and the public sphere

Civil society and the public sphere of the lifeworld are often deployed as synonyms. Building on Habermas' work, however, Scambler and Kelleher (2006) not only differentiate them but distinguish between two sectors of civil society. They argue that the seeds of resistance and mobilising publics are planted in the *enabling sector* of civil society, which is located in the private sphere of the lifeworld. It is in casual meeting places or 'third places' like pubs, cafes and so on that early decisive conversations often occur. The *protest sector* of civil society is located in the public sphere of the lifeworld; it is here that the impulse to resist turns into coordinated action (via embryonic social movements). Referring back to the business lobbying, party political manoeuvring and belated opposition to what eventually became the Health and Social Care Act, it is clear (a) that seeds sown in the enabling sector quickly germinated in the protest sector, giving rise to volatile collective action in the wake of the Arab uprisings; and (b) that the forms that action took were remarkably innovative, not least through their use of new information technologies (see Castells 2012).

Concluding comments

Germond and Cochrane (2010) introduce the notion of *healthworlds* in an attempt to add precision to discussions of health and healthcare deriving from Habermas' work. The healthworld, they contend, mirrors the lifeworld generally and intrudes into people's consciousness as a 'horizon of action'. It is a 'region' of the lifeworld linked to agency and governed by an interest in restoring, maintaining or enhancing health: it directs health-seeking behaviour. Edwards (2012) sounds a note of caution however. It is easier to distinguish the voice of the lifeworld from the voice of medicine *analytically* than it is during actual instances of interaction in the day-to-day worlds we inhabit; nor, she adds, can the voice of medicine be subsumed under notions of system thinking and rationalisation. In other words, Habermas' concepts are like Weber's ideal types or Schutz' second-order typifications; nevertheless, *they are often sociologically compelling*. Whenever a doctor talks to a patient, mixes of speech acts will be apparent; and when a healthcare system is privatised, references to system rationalisation will require a lot of unpacking. What is beyond dispute, however, is that Habermas has produced a body of work of immense depth and sophistication and one steadfastly and unfashionably dedicated to completing the unfinished project of modernity.

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Chapter 24

Pierre Bourdieu: Health Lifestyles, the Family and Social Class

Kate Huppatz

Pierre Bourdieu is a not a theorist readily associated with the sociology of health, illness and medicine. Bourdieu was very much focused on social class cultures and, while he examined the bodily dimensions of classed experience and the production of knowledge, he was generally unconcerned with health issues. Nevertheless, William Cockerham (2013a:251) observes that Bourdieu has recently become fashionable in medical sociology and his concepts 'social capital', 'habitus' and 'lifestyles' are most popular. Cockerham (2013a) claims Bourdieu's new-found popularity is an aspect of medical sociology's recent 'theoretical turn', and that his concepts appeal to medical sociologists who wish to move their thinking from 'methodological individualism' to focus on the relationship between health and social structures. Bourdieu's theory is therefore useful for 'building bridges between mainstream theory and medical sociology' (Williams 1995:601). Of particular interest for this chapter, Bourdieu theorised lifestyle practices, and his understanding of the ways in which these practices are embedded within and enact class culture helps researchers to explain the prevalence of unhealthy lifestyle practices in an era in which rich nations have unprecedented access to health education.

This chapter examines the relevance of Bourdieu's conceptual approach for the analysis of the relationship between health, lifestyles and social class, and focuses on research which seeks to understand *young people's health-related lifestyle practices in the context of family life*. It begins with an overview of Bourdieu's life, work and key concepts. It then moves on to look at what Bourdieu's theoretical approach has to offer the study of lifestyles, and in the final section, charts how his concepts have been taken up in youth health lifestyle research.

Biography

Pierre Bourdieu was a French sociologist/philosopher who was born on 1st August 1930 and died of cancer on 23rd January 2002. Very little is known about his personal life; apparently he was a shy person and a reticent public figure. However, what we do know about his biography explains much about his research focus and theoretical orientation. Indeed, he said at much in his book *Sketch for a Self-Analysis* (2007), a small publication which he described as a reflexive exercise, rather than an autobiography. In this book, where he briefly discussed his childhood and youth, Bourdieu reluctantly conceded that some detail of his formative years must be included in such an analysis because of 'the formation of the dispositions associated with the position of origin, dispositions which we know play a part, in relation with the social spaces within which they are actualised, in determining practices' (Bourdieu 2007:84). Bourdieu was the son of a farmer-turned-postman and then post-office clerk who grew up in a small town in the Bearn region of southwest France, and although he excelled at school, and was very well educated, state scholarships aided his intellectual achievements. He therefore had a rural, working class upbringing but was separated from the children of shopkeepers and peasants in his village because his father was seen as 'white collar' in his clerical position, despite his poor pay. This history informed Bourdieu's critical social analysis, particularly his interest in social class, and his epistemic reflexivity.

Bourdieu was a prolific writer, producing 25 books in his lifetime. *Distinction* (1984) is probably Bourdieu's best-known book and was named as one of the twentieth century's ten most important works of sociology by the International Sociological Association in 1998. The significance of this book is that it uniquely uses ethnographic evidence to link consumption practices to social class and therefore provides the foundation for a culturally based understanding of social class. The text is also particularly relevant for this chapter, as it focuses on the relationship between social class and lifestyles. The following discussion turns to the theoretical perspective presented in *Distinction* and also outlines Bourdieu's key concepts more generally.

Bourdieu's key theoretical concepts

Although Bourdieu published on a diverse range of issues, including (but not limited to) the education system, the Kabyle in Algeria, art, television, masculine domination and language, he maintains a clear focus throughout his work on the role of culture in the production and reproduction of power and inequality. His aim throughout his career has been to examine the production and distribution of a satisfactory life. Using empirical research, Bourdieu interrogates why life is more satisfactory for some than others. Bourdieu is also a master of polemics. He creates his theory of practice in response to the shortfalls he sees in the structuralist approach, opposing the popularity of post-modernism and supporting inter-disciplinarity.

Within his seminal work, *Distinction,* Bourdieu developed a complex theoretical approach in order to understand mundane, everyday life. The book makes use of empirical data, of surveys of the consumption practices of the rich and poor, in order to connect taste to an individual's location in the social order. In developing his theoretical approach within this book, Bourdieu seeks to overcome the dichotomisation of objectivist and subjectivist theories of class and transcend the shortcomings of Marx and Weber's approaches. He does this, within this work and his other writing, with the aid of a triad of concepts: habitus, field and capital.

Habitus

The habitus concept is perhaps the most integral to Bourdieu's theory and is defined as a set of dispositions that inform social practice and perceptions. The habitus is both a 'structured and structuring structure' (Bourdieu 1984:171). This means the habitus is constituted by an individual's history and environment, but at the same time informs practices that then have an impact on that environment. The habitus also aligns practice. As an individual shares their history and environment with others who have similar positions and dispositions, the habitus structures practices so that they are in line with the practices common to an individual's social group. A 'stylistic affinity' is produced which makes each individual 'a metaphor of any of the others' in their social class (Bourdieu 1984:173). The habitus therefore directs what is, but also what is not, 'for us', and in this way 'social identity is defined and asserted through difference' (Bourdieu 1984:172). This process occurs without any explicit coordination; this alignment of practice is a kind of 'social magic' that results in tastes, perceptions and tendencies becoming associated with class lifestyles.

All the minutia of social life, of our lifestyles, are potentially practices of distinction; they display or signal class belonging and therefore social distance or proximity between individuals, cultivating judgement or acceptance. No type of practice is off limits in this process – food consumption, exercise, parenting, clothing and makeup choices are all informed by class culture. For Bourdieu (1984:172), '[l]ife-styles are thus the systematic product of the habitus, which, perceived in their mutual relations through the schemes of the habitus, become sign systems that are socially qualified (as "distinguished", "vulgar" and so on)'. This means that although our tastes and perceptions appear to us as 'choices', they are often necessities directed by our social situation – they are either the result of a lack of resources and/or a product of membership to a social group. The classificatory system:

> . . . continuously transforms necessity into strategies, constraints into preferences, and, without any mechanical determination, it generates the set of 'choices' constituting life-styles, which derive their meaning, that is, their

> value, from their position in a system of oppositions and correlations. It is a virtue made of necessity which continuously transforms necessity into virtue by inducing 'choices' which correspond to the condition of which it is a product (Bourdieu 1984:175).

This means agents tend to 'have a taste for what they are anyway condemned to'; in this way 'Taste is *amor fati*, the choice of destiny' (Bourdieu 1984:178). This does not, however, mean that classed subjects do not have agency. Bourdieu is sometimes accused of social determinism (Jenkins 1992), because of his focus on the reproduction of class habitus and lifestyles, but for him, the practices the habitus generate are always an individual's own, subjective variant of group tendency. Classed practices are also 'regulated improvisations'; there is always potential for divergence.

In *Distinction,* Bourdieu reveals the results of his large-scale study of lifestyle practices and empirically demonstrates class taste and the workings of the habitus or 'the logic of practice'. Bourdieu finds that middle class individuals spend less of their income on food and are also less likely to buy cheap, heavy, fatty foods. However, in line with the rationale for class taste presented above, low income is not the only reason for preference for cheaper foods. For example, Bourdieu finds foremen to express working class food tastes despite earning more than clerical workers (whose tastes are in line with other middle class workers like teachers). It seems then, the:

> ... art of eating and drinking remains one of the few areas in which the working-classes explicitly challenge the legitimate art of living. In the face of the new ethic of sobriety for slimness, which is most recognised at the highest level of the social hierarchy, peasants and especially industrial workers maintain an ethic of convivial indulgence (Bourdieu 1984:179).

In the same study Bourdieu finds that clerical workers, in contrast to manual workers, consume more fish, fruit and aperitifs, but spend just as much money on meat (although leaner meat). In addition, they spend more on beauty and health products, clothing, culture and leisure activities. The affluent therefore have 'dispositions towards the future'; they sacrifice desires in the present for desires in the future. This is a rational calculation, an estimation of possibilities for the future; however, the propensity for the working classes to enjoy the present is just as rational; it 'is a recognition of the limits that define the condition' (Bourdieu 1984:183).

The tendency for healthy consumption is most prevalent among professionals and senior executives and this is because '[t]he disappearance of economic constraints is accompanied by a strengthening of the social censorships which forbid coarseness and fatness, in favour of slimness and distinction' (Bourdieu

1984:185). Tastes for food are therefore also related to class conceptions of the appropriate body; for example, while the working classes value strength in the male body and eat nutritious but cheap and heavy food accordingly, the professionals prefer lighter food that is not fattening. Taste is therefore embodied via the habitus but it also shapes the classed body; the 'natural' body is the materialisation of class culture (and thus Bourdieu also discusses the way how sporting activities are classed and further shape the body in line with class norms).

Capital

The second key concept for Bourdieu's theory is capital. Bourdieu generally refers to three types of capital: economic, social and cultural capital. Economic capital is money and all assets directly convertible to money, and it can also be institutionalised in property rights. Social capital is the advantageous social connections and obligations that come into play in class formation and is institutionalised in noble titles; while cultural capital is cultural knowledge and the competencies that exist in an objectified state (for example, in the form of books), in an institutionalised state (in the form of educational qualifications), and in an embodied state (as dispositions of the mind and body which are either cultivated through 'self-improvement' or socialisation).

According to Bourdieu, economic, social and cultural capitals have the potential to be converted into each other in certain circumstances and all three variants have the potential to become 'symbolic capital', when legitimated. Symbolic capital is the most prestigious and powerful form of capital; it 'refers to degree of accumulated prestige, celebrity, consecration or honour and is founded on a dialectic of knowledge (*connaissance*) and recognition (*reconnaissance*)' (Johnson 1993:7). While both bourgeois and working class tastes and competencies can act as cultural capital within their respective fields of action, working class tastes and competencies are very rarely converted to symbolic capital. As practices are considered more or less tasteful and legitimate than others, they are attributed varying levels of value and this variation in value relates to the class culture with which they are associated. Bourdieu (1984:176) states:

> In cultural consumption, the main opposition, by overall capital value, is between the practices designated by their rarity as distinguished, those of the fractions richest in both economic and cultural capital, and the practices socially identified as vulgar because they are both easy and common, those of the fractions poorest in both these respects.

This legitimation of certain practices over others is due to a 'misrecognition' that takes place. Both the dominant and the dominated tend to accept the 'doxic' categorisation of practices (as high/low, worthy/unworthy and so forth) as natural and legitimate, despite this being a very unnatural human invention, a product of the class system. For Bourdieu, this misrecognition means that an awakening of class consciousness, as Marx predicted, is unlikely.

The field concept and the family as field

The volume and composition of an individual's capital determine their position in 'fields' of social action. 'Field' is Bourdieu's third key concept and refers to a network of social relations. Each field is governed by its own logic, its own rules and regulations. Agents respond to the implicit rules that govern the fields in which they operate and often engage in strategies and struggle to accumulate capital and mobilise themselves within these spaces of social action. Although there is an inequality in the appreciation of capitals associated with different class cultures, the relative value of a capital also depends on the state of play in the field in which that capital is circulating. Thus it varies from field to field (and again, this means that working class competencies might be valuable in a working class field, even though they are unlikely to achieve symbolic status).

According to Bourdieu (1996:22), for the most part, the family functions as a field that contains physical, economic and symbolic relations (and these relations correspond to the form and quantity of capital that each family member possesses). The family is fundamental to the formulation of the habitus and in the transmission of capital, and this means the family also plays a part in the production and reproduction of inequalities. In particular, the family plays a key role in inculcating cultural capital through pedagogical action (Johnson 1993:7). Nuclear families and affluent families have the most symbolic power as they are naturalised so that they are seen as the universal norm, and:

> ...those who have the privilege of having a normal family are able to demand the same of everyone without having to raise the question of the conditions (for example, a certain income, living space, and so on) of universal access to what they demand universally (Bourdieu 1996:23).

This means nuclear, affluent family lifestyles are often misrecognised as the most legitimate and this is a kind of 'symbolic violence' that is enacted against poor and marginalised families. Therefore:

> ...the family plays a decisive role in the maintenance of the social order, through social as well as biological reproduction, that is, reproduction of the structure of social space and social relations (Bourdieu 1996:23).

Moreover, the state plays a role in the normalisation of certain family formations; through policy and discourse the state constitutes 'family identity as one of the most powerful principles of perception of the social world and one of the most real social units' (Bourdieu 1996:25).

Bourdieu therefore demonstrates how the symbolic intertwines with material inequalities and has much to say about the role of lifestyles, bodies, consumption patterns and families in the production and reproduction of social class. In the following section, I will examine how Bourdieu's concepts have been taken up by health and illness sociologists to make sense of one specific health issue – the relationship between social class, health and lifestyle practices, particularly for youth in the social field of the family.

Lifestyles as a health issue

Lifestyles tend to be perceived as 'healthy' or 'unhealthy' depending on the types of practices that are taken up (and the practices that are most often defined as healthy or unhealthy within the literature are food consumption and exercise). Epidemiological research correlates unhealthy lifestyles with low socio-economic status, and healthy lifestyles and longer life expectancy with high socio-economic status (Backett-Milburn et al. 2010:1316). In response to these findings, as well as growing obesity rates among children in the West, social research and policy have been increasingly concerned with young people's lifestyles (Backett-Milburn et al. 2010:1316), and as most young people are in the care of their parents, lifestyle research has also increasingly focused on the family as a site of lifestyle production (see, for example, the Australian Government's initiative 'The National Strategy for Young Australians' 2010, produced by the Department of Education, Employment and Workplace Relations, as well as Marmot and Wilkinson 2005). What is more, healthy eating for families and young people, particularly among poorer socio-economic groups, has become a concern for popular culture. This is evidenced in the TV programmes 'Jamie's School Dinners' and 'Jamie's Ministry of Food', presented by the celebrity chef Jamie Oliver.

In large part, the popular response to these concerns has been to individualise these problems. For example, Oliver skips over the structural and cultural issues that limit working class people's access to healthy lifestyles and instead suggests that change can be achieved by encouraging the poor to make the 'right' lifestyle choices through cooking and food education classes. In so doing, Oliver often makes healthy practices an issue of morality. For example, in a recent interview Oliver stated: 'You might remember that scene in Ministry Of Food, with the mum and the kid eating chips and cheese out of Styrofoam containers, and behind them is a massive TV. It just didn't weigh up' (Milward 2013). Here, Oliver clearly makes a judgement about what is a good parenting and lifestyle practice and what is not. In this way, as Hollows and Jones (2010:308) observe, Jamie Oliver has moved from 'culinary lifestyle expert' to 'moral entrepreneur' who advocates that individual citizens are responsible for the care of the self and therefore operates 'within a wider discourse of class pathologisation'.

Oliver is not alone in his approach. The wider media as well as social policy has shifted from a welfare rationality that views the state as responsible for the care of citizens, and now focuses on individual responsibility and the family as *the* site at which young people's health should be governed (Featherstone 2004). In this process the media and the state have tended to pathologise, stereotype and marginalise the experiences of low-income and lone-parent families while normalising 'the moral possibilities of White, middle class, married, heterosexual families' (Quarmby and Dagkas 2013:15). They have also tended to recreate a gender bias, where mothers rather than fathers are seen as responsible for family and child health, gendering the individualisation of responsibility (Maher et al. 2010). This is clearly problematic. While the media and policy-makers have usefully drawn attention to the everyday and family practices that impact health, an individualised approach only serves to perpetuate class-related health inequalities, as well as gender inequalities, rather than resolve them.

Health and illness researchers have also tended to overlook cultural and structural processes that impact lifestyle practices and have instead taken up 'methodological individualism' (Cockerham 2013a). For example, there has only been a minority focus on the socio-cultural processes underpinning statistics on healthy eating and socio-economic status (Backett-Milburn et al. 2010:1316). However, Cockerham (2013a) argues that there has been a recent appropriation of neo-structural approaches by medical sociologists, enabled by a recognition that agency-oriented theories cannot adequately account for structural constraints and by the statistical techniques that now allow for an analysis of the impact of the various levels of structure on health. In this context a research focus on the family is seen as a welcome consideration of the 'socio-political landscape of obesity' and other lifestyle issues (Maher et al. 2010:236), although researchers must be wary of appealing to the popular discourses described above. In the next section I would like to argue with Williams (1995) and Cockerham (2013a, 2013b) that Bourdieu's theory has much to offer lifestyle researchers who wish to consider the impact of both agency and structure and avoid individualising and pathologising social problems. I will also argue that Bourdieu's approach allows for an account of the significance of mothers for family lifestyle practices, without reproducing gender stereotypes and inequalities.

Bourdieu and the study of the relations between health, lifestyle practices and social class

Simon Williams (1995) appears to be, if not the first, then one of the first social researchers to suggest that Bourdieu has something to offer the study of health-related behaviour and the relationship between health, lifestyles and social class. Williams (1995) argues that the link commonly made between health education and healthy practices has been found to be tenuous, and so Bourdieu's theory offers an understanding of the durability of certain health-related behaviours for different social classes. He (1995) proposes that the strength of Bourdieu's approach is that it enables researchers to understand the durability of classed practice while accounting for structure and agency, as well as the struggle for distinction in lifestyle behaviours, and the power of the dominant classes over the bodily practices of the working class. For Williams (1995), health inequalities are an outcome of struggles for class distinction and he highlights the significance of the habitus concept for understanding lifestyles. He states:

> ... it is in the relationship between habitus and capital, located within the context of the different social fields of society (that is, the relationship between *position* and *disposition)* and the struggle for social distinction, that lifestyles are constructed (Williams 1995:597–8).

Moreover, Williams (1995) argues that a Bourdieusian analysis is more sophisticated than other approaches because it considers factors beyond the economic and makes the body more central than it has been within the sociology of health and illness.

More recently, building on Williams (1995), Cockerham (2013b:131) argues:

> Social factors not only cause disease, but they also cause health and one of the primary mechanisms by which health is socially manufactured or undermined is through lifestyles (also Cockerham 2005, 2010).

Writing against individualistic paradigms of health lifestyles that are 'too narrow and unrealistic ... to consider structural influences on health lifestyle choices' (Cockerham 2013b:149), he advocates for a Bourdieusian approach. He suggests that Bourdieu's seminal work, *Distinction*, has been most influential for medical sociology because it relates taste, including healthy and unhealthy tastes for food and sports, to social class. Cockerham (2013a:252) argues with Williams that the strength of Bourdieu's approach lies in the way in which it can explain the durability of classed health-related behaviour and the way it accounts for both agency and structure. Cockerham (2013b:128–9) claims that lifestyle theorists ask: 'why do lifestyles tend to cluster in particular patterns reflecting distinct differences by class, age, gender and other structural variables?' And in response to this query, Bourdieu helps researchers consider how structure is 'present in every social context in which agency is exercised' (Cockerham 2013b:128–9).

Building on Bourdieu and Weber, Cockerham (2005, 2013a, 2013b) also presents his own preliminary model of health lifestyles in response to a dearth of theory in this area. Cockerham (2005:63) wishes to recognise the significance of both agency and structure for lifestyles choices and so borrows the habitus concept for his model, seeing it as 'the centrepiece' of his health lifestyle paradigm. Drawing on health lifestyle literature, his model hypothesises four categories of structural variables with the capacity to inform health lifestyles: (1) social class circumstances; (2) age, gender and ethnicity; (3) collectivities; and (4) living conditions (Cockerham 2005:56). These variables provide the social context for an individual's socialisation and experiences and Cockerham argues with Bourdieu that dispositions to act are then shaped by socialisation and experience (although Bourdieu is mostly concerned with how social class, rather than these other structural variables, shape the social conditions for this process). Cockerham (2005:60) suggests that socialisation and experience provide the capacity for agency or what Weber called 'life choices', but at the same time, the structural variables construct 'life chances'. Therefore, 'choices and chances operate in tandem to determine a distinctive lifestyle for individuals, groups, and classes' (Cockerham 2005:61). However, they are also 'analytically distinct'; while choices and chances are dialectic, they are not synchronised because society is an 'open system' and agency is always possible (Cockerham 2005:61). This is also where the habitus concept is brought into Cockerham's conceptualisation. Dispositions towards action are produced by the interplay between choices and chances and these dispositions make up the habitus. Once practices associated with health lifestyles become integrated into the habitus they can become unconscious and this means lifestyles follow a 'practical logic' (Cockerham 2005:62). There are a number of health lifestyle practices that are often problematised within research, including alcohol use, diet, smoking and exercise. Cockerham (2005:62) proposes (as does Bourdieu in relation to social class dispositions) that '[a]ction (or inaction) with respect to a particular heath practice leads to its reproduction, modification or nullification by the habitus through a feedback process'. He therefore presents a model that appropriates Bourdieu's concept in order to demonstrate how health lifestyles are produced through the internalisation of social structures.

Mildred Blaxter (2003) proposes that Bourdieu's concept 'capital' could be reworked to include the sub-category 'health capital'. In 1990, Blaxter published a large-scale British study with 9,000 individuals titled *Health and Lifestyles,* but it was not until later in her career that she developed this concept. Blaxter (2003:79) defines 'health capital' as 'bodily currency – strength, fitness, immune status, inherited tendencies, developmental spurts and hiccups, physical damage, vulnerability'. She compares health capital to economic capital in that it can be measured, sometimes depleted or gained in unpredictable ways, but for the most part distributed according to a coherent pattern that researchers can measure. Family may contribute to the loss or strengthening of this capital, as can education and occupation. In addition, lifestyle practices such as eating and physical exercise can also deplete or enhance this capital. Blaxter (2003:81) claims that health capital is unequally distributed along class lines and that 'the determinants of health capital are cohort-specific and not entirely individual: the concept links the individual time-frame with the temporal movement of social history'. She (2003:82) proposes that health capital is a metaphor but also a heuristic device, 'it may serve to direct research towards ways of dealing with the complexity of class-related patterns of health, and at the same time anchoring patterns firmly in the body'. The concept is valuable in that it acknowledges power (the cultural as well as the economic), social *and* physical facts, and the significance of time for understanding health lifestyle inequalities.

While Williams, Cockerham and Blaxter theorise the relevance of Bourdieu for understanding the relationship between social class health and lifestyles, a number of studies operationalise Bourdieu's approach for the study of the lifestyles of young people, and they tend to do this using qualitative methods and in the context of the family. For example, in their study on the relationship between the family and healthy eating, Quarmby and Dagkas (2013) make use of Bourdieu to reflect on informal mealtime pedagogies. In keeping with Bourdieu's perspective, they argue that the family is a field of social practice and an informal site of learning. The family is therefore a site where health-related knowledge is reproduced and so may have a long-term impact on children's healthy eating practices. In their study of 61 young people in the Midland region of the United Kingdom, Quarmby and Dagkas find that young people, especially those from two-parent families, reported that parents use family meal-time to help their children identify healthy and unhealthy foods, and reinforce family doxa ('the natural beliefs and opinions operating within their family field which determine natural practice') in relation to healthy food consumption (2013:9). Parents, particularly mothers, in this context, have 'pedagogic authority' and transmit knowledge to children about healthy practices and dispositions. Children take on this knowledge about healthy eating as their own, and this process can be interpreted as the transferral of 'cultural capital', as it is culturally valuable and consistent with societal orthodoxy about 'good' and 'bad' foods. However, Quarmby and Dagkas also find that family structure and socio-economic variables sometimes prevent families from eating together and therefore limit the possibility for informal mealtime pedagogies and the transmission of cultural capital from taking place. Take-away food and packet meals are also utilised more frequently in single-parent households because they are quicker to prepare and this then translates to young people expressing a taste for fast food. In addition, Quarmby and Dagkas find that blended family households, during their initial transition period, are less likely to experience family meals as the norm, and this (as Bourdieu (1996) in fact, recognised) alters the state of play in the family field, impacting on its identity and boundaries. They conclude that family mealtimes are important for the reproduction of healthy eating knowledge and dispositions„ but socio-economic factors and family structure may prevent these pedagogical practices from occurring.

Backett-Milburn and colleagues (2010) use a Bourdieusian framework in their qualitative study of understandings of dietary practices with 35 middle class parents (mostly mothers) of children aged 13–14 years, living in Eastern Scotland. They argue that social class and 'habitus' are central to debates about the family contexts that promote healthy diets and physical well-being but 'the ways in which socio-cultural influences affect the everyday practices and routines underpinning food choice, taste and dietary behaviours are often left unexamined' (Backett-Milburn et al. 2010:1317). In their research interviews, Backett-Milburn et al. elicit parents' descriptions of their children's food and health practices, descriptions of their attempts to control their children's tastes and appetites, and accounts of their strategies for managing their children's increasing independence and they find that the parents' discussions 'were as much about the kind of family they aspired to as they were eating and diet' (2010:1318). Parents communicate ideals of middle class family life and often distinguish their practices from those they see as undesirable. The majority of the parents report to be meeting nutritional ideals and the few who do admit (guiltily) that they are not meeting ideals claim to be rectifying the situation and monitoring their child/children (and this parental monitoring is viewed by the researchers as consistent with middle class approaches to child education). Most of the parents in this study also claim they do not make use of fast food or ready meals, and that family meals are made entirely at home. Homemade meals are referred to as healthy but also appropriate for 'families like theirs'. Most families claim to eat together (homemade family meals can only be legitimately skipped for extracurricular activities), and those who do not are working towards taking up this practice. Family mealtime is viewed as an opportunity to govern children's portion sizes and monitor vegetable intake, and parental control is extended to snacking and other eating. This type of parental regulation is to ensure healthy practice but also cultivate taste. The researchers find that the parents' value cosmopolitan diets and encourage their children to develop 'adult tastes', which, the authors suggest, are taken up for middle class distinction. Backett-Milburn et al. (2010:1321) conclude that:

> . . . it is important to see parents' and teenagers' food practices as grounded in past contexts, present family life and future aspirations. An important component of this is the family habitus, the unconscious logic of practice which underpins everyday routines and behaviours.

The researchers find that dietary choices and eating practices are in line with middle class notions of 'good parenting' and family food consumption is integral to class distinction. Importantly, the results from this study are quite different from those from their previous study with parents from low socio-economic backgrounds where teenage nutrition was low on the hierarchy of parental concerns. Middle class parents, in contrast, have ‘hierarchies of luxury and choice’ in which managing their children’s diets can be prioritised. This middle class capacity also serves to reproduce class privilege: the eating practices of middle class children are ‘potentially part of their anticipated public worlds and . . . thus endowed with social and cultural capital (Backett-Milburn et al. 2010:1322).

In a very different context, Kwapa Village in rural Uganda, Meinert’s (2004) ethnographic research with young people and their families finds that Bourdieu’s ‘capital’ concept, the Bourdieu-inspired concept ‘bodily capital’ (a concept that Wacquant 1995 and others have proposed might compliment Bourdieu’s formulation), and to a lesser extent ‘habitus’, are useful for explaining children’s health resources and strategies in seeking out a ‘good life’ and good health. Meinert’s findings are drawn from a range of participatory data collection methods, including write-and-draw workshops with a group of school-age children, illness-recall interviews with 70 children and 27 of their mothers or fathers twice a week for seven months, as well as a socio-economic survey with their families. Meinert finds that health and wealth are inherently connected in Kwapa. Good social and bodily health is equivalent to the ‘good life’ and provides social distinction for this community, and so this is something that individuals work towards in everyday life. She finds that education is considered a significant resource for building healthy lifestyles within the home and provides children with the communication skills to interact with institutional officials (such as health workers) and understand medical instructions. In this way education is a cultural capital that benefits the whole family. Personal hygiene, a healthy diet and an investment in appearance are also seen as a way to distinguish families as well as providing the good life. Meinert proposes that local forms of capital that relate to health and status include ‘unity’ which is a form of social capital that can be drawn upon in ill-health; ‘smartness’ in home and body which is a form of social capital and integrates moral and aesthetic elements; and children’s ‘bodily capital’ which is a constant concern for families, and investments in this capital (for example, through healthy diets) are expected to eventually be recovered in the form of other resources like labour and ‘unity’. However, Meinert proposes that certain elements of Bourdieu’s theory do not apply to this culture. For example, capital is not the possession of the individual; rather, capital is perceived as embodied in the home even after the capital-accumulating individual is no longer alive. While she sees the habitus as useful for understanding the generative principles of health practice, and particularly the relationship between an individual’s family and their own health practice, she sees the concept as repressive of children’s agency in the socialisation process. Nevertheless, Meinert (2004:23) claims that

Bourdieu's theory usefully captures 'how children draw upon a multiplicity of convertible resources in their striving of a good life and good health'.

Finally, Macdonald et al. (2004:307) make use of Bourdieu's theoretical approach (albeit minimally) for their study of the ways in which physical activity is valued and managed within Australian families. In their research with 12 families of varying socio-economic statuses and structures, Macdonald et al. (2004:307) explore the relationship between children's 'physical activity patterns, skills levels, and recreational interests, and their families [*sic*] location, income, commitment to physical activity, and other responsibilities'. Their research highlights the role that parents play in children's take-up of organised sport and physical play. McDonald et al. find that parents across different family contexts are aware of healthy lifestyle rhetoric and highly value physical activity, and as such, children's involvement in organised sports is a task managed within the families' lifestyles. Parents across different contexts attempt to customise children's activities so that they are in line with their children's current interests, gender and parents' backgrounds and interests, and this demonstrates that children are active in constructing their lifestyles but also that 'intergenerational habitus' influences their physical activity choices. However, parents often make sacrifices to ensure children are involved in these activities in the form of 'their own ability to engage in physical exercise due to lack of time, complex childcare arrangements, and cost for the lower socio-economic and single parent families', and this potentially reproduces classed as well as gendered experiences and understandings of leisure. McDonald et al. (2004:310) conclude:

> The work of Bourdieu reminds us that the disposition to engage in physical activity arises from a complex interplay of various capitals – economic, social and cultural capital – that constitute a family's cultural disposition towards physical activity.

Conclusions

Bourdieu's theoretical approach has much to offer sociologists of health and illness. In particular, his theory offers lifestyle researchers the conceptual tools to unpack the relationship between health, lifestyle practices and social class. His approach is useful in that it moves beyond an understanding of lifestyles as merely the product of individual choice and allows researchers to depart from the individualism that pervades popular understandings of classed health inequalities as well as medical sociology. His conceptual triad of habitus, capital and field facilitates an understanding of the structural and cultural causes of health inequalities, but not at the expense of agency; rather, healthy and unhealthy lifestyles result 'from a dialectic exchange between agency and structure' (Cockerham 2013b:130).

This chapter has not provided an exhaustive overview of the health research that has been inspired by Bourdieu's theory. Rather, it has focused on research that examines youth health lifestyles in the context of the family. Importantly, in making use of Bourdieu's concepts, these studies have moved away from framing the lifestyle experiences of young people and families as a governance problem for individual mothers. This research finds that families and in particular mothers, tend to be the gatekeepers of young people's lifestyles, but it also identifies health-related lifestyle practices as the result of interplay between agency and culture. Thus, this research highlights societal responsibility for healthy and unhealthy practice, denaturalising women's roles and reframing mothers as classed subjects. Moreover, as they link lifestyle practices to working-*and* middle class cultures these studies provide analyses that move away from the pathologising explanations for classed health inequalities found in popular culture.

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Part IV

The Late Twentieth Century and Theorists of the Present

Chapter 25

Colin Leys and Colin Hay: Market-Driven Politics and the Depoliticisation of Healthcare

Heather Whiteside

Medicine may be age-old but healthcare is not. As a system of organised service provision, healthcare is largely a twentieth-century phenomenon. In spite of (often significant) sub-national differences, broadly speaking there have been two distinct eras in Canada which divide the post-war sociopolitical organisation of public healthcare services: the initial Keynesian welfare state model of de-commodified services and public insurance provision and the current neo-liberal mode of increasingly private, for-profit, commodified health services, which erode the spirit of a collectively oriented public system. Here, the historical bifurcation will be approached from a political economy perspective by linking Colin Leys' description of 'market-driven politics' with Colin Hay's theory of depoliticisation.

Market-driven politics arise when global economic forces come to shape and constrain domestic policy choices (Leys 2001) – which is particularly relevant to the funding and organisation of healthcare services, given they are both expensive and expansive. For its part, depoliticisation involves 'the displacement of responsibility from governmental to public or quasi-public authorities and the offloading of areas of formal political responsibility to the market (through privatisation)' (Hay 2007:82). Merging these two considerations helps to uncover the ways in which market-driven politics are not only an imperative but also a governance strategy, making the increasingly depoliticised nature of healthcare services at once reality and rhetoric.

Following a discussion of 'market-driven politics' and 'depoliticisation', the second half of the chapter examines the policies that have transformed healthcare as an organised public service in Canada. The politicisation of healthcare services in the Keynesian era will be contrasted with the ever-greater commodification and depoliticisation occurring since the onset of neo-liberalism in the 1980s.[1]

Biographies

Colin Leys is Emeritus Professor at Queen's University in Ontario, Canada. His publications centre on the political economy of development (with a focus on Africa in particular) (for example, Leys 1977, 1966) and politics/public policy in Britain from a Marxian perspective (for example, Leys 1989). He began teaching at Balliol College in Oxford in 1953 and later held positions at Kivukoni College in Tanganyika, Makarere University College in Uganda, the Institute of Development Studies and the University of Sheffield (Bakan and MacDonald 2002). He was co-editor of the *Socialist Register* until 2009. This chapter will summarise his work on 'market-driven politics' as contained within *Market-Driven Politics* (2001) and *Total Capitalism* (2008), and, where relevant, this will be joined with other recent publications on the issue of healthcare services and marketisation. Several reviews of Leys' work are available for consultation (for example, Rachlis et al. 2001; Grahl 2004; Roberts 2004), and these indicate the important contributions he has made to socialist theory, development theory and understanding the impact of globalisation on national politics.

Colin Hay is professor of political analysis at the University of Sheffield. While completing his PhD in the Department of Sociology at Lancaster University under the supervision of Bob Jessop, he first taught at Lancaster and, in 1995, moved to the University of Birmingham. He was the founding co-editor of two leading journals in 2003 and 2006, respectively: *Comparative European Politics* and *British Politics*. He publishes on a diverse range of topics, from political theory and political studies (focusing on Britain and Europe) (for example, Marsh et al. 1999; Hay 2002; Dunleavy et al. 2006) to political economy (including globalisation, regionalisation and financial crisis) (for example, Hay 1999; Hay and Marsh 2000). This chapter examines how his arguments on depoliticisation pertain to healthcare services and policy. However, as indicated through reviews of Hay's *Why We Hate Politics* (for example, Flinders 2007; Goldsmith 2008), his work speaks to a range of issues such as political participation, policy-making more broadly and the constraints (or lack thereof) imposed by globalisation.

Market-driven politics

Colin Leys argues that 'market-driven politics' arises when economic forces come to shape and constrain domestic policy choices (Leys 2001). This occurs principally through the impact of economic globalisation whereby deregulation and institutional restructuring augments the power of global markets. In contrast, prior to the 1980s, 'markets were to a significant degree still politically controlled' (quoted in Roberts 2004:449). Leys proposes that 'all national politics are now market-driven ... to survive [governments] must increasingly manage their national politics in such a way as to adapt them to the pressures of trans-national market forces' (Leys 2008:65).

The onset of globalisation in the late 1970s has therefore forged a novel relationship between the state and markets. For example, he states that 'market-driven politics' describes the 'way national politics and global market forces are *now* connected' (Leys 2008:26, emphasis added). He also suggests that 'we have to recognise how far the balance of power between governments and corporations has shifted' (Leys 2008:76). Market-driven politics are the political manifestation of the shift in the balance of power from the public (citizens, voters, labour) to corporate interests, following the liberalisation of capital flows in the neo-liberal period (Leys 2001:6). His perspective therefore points to the internalisation of global market pressures (Rachlice et al. 2010).

Along with globalisation are four domestic drivers of marketisation: neo-liberal ideology (beginning with Thatcher in England); corporate pressure to open new markets and expand the potential for accumulation; decades of attack on organised labour, which has weakened resistance and contributed to the hegemony of market-based reasoning; and widespread agreement that government should be enacting policies which reduce taxes and increase productivity (Leys 2001:213–4). Domestic policy and politics have therefore shifted in ways which fit harmoniously with the larger context of economic globalisation.

Exposing society to market forces alters the nature and purpose of public services. Market-based provision not only substitutes one service provider for another but fundamentally transforms public services (Leys 2001:211). Healthcare services, for example, become a commodity – a different product with different ends.

Leys describes four steps that allow for commodification (Leys 2001:4). First, reconfiguration: the good or service must be monetised in preparation for its sale (that is, given a price). Second, want creation: demand must be induced. Third, proletarianisation: workers are no longer to identify with a public ethos and must instead service the needs of profit-making by capital. Fourth, risk underwriting: the risks inherent to the market-based provisioning of core public services must be underwritten by government. In sum, converting a public service into an exchangeable commodity involves wide-ranging social transformations with uneven risks and rewards. The process impacts service demand, consumption/use, labour, capital, and the state. In addition, commodification severs the link between democracy and public services (such as healthcare). The erosion of democratically determined collective values and institutions is thus hastened by market-driven politics. This topic will be returned to shortly when discussing depoliticisation.

The marketisation of healthcare services creates a range of markets and commodities. In Britain, the formation of an 'internal market' within the National Health Service established contracts between purchasers and providers, standardised and monetised procedures, replaced clinical criteria with new emphases on cost and austerity in policy-making and substituted 'treatments' for 'care', which was now 'individuated, standardised, and priced' (Leys 2001:189). Marketisation affects not only patients but also doctors, nurses, hospitals and insurance schemes, and is influenced by markets for laboratory testing, pharmaceuticals, long-term care and ambulatory care, just to name a few (Leys 2001:100). The implications of commodification are greater inequality of provision and access, higher costs and the creation of new avenues for corruption. At the extreme, private for-profit care can even lead to higher mortality rates when understaffing is turned to as a device for generating cost savings/profit-making (Devereaux et al. 2002).

Not only is Medicare challenged by marketisation and commodification but health itself can be harmed by capitalist accumulation. In other words, capitalism poses problems for health and well-being regardless of whether marketisation occurs. Leys summarises this contradiction in the following manner: capitalism produces and relies upon inequalities, yet leading research into the social determinants of health strongly indicates a connection between poverty and ill-health (physical, developmental, social), with health indicators varying by income group (Leys 2010). Income and ill-health are thus inversely related to one another, and this means that those who are in greatest need of healthcare coverage are those who, if forced to fully rely on the market, are least likely to be able to secure adequate coverage. The establishment of national public Medicare systems in the twentieth century was therefore as much a boon for the public at large as it was for capital.

Notwithstanding the usefulness of 'market-driven politics' as an analytical construct, there are several potential caveats and critiques worth mentioning. First, rather than viewing global economic forces as wholly determinant, policy analyses might instead be attuned to the persistence of choice and programme evolution within the over-arching context of market constraint. Market forces (global and local) have, to one extent or another, always influenced capitalist state policy. It is therefore necessary to not overstate the novelty of market-driven politics today.

State restructuring can be thought of as strategic and historically specific instead of strictly dictated by the market. The recent 2008 global financial crisis and subsequent state intervention paradoxically indicate both the constraining influence of markets and the continued flexibility of state policies. Stimulus spending on the heels of high cost bailouts, buyouts and guarantees offered to capital at public expense can be interpreted equally as market-driven politics and as an indicator of the undiminished power of the state to intervene in markets and help guide domestic development (McBride and Whiteside 2011; Whiteside 2012).

Second, and related to the first point, the notion of market-driven politics rests on an uneasy assumption that deep connections between states and markets have only recently been forged and that this power shift is zero sum in nature. In this sense, Leys casts states and markets as antagonistic, implicitly reproducing a liberal or Weberian dichotomy, which is ill at ease with a Marxian analysis.[2] Instead, it would be more fitting to understand the state and capital as non-rival and intrinsically interconnected. As Wood describes it:

> Marx's approach … insist[s] that a productive system is made up of its specific social determinations – specific social relations, modes of property and domination, legal and political forms. This does not simply mean that the economic 'base' is reflected in and maintained by certain 'superstructural' institutions, but that the productive base itself exists in the shape of social, juridical, and political forms (Wood 1981:69).

Third, Leys' domestic drivers of marketisation (neo-liberalism, corporate pressure, the silencing of alternative voices and passive support from the public) are applicable mainly to the formal political arena. This focus could be broadened to capture the drive for market expansion from the perspective of capital as well. Harvey's analysis of accumulation by dispossession and over-accumulation are useful companions in situating market-driven politics (Harvey 2001, 2003a, 2003b, 2006). The latter refers to 'condition[s] of surplus capital', represented by a 'glut of commodities on the market, idle productive capacity, and/or surpluses of money capital lacking outlets for productive and profitable investment' (Harvey 2003b:64). The former is a predatory mechanism of market expansion achieved by incorporating (back) into the realm of private accumulation that which has come to exist 'outside' of the normal circuits of capital accumulation. Dispossession creates new investment and profit-making opportunities, helping to resolve crises of over-accumulation.[3] Marketisation and privatisation are examples of dispossession. This gives context to, and explains, the economic impulse underpinning market-driven politics.

Finally, Leys' analysis calls for a reassertion and protection of the non-market domain (Grahl 2004:196). He identifies the transformation of public broadcasting and healthcare in Britain as key examples of market-driven politics, but remains vague as to whether all areas of marketisation are of equal concern. Roberts asks salient questions such as, 'should we be as troubled by the process of marketisation in telecommunications, electricity, water, or gas sectors? What criteria should we use to demarcate the terrain in which marketisation must be resisted?' (Roberts 2004:452). These questions need not concern us here since we are specifically interested in the marketisation of healthcare services, but they point to a lacuna.

The importance of Leys' analysis centres on its identification of public programmes, services and whole swaths of policy-making which have been or are being removed from democratic control and transformed in profound ways through commodification and marketisation. Colin Hay's notion of depoliticisation is a useful companion to this analysis as it indicates other ways in which neo-liberal restructuring occurs – as much within the public sector as between states and markets. Next, we turn to a discussion of how state restructuring and alterations to state–society relations are not just market-driven but at least in part accomplished through depoliticisation as well.

The politicisation and depoliticisation of public policy

Colin Hay's book *Why We Hate Politics* seeks ostensibly to account for why scepticism, suspicion and a sentiment of anti-politics are increasingly widespread and persistent in developed countries with liberal market economies such as the United States, Canada and Britain (Hay 2007).[4] He suggests the following tripartite analysis of factors contributing to low political participation and voter apathy (or 'supply side factors'), some of which dovetail with Leys' market-driven politics, although others point to alternative explanations. First, politicians have internalised theoretical assumptions inherent to public choice theory, which hold the public sector to be less inefficient than the market; second, there is a pervasive perception that globalisation has diminished the capacity of the nation-state to craft independent, democratically driven policy; third, responsibility for policy-making is being evacuated from the formal democratic realm (Hay 2007:56).

The rise of public choice theory as a governing paradigm helps explain why neo-liberalism favours shifting decision-making to market actors through privatisation and marketisation. On the neo-liberalisation process, Hay (2007:98) writes:

> We must differentiate between the rise of neo-liberalism in the late 1970s and 1980s . . . and its subsequent and more general diffusion and consolidation in the 1990s and beyond. The highly politicised nature of the former process contrasts markedly with the latter – a process of institutionalisation, normalisation, and depoliticisation.

Hay (2004) labels initial forms 'normative neo-liberalism' and later forms 'normalised neo-liberalism'. His periodisation of neo-liberalism suggests Leys' market-driven politics might also be analysed in terms of sequences or phases of development with spatial and historical attributes.

Beyond domestic factors lie globalising forces and the impact they can have on public policy formulation and political engagement. Hay argues globalisation has not eroded state decision-making, stating that 'there is plenty of evidence of its [the nation-state's] continued activity and, indeed, its continued efficacy' (Hay 2007:151). This sentiment stands in direct contradiction to Leys' notion that increasing economic interconnectedness through globalisation leads to market-driven politics. On the other hand, Hay acknowledges the power of rhetoric and perception, arguing that despite the lack of empirical evidence, 'globalisation continues to exert a powerful influence on policy-making ... [through] the *idea* of globalisation' (Hay 2007:151).

The final 'supply side' factor encouraging political apathy is depoliticisation. However, before presenting Hay's view of depoliticisation, we must first consider what 'the political' refers to. While innumerable definitions exist, Hay provides his own; casting politics as 'the capacity for agency and deliberation in situations of genuine collective or social choice' and clarifies the way 'politics does not, and cannot, arise in situations in which human purpose can exert no influence. Politics is synonymous with contingency; its antonyms are fate and necessity' (Hay 2007:77). The latter is particularly important as it signals, contra Leys, an intrinsic critique of the notion that globalisation and economic interconnectedness *necessitate* particular political or policy responses.

Politicisation and depoliticisation intentionally use process-indicating suffixes; there are, just like with neo-liberalism (or, as Peck and Tickell (2002) call it, neo-liberalisation), gradations to both, and neither are static conditions. Four social realms are implicated in both processes: the sphere of necessity, the private sphere, the public sphere and the governmental sphere. Politicisation occurs in stepwise fashion when issues are promoted from the realm of necessity to the private sphere, the private to the public sphere and the public to the governmental sphere. Conversely, depoliticisation occurs when issues are demoted from the governmental sphere to the public sphere, the public sphere to the private sphere and the private sphere to the realm of necessity (Hay 2007:80–7). The political public arena is therefore split into governmental and non-governmental realms, with the private sphere (which includes the market) containing political attributes, consistent with his definition of politics provided above. Whereas Leys' market-driven politics is concerned with what is happening within government, Hay's expanded notion of 'the political' is not exclusive to the formal political process.

Hay's (2007) description of depoliticisation is particularly adept at explaining how marketisation and privatisation occur through several phases, complementing Leys' (2001) analysis of commodification. As will be examined in greater detail shortly, Medicare as a political construct can be demoted from the government to the public sector (for example, when arm's length public sector managers come to take responsibility for decision-making), and from the public sector to the private for-profit and charitable not-for-profit sectors (for example, through privatisation, fiscal austerity and programme reform).

To Hay's account, we might add Burnham's views on internal state restructuring. Burnham connects depoliticisation to a particular governance strategy, which 'plac[es] at one remove the political character of decision-making' (Burnham 2001:127). State managers benefit from depoliticisation as it redirects blame and dampens public expectations while still allowing them to retain control. More than merely rhetoric, depoliticisation also relies on new bureaucratic practices and a shift from discretion-based to rules-based regimes in particular (Burnham 2001:130–1).

In summary, an important part of the success of the 'market-driven politics' over the past decade has been the normalisation of neo-liberal ideology, policy techniques and practices through depoliticisation. Depoliticisation facilitates market-led restructuring, and marketisation can occur through technocratic decision-making as well as via grand normative gestures. However, given that risk and responsibility for core public services (whether commodified or not) remain insured by the state (Leys 2001), healthcare service provision will always remain political (Hay 2007). This makes depoliticisation both a market-oriented governance strategy and a material reality.

Market-driven politics and the depoliticisation of Medicare in Canada

This section looks at some of the specific market forces and policy choices that have transformed Medicare as an organised public service in Canada over the past few decades. The politicisation of healthcare services in the Keynesian era stands in contrast to the commodification and depoliticisation, which have occurred since the onset of neo-liberalism in the 1980s. The establishment of a Keynesian welfare state politicised core areas of social concern such as health, education and welfare, thereby dampening market-driven politics through de-commodification. The initial normative phase of neo-liberalism involved rolling back the Keynesian welfare state and its more recent normalised phase involves rolling out its own prescriptions, reforms and governance strategies (Peck and Tickell 2002).

The Keynesian welfare state was designed to support a Fordist-style regime of mass production and consumption through policy measures such as counter-cyclical demand management, public ownership of enterprises in areas supportive of the production process and expenditures on public works and social services (Jessop 2002). It was this political economy backdrop which allowed for the politicisation of ill-health experienced during the Great Depression of the 1930s and ultimately supported the post-war creation of a system of public healthcare insurance.[5] Prior to that point, health services were mainly provided by charities and the private for-profit sector. Market and physician-led resistance delayed legislative reforms until the late 1950s, but ultimately, market-driven politics were curtailed.[6]

Beginning in 1957, the *Hospital Insurance and Diagnostic Services Act* fully insured inpatient hospital services through a federal-provincial 50–50 cost sharing agreement (Auer et al. 1995:5). This was followed by the 1966 *Medical Care Act*, which publicly insured doctors' services. Finally, in 1968, the Medical Care Insurance programme ('Medicare') went into effect, combining the previous two (Auer et al. 1995:6). Five cost-sharing conditions were attached to the new public Medicare programme: universal coverage for all Canadian residents, full accessibility (no means tests or extra charges), portability of coverage across Canada, comprehensiveness (Medicare was to cover all 'medically necessary' hospital and physicians' services), and each provincial plan was to be publicly administered on a non-profit basis (Vogt 1999:185). Each step either de-commodified what was a previously market-based service (for example, healthcare insurance), shut out private for-profit involvement (for example, medically necessary services provided in hospital) and/or reflected a high level of programme politicisation (for example, the five cost sharing conditions imposed by the federal government).

Even at its most public and politicised, the Medicare system in Canada was never free from market pressures, and, in many ways, its scope has remained quite narrow. Medicare does not cover some important aspects of healthcare related to home care, long-term residential care and dentistry; furthermore, doctors were not fully absorbed into the public system but rather left to make their own decisions about where and what they would practice. Moreover, they were not made salaried employees of the state but rather paid on a fee-for-service basis by provincial governments (see Armstrong and Armstrong 2008:43–9). In addition, the uneasy federal–provincial division of responsibilities and costs was never adequately resolved. The federal government became responsible for national oversight and a large portion of the funding, whereas the provinces were left to administer provincial Medicare insurance programmes and oversee associated aspects (such as hospital infrastructure and service planning and delivery). As a result, there has always been some degree of inter-provincial variation in terms of the breadth and depth of health service coverage across the country. Variations have only widened with the onset of neo-liberal market-driven politics in the 1980s.

Market forces and certain forms of depoliticisation over the past 30 years have transformed the public healthcare system in Canada, despite the tenacity of widespread public support for Medicare across the country. Given the continued politicisation of core elements of the system (hospital stays and doctor's visits), internal erosion rather than an outright dismantling of Medicare has occurred. Marketisation has proceeded largely through federal level fiscal austerity and spending reforms, provincial level funding changes imposed on local authorities and the privatisation of hospital infrastructure and ancillary services (elements such as hospital cleaning, dietary and linen services). Each will be discussed in turn.

As early as 1977, problems with economic growth and inflation were used to justify curbing federal government spending on Medicare. The previous federal–provincial 50–50 cost sharing plan was replaced with a block funding scheme (known as the *Federal-Provincial Fiscal Arrangements and Established Programs Act*, or EPF), and increases in federal funding were de-linked from changes in real Medicare costs. Not only did the EPF reduce the value of the amount transferred to the provinces, it also hindered the ability of the federal government to enforce national standards since the provinces were given more power over the allocation of funds. The federal government later imposed ceilings on EPF payments in 1986, 1990–1991, 1991–1992 and froze healthcare expenditures from 1992 to 1995.

The 1995 federal budget stands as a watershed moment signifying the unambiguous shift to neo-liberalism through the onset of fiscal austerity and depoliticisation. An even greater block fund, known as the Canada Health and Social Transfer (CHST), was created, merging health, social services and welfare spending into one programme and dramatically reducing transfer payments, with 1996–1998 cash transfers to the provinces alone declining by 33 per cent ($6 billion) (Vogt 1999:193; Browne 2000:21).

Health spending rebounded in 2001, increasing to almost $60 billion (well above its 1992 level of $52 billion) (Rachlis et al. 2001:6).[7] However, expenditures on hospitals remained well below their 1992 level, and jobs eliminated (primarily nursing staff) were not restored (Rachlis et al. 2001). In 2004, health and social transfers were separated once more through the creation of the Canada Health Transfer (CHT) and the Canada Social Transfer (CST). At this time, the ten-year ‘Plan to Strengthen Health Care’ (sometimes referred to as the Health Accord) was launched, and the federal government agreed to 6 per cent annual increases in federal spending transfers to the provinces. This commitment brought federal spending up to 20 per cent – an improvement after the deep cuts implemented in the 1990s, though substantially less than the 50 per cent originally provided prior to the EPF. The Health Accord is set to expire in 2013–2014 and, as Bhatia (2011:81) puts it, ‘this will become a big deal politically over next few years’. What will come of greater politicisation remains to be seen; the lack of economic growth and growing indebtedness of federal and provincial governments in the wake of the 2008 global financial crisis and subsequent economic slump might indicate a reassertion of market-driven politics. At this juncture, it appears that by 2017 the federal government aims to relink annual spending increases to economic growth rather than non-market considerations related to Medicare-specific needs (CUPE 2012).

Federal spending cuts and programme reforms over the past few decades have downloaded far greater responsibility and oversight onto the shoulders of the provinces than originally envisaged in the 1950s and 1960s. Several provinces have turned to privatisation due to lax national oversight and/or as a reaction to cost pressures amid spending cuts. Examples of privatisation include service de-listing (which narrows the range of services covered by Medicare), shifting care into the home (where Medicare coverage often does not extend), allowing for-profit clinics to provide some surgical procedures (helping to foster two-tier healthcare and siphoning off doctors and nurses from the public system), the use of public–private partnerships (P3s) to provide hospital infrastructure and support services and contracting out public sector jobs to for-profit companies (Whiteside 2009).

Provinces have also shifted the burden of neo-liberal adjustment into the relatively depoliticised realm of local health authorities (such as Regional Health Authorities (RHAs) or hospital boards), subjecting them to years of spending restraint, restructuring and marketisation. RHAs and hospital boards must now comply with performance agreements, which stipulate that budget cuts imposed by the province cannot be dealt with through deficits at the local level, forcing hospital restructuring and amalgamations, service cuts (for example, cancelling elective surgeries), fee hikes (where applicable, for example, parking lot rates[8] and private hospital rooms) and cuts to labour costs (for example, freezes on hiring and overtime, layoffs). Local agencies are thus reoriented towards the bottom line, often at the expense of healthcare service provision and a consideration of wider social needs. The boards of RHAs and hospitals have furthermore been corporatised, as leaders are now largely selected for their business acumen rather than experience in the health sector (Murphy 2007).

Funding schemes for hospital operating costs have also changed, another important way in which marketisation is gradually encouraged. The provinces of British Columbia (BC) and Ontario have recently (in 2010 and 2009, respectively) made two changes worth noting in this regard. As of 2010, BC began to move away from line item-based[9] hospital funding to an 'activity-based' model in dozens of hospitals across the province, impacting roughly 20 per cent of hospital funding overall (Cohen et al. 2012:6). Cast as a 'patient-focused' model able to reduce surgical wait times and improve access to emergency services (BC Ministry of Health 2010), under an activity-based model, financing for procedures becomes linked to the volume of activity and payments are made by procedure or by patient. Funds are distributed using metrics such as efficiency, throughput and lowest price rather than other non-marketised considerations – such as ensuring patients are receiving the highest quality care possible and equity of access across the population (Canadian Doctors for Medicare 2008). Patients with the most complex care needs are particularly disadvantaged by this funding model (Cohen et al. 2012).

In 2009, Ontario began to change its funding model as well, taking steps to move away from global budgets (lump sum amounts) through the introduction of 'pay for results' and 'pay for performance' schemes that provide extra funding to hospitals on the basis of, and tie hospital board member compensation to, performance measures (Ontario Ministry of Health and Long Term Care 2009; McFarland 2010). They also began to focus on population-based funding whereby money is diverted to areas with faster growing or more elderly populations. Concerns similar to those associated with activity-based funding arise: regional disparities (urban vs. rural) can skew access to care, and the quality of care is not adequately assessed when 'performance' is gauged through market-emulating efficiency measurements and cost reductions (Howlett 2010).

The depoliticisation and marketisation of public healthcare services in Canada is therefore occurring in two ways. First, social needs are made to increasingly conform to market dictates and public sector responsibilities are met through for-profit providers. Privatisation is a clear example of both depoliticisation and marketisation since it shifts areas of social concern away from the public sector and into the realm of capitalist accumulation. However, referring to privatisation as 'depoliticisation' should not be taken to suggest that it is an apolitical process; instead, it points to the elimination/reduction of public sector (and democratic) control, decision-making and authority over important facets of society. Privatisation will always remain *inherently* political, given that the creation of exclusive rights of private property and the commodification of labour alters the production, allocation, distribution and consumption of goods and services and, thus, power and well-being throughout society. As Wood says of Marx's account of the social dimensions of power within capitalism – a mode of production is a 'relationship of power' (Wood 1981:78), and capitalist private property represents 'the ultimate "privatisation" of politics' (Wood 1981:92).

It remains ambiguous as to whether healthcare policies are truly 'market-driven' in Canada, given the degree of inter-temporal and inter-provincial policy variation. One thing that is certain is that once marketisation is introduced, the anti-democratic changes identified by Leys (2001) have been occurring. Wider social goals such as those related to health outcomes, popular input and control, transparency, accountability and service quality are being compromised as reforms encourage or focus on market-based outcomes and metrics, partnering with unaccountable private actors, commercial confidentiality, market discipline and the quantity/speed of services provided.

Conclusion

Leys reminds us that healthcare 'is an ideological construct almost as much as a material reality' (2010:15). While the principles of Medicare in Canada, namely universality and accessibility, remain in place, the era of neo-liberal rule has meant that attempts to achieve these goals are now subsumed within a policy discourse of efficiency, sustainability and risk transfer to the private sector, as well as the material reality of fiscal austerity and cost control. Similar changes have occurred elsewhere, commodification and marketisation in Britain having also been highlighted here. Developments such as these exacerbate the tension between capitalism, health and healthcare by widening inequalities.

Canada's public healthcare system, a holdover of the Keynesian welfare state era, remains one of the country's few progressive, collectively oriented, relatively generous areas of public policy; and it is increasingly encircled by the regressive, individualist and austere political economy of the neo-liberal era. The universal need for some form of Medicare makes it an ideal target for market expansion, but its highly politicised nature in Canada simultaneously wards off the onset of true market-driven politics. The mundane and less obvious aspects of marketisation within this sector are the current home of neo-liberal normalisation, rendering depoliticisation an important component of health service privatisation.

Notes

1. Unless otherwise specified, this chapter focuses specifically on Medicare and healthcare service provision in Canada. For examples of privatisation and marketisation in other national contexts, see White and Collyer (1998); Haque (2000); Kearns et al. (2003); Holden (2005); Clifton et al. (2006); Waitzkin et al. (2007); Phua and Barraclough (2011); Collyer and White (2011); Quercioli et al. (2013); Collyer et al. (2014).
2. In contrast to certain Marxian interpretations of the state as being 'but a committee for managing the common affairs of the whole bourgeoisie' (Marx and Engels [1848] 2001:11), for Weber the historical struggle between the state and capitalist classes during the early development of the capitalist system was resolved through a 'memorable alliance' whereby neither the state nor capital are subordinate to the other but instead remain semi-autonomous (see Weber [1927] 1981).
3. A word of caution is required here. Arrighi et al. (2010:411) argue that over the long run, accumulation by dispossession 'undermines the conditions for successful development'. Harvey (2003a:154–6) agrees with this, suggesting it can end up disrupting or destroying paths to expanded reproduction.
4. McBride and Whiteside (2011) address the phenomenon of 'democratic malaise' in Canada over the neo-liberal era.
5. Under the leadership of Tommy Douglas in 1947, the Saskatchewan provincial government was first to introduce a universal health insurance scheme in Canada. Douglas felt that access to health services ought to be considered 'an inalienable right of being a citizen' (Fuller 1998:38).
6. The constitutional division of powers also presented a hurdle for the creation of a pan-Canadian system, given that the *British North America Act* (1867) stipulated 'provinces were to establish, maintain, and manage hospitals, asylums, charities and eleemosynary [charitable] institutions' (Fuller 1998:13).
7. Health expenditures of 1992 and 2001 were both roughly 10 per cent of GDP; and over the past decade, from 2000 to 2010, health spending as a percentage of GDP rose in Canada from 9.2 per cent to 11.9 per cent (CIHI 2012:9).
8. In a *Canadian Medical Association Journal* editorial, high parking fees associated with urban hospitals have been flagged as being a hidden user fee, which contradicts the

1984 *Canada Health Act* ban on user fees and assurance of equal access and free care at the point of delivery (Kale 2012).

9. Line item funding 'involves negotiating amounts for specific line items in a budget. The sum of all line items equals the total hospital budget' (Canadian Doctors for Medicare 2008:3). In practice, this has operated like global lump sum funding since healthcare providers receive a set budget each year (Cohen et al. 2012).

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Chapter 26

Vicente Navarro: Marxism, Medical Dominance, Healthcare and Health

David Coburn

Is the medical profession the dominant force in health and healthcare? Why do some nations have universal health systems and others not? What are the fundamental causes of health status and health inequalities? This chapter describes Vicente Navarro's explanations for such health and healthcare issues through examining the key concepts he employs in his theoretical and empirical writings.

Navarro is renowned for his Marxist-based analyses of political and health issues. Navarro's fame is remarkable considering that he has spent much of his career in the United States, a nation not known for its tolerance of the Left. Though a Marxist, Navarro clearly delineates his own critical perspective from that of other forms of Marxism (particularly those he considers too economically determinist), as well as from twentieth-century versions of communism and from other radical writings (Navarro 1976, 1983).

Biography

Born in 1937 and educated as a physician in Spain, Vicente Navarro left that country in 1962 because of his anti-fascist activities and undertook further study in economics in Sweden and Britain. However, Navarro has spent most of his life after 1965 at Johns Hopkins University in Baltimore. In a scholarly biography, Navarro notes the antipathy to progressive analyses in the 1970s and 1980s. For example, several editors of academic journals suggested 'that I should not use the term working class because it was excessively ideological, and encouraging me to replace it with the less value-laden term socioeconomic status' (Navarro 1998b:391). *Social Science and Medicine* published what Navarro describes as 'an abrasive review' of his work. In an important show of support, distinguished professor Howard Waitzkin resigned as a member of the editorial board. *Social Science and Medicine* has since become much more welcoming of progressive writings suggesting that Navarro and colleagues such as Waitzkin helped create more academic space for critical scholarship in the health field.

In the 1960s, Navarro became the founding editor of the *International Journal of Health Services* (IJHS). The IJHS, of which Navarro is still chief editor, has published hundreds of articles, occasionally collected into edited books, critiquing mainstream and more recently neo-liberal approaches to health and social issues and providing commentary and analyses of all the major health-related issues of the day (for example, Navarro 1986; Navarro and Muntaner 2004; Navarro 2007b). In addition to his academic and editorial work, Navarro was an advisor to Chilean President Salvador Allende and Jesse Jackson. He has served as a consultant to many different organisations and governments and frequently comments on political, economic and health affairs (see his blog: www.vnavarro.org).

Navarro's scholarly output includes hundreds of theoretical and empirical papers from his early writings on the rise of the welfare state to his current critiques of neo-liberalism. He has reviewed all of the major international commissions of health, from Alma Ata (Navarro 1984a) to the recent Commission on the Social Determinants of Health (Navarro 2008). Navarro has also critically analysed central writers in the health area from Illich (Navarro 1975), through Starr (Navarro 1984a) and Freidson (Navarro 1998a), to Amartya Sen (Navarro 2000). Thus, his work is in constant conversation with other major thinkers. As a Marxist political economist rather than a sociologist, Navarro's work should be read in relation to the field of political economy as a whole and not only to sociological analysis, although in this paper my focus is mainly on his sociologically related health writings.

Major concepts: Mode of production, class, politics

The main outlines of Marxist theory, or at least an over-simplified 'vulgar' Marxism, are well known. For Marxists, history consists of a succession of different modes of production. Each mode of production has a material economic sub-structure, which Navarro calls the 'social relations of production', which conditions, shapes and provides limits to the superstructure of law, politics and culture. The presently dominant mode of production, capitalism (there can be different modes of production within a single social formation but one is pre-eminent), is characterised by specific contradictions and tendencies and by the division of society into two major antagonistic classes – capitalists, those owning and controlling the means of production, and the working class, those having to work for capitalists in order to survive. The focus of many of the class struggles and contradictions of capitalism occur in the realm of politics. Hence, in what follows, I briefly explicate in turn, mode of production, class and politics as concepts central to Navarro's Marxist-based theoretical schema (for a beginning taste of the Marxist perspective, see Ollman 1977; Cohen 1978, 2000; Tucker 1978; Bottomore 1991; Harvey 2010; and Marx's widely available original writings).

Mode of production

The mode of production (see Cohen 1978) approach is critical to understanding Navarro's insights on health phenomena, which he argues cannot be understood apart from their political, economic and social context. Navarro's interpretation of the capitalist mode of production sometimes coincides, and sometimes contrasts, with other Marxist approaches (Navarro 1983). It also places his analyses in sharp distinction to those non-Marxist theories of health which analyse major social institutions and organisations as if they were relatively free-floating and not already embedded in a larger whole (Navarro 1984a, 1989).

Capitalism, if of somewhat different varieties, is the dominant mode of production globally. Even self-described non-capitalist nations, like Cuba, exist within this dominant world context. While both Left and Right agree about the present hegemony of capitalism, they disagree regarding what such a term means. Non-Marxist analysts, particularly those within economics, view capitalism as simply meaning 'free markets'. To them capitalism is equated with economies that are largely privately owned and controlled, and in which the major aim within markets should be private gain or profit. Free markets are the engines which produce surpluses, which then lead to interest group or elite conflict over its distribution, including regarding state services such as welfare and health. Thus, whereas economics is about 'economies', political science concerns a political sphere separate from economic life, and sociology focuses mainly on civil society. In these mainstream views democratic politics and the state are the more or less neutral arbitrators over the distribution of a social surplus, although there are wide variations in the degree to which the state is seen as somewhat neutral or elite dominated. Navarro and other Marxists, however, tend to conceptualise capitalism in a more holistic sense, hence their frequent self-identification as Marxists or political economists. For them, capitalism in its historical and contemporary variations displays a relatively consistent set of relationships among production, exchange, consumption and reproduction, that is, between economies, the state and civil society. There is much discussion within Marxism about how strongly determinative the economic base is to social life, with Navarro adhering more to the 'dialectical' relationship end of the continuum (see for example, Navarro 1976, 1983). The structural characteristics of capitalism have important consequences for the analysis of health since it means that health cannot be properly understood without analysing class relations and class struggles (for some recent examples, see Coburn 2004; Panitch and Leys 2010; Waitzkin 2011; Scambler and Scambler 2013). From a mode of production perspective, contemporary health issues are as firmly characterised by their embeddedness within the capitalist mode of production as feudal health issues were within the feudal mode.

A central aspect of capitalist interrelationships concerns markets and states. While a good deal of economic, political and social theory analytically separates economies from states, Marxists feel that states have a particular class character. States rely on the capitalist economy to create a social surplus; hence, states assume the role of keeping the capitalist economy expanding. They act as a 'general capitalist' through carrying out policies in the interests of capital as a whole as opposed to the sometimes conflicting interests of particular capitals or capitalist fractions. Moreover, given widespread capitalist ideologies, most of the 'democratic' rulers of capitalist society as well as most members of state bureaucracies are strongly in favour of capitalist policies and interests. Capitalist interests are supported by a business controlled media and by mainstream economic 'science'. Given this over-arching capitalist power, it is simply not the case, as pluralist interest group political theory assumes, that the state is free to respond more or less equally to the political demands of all. In Navarro's view, the state is not an instrument which can be freely used by governments since the state itself is class structured and exists within a class structured mode of production. According to Navarro, while important reforms benefitting citizens are possible within capitalism (for example, through Social Democracies), real emancipation would only come through supersession of the capitalist system. Creating 'socialism within capitalism' is simply not possible, and Navarro believes that to change the system itself would require a revolutionary break.

Within contemporary capitalism, Navarro's view is that the state responds to the needs of capital and the demands of labour, but the tension between capitalist needs and worker demands are most often resolved in favour of capital. Ironically, in a number of instances, capitalist class dominance is actually 'bad' for capitalism as a whole. The US capitalist class, for example, is, Navarro asserts, too powerful for its own good (1999:26), because its excessive appropriation of the social surplus hinders capitalists selling commodities in the marketplace due to decreased demand. Such an analysis, of course, may usefully be used to explain the recent 2008 economic crisis insofar as the working class were encouraged to artificially sustain demand by heavily indebting themselves. As we know, the costs of such a crisis were overwhelmingly borne not by its creators but by working people throughout the world with important health consequences (Stuckler and Basu 2013). For Navarro also, current debates between policies of 'austerity' or neo-Keynesian demand stimulation are on far too narrow a territory. In fact, Navarro regards Keynesianism, a strictly fiscal policy tool, as a product of weak states, politically or structurally unable to intervene directly in economies, as in some Social Democratic nations, to create institutions supporting full employment and productive investment.

Navarro contends that analysts who do not use a holistic perspective, but study 'variables' within capitalism, miss the fact that institutions and their inter-relationships are already shaped in specific ways, have particular relationships with other 'variables' and are set within parameters of variation by their location within capitalism. Analyses that neglect to contextualise political, economic, social and health issues within the logic of the capitalist system of which they are a part are, Navarro asserts, likely to be either wrong or radically incomplete (for example, see Navarro's somewhat different critiques of Starr (Navarro 1984b), and of Sen (Navarro 2000)).

Though we have been speaking of capitalism as a whole, in many of his publications Navarro analyses 'types of capitalism' rather than capitalist versus non-capitalist types (Navarro 1999; Navarro and Shi 2001; IJHS 2003). The advantages of Social Democratic forms of capitalism as compared to liberal, neo-liberal or market fundamentalist forms are frequently noted. There is, then, leeway within capitalism for different types of capitalist social formation, some (Social Democracies, for example) better for their citizens than are others. And, capitalist dynamics can change over time, Navarro stresses, for example, the powerful contrast between the post–Second World War era of welfare state expansion and the emphasis in the last few decades on market fundamentalism. Implicit in Navarro's writings is the focus on different capitalist historical phases and contemporary capitalist variants.

Class

Assumed in what we have said about mode of production is the division of society into classes, capitalists and workers. The capitalist class consists of the owners and controllers of capital, a class which exploits and dominates middle or working classes. While the owners and controllers of the means of production have internal fractions (for example, financial vs. industrial capital), with possibly differing interests, nevertheless they also have over-arching common interests in perpetuating, reproducing and extending a capitalist system from which they disproportionately benefit. Capitalists act to fulfil these interests, partially through their influence on the state, but also through politics and through their influence on state bureaucracies and on law, the media, ideology, political parties and so on. Yet, this dominance is not entirely one-sided. There is struggle between capitalist classes and other classes. Such struggles are evident throughout society, both inside and outside the workplace and inside and outside the state and medicine (Navarro 1976, 1983, 1989).

In the class struggle, the capitalist class has immense advantages because of its general control over societal resources and because of the dependence of workers on continuous employment for survival. Hence, one measure of working class power is the degree to which workers can survive outside of market relations (that is, de-commodification – for example, through universal unemployment benefits and social supports; see Esping-Andersen 1990, 1999). Navarro thus argues that there are on-going class oppositions, even in instances in which the participants might not self-identify their actions in class terms or might strenuously deny the very existence of classes.

Even within putatively electoral democracies in which most people have a vote, capitalists have major advantages. Capitalists or their supporters influence or own the print press and other media, contribute massively to political parties, proselytise through setting up think-tanks and strongly influence states and state laws and regulations. Other classes, which Navarro sometimes refers to as working classes or popular classes, are suppressed or disorganised or out-resourced or their demands are shaped through policy trajectories to remove much of their radical content (see for example, Navarro 1978, 2006).

A major distinction within the mode of production/class Marxist view is between the formal rules and laws within current forms of democratic capitalism and their actual enactment. For example, there is said to be in the advanced nations a 'free press', but obviously the press is dominated by business interests as the Murdoch phenomena testifies. There are similar situations within legal, educational and other societal institutions. Moreover, constitutions and legal norms are skewed towards capitalist interests, importantly enshrining in law the rights to private property (referring not to personal property but to that property which creates profit), as superseding other human economic, legal or social rights. In the early twenty-first century, after the economic crisis of 2008, it is more obvious than before that the 'needs' of a capitalist economy are more important than democratic representation: as exemplified by the nations in Europe which have leaders parachuted in by the International Monetary Fund (IMF) and the European Union (EU) or which conform to IMF and EU dictates despite massive public opposition.

What about sources of oppression other than that of class? Navarro adds to the notion of class oppression that of race, gender and ethnicity. In his autobiographical account, Navarro notes the importance he attaches to class: 'class relations do not determine but do condition most potently how other variables affect the population's health' (1998b: 397). However, he adds that:

> We also studied how race, gender, and ethnicity affect health and well-being in our societies. But we analysed the effects of these variables on health as part of a matrix of relations in which class relations were of great importance in understanding how such variables relate among themselves and with health (Navarro 1998b:398).

Navarro emphasises that his own focus on class 'does not aim at denigrating the importance of other factors' (1989:896).

While we have mentioned capitalists or the bourgeoisie and the working class, everyone agrees that a two-class version of Marxism does justice neither to Marxism nor to today's complex social structures (see for example, Wright 1989). Navarro himself often points to other classes or class fractions, including, for example, a landowning aristocracy, a holdover from the feudal era and a middle class itself consisting of upper and lower fractions with somewhat complex and shifting relationships with the two main classes (see for example, Navarro 1978). On more than one occasion, Navarro states his adherence to Erik Olin Wright's (1989, 1997) vision of fundamental classes and various contradictory or ambiguous class locations based on different modes of exploitation – ownership of capital, control over bureaucratic resources or scarce skills (Navarro 2000).

As Navarro points out, the Marxist vision of 'real' social classes contrasts with the mainstream emphasis on 'stratification' or socio-economic status. SES refers simply to hierarchies regarding such factors as educational attainment, occupational position and income, or some combination of these (Navarro 2007). A key difference is that the Marxist versions of class are relational rather than simply gradational, that is, a capitalist class implies the working class, and vice-versa. Critically, this is a relationship of exploitation, not simply a question of being higher or lower on some criteria. In fact, it can be argued that socio-economic status differences have class structural bases (Coburn 2004). The underlying cause of the rapid rise of inequalities after 1980 in nearly all of the developed nations, but particularly in the Anglo-American countries, is the increasing dominance of capital in the past three decades. Class struggles and the increasing dominance of capital nationally and globally also help Navarro analyse the movement from the establishment of welfare and state services, based on a period of relative working class power in the immediate post-war era, to the latest neo-liberal attacks on state-provided or -financed welfare and health measures at a time of the global dominance of capital.

Politics

Almost inevitably, Navarro's critiques of the analyses of others contend that these do not go far enough because they neglect the role of the uneven class struggle and hence politics. In the instance of the *Social Determinants of Health Report*, for example, he notes his agreement with many of the findings of this report, including its key point that 'inequalities kill', but points out that the Commissioners fail to bring out the specific underlying political sources of the inequalities which they decry. There is a causal sequence, but one which fails to explain how the social determinants came to be what they are. It is an analysis without villains and without blame (Navarro 2009).

Whereas Navarro notes that he is often portrayed as an 'ideologue', in opposition presumably to social 'science', Navarro feels that such commentators are themselves politically biased because they fail to point out the political underpinnings of the health phenomena they study. Navarro contends that all major national and international agencies, including the United Nations (UN), the World Health Organization (WHO) and other organisations reflect prevailing class forms of domination (Navarro 1983, 2008). From Navarro's perspective, the failure to deal with class power is itself a symptom of the hegemony of a capitalist ideology, which naturalises and makes invisible exploitative class relations.

A key ideological weapon in political struggle is the ability of capitalists to portray their own specific interests as in the interests of everyone or to turn political issues into purely technocratic ones (Navarro 1984b). Everyone is said to benefit: provided capitalists make huge profits. Matters that should be publicly debated are rather assigned to experts or technocrats, who are asserted to be 'neutral'. Most evident in today's world, for example, is the attempt to make most economic decisions seem purely scientific and technical and therefore not open to debate – incidentally a corollary of which is the social science discipline of economics' vision of itself as not a 'social' but a 'natural' science. Internationally, the role of the IMF, the *World Bank*, the WHO and other organisations are legitimated through arguments that these deal only with issues which are technical rather than political in nature.

It is the realm of class struggle and politics that Navarro can manage to theorise both the structural influences of capitalism with a more actor-oriented, conflictful and contingent view of the functioning of advanced capitalism. Throughout his work Navarro emphasises that our fates are not predetermined, there are political choices to be made and actions to be taken, which can lead to reform, although he feels that reforms have limited ultimate purchase. Very few sociological theories in health are as capable as Navarro's approach of helping us understand both structural influences and historical and social change.

Analytical examples

I focus on three health issues: medical dominance, the social origins of healthcare systems, and health and health inequalities as key illustrative examples of Navarro's employment of the concepts of mode of production, class and politics.

Medical dominance

The power of the medical profession is an important topic in the sociology of health. If it is true that medicine can define not only what is meant to be health/illness but also what should be done about it and how these interventions should be carried out, then medical power could be the key to explaining a variety of health problems, from disjunctions between the provision of care and the health needs of the population to the current predominance of cure over prevention.

In the 1970s, Freidson (1970a, 1970b) argued that medical knowledge might be relatively interest free but, in the application of that knowledge, the medical profession came to be dominant over definitions of health, over patients, over other healthcare workers and over the provision of health services generally. Such power, conceptualised as medical dominance, was as much used in the interests of the medical profession as it was for the benefit of the community or of patients. Following Freidson, there has been much discussion about dominance, its historical emergence and possible future, and its geographical distribution (for a recent re-consideration, see *Health Sociology Review* 2006, volume 15, issue 5). That is, has medicine always been dominant and will it remain so, and was it as dominant in Europe as in North America or the other Anglo-American nations? In the latter part of the twentieth century came subsequent debate about a possible decline of medical power. Medicine faced state and business intrusion into healthcare and the struggles of other health occupations and patients against the interests of the profession. Some went as far as to claim that medicine was being proletarianised (McKinlay and Arches 1985), that is, becoming routinised and subject to the same kinds of controls as working class labour.

In the context of debate about medical dominance and its possible decline, Navarro wrote a paper titled in typical provocative fashion: *Medical Dominance or Proletarianisation: Neither* (Navarro 1998a). In that article, Navarro not only critiques the hypotheses of both dominance and proletarianisation but opposes Freidson's seldom discussed assumption that 'medical science' is neutral.

Navarro's main point is that while medicine has a great deal of power, it has never been dominant in health and healthcare. Rather, at particular points in history, there have been conflicting notions of health, with modern medicine representing the victory of one pole of this conflict. Pointing to the beginnings of medical power in late nineteenth century Germany, Navarro notes that one vision of health, associated with Virchow and Engels ([1845] 1987), asserted that poor living and working conditions, and poverty, were the major factors leading to poor health. Hence, the solution would be a collective attack on the conditions underlying poverty, a political task. On the other hand was an approach supported by elements within an emerging medical profession that focused on specific germs and an individualist process of disease production as the causes of ill-health. Within this perspective, the human body was like a machine and the focus was on the specific noxious organisms that caused disease and sick individuals. Such a vision was spread to North America and elsewhere through such means as the Flexner Report of 1911, whose major aim was to 'scientise' medical education along individualistic lines.

Navarro contends that the Engels and Virchow vision of health and illness was opposed by an emerging industrial capitalist class, which saw the political and collective version of health as a threat to their burgeoning power and interests. The idea that illness was a product of poor capitalist workplaces, inadequate housing or the like was an anathema, while an individualistic mechanistic model was much less threatening. The formative period for the establishment of medical power was thus in the late nineteenth and early twentieth centuries and centred partly on the highly influential medical debates in Germany. Hence, the individualist mechanistic view was not 'imposed on' society by a powerful profession but rather a particular version of medicine was 'selected' by the power structure of the time. Medicine became what it was as a result, not necessarily or only, because of its ability to influence events (although that certainly was a factor), but because of the coincidence of a particular kind of medicine within a particular kind of class power structure.

Nor did medical power simply naturally build on the discoveries of medical science. One of the sources of medical power certainly is the appeal of science. But Navarro would contend that, first, there was and is more than one version of science and, second, that medical science itself is not entirely class neutral or objective. In places, Navarro states that there are various types of science emanating from the different classes within capitalism (Navarro 1980). More broadly, science, what is considered scientific and its application are all conditioned by class factors.

Navarro concludes that medicine has never been dominant but has always been an intermediate rather than ultimate source of power. Conversely, in commenting on speculation in the late twentieth century that medicine was losing its dominant position, Navarro thought it unlikely that medicine would be completely proletarianised. Rather, medicine would be subject to constraints, from corporations and from states interested in greater health efficiencies, from other health occupations, or from other interests such as the pharmaceutical industry. However, physicians were unlikely to become like the mass of industrial workers either in their work or in their social position. Navarro's final conclusion about medical dominance was thus that medicine was and is powerful, and might be somewhat declining in overall influence, but its power was and is always ultimately subordinate to the power of dominant classes.

Healthcare systems

Like most other contemporary social analysts, Navarro believes that health is determined as much or more by the general conditions under which people are born, live and work than it is by curative healthcare. However, he also feels that healthcare systems have a role to play in improving health, hence the degree of universality of healthcare systems, what percentage of the population are covered, how extensive the coverage is and what form healthcare services take are significant.

In 1989, Navarro tackled the question, '*Why some countries have national health insurance other have national health services, and the US has neither?*' In this paper and elsewhere, Navarro's familiar contention is that national differences in types and forms of healthcare are determined by variations in class power structures. In the developed world, the balance of class forces and class alliances is crucial to explaining national differences in the enactment of welfare state regimes generally and more universalistic healthcare systems specifically. Working class strength is demonstrated by higher degrees of unionisation, by the existence of working class organisations and, most importantly, by expression in a working class political party. Alliances between the working class and middle strata often prove crucial in advancing working class interests. The working class cause is aided when the capitalist class is divided, lacks unity or is opposed rather than in coalition with a landowning aristocracy. Thus, greater universalism in healthcare, in which healthcare is seen as a right of citizenship rather than as a work-related privilege, is more likely to appear in social formations characterised by a strong and united working class and weak or divided capitalistic classes.

Following Esping-Andersen (1990, 1999) on welfare state types, Navarro argues that working class power, as in Social Democratic Sweden, helps push universal or state-run forms of care onto the political agenda. Strong capitalist class structures, as in the United States, lead to fragmented or largely privatised forms of care (residual and essentialist, Navarro 1983, 1999). The traditional Christian Democratic or familist welfare regime nations (such as Italy) tend to have weaker working class structures and parties, and in such nations healthcare is provided on the basis of employment, the male breadwinner model, or associated with an individual's occupational ties or history, rather than being universal. Spain, Portugal and Greece have systems just emerging from dictatorships, have the weakest form of welfare state and are generally more like familist than other regime types (Navarro 1999).

Even in instances in which it might initially appear that health reforms were first brought in by dominant landowning or capitalist classes, as in the case of Bismarck's Germany, Navarro contends this was largely done to pre-empt the more radical reforms demanded by working class movements. Though getting health reforms on the political agenda was a success, nevertheless these were, in their enactment, frequently skewed against working class interests by class-biased states or state bureaucracies. Navarro's book length treatment of the historical establishment of the *National Health Service* in Britain (1978) makes much the same points in detail. That is, Navarro notes the ability of organised working class movements and parties to create political situations favourable to more universal services, yet these left in place institutions which worked against equality in treatment for all and could divert reforms in less radical directions. In the richer nations studied, the causal sequence thus leads from class struggle, through types of welfare states, to healthcare systems.

However, it is not only the universality of systems that is important, rather such systems have to be set within the larger whole of the determinants of health in general – of which healthcare systems are only one part. There are differences in types of healthcare systems, with very few advanced nations emphasising health promotion and disease prevention, as they might. In almost all instances, expensive and technologically advanced tertiary care services, of most use to the rich, are emphasised. This is true even in nations in which primary care is highly underdeveloped and would be of the greatest use to the majority of the population. And, given the importance of general living conditions, other welfare state services, including rising income and other equalities, are highly significant. Even in cases of nationalised health services, Navarro contends that these are still hierarchical and managerial, are under continuous pressure to privatise, and serve to reproduce the capitalist system. He similarly critiqued the welfare and health systems of the Soviet Union, for example, claiming these were still hierarchical, unequal, not responsive to the people they served and dominated in the upper echelons by males (Navarro 1977). Navarro would not characterise nationalised systems of healthcare as 'socialist' because he believes real socialism is not possible without a revolutionary break with capitalism.

Whereas the rise of welfare and health systems were viewed in terms of an era of relative working class power after the Second World War and up to about 1980, many of Navarro's recent writings have been critiques of the neo-liberalism of the late twentieth and early twenty-first centuries (Navarro 2007a, 2007b and IJHS volume 33 issues 3 and 4). Navarro regards globalisation as a neo-liberal project to spread capitalist class–positive policies throughout the world. The result since the 1980s has been rapidly increasing social inequalities, more and more attacks on the universality of services, and a call for user fees as well as for the privatisation of state health services. Again, Navarro argues that nations with a stronger and more organised working class have been better able to resist the neo-liberal global undermining of the welfare state and universal health services than have countries with weaker working classes or stronger capitalist classes.

Health status and health inequalities

Health

The health of individuals, regions and nations is the topic of an immense literature from Engels, Virchow and Chadwick to the *WHO Commission on the Social Determinants of Health* (2008) and the *Socialist Register's* special edition on capitalism and health (Panitch and Leys 2010). Like many other social analysts, Navarro has a 'social, economic and political determinants' approach to health status and to health inequalities within and between nations. Navarro, however, goes further than most theorists in arguing that we have to go beyond simply documenting how social factors such as class/SES condition health status, because he regards social conditions themselves as largely a reflection of specific class/political regimes (Navarro 2008). The added value of Navarro's approach thus focuses not as much on the immediate determinants of health as on their distal structural origins. Analyses which exclude such political factors, Navarro argues, are truncated, misleading and theoretically inadequate.

Much of Navarro's attention has been focused on the influence on health of different national capitalist types or variants. Often in collaboration with colleagues, Navarro has demonstrated that the Social Democratic nations show better health status than do the 'liberal' or neo-liberal Anglo-American welfare regime nations. The Christian Democratic Welfare States' of central Europe, highly influenced by the conservative Catholic Church, have tended to show higher average levels of health than the neo-liberal nations, although generally poorer than the Social Democratic countries (Navarro and Shi 2001; IJHS 2003 volume 33, issues 3 and 4). The Social Democratic nations are much more efficient than other countries in translating increasing economic development into improved human well-being.

Since the 1970s Navarro has particularly attacked neo-liberalism, the highly market-oriented forms of regime associated with Thatcherism and Reaganism, on health grounds, but also for other social and economic reasons (Navarro 2007a, 2008). Navarro's contention is that the Social Democratic nations of Scandinavia and Northern Europe have both better economic performance and higher human well-being than the more market-oriented Anglo-American countries (see for example, Navarro and colleagues IJHS, 2003 volume 33, issues 3 and 4), and that class equal historical eras (for example, the 1960s to 1980s) have more rapid health improvements than do capitalist class–dominant periods (as in the post-1980s decades).

While the United States is generally seen as one of the major promoters of neo-liberalism around the world, Navarro points out that the United States has been much more eager for other nations to adopt neo-liberal policies than it has itself. In fact, he contends that Reaganism was more associated with a form of 'military Keynesianism' than with actual neo-liberal or market rule (Navarro 2007a). Navarro argues that the liberal, or neo-liberal, regimes, dominated by capitalists politically yet contrary to the ideology of neo-liberalism, did not dismantle the state. Rather, the state took on a different form of supporting military and corporate interests rather than state support for social and health services (Navarro 2007a, 2009). The state did not shrink; it altered its functions to favour capitalist class interests leading, ironically, to higher inequalities, lower demand, worse performing economies and less progress in improving health status. Big corporations, while using neo-liberal arguments in the abstract for ideological purposes, saw both socialism and possible libertarian regimes as against their interests.

Health inequalities

A major issue for Marxists is that the capitalist mode of production has the capacity to produce a huge social surplus, but this surplus is, according to the logic of the system, appropriated by the few while the many are oppressed. There is no end to ever-increasing accumulation in a world which demonstrates more and more economic, social and ecological problems. Today's world is the product of 30 years of neo-liberal attacks on state services and workers benefits resulting in a situation in which a few have almost unimaginable wealth while others starve. There is enough for everyone, but under capitalism we are not able to realise the fruits of such productivity in improved well-being for all (Navarro 2007a, 2007b, 2008, 2009).

Navarro notes that there are massive health inequalities within both the developed and the less developed nations. Policy-makers in the developed nations show increasing concern over the persistence of large inequalities in longevity and infant mortality rates by SES and region (for a recent expression, see WHO 2008). In fact, 'the gradient' or SES differences in health status has been proclaimed as a 'fundamental cause' of health disparities and poorer overall health (Link and Phelan 1995). Navarro agrees with others (for example, Kawachi et al. 1999; Wilkinson 2005) that there are real SES differences in health, that these reflect the effects of relative and not only absolute material inequalities, and that social inequalities can help explain differences in national health status. It is Navarro's contention, however, that the many studies which demonstrate health inequalities or the relationship between class/SES or income inequalities and health are useful but fail to make the connection between inequalities and the underlying class and political structures. Quite clearly, the past 30 years have seen a shift to greater capitalist power and the undermining of working class organisations, including frontal attacks on labour unions. Navarro feels that these changes have had the effect of producing massive income, wealth and social inequalities, all of these with effects on health. Any consideration of SES or income- or region-related health inequalities thus needs to take into account class structure and class struggle as underlying causal factors.

Navarro argues against the determinant effect of an abstract form of 'globalisation'. That is, it is often assumed that globalisation reduces national choices in the direction of acceding to the demands of capital for privatisation, labour 'flexibility', free trade, easier capital flows and the like. For Navarro, however, globalisation is not as constraining as various national governments would have their populations believe. Navarro (2009) strongly feels that individual nations retain considerable leeway to make their own political and policy choices. The real issue is class power within nations. And, unlike those analysts who focus on one or more powerful nations (usually the United States) dominating others, Navarro (2009) argues that, though there is a national power hierarchy with the United States at the top, the major problem of massive international health inequalities is the collaboration between the ruling classes of the developed, with the ruling classes of the less developed nations. Many of the problems of the poorer nations can thus be laid at the feet of their own ruling classes and not simply on external constraints.

A solution for the problems of many of the less developed nations, those suffering the highest burden of poor health, would be a greater focus on internal markets rather than, through the pressures of globalisation, an exclusive focus on exports: 'What poor countries need to do is to change from export-oriented economies (the root of their problems) to domestic oriented growth' (Navarro 2007a:55). Yet, such organisations as the WTO, the IMF and the *World Bank* and, as Navarro would add, the UN, the WHO and similar institutions, continue to spread policies which benefit the rich and the capitalist classes in the north and south rather than the oppressed classes in such countries (Navarro 1984a, 2009). The result is intolerable levels of health inequalities both within and between nations.

Comments

I have described, hopefully accurately, how Navarro applies a theoretical scheme derived from Marxism to selected health issues. Insofar as much of social theory is said to be a debate with Marx's ghost, any assessments of Navarro's scholarly work must reflect the continuing enormous debates which have taken place over such issues as capitalism or class (see for example, Wright 1989). I do not comment on these debates here since they are prominent parts of general sociological theory.

Navarro's efforts to develop a distinctively Marxist approach to the health field should really be judged in the context of the many other theorists or theories offered in this volume. Does the approach described offer something other than or more than alternative theories or theorists? Does Navarro add something to our understanding of or explanations for health and healthcare issues and events that other theorists do not? That assessment is for the reader to decide. Navarro obviously succeeded in one of his major aims, that is, in helping to end the relative silence about class in health studies. Navarro's holistic Marxist political economy helped create space in mainstream health analyses for alternative perspectives. He inspired others to explore the topics he introduced.

Given his voluminous and immensely broad writings, there are always specific aspects of Navarro's work for which one would ask for more detail, more theory or more research support. However, here, from someone interested in the more global aspects of Navarro's work, I point to four issues which may be fruitful areas for further study. My intent is not critique but rather an attempt to build on and to advance Navarro's approach.

Given general absolute improvements in health for at least the last 100 years in nations with varying political regimes, it would be useful to see a discussion by Navarro of some of the important factors national and global, perhaps not directly related to class, involved in these health gains (for a beginning discussion of health trends and inequalities, see Coburn 2011).

Welfare regime type analyses raise numerous theoretical and empirical issues; I will mention only two. First, there are national overlaps regarding health status among the regime types, implying that there is more than one route to better average national health or that welfare regime models need greater specification. Second, many less developed nations have quite different forms of economic and social structure than those shown by the developed nations. In some poor nations, there are important populations of pre-capitalist subsistence or peasant farmers, while in others there are combinations of capitalist markets with overtly communist party governments. How generalisable to these situations is a Europe-derived welfare regime model (for one attempt, see Gough et al. 2004), or a class analysis developed from study of the richer nations? In general, more analysis of the less developed nations, those comprising the vast majority of the world's population, would be useful.

Does the rise of a more international capitalist system bring more national constraints than Navarro believes? Regional economic pacts, such as the EU or NAFTA, have had powerful effects on member states. These have been partially the result of globalisation pressures. And, there are also global forces and institutions (the IMF, the WTO, the *World Bank*), whose functions are reducing borders and barriers, as Navarro puts it, which, as he notes, have had manifold consequences for nations throughout the world. These institutions may be placing increasingly stringent limits on national choices and much more for some nations than for others.

Finally, as Navarro has pointed out, any theories based on class struggle, the influence of labour and the welfare state need to confront, at least in the English-speaking world, the defeats and decline of unions and the organised labour movement in the past 30–40 years and the increasing disassociation of 'Labour' political parties from progressive policies. Labour-related movements were important in the past, but are they likely to be so in the future? The rise of labour in the less developed nations and the increasing number of potentially anti-capitalist but non-labour-based social movements are significant developments which require greater theoretical integration with class-related theories (see Navarro 1988, 2006).

Navarro's framework is the most encompassing one today regarding the contemporary capitalist political economy and its variations in relationship to health and health inequalities. Navarro's insights permit a historical theory of change which incorporates both the rise of the welfare state and health services and attacks on these in the neo-liberal era. After the economic crisis of 2008, Navarro's conceptual approaches remain of striking relevance regarding the fate of health and healthcare within a capitalist world.

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Chapter 27

Anthony Giddens: Structuration, Drug Use, Food Choice and Long-Term Illness

Jonathan Gabe and Joana Almeida

Anthony Giddens is one of the world's most authoritative and widely cited social theorists. Having started his career writing about classical social theory, he has developed a new sociological lexicon, ranging from structuration theory to social reflexivity, the recursive character of action, ontological security and late modernity. This chapter focuses on the application of Giddens' theoretical contribution to the field of sociology of health and illness. It begins with a brief summary of Giddens' academic life and career before describing his theory of structuration and the concept of social reflexivity. The chapter then considers the relevance of Giddens' theoretical framework to the sociology of health and illness, by illustrating its use in three main areas of empirical research: prescribed drug use, food choices and eating practices, and long-term illness. Finally, the potential of Giddens' theoretical contribution for sociology of health is assessed.

Biography

Anthony Giddens has been considered by many as one of the foremost contemporary essayists of modern social theory in the English-speaking world. As Kaspersen (2000:vi) puts it, he is a 'global phenomenon'. Since 1960, Giddens has published more than 30 books and hundreds of articles, essays and book reviews, which have had a profound impact on social theory and social sciences in general. His work has been not only translated into many languages but incorporated into undergraduate and postgraduate teaching curricula in sociology in many countries (Kaspersen 2000:vi). As O'Brien (1998:1) states, Giddens is a 'virtual one-man publishing industry'.

The social context of Giddens' academic career helps explain his theoretical orientation. Giddens was born in 1938 in Edmonton, an underprivileged north

London suburb. His father was a clerical worker for London Transport, and he was the first member of his family to go to university. Giddens portrays himself as ‘relatively untalented’, and describes his incursion into academia as influenced by contingency rather than motivated by passion or enthusiasm (Giddens and Pierson 1998). He graduated with a first class honours degree in sociology from the University of Hull, in 1959, where he developed an interest in the subject under the influence of Peter Worsley. While at Hull, his awareness of its industrial heritage made such an impact that it later shaped his approach to sociology as a discipline, where the aim is to understand the relationship between the nature of the social world and people’s actions.

Giddens then moved to the London School of Economics (LSE), where he wrote a thesis for his master’s degree on sport and society in contemporary England (Giddens and Pierson 1998). In 1961, he became a lecturer at Leicester University, where he stayed until 1969. During his time at Leicester, he worked alongside Norbert Elias, from whom he learned the significance of developmental processes and the contingent nature of social life (Giddens and Pierson 1998). In 1970, he took up a lectureship at Cambridge, replacing John Goldthorpe as a fellow at King’s College, becoming a professor of sociology in 1985. Giddens describes his time in Cambridge as a difficult period of adaptation, with endless battles over the social recognition of sociology, although he was very productive throughout his time there (Giddens and Pierson 1998). It was while still at Cambridge, in 1984, that he co-founded Polity Press, with David Held and John Thompson, now one of the best known publishing houses in the social sciences and humanities worldwide. In 1996, Giddens left Cambridge to become the director of the LSE. This new role coincided with his decision to move beyond social theory and become directly involved in politics. He thus contributed to the Britain’s New Labour government’s policies, through the *Third Way* (Giddens 1998), an attempt to set up a new political agenda for the world between Left and Right (Kaspersen 2000:5). In May 2004, following his retirement from LSE, he was given a Life Peerage. He is currently a Life Fellow of King’s College, Cambridge, and Professor Emeritus at LSE.

Along with his professorship, Giddens has also been a visiting professor at various universities. His visits to Simon Fraser University near Vancouver and to the University of California Los Angeles during the 1960s and 1970s, at the height of the counter-culture and related social movements, for example, are said to have heavily influenced Giddens’ writings (Kaspersen 2000:1). As Giddens himself puts it:

> ... the first afternoon I got to Los Angeles I went down for a walk along the beach. I thought it would be deserted but it was full of people, an utterly amazing scene... The beach looked something like the fall of the Roman

> Empire. It was a maze of gaudy colours. People were dressed like characters from a biblical scene, or so it seemed for someone who'd not encountered the hippies before (Giddens and Pierson 1998:41).

This encounter with the American counter-culture of the 1960s and 1970s reinforced Giddens' view of sociology as a hermeneutic discipline, which draws in part upon laypeople's motivations for their actions and interactions.

Giddens subsequently developed an original and highly influential theoretical framework for the social sciences, which is said to have shaped social theory in the twenty-first century (Tucker 1998). His primary concern was to reconstruct social theory in terms of 'structuration theory'. In addition, he has sought to enhance our understanding of the dynamics of modernity, globalisation and what he calls 'late modernity'. Giddens has also developed the concept of 'social reflexivity', which he analyses at a micro (the self, the transformation of intimacy and sexuality) and macro (social structural) level. More recently, he has become interested in environmental issues and the politics of climate change (Giddens 2009). Despite the range of Giddens' contributions to social theory, this chapter will focus solely on Giddens' structuration theory and his discussion of social reflexivity. It is to these that we now turn.

The theory of structuration and the concept of social reflexivity

Giddens' conceptual framework for analysing the social world attempts to overcome competing theoretical classical traditions in social theory, conjoining what he called the 'orthodox consensus', associated with the work of Parsons who was clearly influenced by the writings of the founders of sociology, and a phenomenologically inspired alternative. It is in the context of this theoretical division in the social sciences in the 1980s that the originality of Giddens' contribution should be located. From his reflections about and critiques of structural-functionalism and ethnomethodology, Giddens created the foundations for his own conceptual work. In writing about Giddens' legacy, this chapter will concentrate exclusively upon his books *New Rules of Sociological Method* (1976), *Central Problems in Social Theory: Action, Structure and Contradictions in Social Analysis* (1979) and *The Constitution of Society* (1984). In these works, Giddens identifies certain key problems in social theory, in particular the agent–structure or subject–object dualism. He tries to transcend this impasse by reformulating it.

Giddens' starting point is the idea that traditional competing sociological perspectives of the macro and micro analysis of social practices should be merged in order to create a novel framework to examine modern societies.

As he says in the introductory chapter to what has been considered his most influential work in sociology, *The Constitution of Society*:

> ...I acknowledge the call for a decentring of the subject and regard this as basic to structuration theory. But I do not accept that this implies the evaporation of subjectivity into an empty universe of signs (Giddens 1984:xxii).

In *The Constitution of Society*, Giddens develops his structuration theory in detail, based on the premise that the gulf between naturalistic and interpretive traditions of thought needs to be bridged by a theory that reconceptualises this taken-for-granted division. For him, there is always a dualism deeply embedded in social theory, a division between objectivism and subjectivism (Giddens 1984). Giddens proposes to reconceptualise this division by presenting his idea of 'duality of structure'. For him, structure, defined as sets of rules and resources, has no existence without the 'knowledgeability' of agents in social life. That is to say, by reproducing rules (through habit and routine) and resources (institutions), agents reproduce the conditions that make such reproduction possible. In this sense, structure is both the medium and outcome of activities of human agents and is always both constraining and enabling. In sum, the 'duality of structure', according to Giddens, is where structure and agency are presented as mutually dependent, thus arguably transcending the classical dualisms of social analysis.

Giddens' first discussion of structuration theory and duality of structure can be found in his book *New Rules of Sociological Method* published in 1976. The irony in the title refers to Durkheim's *Rules of Sociological Method*. Giddens outlined in his book some 'new rules' of sociological method and an alternative way of analysing how society is produced:

> The production of society is brought about by the active constituting skills of its members, but draws upon resources, and depends upon conditions, of which they are unaware or which they perceive only dimly (Giddens 1976:157).

Furthermore, Giddens (1976:161) identifies the 'duality of structure' as a new rule:

> ...*structures must not be conceptualised as simply placing constraints upon human agency, but as enabling*.... To inquire into the structuration of social practices is to seek to explain how it comes about that structures are constituted through action, and reciprocally how action is constituted structurally (emphasis in the original).

The fact that the duality of structure draws upon the idea of continuity and flow of social action leads us to another of Giddens' main concepts – that of 'reflexivity' or the 'reflexive monitoring of action'. For the theorist, human agents have the reflexive capacity to understand what they do while they are doing it. In other words, they have the ability to monitor their actions by continuously reflecting on their day-to-day conduct. Giddens (1984) adds that this reflexivity involves the psychological mechanism of recalling and reviewing past experiences, and operates on a discursive or analytical level (those forms of recall which the agent is able to talk about or express verbally) as well as at the level of practical consciousness. The latter involves agents having access to forms of recall *in* the course of their action, without being able to express what they know and to incorporate it within their reflexive monitoring of conduct.

Furthermore, the reflexive monitoring of action is closely related to the concept of 'routinisation'. As Giddens (1984:60) states:

> ... routine is integral both to the continuity of the personality of the agent, as he or she moves along the paths of daily activities, and to the institutions of society, which *are* such only through their continued reproduction.

The routine of day-to-day life is a key element of the 'ontological security' of agents, another core concept in Giddens' structuration theory. 'Ontological security' refers to the generation of feelings of trust in others, which depends upon predictable routines.

Finally, Giddens' theory of structuration is closely linked to power, and to time and space. The fact that agents are able to offer accounts of their conduct through reflexive monitoring of their action and to have transformative capacity over their conduct means they can exercise some sort of power. Giddens (1984:16) conceives power not as a resource, but as a 'routine element of the instantiation of conduct in social reproduction'. Power is the capacity of human agency 'to intervene in a series of events so as to alter their course' (Giddens 1976:111). In this sense, resources and rules (structure) are recursively offered to agents in order for them to exercise power; that is, to intervene to change, resist or maintain the social order. They are thus asymmetrical vehicles of power, as agents' differential access to them has consequences for their varying capacity to intervene to change, resist or maintain the social order in the face of time and space constraints. As Margaret Archer (1982:457), a commentator on Giddens' contribution to social theory, concludes:

> ... because of the dynamic interplay of the two constituent elements [structure and agency], 'structuration' does not denote fixity, durability, or even a point reached in development. 'Structuration' itself is ever a process and never a product.

Social life thus has a ‘recursive character’, since structure and action are complementary rather than opposed. Structure has ‘virtual existence’ by being deeply layered in time and space; action is immersed in communication and interaction and is monitored by agents.

Giddens’ contributions to social theory have been at the forefront of debates in the social sciences. Although his structuration theory has been extremely influential, it has not escaped critical attention. Margaret Archer (1982:459), for example, points to the fact that although structuration theory amalgamates structure and agency, it provides no analytical tools for understanding:

> ... which is likely to prevail under what conditions or circumstances ... In other words, the ‘central notion’ of the ‘structuration’ approach fails to specify when there will be ‘more voluntarism’ or ‘more determinism’.

Archer (1982:460) continues that what is wrong with Giddens’ duality of structure:

> ... is that it does not allow for some behaviour engendering replication whilst other action initiates transformation. Rather than transcending the voluntarism/determinism dichotomy, the two sides of the ‘duality of structure’ embody them respectively: they are simply clamped together in a conceptual vice.

For Archer, Giddens emphasises the structuration of social systems but fails to analyse how social systems are structured over time. So while structure and agency are interdependent, she argues that it is possible to disentangle them from an analytical point of view. In the same vein, Layder (1994) states that the fact we can separate the two aspects of the duality of structure when doing empirical research suggests these represent different aspects of social reality, although they are also interdependent.

Callinicos (1985) also criticises Giddens for drawing parallels between the case of language and social practice. Callinicos states that social practice is not rule-governed like language. In social practice, ‘rather than generating practices, rules collapse into them’ (Callinicos 1985:139). Thompson (1989) also questions Giddens’ definition of structure as composed of rules and criticises his lack of clarification about the meaning he attributes to rules. For Thompson (1989), there are more than rules and resources constraining human action, and the reproduction of institutions should be clearly distinguished from the reproduction of social structure. In other words, structural analysis should involve more levels than those explored by Giddens. As Thompson (1989:70) puts it: ‘the extent to which an action transforms an institution does not coincide with the extent to which social structure is thereby transformed’.

In addition, Callinicos criticises Giddens' conceptualisation of 'knowledgeable human agents' for being ahistorical. For this theorist, Giddens does not provide a discussion of the historically specific conditions which shape human agency. The 'knowledgeability' of human agents to resist, maintain or alter their life conditions, instead of being a gift or a general property attributed to them, depends on the specific circumstances in which they find themselves. For Callinicos (1985), this reveals Giddens' preference for agency in his theory of structuration as well as the latter's failure to overcome the dualism of agency and structure.

Criticising Giddens for preferring a humanistic approach to contemporary society and for underplaying the objective force of structural constraints by over-emphasising the subjective nature of an individual's actions are very common in the literature. Layder (1994:142), for example, comments that 'social systems have more durability and independence than Giddens seems to want to admit', and that Giddens underplays the objective force of structure when he suggests they only exist in the reasons and motives of actors.

Despite the debate over the value of structuration theory sociological researchers have increasingly recognised the importance of finding a balance between structure and agency and have drawn on Giddens' framework to achieve it. We now move to the field of sociology of health to illustrate the uptake of structuration theory and offer a critical discussion of its use.

Giddens and the sociology of health and illness

In this section, we look at empirical work on health and illness, which has challenged the macro-micro dualism in social theory by drawing on Giddens' structuration theory as a frame of reference. In order to illustrate this empirical work, we concentrate on three key issues concerning health and illness in late modern society – prescribed drug use, food choices and eating practices, and chronic illness.

Prescribed drug use

Gabe and Thorogood (1986), in an early application of Giddens' ideas to the sociology of health and illness, identified the limitations of existing social research on prescribed drug use while studying this topic among black-and-white working class women in London and proposed an alternative approach using structuration theory. The authors criticised the fact that social researchers tend to divorce the individual from their social context, thus ignoring the importance of social structure and power relations in individuals' routines and everyday lives. In other words, although social research has put prescribed drug use in a social context by describing the prevalence and patterns of drug use, it has failed to explain why and how such prevalence and patterns have arisen. As a consequence:

> . . . the individual is, in effect, treated as if he or she belongs to a single population instead of to distinctive class, race and gender groupings whose relations are structured unequally in terms of wealth, power and privilege (Gabe and Thorogood 1986:738).

In order to bridge this gap between structure and everyday life, Gabe and Thorogood (1986) suggest an alternative approach, which focuses on the availability of prescribed drugs and the meanings that individuals who belong to particular social groups attach to the use of these drugs. For the authors, prescribed drug use is a 'resource' which, along with other material and socio-cultural resources (such as paid work, housing, social support, leisure, religion, alcohol and cigarettes), is experienced in different ways depending on the particular structural position of individuals. Thus, these resources have different meanings for individuals' everyday lives, since everyday life is conceived 'as the lived experience of particular class, race and gender groupings' (Gabe and Thorogood 1986:740). Resources, in this sense, along with rules, make up structure, and are themselves enablers and constrainers of social action. Gabe and Thorogood (1986) proceed to show how prescribed drug use, along with other socio-cultural resources, is differentially distributed and available to people in the management of their everyday lives. They focus primarily on the meaning of benzodiazepine tranquillisers (such as Valium and Librium) to indigenous white women and West Indian-born, black women aged between 40 and 60 who were identified as working class. Each of these social groups was divided into 'users' (long-term and short-term users) and 'non-users' of benzodiazepines.

Gabe and Thorogood (1986) conclude that the availability and acceptance of benzodiazepines and the other resources considered above are structured asymmetrically, depending on these women's structural position in society. Furthermore, the authors demonstrate the value of Giddens' concept of 'resources' by showing that the nature of benzodiazepine use depends on the accessibility to, or absence of, other resources, and whether these resources are experienced as enabling or constraining. In their study, tranquillisers were reportedly used more often and over a longer period of time by indigenous white working class women than by their West Indian counterparts. This was explained in terms of the resources which were primarily available to the West Indian women and experienced by them as enabling – namely, a full-time job, supportive female children living at home and regular church attendance, alongside their distrust of tranquillisers. At the same time, white women who used tranquillisers were constrained to maintain their pattern of drug use because they had fewer resources available to them than white women who were non-users, and those that were available were rarely experienced as enabling. The authors thus demonstrate that in order to understand how actors manage their everyday lives, one needs to take into consideration, not just their access to and experience of a single resource, but the intersection of a range of resources. In so doing, they reveal the usefulness of Giddens' notion of 'resource' as a bridging concept between structure and everyday life (agency) and, by extension, the applicability of structuration theory, where agency and structure are mutually dependent.

Food choices and eating practices

Delormier et al. (2009) also employ Giddens' structuration theory and the notions of rules and resources as a theoretical framework for understanding routine food and eating practices in late modern societies. The authors question the adequacy of social-cognitive approaches which dominate nutrition education and counselling and obesity prevention programmes, as they focus upon the behaviour and the psychosocial characteristics of individuals, thereby separating individuals from the social context in which they live. For Delormier et al., in order to understand population eating patterns one needs to take into consideration the intersection between changes in individuals' dietary behaviour and choices and the socio-cultural context which can enable or constrain these individuals' food choices. In other words, one needs to focus not only on 'agency' (voluntary action) but also on 'social structure' (rules and resources). As the authors state:

> . . . the social structure, therefore, does not determine individual action; it is enacted and reified by people through the choices they make during social practice, and people, through their social practices, reinforce or possibly change the social structure (Delormier et al. 2009:218).

By proposing this theoretical framework, the authors aim to guide health promotion interventions to change the conditions under which the practice of family feeding is undertaken.

Delormier et al. (2009) extended their analysis of Giddens' structuration theory by emphasising the role of norms (rules, tradition, rituals) and authoritative and allocative resources during family feeding. For example, decision-making power is an authoritative resource since it provides actors with the capacity to make food choices. At the same time, authoritative resources are linked to allocative resources, such as money or a busy lifestyle; money and being employed are allocative resources, which enable or constrain decision-making power as an authoritative resource. Resources can thus constrain or enable the conditions that transform food choice practices into eating patterns. Here, then, we can see the utility of Giddens' theoretical framework for studying collective feeding practices. The authors conclude that nutrition and obesity prevention programmes should not only take into consideration changing individuals' dietary behaviours but also assess the authoritative resources of families in the making of food choices.

In the same vein, Chan et al. (1996) have made use of Giddens' structuration theory to analyse childhood obesity and food and eating practices in rapidly changing societies such as Hong Kong. As they state:

> ... traditions, norms, moral codes, and 'established' ways of doing things strongly influence our behaviour but they gradually and iteratively change when we start to ignore them, replace them, or reproduce them differently. Structure is both external ('out there') as discernible social structures and internal ('in there') as embodied and enacted by human actors (Chan et al. 1996:712).

Chan et al. (1996) apply structuration theory to explore how the social context of home and school in the rapidly commodified city of Hong Kong interacts with the agency of children, parents and teachers to enable or constrain childhood obesity and eating practices. They conclude that in the main the lack of ontological security of the primary caregiver is a significant driver of obesity in Hong Kong children. That is, the lack of the main caregiver's ability to give meaning to eating practices, caused by the rapidly changing social context of Hong Kong and the transformation of its food system, which questions what is normal, legitimate and expected dietary behaviour, enables the development of obesity in children and constrains traditional and routine family meals.

Furthermore, Chan et al. show how time and space constitute resources which create the conditions to enable or constrain eating practices and food choices. They observe that:

> ... food preparation space in the typical home is very limited. But the built-up environment and ubiquity of food outlets means that nobody lives far from a source of ready-prepared food (Chan et al. 1996:719–20).

Space constraints at school also undermine physical activity in children: an activity replaced by high-technology activities and reading, writing, music and languages classes. Furthermore, a busy lifestyle is again seen as a resource constraining eating practices. For example, the way children are fed (if the child eats too slowly, the mother takes over and feeds the child), the meals chosen (the more sauces added, the more palatable the food and therefore the quicker the meal is finished), and the conditions under which children's meals are undertaken (often alone and without family eating rituals) strongly influence the decision of caregivers to eat outside the home. This recent research on diet and childhood obesity thus clearly shows the value of Giddens' conceptual framework for analysing food practices in late modern and rapidly changing societies.

So far we have presented empirical research, which has attempted to bridge agency and structure by employing Giddens' structuration theory and his notions of rules and resources. We move now to our third health issue, chronic illness, and discuss it in relation to his theory of structuration and also his concept of reflexivity or 'reflexive monitoring of action'.

Chronic illness

Greener (2008) critically examines the UK Labour government's health policy for the management of long-term illness in the National Health Service (NHS) in the twenty-first century: the Expert Patient Programme. Greener criticises the policy, which aims to promote self-care and empower the patient to control their own illness and thus places considerable onus on human agency. According to Greener, this programme disentangles agency from structure, by responsibilising chronically ill patients (agency) for the management of their condition and reducing the role of the state, healthcare professionals and medical expertise (structure) in managing this condition. Ironically, the 'Expert Patient' programme, introduced by the Blair government in 1999, reveals the considerable influence of Giddens' notion of reflexivity. According to Greener (2008), it places too much emphasis on voluntary action and on the self as an on-going project. In his article, he shows the previously noted flaws of Giddens' theoretical legacy: how much voluntarism and determinism should exist in order to create effective healthcare for long-term conditions? What should the limits of reflexivity be? Greener concludes that caution needs to be shown as the chronically ill person's knowledge of their condition is based more on experience than on medical knowledge. As the author remarks:

> ... patients, with the experience and knowledge they have acquired about their conditions, clearly can make a positive contribution toward their own care [agency], but this must be tempered with a recognition of the dependency that we place upon doctors [structure] – dependency in a positive, caring sense (Greener 2008:287).

Striking a less critical tone, Greenhalgh (2009) also reflects on different models of involvement of patients with long-term illnesses. She too mentions the concept of the 'expert patient', as featuring in national healthcare policies in the Western world, as a way of eschewing a paternalistic approach and encouraging self-care. She challenges this new governmental approach to preventing and managing chronic conditions and proposes a more holistic model ... which consider(s) a person's family, social and political context'

(Greenhalgh 2009:631). In other words, Greenhalgh emphasises the value of voluntary action through the reflexive self-monitoring of health and the involvement of patients and the public in preventing and managing chronic illness, but highlights the importance of structure and social context (peers, family, community and health professional support) in order to create effective programmes of healthcare.

Giddens' concept of 'reflexivity' or 'reflexive monitoring of action' has been particularly useful in analysing the relationship between the lay populace and modern medicine. Williams and Calnan (1996), for example, discuss this changing relationship in the 'late', 'reflexive' social order. They acknowledge the merits of Giddens' work in re-centring the subject in social analysis (without forgetting their interaction with institutional social forces), and claim that his structuration theory is beneficial in analysing the changing nature of the relationship between modern medicine and the lay populace, including those with chronic illness. We have previously mentioned that for Giddens, actors have become increasingly reflexive in late modern societies. Moreover, at a macro level, reflexivity has also been a feature of institutions and organisations. Reflexivity, as Williams and Calnan (1996) observe, has become chronic as it has come to span all aspects of modern life. Furthermore, with the help of the media and new information technologies (which can act to mystify and also demystify social issues), the reflexive actor has become resistant to the dominance of medical knowledge. Williams and Calnan (1996) call this the 'lay reskilling', that is, a critically informed lay public, which is routinely appropriating technical and medical knowledge, skills and expertise for its own purposes. This has resulted in the end of the era of the passive patient, dependent on modern medicine, medical expertise and ideology (that is, on structure): 'rather, in late modernity, a far more "critical distance" is beginning to open up between modern medicine and the lay populace' (Williams and Calnan 1996:1617).

At the end of their article, Williams and Calnan (1996) ask if the growth of social reflexivity will make medicine recognise its limitations or, instead, encourage it to move towards more 'defensive' forms of medicine. Williams and Calnan's article was written in 1996, while the 'expert patient' care programme and its new approach to chronic disease was introduced by the Labour government in 1999. In light of these facts, one could ask whether the implementation of this new model of care, with strong links to Giddens' notion of reflexivity, suggests that a reconfiguration of medical power and dominance has taken place in an era of the empowered patient.

Conclusion

The field of the sociology of health and illness has been traditionally dominated by two major sociological perspectives: a Parsonian and structural functionalist perspective, predominant in the 1960s, which has been re-invoked in the first decade of the twenty-first century, and a symbolic interactionist perspective (Cockerham 2013). However, the necessity to produce more complex and multi-level explanations for understanding health and illness in 'late' modern societies has been recognised. Anthony Giddens' concepts of structuration, duality of structure and reflexivity have been seen by social theorists as innovative contributions to that understanding, while being open to some criticism.

This chapter has focused on the application of Giddens' theoretical ideas to the sociology of health and illness. It has shown that Giddens' dissatisfaction with the sociological orthodoxy of the 1960s and 1970s and the emergence of counter responses (phenomenological and interactionist schools of thought) set the context for the formulation of the structuration theory. It is said that one of the most innovative aspects of Giddens' theory is the weight given to the autonomy and reflexivity of the individual, to practical activity, routine, trust and ontological security, which he sees as crucial to the continuity of institutions (Tucker 1998).

We have considered structuration theory in relation to three specific issues concerning health and illness. We have shown how empirical research in this field has attempted to overcome dualistic approaches and to take account of the role of social structure in shaping health and illness, mediated through individuals' decision-making. In other words, the research presented here has unravelled the complex link between individuals and the social context within which they are embedded. We have shown the application of this conceptual framework by presenting the case of prescribed drug use, eating practices and long-term illness in late modern or rapidly developing societies. In the first two cases, the authors argued that structure (resources) seems to heavily constrain the actions of prescribed drug users and children as consumers of food, thereby recognising its importance for sociological research. In the third case, one can see a critique of the emphasis of agency over structure in new health policies for the chronically ill; these policies overstate the 'expert patient' and the abandonment of state responsibility for chronically ill patients. Finally, Williams and Calnan (1996) have discussed Giddens' notion of reflexivity in the context of the changing relationship between modern medicine and the lay populace and have concluded that patients, including those who are chronically ill, are not passive consumers duped by the medical profession, but reflexive, critical and active agents.

While the application of Giddens' theoretical ideas to the sociology of health and illness has been illuminating, such ideas remain controversial. His attempts to synthesise the rival traditions of interpretivism and structuralism (the subject–object dichotomy) through the theory of structuration have been criticised for not providing us with an answer as to whether agency or structure tends to prevail in certain temporal and spatial circumstances (Archer 1982).

However, investigating which of these polarities prevail at a particular time and place might not make the best use of Giddens' approach. He would reject the need to assess the degree of significance of agency or structure in health issues at a particular moment in time and place, as social (health) practices and their contexts exist in a recursive relationship. For him, structuration is a process; therefore, it never privileges one element of the binary opposition, because neither can exist without the other and both are complementary and related. Accordingly, the sociological study of health and illness should therefore take into consideration the recursive interaction between individuals' actions and their social contexts if it wants to capture more accurately the dynamic nature of the social world.

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Chapter 28

Anthony Giddens: The Reflexive Self and the Consumption of Alternative Medicine

Kate Hughes

This chapter explores some of the work of Anthony Giddens with regard to its application to biomedicine and complementary medicine. It begins with a brief biographical outline of Giddens' career to date, following with an overview of his central themes and concepts. The theme of self-identity and the concepts of the reflexive self, trust, risk, expert systems and claims of truth, offer a way to interrogate the field of modern healthcare. It is proposed that the notion of the reflexive self, in particular, has the capacity to explain some of the ways in which contemporary individuals contemplate not only their health but also medical care in general. These ideas are applied to the notion of consumer choice and the view that there are a number of competing health service providers from whom consumers may choose the best fit therapy for their 'lifestyle'. The corollary of this is a sense of relativism, where the historical authority of the medical and pharmaceutical industries is challenged by increasingly popular competing healthcare industries, which contest the scientific method and offer alternative epistemologies through which to contemplate health, and treat illness.

Biography

Anthony Giddens, a prolific British sociologist, was born in London in 1938. He came from a lower middle class family, with a father who was a clerk, and was the first in his family to go to university. He did his doctoral work at Cambridge, but it was not until he took up his first teaching post – in 1961 at the University of Leicester – that Giddens began to build his theoretical position. He returned to King's College, Cambridge in 1969 (becoming a full professor in 1987) where he spent ten years before becoming the director of the London School of Economics (LSE), at the time of the election of the Blair Labour government in 1994.

Giddens has had a major theoretical impact on the discipline of sociology, while also participating in public conversations about government policy and, more recently, on climate change (2009). During his years at the LSE, Giddens advised the then British prime minister Tony Blair, and Giddens' book *The Third Way: Renewal of Social Democracy* (2000) influenced both Blair and Clinton in the United States in their attempts to re-frame the political landscapes of their respective countries. They did this through harnessing market forces to both build stronger democracies while retaining the infrastructure of the welfare state (in the United Kingdom, at least). In this endeavour, Giddens followed an intellectual journey begun early in his career – employing innovative sociological theory to address contemporary social issues.

Giddens marked out an intellectual field which differed from his contemporaries insofar as he asserted that the work of the founding fathers of social theory, Marx, Weber, Durkheim and Simmel, was no longer able to usefully address many of the complexities inherent in contemporary society – particularly in the developed world (Giddens 1984). These complexities are linked as much to late capitalist economies and the resulting class system as they are to the emphasis placed on both structure and agency. His early – and continuing – belief is that social theory should help us to understand and explain social institutions and human endeavour. He argues that, historically, social theory is marked by a concentration on either the individual or on social structures, and this dichotomy should be breached. His work reflects this belief by focusing on the nexus between the two, which he calls the theory of structuration (Giddens 1984; Kaspersen 2000).

Giddens' career to date can be seen to have three contiguous phases. The first phase (1971–1985) laid the critical theoretical foundation for his critique of early social theory and theorists. The second phase (1990–1994) explored structuration and, particularly, the ways it is manifested in late modernity (Giddens 1990, 1991, 1992). These ideas will be discussed in this chapter. In undertaking this work, Giddens explored areas of social life such as intimacy and reflexivity (which were pioneering for social theory at that time), and, writing with the German sociologist Ulrich Beck, made a major contribution to the ways in which modern sociologists interrogate social life through investigating the connections between social and personal lives (Beck et al. 1994). In his third phase (1994 to the present), Giddens coined the term 'the third way' and began to address contemporary political life: the ways the British Labour party might begin to renew itself and move beyond what he considers to be the outmoded prevalence of class analysis (1998, 2000, 2002, 2007a). Around the same time, Giddens began to approach an exploration of climate change and what he terms 'the global age' (2007b, 2009).

Perhaps the most distinctive feature of Giddens' work is his capacity to write about contemporary social life from a scholarly, complex theoretical standpoint but to do so in a way which is accessible for both novice and expert readers. This again reflects his ambition to make contemporary social theory approachable and useful to a wide audience.[1] Giddens is also prolific, sometimes publishing a book a year. Partly due to his productivity, but also because of his incisive understanding of the relationship between powerful social structures and individual people's freedom to act, Giddens is considered a leading contemporary British sociologist and social theorist.

Reflexivity

The term 'reflexivity' refers to dynamic relationships between cause and effect where both are changed by their interaction. Reflexivity involves a process of self-reference where the consideration or action refers to, and then has an impact upon, the object which generated the consideration or action. Coined early in the twentieth century by sociologists William Thomas (1923), followed by Robert K. Merton (1957), it was later developed not only by Giddens but by Pierre Bourdieu (1992) and, to some extent, Michel Foucault (1970).

In his first book to seriously address the ways in which contemporary individuals and social structures interact and consequently effect one another – *The Consequences of Modernity* – Giddens makes the case that:

> The reflexivity of modern social life consists in the fact that social practices are constantly examined and reformed in the light of incoming information about those very practices, thus constitutively altering their character (1990:38).

Giddens argues that this state of affairs developed in the twentieth century through a mix of both micro and macro forces generated by economic and social imperatives such as globalisation, technology, communication speed, the increased movement of goods and financial capital, an increase in population and socio-economic mobility. In the latter part of the twentieth century, these profound changes came to have a powerful impact on what he calls tradition, whereby both people and social institutions tend to reproduce what went before; habits of mind and habits of practices which involve 'ritual and formulaic truth' (Giddens1996:34). Within this conceptualisation, tradition is a generator of identity, and identity emerges from persistent ritualisation where the past determines – to a large extent – the future (Giddens 1996:34).

Giddens (1995) asserts social change is more amorphous than others have argued – that it does not have one driving factor, nor clearly delineated historical époques, but comes about through the dynamic interactions of human agency and social structures. He broadly uses the term 'modernity' to refer to the era which followed the traditional era (or pre-modernity), which he defines as:

> . . . a shorthand term for modern society, or industrial civilisation. Portrayed in more detail, it is associated with (1) a certain set of attitudes towards the world, the idea of the world as open to transformation by human intervention; (2) a complex of economic institutions, especially industrial production and a market economy; (3) a certain range of political institutions, including the nation-state and mass democracy. Largely as a result of these characteristics, modernity is vastly more dynamic than any previous type of social order. It is a society – more technically, a complex of institutions – which, unlike any preceding culture, lives in the future, rather than the past (Giddens 1998:94).

Inherent in this is a new understanding of what the self, or the individual, is. Giddens argues that personal identities are strongly aligned with one's connections with wider society and that the social traditions or rituals inherent in each society produce each identity to varying extents. He goes on to argue that this explains the common, emotionally charged resistance to the disruption of traditions – people see such change as a threat to their own sense of identity, even security. According to Giddens, contemporary individuals see themselves as neither fixed nor stable, but always in a process of change and adaptation to external phenomena:

> . . . the self is seen as a reflexive project, for which the individual is responsible . . . . Outside events or institutions . . . only intrude in so far as they provide supports for self-development, throw up barriers to be overcome or are a source of uncertainties to be faced (Giddens 1992:75–6).

In other words, people see themselves as constantly being made or developed, and as ultimately atomistic, without links to community which had shaped their sense of self in the past. They see themselves as a 'work-in-progress'. Contemporary individuals do this both through assessing the knowledge available, by choosing which expert opinion fits best with their sense of self, and then by undertaking a reflexive monitoring of themselves and their choices. To put this simply, they make their own decisions based on their chosen lifestyle.

Expert systems

Giddens (1991:141) argues that this configuration of the modern self has arisen partly through a weakening of unassailable, authoritative systems of truth and expert opinion. He defines expert systems as 'systems of technical accomplishment or professional expertise that organise large areas of the material and social environments in which we live today' (Giddens 1990:27). In the field of medicine and health, traditional 'hard' science is under challenge, seen as contingent, with competing truth claims being made by a wide range of lay practitioners and theorists who proffer alternative knowledges of various kinds:

> Consequently, sectional interests which rely on the traditional authority of science can now be challenged with greater conviction by alternative knowledge claims such as 'alternative medicine', 'alternative food' and 'green consumerism'. Reflexivity also manifests itself in the appropriation of technical expertise by lay agents as part of their routine dealings with abstract systems (McNally and Wheale 2001:107).

In part, this reflexivity arises from the scientific method itself where theories are continually tested, revised and sometimes discarded. This being so, it is perhaps not surprising that lay experts enter this terrain, nor that they offer direct challenges to medical science.

Giddens' analysis of the operation of expert systems in the imaginations of individuals as well as practically (in terms of data collection, surveillance and so forth) was partly derived from the work of Michel Foucault (see 1970, 1972, 1973), who also produced seminal work on the (as he calls it) archaeology of epistemology. Borrowing from Nietzsche's 'will to power', Foucault argues that modern expert systems demonstrate a 'will to truth', with a contested authority base which seeks to wield technological expertise and unassailable truth claims. As such, expert systems, according to Giddens, have become a dominating force in post-traditional societies where tradition has been disrupted. In this context, conflicting epistemologies battle for supremacy in the public imagination (Giddens 1996). Giddens offers an extension of this work through focusing on the challenges to medical bodies of knowledge arising from new expert systems with a broader remit generated by modernity.

Risk

Building on the work of Niklas Luhmann (1993) and Beck (1992), Giddens contends that we live in 'a society increasingly preoccupied with the future (and also with safety), which generates the notion of risk' (1999:3) arising from the new dangers to be faced. Paradoxically, individuals living in modern societies are not faced with anywhere near the levels of risk of disease, disability or early death inherent in earlier societies, yet 'high-modern society is a risk society in which modern systems force us into a permanent state of risk' (Kaspersen 2000:100).

The vagaries of disease or poor harvests leading to starvation have (in the developed world at least) been largely eradicated by scientific and technological advances, yet have been replaced by risks emerging from environments shaped by humans. Environmental damage caused by climate change, the possibility of nuclear warfare or the fluctuations of the international money markets are just three examples of risk factors capable of changing individuals' futures for the worst, yet being entirely outside the control of ordinary citizens. Giddens calls these risks 'manufactured' insofar as they are the result of human agency, and human agency is involved in assessing and mitigating them (Giddens 1999). He argues that society generates an insistence that individuals consistently calculate risk levels, set against the potential possible benefits of any action. In doing so, they are engaged in the production of the future which is not repetitious (in the manner ubiquitous in traditional societies). He suggests that contemporary populations in Western countries are subjected to a plethora of information about health risks in particular (smoking, drinking, a lack of exercise and overeating being the most obvious examples). Giddens makes the point that – in terms of health – the contemporary risk levels to individuals are extremely low, given the advances in both sanitation and modern medicine (Giddens 1991:115).

Yet, risks are seen as ubiquitous, disseminated via the expert systems mentioned earlier and sometimes challenged. In this nexus, the reflexive individual continually assesses risk based on the information available and makes a judgement about whether the risk is worth taking (Kaspersen 2000:100). Giddens uses a less nuanced approach to the calculation of risk levels and risk aversion than others who argue that social risk positions are inherently connected to social class (see Beck 1992) – simply, some are a position to assess and avoid risk through accessing knowledge systems and networks which provide accurate risk information, and other are not.. Similarly, Luhmann (1993) makes a more detailed and comprehensive contribution to the concept of risk using both an individual and a systems approach. Giddens, however, uses risk as a broad mechanism in his analysis of post-traditional society rather than as a key determinant.

Trust

Extending the work of Luhmann (1979) and Fukuyama (1995), Anthony Giddens turns his attention to the issue of trust and the ways it is connected to risk. He defines it as the level of confidence an individual has in the reliability of another person, or a system (expert or otherwise). Trust is intertwined with risk since trust acts to minimise or reduce the effect of risk insofar as the individual is likely to accept risk when it is associated with a trusted source (Giddens 1996:38).

Giddens (1990) explores the ways in which trust is linked to expert systems and the reflexive individual, and argues that one result of the relative breakdown of tradition and of authoritative expert systems is the contingent trust levels in reflexive individuals. Moreover, with the move away from tradition and ritual, norms and beliefs become less stable, resulting in a situation where individuals (yet again) exercise choice about who to believe based on an assessment of their claims of truth (Kaspersen 2000). The perception of risk level, in turn, determines the decision to trust (or not) a particular expert opinion (Meyer et al. 2008).

Giddens goes on to explain the nuances of trust through arguing, like Luhmann, that trust is extended to both institutions and individuals, and that these are linked. If, for example, interpersonal trust is developed between an expert (of whatever kind) and a client, it is likely that trust will also be extended to the institution which that practitioner represents. Giddens (1994) calls institutional trust 'faceless' (in that the level of gravitas of the institution or organisation per se generates trust levels), and individual trust 'facework' (in that individuals commonly have trust in others through building relationships). The notion of 'facework' was originally used by Goffman (1967) and relates to the way(s) in which individuals present a mask according to audience – with the flipside of 'losing face', of course. Giddens suggests (1994) that representatives of expert systems create and maintain trust using persuasive facework, which carries with it a sense of authority, expertise and professionalism. This dynamic assists in the understanding of the choices made by the reflexive individual who may choose to have faith in a trusted individual to assist them, rather than in an institution unknown to them – or vice versa. Trust in systems is earned and then maintained through social interactions and by the facework of individual representatives of systems.

Structuration

This last point is a fine example of structuration – Giddens' major contribution to the field of social theory – where he argues that 'the basic domain of study of the social sciences . . . [is] neither the experience of the individual actor, nor the existence of any form of societal totality, but social practices ordered across space and time' (Giddens 1984:189). For Giddens, there is a dynamic relationship within this nexus, and his work is marked by the exploration of this dynamic which focuses upon both structure and agents as actors.

Giddens sees the division between these actors as a fault line in traditional sociology and perceives these as two distinct theoretical camps: one in which individuals define, drive and comprise society and another in which society consists of independent structures, which are effectively separated from human agency (Kaspersen 2000:3). He delineates four sociological traditions – functionalism, action theory, structuralism and Marxism – and each, in turn, fails to adequately approach this dynamic (Giddens 1984). The central conundrum for Giddens, then, is the extent to which individuals are compelled or restrained by the strictures of the societies they are born into. He argues that all individuals are agents drawing on the resources available to continually interact with, and change, society, while being bound by the structures surrounding them (Kaspersen 2000:33).

In making this argument, Giddens appraises the individual actor as a rational being who draws upon knowledge resources, making a series of action choices. This introduced one of Giddens' most influential ideas, which he used widely during the 1990s – the concept of the reflexive self. The process of contemplation also involves the reflexive monitoring of actions whereby individuals watch and inspect what they do, and the contexts in which they act, adjusting their actions according to impact and their own abilities and desires (Giddens 1990, 1991, 1992, 1994, 1996). There is an on-going objective here:

> Instead of understanding intentionality (that is, the agent having a purpose and a motive for an action) as a concrete cause of a given action, Giddens emphasises that intentionality must also be seen as a process. The vast majority of actions are purposive, the intentional being an inherent element in all human behaviour (Kaspersen 2000:37).

For Giddens then, a discursive reflexivity surrounds each social action, offering an explanation for the series of actions performed – again, this is undertaken and continually monitored by the engaged agent. Later in the chapter, these key themes in Giddens' work are explored in the field of health sociology, but Giddens' work, while very influential, is not without critique.

Critiques of Giddens

A central theme in evaluations of Giddens' work, to date, is that he is relatively conservative, acritical and overall does not engage with the emancipatory impulse to contemplate, understand and explain social inequality which social theory (generally) and sociology (specifically) have as their central focus and concern. King, for example, claims that Giddens' 'later writings have become an apology for the *status quo*' (King 1999:61), and goes on to argue that his work is inextricably entwined with the social order which it simultaneously attempts to analyse. His conception of the reflexive individual, for example, is too closely aligned to the atomistic consumer of the free-market economy whose lifestyle choices are determined by the service economy (King 1999:77). Here, King faults Giddens for his descriptive tendencies, arguing that his work would be better directed towards a contestation of the ways in which reflexivity is marshalled by the free market to stimulate consumerism.

Similarly, others (see Sica 1986; Thompson 1989; Skeggs 2004; Atkinson 2007) point to gaps in Giddens' work: particularly the importance of social class, which they view as an increasingly more diverse dynamic rather than a social structure per se. Giddens' conceptualisation of the reflexive self, for example, appears to lack cognisance of the ways in which identities are produced by class cultures, as much as by individual choice, since not everyone has the ability to choose freely (Atkinson 2007). Furthermore, the argument is made that Giddens' blindness to class differences leads him to conceive the reflexive individual as having middle class resources and tastes, and these are projected onto whole populations without attention to the nuances of class or other elements of an individual's identity (Skeggs 2004). One might contemplate the influences of ethnicity, disability, gender or religion here. Linked to such considerations, Thompson (1989) makes a case that Giddens is silent on the causes of lifestyle choices: perhaps because it would require a more rigorous account of the other identity builders just mentioned, class and gender in particular.

Another problem in Giddens' work is its lack of empirical engagement (Sica 1986; Fuller 2000). Some have found this 'symptomatic of the unhealthy schism between the social theory and quantitative research genres' (Gross and Simmons 2002:541). The argument is made that his broadly sweeping approach to late modernity, while impressive, does not sufficiently engage with the dynamics of contemporary society, or even past societies. King (1999) questions Giddens' foundational idea for structuration that 'traditional' societies were static, ritual-following civilizations, and argues that our own is similarly imbued with tradition and ritual, many of a religious nature.

Overall, these criticisms point to a lack of empiricism and detail in Giddens' work, criticisms which can be upheld. Yet, the sheer breadth, depth and volume of his work may not have been possible if he had engaged more closely with empirical data. He has however, provided contemporary sociologists with a large body of work with which to engage.

The following section includes a consideration of the key themes of Giddens' writing discussed above to explore the relationship between biomedicine and complementary and alternative medicine (CAMs).

Biomedicine

It is time for the scientific community to stop giving alternative medicine a free ride. There cannot be two kinds of medicine – conventional and alternative. There is only medicine that has been adequately tested and medicine that has not, medicine that works and medicine that may or may not work. Once a treatment has been tested rigorously, it no longer matters whether it was considered alternative at the outset. If it is found to be reasonably safe and effective, it will be accepted. But assertions, speculation and testimonials do not substitute for evidence. Alternative treatments should be subjected to scientific testing no less rigorous than that required for conventional treatments (Angell and Kassirer 1998:840).

'Biomedicine' is necessarily a complex term, which, while widely used across a range of literatures, does not have a clear definition. Instead, it can be argued that there are three linked ontological domains which contemplate biomedicine as a field. The first of these is the orthodox empirical perspective, which conceives of biomedicine as the dominant classifying and organising framework for modern medicine, based on the foundational notion that disease is physical and connected to some damage to the body – normally through a pathological injury. The patient, in this context, is conceived as a passive recipient of medical enquiry. The second perspective perceives biomedicine as a symbolic cultural practice, which masks its ideological power behind a measured professionalism and scientific integrity. The third goes further by seeing biomedicine as an agent of social control, one particularly interested in the maintenance and reproduction of class divisions, power and privilege (Baranov 2008).

Biomedicine has historically been closely bound to not only an epistemological regime of truth but economic regimes of power. With its roots in eighteenth-century Europe (Hardy 2001), it appeared in the middle of the nineteenth century as:

> . . . a hybrid branch of the biological sciences at a unique historical moment in the sociocultural development of the Western world. By the early decades of the twentieth century, having demonstrated its value as an effective tool for the diagnosis, treatment and prevention of disease, Western scientific medicine had become singularly identified with biomedicine (Baranov 2008:236).

This came at a time when the scientific method itself became a vehicle through which older treatment regimes could be replaced, not only by a set of investigative tools but by a new self-confidence in progress, empiricism and rationalism:

> Consequently, from this perspective, biomedicine represents the culmination of a long history of (Western) advancements in medical knowledge from Galen's humoral pathology through Thomas Sydenham's doctrine of specificity to the current genome mapping that were made possible by dramatic shifts in how medical science was conducted and understood (Baranov 2008:238).

Medical science was (and is) conducted and understood as a method of examination based on empirical and measurable evidence and produced by principles of reasoning. Inherent in this method, then, are methodical observation, measurement and experiment on the object of enquiry and then the construction, testing and revision of the original hypotheses. In a sense, this is precisely the method which some of Giddens' critics argue he should follow more carefully (Sica 1986; Fuller 2000; Gross and Simmons 2002), since it is the one that predominates as a guarantor of epistemological precision.

Proponents of biomedicine adhere to the idea that the problems of humanity can be explained through the use of logic and the application of increasingly sophisticated scientific discoveries made by heroic medical specialists (Duffin 2010). Built into this viewpoint is the notion of progress – that all medical developments are 'advances' and humankind is increasingly improving itself, through science. This understanding came to replace previous explanations for matters to do with disease and death – religion and various 'lay' understandings of diseases and their treatment, although these understandings are now becoming increasingly evident once again.

These developments were an integral aspect of the establishment of medicine as a respectable, accredited profession (Lane 2001). Biomedicine has grown incrementally since the nineteenth century in terms of its explanatory and diagnostic power, in its relationship with healthcare and medical bureaucracies, and its links with the pharmaceutical industry, the insurance industry, universities and the welfare state. Its influence on society generally, on particular populations and its role in increasing social inequalities, has been explored in depth elsewhere by those interested in the third critical perspective noted above (see Rose 2007; Lock and Nguyen 2010; Bradby 2012).

The second key feature of biomedicine is its emphasis on measurement and the physico-chemical data that arise from this (Lupton 2012). Beginning with the development of the diagnostic instruments which enabled physicians to collect data (beyond the patient's account) in the nineteenth century with the stethoscope (1819), ophthalmoscope (1850s) and X-rays (1895), it became possible to classify diseases and identify causes of illness. These tools, in turn, facilitated a growing self-confidence in a field which drew upon other scientific developments in chemistry and physics to become the leading model of healthcare (Baranov 2008). Diagnostic technology is becoming increasingly comprehensive in the bodily functions it can measure,, and it is routine for medical staff to collect and record data about each patient: blood pressure, weight, cholesterol level, blood sugar level, heart rate, BMI and so on. The purpose of the collection is to measure the patient's individual data against established norms, thereby illustrating Foucault's (1973) assertion that populations fall under the clinical gaze where what can loosely be described as the medical profession collects, stores and evaluates medical data for the purposes of both risk assessment and epidemiology. In terms of Giddens' work, and the discussion which follows, such biomedical data collection forms a significant part of an individual's risk assessment and the reflexive actions flowing from this.

Complementary and alternative medicine

Complementary and alternative medicine (CAM) was named in nineteenth-century Europe, existing alongside biomedicine (Porter 1988), offering a range of alternative therapies and treatment systems and distinguished by its status as non-mainstream:

> Complementary and alternative medicine (CAM) is a broad domain of healing resources that encompasses all healthcare systems, modalities, and practices and their accompanying theories and beliefs other than those intrinsic to the politically dominant healthcare of a particular society or culture in a given historic period. CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and wellbeing. Boundaries within CAM and between the CAM domain and the domain of the dominant system are not always sharp or fixed (O'Connor et al. 1997:52).

Like biomedicine, CAM is not only a set of health practices – it is a set of beliefs about health, which involve, as discussed above, levels of trust in expert systems and the inclination of the reflexive individual to make choices. Easthope (2004) argues that biomedicine's appeal is waning and sees three main causes, thus echoing the standpoint of Giddens:

> The first is the increasing emphasis on consumption rather than production as the key characteristic of the postmodern economy. The second is the growth of an increasing awareness of risk and shift in attitudes towards science and the commodification of the new attitudinal dispositions. The third is the declining power of the state to influence the market and the increasing salience of multinational corporations (Easthope 2004:318–19).

Focusing on the first of Easthope's contentions, it is clear that there is a growing belief in the astuteness of consumer choice in a market with a number of competing service providers from whom consumers may choose the most appropriate treatment for their lifestyle and trust level. The corollary of this is a sense of relativism, where the historical authority of the medical and pharmaceutical industries is challenged and becomes simply one of many explanations for a medical condition. In this context, then, consumers pursue the treatment they believe in, trust and can afford. Alongside this relegation of biomedicine to one of many possible interventions comes an emphasis on one's individual responsibility for reducing health risks.

CAM therapies are numerous, but it is possible to categorise them in terms of their focus and their philosophy. All share a resistance to the scientific method and most are presented as a discrete expert system. Alternative medical systems, for example, include homeopathy, naturopathy, Chinese medicine and Ayurveda. These propose the body to be a connected system rather than an entity with discrete parts. Mind–body interventions, conversely, are dedicated to enhancing the mind's capacity to heal. Examples include cognitive-behavioural therapy, mediation, art, music and dance therapies. Biologically based therapies use plant material (as do some alternative medical systems), vitamins and dietary supplements to maintain wellness – these are the most widely used therapies. Manipulative and body-based therapies are also prevalent in the general population and involve massage, chiropractic techniques and osteopathy. The final group, energy therapies, are the most eclectic, purporting to use energy fields surrounding the body. Some examples are qi gong and Reiki (Hawks and Moyad 2003:222).

What is perhaps clear from the above is the very different philosophical position of these treatments (or therapies) from those of biomedical science; they do not use scientific methodologies. Practitioners rely on trust and belief as a means of procuring patients, and they constitute the patient/consumer as an active participant in their treatment. They appeal to consumer choice and the predilections of the reflexive individual (according to Giddens 1991), to perpetually make and remake their identity, lifestyle and life choices in relation to new knowledges which emerge:

> What does it mean to say that the body has become part of the reflexivity of modernity? Body regimes . . . become open to continuous reflexive attention, against the backdrop of plurality and choice. Both life-planning and the adoption of life-style options become (in principle) integrated with bodily regimes . . . We become responsible for the design of our own bodies (Giddens 1991:102).

The reason for the growth in CAMs can be approached using Giddens' theory of structuration and his work on trust, risk, reflexivity and expert systems. All play a role in the growth of CAM as a system and in the individual's decision process to invest in CAM that centres on the desire to avoid the impersonality of conventional medicine and the preference for preventative strategies and natural rather than chemical therapies. We can see in the broadest terms that health consumers are shifting their trust levels, and the sense that the reflexive self knows itself and can provide an account of its actions (Kaspersen 2000:23) is demonstrated by the reasons provided by consumers of CAMs for their choice (Hawks and Moyad 2003:223).

Conclusion

Anthony Giddens' intellectual stretch and focus have been manifold since his early career. His early and on-going use of structuration as a critical contemporary critique of the central dynamics of traditional social theory leads to an energetic revisioning of the ways in which scholars might approach contemporary life. He has, at times, discussed health, medical practices and the body itself, but it has by no means been a central focus. He has, however, contributed an important prism through which to view contemporary individuals' perception of heath – as both providers and consumers. This emerged from his engagement in the 1990s with a critique and analysis of some of the features of late modernity and the ways in which this period determines a particularly reflexive self involved in assessing expert systems. His discussion of truth claims and expert systems offers a valuable lens through which to explore contemporary encounters between biomedicine and CAMs.

Yet, he accomplishes his aim of producing social theory which successfully links the comprehensive vision connecting the individual with society. This theory, as his critics have argued, may be sweeping and empirically untested by Giddens, but it has the explanatory power to approach the rapid changes to the authority of science and the growth in health consumer efficacy being increasingly felt in Western societies.

Notes

1. In 2013, for example, he published the seventh edition of his best-selling undergraduate text entitled simply *Sociology.*

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Chapter 29

Anthony Giddens: Risk, Globalisation and Indigenous Public Health

Eileen Willis and Meryl Pearce

This chapter outlines Giddens' theories of radical reflexive modernity, trust and risk. In illustrating Giddens' arguments, we take a case study from our own research with Indigenous people in remote regions of South Australia and their reactions to safe water supplies and the impact this might have on their health. We demonstrate how Giddens' theoretical insights provide an alternate account of Indigenous responses to modernity than is commonly accepted. We argue that Indigenous people are not dupes of tradition, but are reflexive individuals who engage critically in modernity, understand the nature of technology and science, including the risks to their health embedded in expert systems (Giddens and Pierson 1998). The chapter begins with an overview of Giddens' life and work, followed by an exposition of his theories of modernity, risk and reflexivity. This is followed by a critique of his ideas offered by other social theorists. We then move to the case study to illuminate Giddens' theoretical ideas. In the final section, we suggest Giddens' approach challenges popular post-colonial interpretations.

Biography

Anthony Giddens, born in London in 1938 and educated in the United Kingdom (University of Hull; London School of Economics; Kings College, Cambridge), became the first British social theorist of note. He commenced work as an academic at the University of Leicester, and then moved to Cambridge University, where he gained a professorship in the late 1980s. Internationally acclaimed, Giddens is described as an eloquent and sought-after presenter and a prolific writer (Kaspersen 1995).

Giddens' main writings came to the fore in the 1970s. His first book *Capitalism and Modern Social Theory* was published in 1971 (Giddens 1971a), and his second *The Class Structure of the Advanced Societies* in 1973 (Giddens

1973). His critiques of the thoughts of Karl Marx, Max Weber, Emile Durkheim, Georg Simmel, Talcott Parsons, Robert Merton, Alfred Schultz, Erving Goffman, Martin Heidegger, Jurgen Habermas, Claude Levi-Strauss, Ferdinand de Saussure, Louis Althusser, Michael Foucault, Herbert Marcuse and Ludwig Wittgenstein dominated his publications at this time (see Giddens 1965, 1968, 1970a, 1970b, 1971a, 1971b, 1971c, 1972a, 1972b, 1977). While Craib (1992:2) comments that these publications brought a degree of order to sociological thinking, they also provided the foundations for Giddens' own theory building.

In the 1980s, Giddens moved from critique to the production of his own theories; in 1984, he published *The Constitution of Society* in which his theory of structuration is outlined. In the mid-1980s, in *The Nation-State and Violence,* Giddens wrote 'it is the task of sociology ... to seek to analyse the nature of that novel world [in] which ... we now find ourselves' (Giddens 1985:33). Given this frame of thinking, Giddens' subsequent writings in *The Consequences of Modernity* (1990), and *Modernity and Self-Identity* (1991) provide insight into modern world and the role of the self. Though producing his own theories, Giddens' work builds on others; his theory on risk, for example, develops the work of Niklas Luhmann on system or impersonal trust and Ulrich Beck on interpersonal trust (Lane 1998). Giddens' analysis of modernity sees modern society (compared to traditional societies) as both a producer of risk, and at the same time a reducer of certain risks. According to Giddens, there have always been risks (in pre-modern [traditional] and modern times), but the periods differ in their 'risk profiles' – earlier risks tended to be natural events, whereas modern risks are mostly from 'human-manufactured environments' (such as nuclear power plants or industrial pollution).

Giddens' work of the 1990s moved into the political arena, though his theories have never drawn a distinction between politics and sociology. The titles of some of his publications reflect his shift in focus: *Beyond Left and Right– The Future of Radical Politics* (1994a), *What's Left for Labour?* (1994b), *Agenda Change* (1994c) and *Brave New World: The New Context of Politics* (1994d), to name a few. Giddens' (1998) *The Third Way – A Renewal of Social Democracy* provided input to the New Labour policies; though it was not without its critics (Giddens 2000). Giddens' thoughts in the political arena led him to serve as an occasional political advisor to British Prime Minister Tony Blair from 1997 to 2007. His continued interest in politics is exhibited in his membership of the House of Lords (since mid-2004), and the Council for the Future of Europe. Giddens holds positions as Emeritus Professor, London School of Economics; Political Science Fellow, King's College, Cambridge and Director, Centre for Social Research.

Giddens' theoretical contribution

Giddens initially wanted to study philosophy, but when this option was not available, he studied sociology and psychology. These early beginnings may have laid the groundwork for Giddens' approach to social theory in which he has been identified as one who has been 'breaking down the barriers among disciplines' (Craib 1992:1). While some critics have described Giddens' work as 'flitting from theory to theory' or 'like trying to catch quicksilver', his approach is also seen as 'offering a solution to divisions which have plagued sociological thought', as he gathers 'insights from many different disciplines and thinkers' (Craib 1992:3). Giddens frequently used concepts 'in a very different way to their original use, but seems to think that the advantages of doing this outweigh the disadvantages' (Craib 1992:4). He has been a firm critic of classical sociology but also built on, synthesized and brought clarity to the works of others (Craib 1992; Kaspersen 1995).

The theory of reflexive modernity

Giddens' (1990:1) theory of modernity starts with a challenge to the proponents of postmodernity who argue that sociology can no longer sustain an evolutionary and optimistic conception of social change provided by the classical sociologists such as Tônnies, Marx and Durkheim. Proponents of postmodernity suggest the idea that social change can be understood in optimistic evolutionary terms where societies move from tribal (and primitive in all its social institutions from the division of labour to forms of governance) to progressive forms of Western democratic capitalism (as a sophisticated form of social democracy with heightened individualism and differentiated specialisation) can no longer be sustained. The history of the twentieth and twenty-first centuries illustrates some of the failure of this 'grand narrative', best epitomised in the challenges to social democracy in the rise of totalitarian states such as Nazi Germany, Kim Jong-Un's North Korea and the devastating impact of industrial capitalism on the environment.

For Giddens (1990:3), a more fruitful activity is to examine the 'discontinuities' in the social institutions of modernity for features that are distinctively different from other periods in history, rather than suggest a completely new era or postmodern period has arrived. What is required is to identify exactly what these discontinuities are and to understand their radical and universal features (Beck 1994). For Giddens, the key to recognising the fundamental differences between previous social institutions and social order and the present is in separating out or disembedding time from space. What characterises modernity is that time and space have become separated. He defines this as 'the "lifting out" of social relations from local contexts of interaction and their restructuring across indefinite spans of time-space' (Giddens 1990:21). Underlying his approach is an argument that all is not chaos. There are discontinuities in the explanations, but not in the basic sociological questions that deal with social order, social change and the notion of society. There is logic to the flow of social history, although it may not be progress towards a utopian ideal as Marx might have us believe. Indeed, the very idea itself of postmodernity suggests an evolutionary transition. Giddens dismisses the idea of an end to history, arguing rather for a radical reflexive modernity where trust and risk become the key unifying components for understanding everyday life (Giddens 1990; Giddens and Pierson 1998).

Disembedding mechanisms

Giddens (1990:22) identifies two major disembedding functions. These are symbolic tokens and expert systems. Money is one example. In traditional societies, money was a concrete object, a coin or token passed from one person to the other in exchange for services. In the modern world, money is a form of exchange that transcends time and space. Money exists independently from the paper it is written on. It exists in the exchanges at banks, or in the figures on Excel charts on computer screens. The speed of exchange is not dependent on the amount. An Indigenous pensioner in a remote community can cash their pension cheque as quickly as a real estate agent managing the several hundred thousand required to purchase a house. The relationship between time and space that once governed financial exchanges has been broken. Financial exchanges are now dissociated in time and space.

Giddens (1990:26) notes that engaging with money in the modern world under these conditions requires considerable *trust* in the systems that govern the exchanges. This is true for all disembedding mechanisms. Both the wealthy stock broker and the welfare recipient must trust that their credit card is linked to their finances, whether this is an exchange with CentreLink (the welfare services centre in Australia) or the stock exchange in New York. The use of one's credit card assumes trust between the purchaser and the owner of the product. We need to trust the abstract processes whether it be the bankcard machine or the computer-generated personal statement we download. We trust that the society we inhabit with its regulatory financial institutions ensures our transactions will be honoured.

Our trust in these symbolic tokens comes from the second disembedding function: expert systems. Expert systems come in two forms. They are both the technical artefacts of modern life and the expert professionals who guide our use of this technology (Giddens 1990; Lupton 1999). Our trust in these experts and their guidance comes from their professional knowledge and the regulatory agencies, rules and by-laws that govern their work and the operation of the technology. For example, we trust the water supplies in large cities is safe to drink because of our trust in the various public health acts, the hydrologists managing the water, the environmental health officers doing their regular testing and engineers providing the infrastructure necessary for the supply of safe drinking water.

The ten elements of trust

In outlining his theory of trust, Giddens (1990) assigns ten elements or features that situate it within a period of radical modernity, rather than postmodernity. First, he argues that trust is required in situations where we do not have direct here and now (in time and space) contact with the individuals. As he notes (Giddens 1990:33):

> There would be no need to trust anyone whose activities were continually visible and whose thought processes were transparent, or to trust any system whose workings were wholly known and understood.

Second, trust is contingent and to some extent based on an emotional response to either the individual/s or institutions. Third, he notes that trust is not the same as faith (Giddens 1990:33), but rather it is the confidence we have in the principles that govern the operation of expert systems. Fourth, this confidence is based on a clear understanding that technology is a human and a social invention, rather than one arising from some divine intervention or a sense of faith. Hence, when we experience a breach of trust we do not attribute it to bad luck, karma or divine retribution, or even natural causes. Breaches are a result of human failure and its technology. The above four elements provide the framework for a definition of trust, which Giddens labels the fifth element. Giddens (1990:34) writes:

Trust may be defined as confidence in the reliability of a person or system, regarding a given set of outcomes or events, where that confidence expresses a faith in the probity or love of another, or in the correctness of abstract principles (technical knowledge).

The sixth element acknowledges that risks are socially created, not the result of misfortune or nature. For this reason when we trust, we are aware of the social nature of our trust and of the risks. In the seventh feature, Giddens (1990:34) separates out danger from risk. Danger and risk are not one and the same; we can be aware of the danger, but not the extent. In identifying the eight element, Giddens argues that one of the ways we manage danger is by calculating the risks from the knowledge we gain from experts and our own experiences. The ninth element suggests that some risks go beyond individuals to impact on large population groups. Giddens refers to these as environments of risks; nuclear war is the prime example (Giddens 1990:35). Finally, he also suggests that the opposite of trust is not mistrust, but dread. This definition is tied up with his concepts of ontological security; the trust we accord to experts and the abstract systems they operate. Our sense of security is bolstered or challenged when we encounter these at what he refers to as access points or fateful moments (Giddens 1990:115).

Giddens and trust in expert systems

The key to Giddens' argument is globalisation. Globalisation separates out all other previous historical periods from the present by its time–space distanciation, made possible through communication technologies in their various forms. The certainties that came with the strong bonds of kinship, community, religion and tradition at the local level have given way to a separation between time and space (Giddens and Pierson 1998; Lupton 1999). Modern problems are for the most part caused by the way humans organise their social world, be it the impact of industrial waste on the environment or the increases in community-generated infections through the overuse of antibiotics. In the globalised world, individuals can connect to others either in the physical present, in time and space, or across space, but in the same time. Time–space distanciation defines globalisation as it allows social relationships to stretch across the world, for people in distant places to link with each other in the here and now and for what happens in one space/place to impact on people in other places (Beck 1994). Some examples of these abstract systems and the experts and artefacts that operate include banks, tellers and credit cards, welfare cheques, voting cards or electoral systems. Trust arises at the point of interaction with these systems and their experts. Giddens refers to these intersections as access points. Crises in any one of these abstract systems can impact on individuals in remote towns, or in cities. A pertinent example for Indigenous Australians is mechanisms of the legal system in its dealings with land rights, where the abstract political systems and courts in major capital cities determine ownership of land in remote locations.

Access points occur at the intersection of abstract systems and experts, and individuals. For the most part, individuals have to put their trust in the various social systems that make up their society, be it the regulations that govern water supplies or the processes for applying for a place at a university. They need to trust that the experts, be they engineers, surgeons or educators, know what they are doing. Giddens acknowledges the leap of faith required, and the tensions between lay people with their scepticism, and the professional experts. This is a source of vulnerability (Giddens 1990:91). However, we trust that the world will operate according to plan. Giddens refers to this as ontological security. Ontological security is the confidence we have in our own continuity and in the material and social world around us (Giddens 1990:92). It generates trust that is both emotional and cognitive (Lupton 1999).

Giddens and Beck on trust

For the purposes of the case study below, it is useful to make some distinctions between Giddens and Ulrick Beck's (1992, 1994) approach to trust and risk, given the convergence of their ideas (Lupton 1999). Giddens has a stronger focus on trust than Beck (Kurtz 2006:88). He argues that most of our life is an interaction with disembedded abstract systems and experts. The actions of these experts impact on our lives. As a consequence, trust in expert systems is essential for our mental health or ontological security. Both Giddens and Beck explore the role of experts in the construction of risk; experts generate both trust and cynicism in the lay population about their capacity to manage risk; however, Beck goes further to examine the contradictions in expert knowledge and the difficulties of trusting in expert systems. Giddens and Beck both situate globalisation as one of the cornerstones of risk, but Beck's analysis is built on our knowledge of the contradictions endemic to science professed by experts. Beck (1992, 1994) argues that each new invention generates new risks and danger. Lay people are acutely aware of the fallibility of science and other forms of knowledge, both its capacity to generate error and its inability to agree over causation, global warming being the most pertinent example. Giddens' approach is more focused on the time–space distanciation and reflexivity. Beck tends to the view that science has created new risks, and Giddens is of the view that we are simply more aware of risk, a result of our access to a globalised world. They both share the view that one of the unifying features of modernity is a preoccupation with risk avoidance (Beck 1994).

The differences between these two theorists also extend to their analysis of the relationship between class and risk. Giddens might argue that risk has replaced class, but for Beck, inequality remains, but its face has changed. Capitalist enterprises produce risk, and while the negative impacts fall unduly onto the poor, eventually these risks 'boomerang back' on those that produced them (Beck 1992:23). Beck suggests that risks can be challenged through social movements or sub-politics. Giddens finds this idea naïve – the notion that a social movement could deal with an issue that governments find too difficult. However, Giddens does not dismiss the possibilities of government engagement in the alleviation of risks. His Third Way proposes that Left Wing politics should embrace neo-liberal reforms as a way of dealing with the risks linked to capitalism. Kurtz (2006:89) refers to these ideas as politics through rose-coloured glasses, suggesting that Giddens fails to acknowledge the compromises to equality, ethics and values that result from his denial of class inequality.

Critiques of Giddens

Giddens (1990:32) also takes issue with Luhmann's conception of risk, danger and trust. According to Giddens, where Luhmann makes a clear distinction between trust and confidence, he sees them as a continuum. He suggests that Luhmann argues trust is based on sizing up the alternatives and opting for the most expedient, judicious or least dangerous, based on our knowledge of the situation. Some contingency remains. Confidence, on the other hand, is based on what we see as a firm assessment of the facts, with no sense of the risks or dangers involved. Giddens (1990:31) writes, 'in a situation of confidence, a person reacts to disappointment by blaming others; in circumstances of trust she or he must partly shoulder the blame and may regret having placed trust in someone or something'. Where Luhmann (2000) distinguishes between trust and confidence as two separate approaches to the social, Giddens sees trust as a particular kind of confidence. Giddens also takes issue with Luhmann's view of the separation of risk from danger, which is the implication that if you do not act, there will be no risk. He argues that often not to act is in itself risky. Despite these differences, Giddens' ideas on trust are indebted to Luhmann's conceptual building (Lane 1998).

Another area where other social theorists appear to take issue with Giddens is his suggestion that individual trust involves emotional responses. This may be based on love of individuals or, in the case of institutions, trust replete with expectation and feeling. Mistrust generates cynical pessimism and anxiety. Two commentaries on Giddens' work are useful. In the field of social psychology, a distinction is made between trust in individuals and trust in institutions (Zucker 1986; Poortinga and Pidgeon 2003). Trust in individuals who are known to us assumes some affect, but trust in strangers and institutions cannot generate emotional responses as such. For example, Bigley and Pearce (1998) suggest that our trust in strangers and institutions is not motivated by emotions, although our response to breaks in trust may generate disappointment or anger. Similarly, Barbalet (2009) argues that we can trust individuals, but it is ridiculous to talk about trust in institutions or society; these are reified concepts that cannot generate affect. This makes Giddens' claim that we put our trust in expert systems problematic. Barbalet argues that in the case of expert systems or institutions our response is more akin to confidence, coercion or fear of the law. Despite these distinctions about where our trust is directed, citizens experience an emotional let-down when experts and institutions fail them. These events are examples of access points that engender either trust or mistrust.

Indigenous approaches to risk and trust

In the case study below, we apply Giddens' theories to argue that the Indigenous approach to the risks of modernisation is more complex than in mainstream society, partly because we erroneously assume they are still steeped in tradition but, more importantly, because they bring to any risk issue a history of colonisation chequered by broken promises and catastrophes. Engaging with the coloniser is indeed risky business requiring irrational trust (Moran 2005).

The story: Iwantja community and its water supply

Our story begins in Iwantja, formally known as Indulkana, following a breach in the quality of the reticulated mains water supply. Iwantja is a small (population: 200–250) remote Indigenous community 575 kilometres south of Alice Springs in the An̲angu Pitjantjatjarra Yankunytjatjara (APY) Lands, South Australia. Despite its remoteness, like many Indigenous communities, it has access to Internet, telephone and mobile communication services as well as the Australian Broadcasting Corporation television services, including many commercial channels (PY Media 2006). Other services include a clinic, school, store and art centre.

The extent of the media services available at Iwantja should not be underestimated. The iConnect Project (PY Media 2006), a telephone subsidy scheme operating since 2006, oversees the delivery of residential telephones across the central desert region. Iwantja is one of six communities linked by a fibre-optic cable network to facilitate access to government services online (such as vehicle and firearm registrations, and social benefit payments and claims). Radio 5NPY An̲angu Winkiku, (roughly translated as ‘everyone’s satellite network’), extends to 11 communities and is part of a package of Information Technology services that includes training and production in radio, video, television and computer services. The PY Media website notes that it has around 6,000 hits per month from around the globe and that ‘someone somewhere in the world had looked at it. This was so impressive that members of APY communities started taking an interest in presenting their culture to the rest of the world’ (PY Media 2013). This is a two-way endeavour. The site boasts:

> In the future, the whole of Australia will be listening to us. We’ll be able to talk with the government through our radio. We’ll have a voice to reach the people on the outside . . . New forms of communication will help An̲angu [*a term used in the APY Lands by Indigenous people to refer to themselves*] people transmit the truth about their culture, about their lives, and shape their own self-representation . . . (PY Media 2013).

The empirical evidence and context

Despite the evidence of links to a global world via telecommunications, Iwantja is remote. ‘Remoteness’ in the Australian context refers to communities that are small, located vast distances from service centres and have limited employment opportunities. In the APY Lands, these constraints are coupled with environmental ones such as an arid climate and a paucity of water resources (quality and quantity). Despite these constraints, there has been significant expenditure and improvements in water and wastewater removal services in Indigenous communities. Willis et al. (2009) document the progress of services from ad hoc provision prior to 1979 through to the current standardised approach and strong adherence to the Australian Drinking Water Guidelines (ADWG; National Health and Medical Research Council 1996) overseen by the state water service provider. For example, at Iwantja, a dual reticulated water supply (potable and non-potable systems) has been installed where both systems undergo disinfection using ultraviolet-light treatment even though the non-potable supply is only used for practices such as evaporative cooling, flushing toilets and showering. Potable water supplies meet the ADWG for the health-related parameters, though aesthetic parameters may be exceeded as determined by the source water (which varies with locality). The water supply in the APY communities has been branded 'best practice' for arid environs (Willis et al. 2004) and relatively free of the insecurity and water quality concerns present in many outback towns (Pearce et al. 2010; Wadham et al. 2013).

The 'incident'

Against this backdrop of 'best practice' in water supply and continuous improvements in water infrastructure, in 2000, during an infrastructure upgrade, incorrect piping was laid in Iwantja resulting in elevated lead levels in the drinking water supply. It is unlikely that such an event would have occurred before this time. In South Australia, water supplies in the 18 larger discrete remote Indigenous communities were handled under a Commonwealth–State Bilateral agreement with infrastructure managed by a designated specialist division within state government: the Aboriginal Affairs and Reconciliation Division (AARD). The shift to new public management, specifically the practice of contestability whereby all government-funded projects have to go to open tender, meant that the state government unit charged with managing water supplies did not win the tender from the Federal government, nor could they brief the successful private provider on safety issues despite the fact that the company that won the tender outsourced the work to another provider. Although the third party laid the new piping, AARD were responsible for the on-going maintenance and risk management of the infrastructure. Some six months after installation during one of their routine water quality monitoring exercises, they detected elevated lead concentrations in the drinking water supply, immediately referring the matter to the Department for Health. The community was immediately notified in writing by the South Australian Department for Health, warned not to drink the water and supplied with potable bottled water. Continued monitoring indicated that the lead levels remained high some six months after installation (that is, lead attenuation had not been adequate); thus, it was decided by an independent consultant that the offending pipework should be removed in its entirety, and the Iwantja residents were notified.

On completion of the work, water tests were conducted and the results conveyed to the community indicating the lead problem had been fully resolved and the bottled water supply was discontinued. However, in focus group discussions we held in 2004 with community residents, they revealed an abiding distrust in the replaced water system, despite acknowledging being told by the various expert officials on a number of occasions that the water was safe to drink. This expert information did not instil confidence in the safety of their water supply, with much of their distrust fuelled by local non-Indigenous residents, many of whom openly stated that they would only drink costly bottled water. Meanwhile, Indigenous residents, unable to afford bottled water from the store, chose to drink water from their household rainwater tanks rather than the reticulated system. Ironically, there was a greater health risk associated with the bacteria in their rainwater tanks compared to the reticulated supply, which was disinfected using ultraviolet-light treatment (Willis et al. 2004). Such is the risk associated with drinking rainwater from household tanks that no agency will take responsibility for tank maintenance. The South Australian Department for Health will only react if a health issue arises but is not proactively involved in managing rainwater tank systems, and the local Indigenous health service has engaged in an extended and very successful health promotion campaign to discourage the drinking of rainwater stored in household tanks (Willis et al. 2004).

In a more recent visit in 2012 to two neighbouring remote Indigenous communities in the APY Lands, we observed developments in housing that have resulted in UV filters being attached to the rainwater tanks, making the water safe to drink. In our conversations with residents, we discovered that many were not aware that once they turned the UV on, the rainwater was safe to drink. Older Indigenous residents who were unable to read the instructions on the UV units had not switched on the UV filter and insisted it should not be done, despite being told it was safe to do so. The strong messages put out by the local Indigenous Health Service remained fixed in their minds. Rainwater in tanks was perceived as unsafe to drink, even though the UV filters would overcome this risk.

Aboriginal people engaged in modernity

Our reports to bureaucrats and experts on the Indigenous response to these events were sometimes met with exasperation that the 'irrational' A<u>n</u>angu did not trust the experts, or that they continued to engage in magical and traditional thinking. Contrary to this we would argue that A<u>n</u>angu behaviour can be viewed as a rational response to the problems of modernity, time–space distanciation and the disembedding of water supply from its traditional modes. Indeed, their response is similar to other citizens in urban areas and demonstrates their deep engagement in modernity. Their response arises from two access points: the first is the incident in 2000 when the experts reported that the water was contaminated, and the second arises from a much deeper suspicion embedded in their experiences of colonialisation and subsequent post-colonial policies at various access points over the last 100 years.

Indigenous people on most remote communities in Australia have a much closer relationship with essential service technology than the majority of citizens in urban areas, and it is this close understanding that enables them to distinguish danger and hazards arising from tradition and the supernatural from risk and technology. Most communities employ an essential service officer (ESO) to maintain water, power and sewerage systems, and in the case of breakdowns, someone is delegated to notify authorities. In small communities, the ESO may well be both neighbour and kin. As a consequence, knowledge of the technology and its vulnerability is more immediate than would be the case for the majority of urban and non-Indigenous citizens who, for the most part, know little more than the telephone number to ring in the event of a breakdown.

Aboriginal people living in remote communities also have closer links with the outside experts than many urban populations. They are constantly being asked about how they use science and technology, whether they want it or not or what impact it might have on them. These political and consultative aspects of modernity become the guiding principles of their understanding of science. It would not be an exaggeration to suggest that they are provided with more opportunities than most to think reflexively about their condition and to be presented with an array of either/or scenarios and the potential risks and benefits of their decisions, including international comparisons and examples. Reflexively they are hyper-aware of their disadvantage.

However, we would argue that despite being told by the experts that the technology was now safe to use, there was little opportunity for the An̲angu to have this demonstrated via observation of test results. In our own interviews with An̲angu, they indicated that they wished to be informed on a regular basis about their water supply in order to make judicious daily decisions about its use. They noted that they understood that science and technology must be constantly monitored for risk and danger, but appeared not to be part of this monitoring. Being simply told it was safe was not sufficient. They wished to view the science for themselves. This response does not arise from some form of dogged adherence to tradition and danger; it is the approach taken by many citizens conscious of the risk implications of modernity and its technology. Like other citizens, they have access to global information about the risks inherent in everyday technology despite their remoteness from capital cities. This is achieved via the sophisticated communication infrastructure that makes up A<u>n</u>angu life at Iwantja. As noted above, people's responses to the risks and dangers emanating from science and technology are characterised by ambivalence arising from contradictory information both expert and lay (Lupton 1999).

This ambivalence arises from distrust in the bureaucratic processes as well as the technology. What the experts failed to acknowledge were the risks embedded in the processes. This was despite the fact that the incident occurred because of a series of failed risk management actions on the part of the expert system as well as failed technology. In granting the tender to a private company, the Federal government failed to take into account the local knowledge of the state government experts managing these remote water supplies and the way in which they had developed a particular expertise. In their endeavours to avoid the risk of favouritism, they produced a risk for the Indigenous population and additional costs for state government. In our view, the A<u>n</u>angu response arises out of their awareness of the globalised world, including their understanding of the workings of state and Federal governments. This comes from their sophisticated links to media and their much closer engagement in their own political processes, than is the experience of many urban citizens. This resonates not only with Giddens' ideas of globalisation but also with Beck's notion that citizen awareness of the fallibility of science and expert systems arises from knowledge of disasters elsewhere in the world, which they are able to view in real time as they watch television in the remotest of outstations, and also their capacity to link these events to their own lives.

Risk rationality and post-colonialism

The second contributing factor to the A<u>n</u>angu response arises out of their long history of colonialism and uncertainty. For this reason, their response to risk may differ from other population groups. In Australia, Indigenous peoples' history is marked firstly by them being the object of danger to settlers only to be later corralled into settlements supposedly for their own safety. They also know that despite varying ideological approaches to policy, they remain at risk of numerable illness and social conditions. Many of these illnesses arise out of their situation, rather than any risky or irresponsible actions on their behalf. For example, diabetes would appear to be linked to lifestyle, but may also be partly genetic (Busfield et al. 2002), while the infections underlying otitis media or the HINI virus are simply a matter of being Indigenous in a particular geographical location (Sanchez et al. 2012; Driedger et al. 2013). To be born Indigenous is a risk, and it is difficult to see how individuals develop a strong sense of ontological security in this context. When experts transport potable water at great cost, but people continue to live in sub-standard houses, it is not difficult to see the logic and rationality of taking direct action, or developing your own lived experience theory about what the dangers and risks are. These everyday aspects of post-colonial policy engender in A<u>n</u>angu a sceptical approach to expert systems. A key component of this scepticism is a distinction Indigenous people make between those risks associated with colonisation and its technologies and those that arise from their own epistemologies. Lead contamination of water arises out of faults in modern technologies, not some malevolent force. The A<u>n</u>angu know they share with many other Indigenous peoples worldwide a struggle for healthy water, linked to land rights as well as the difficulties of ensuring water quality for small and isolated communities. Indeed, many of the improvements in water supplies in the APY Lands were motivated by the lessons learned from the Walkerton Tragedy, Canada, where several people died or were hospitalised as a result of the failure of the local water supply and the reliance on untrained personnel (see Water Quality and Health Council 2013).

Conclusion

Giddens' theories on risk and trust provide a sound basis for examining the political and everyday responses of Indigenous and colonised peoples across the world, be they the Timor Leste politicians taking the Australian government to court in the Hague over the Gas Treaty or a Sami police officer in Norway using the Indigenous language (Isaksen, date unknown). These responses are not naïve, but carefully nuanced understandings of modernity. While there are arguments that Giddens' work lacks empirical evidence, it is clear other social scientist can apply his ideas to issues of everyday life and come to understand why and how people behave. His breadth of theoretical insight goes much wider than we have presented in this chapter. He has extended the ideas around risk and trust into relationships of intimacy and also into political life. His theory building is based on a solid foundation in the classical sociological tradition. Support for the authenticity of his insights comes from the fact that his ideas resonate with other contemporary sociologists such as Beck, Luhmann Lash and others.

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Chapter 30

William C. Cockerham: The Contemporary Sociology of Health Lifestyles

Brian P. Hinote

In Western societies, lifestyles now represent one of the most significant predictors of health, or conversely, disease. Multiple authors (for example, Omran 1971; Cockerham 2007; Hinote and Wasserman 2013) carefully outline many recent social and epidemiological transformations in these societies, and lifestyles emerge from these shifts with renewed prominence in health matters. Theorists, researchers and practitioners conceptualise the term 'lifestyle' in various ways, but health lifestyles are of particular theoretical and empirical significance for medical sociologists and social epidemiologists. However, a comprehensive theoretical framework that specifically articulates the roles and mechanisms of these important health phenomena did not exist until the early twenty-first century, with the work of American medical sociologist William Cockerham (2005). This chapter provides a thorough background, explication and application of Cockerham's health lifestyles theory, which effectively accounts for the interplay of the individual and their inextricable connections to social structures, and demonstrates the value of critically applying core sociological concepts to the typically individualistic concept of lifestyle.

As an innovative synthesis that recasts and further develops earlier social science thinking, health lifestyles theory represents a seminal contribution to theoretical and empirical work analysing health behaviour in the social sciences by pushing our thinking past individualist conceptualisations of health lifestyles. It draws insights from the classical and contemporary sociological canon to synthesise earlier lifestyle formulations, as well as revisiting long-standing theoretical and philosophical impasses like the agency–structure problematic and the subjectivist–objectivist dualism. In doing so, this theorist brings into focus the critical role played by lifestyles in how individual health outcomes and aggregate behavioural trends emerge, while simultaneously accounting for the dynamic and fluid connections between the individual and the social group(s) to which they belong. In the coming pages, I will first provide some summary biographical information for the sociologist responsible for health lifestyles theory, William Cockerham. Next, I summarise the intellectual, social and epidemiological developments that buttress the need for such a framework in late modernity. In the process, I will review earlier conceptual formulations of lifestyle before providing a full explanation of the contemporary health lifestyles theory proposed by Cockerham. Finally, I will explore the theoretical and practical significance of these developments before discussing recent applications of these ideas in the social sciences.

Biography

William Carl Cockerham was born in Oklahoma City, Oklahoma, in 1939. He studied initially at the University of Oklahoma, served on active duty in the United States Army and then attended the University of California at Berkeley, where he earned his doctorate in sociology in 1971. This was a time when structural-functionalism had begun falling out of favour in the United States, and Cockerham early on identified closely with the symbolic interactionist tradition of sociological thought. Among his formative intellectual influences were Norman Denzin and Herbert Blumer at Berkeley, and Anselm Strauss, then at the University of California at San Francisco. Cockerham secured his initial academic appointment at the University of Wyoming, where he led his first course in medical sociology and laid the groundwork for his widely adopted textbook in the field, now in its twelfth edition, currently one of the leading texts in medical sociology worldwide and available in more than half a dozen languages. Cockerham's foray into American medical sociology was a timely one, and in 1975, he assumed a joint appointment in the School of Medicine and Department of Sociology at the University of Illinois at Urbana-Champaign. He joined the faculty of the University of Alabama at Birmingham (UAB) in 1991, where he helped establish a doctoral programme in medical sociology shortly thereafter. He is former Director of the Centre for Social Medicine at UAB and currently a Distinguished Professor of Sociology, Medicine and Public Health, where he remains active as an administrator, researcher, author and scholar.

Cockerham's full conceptualisation of health lifestyles theory is a more recent development, however. His research in Germany during the 1980s provided compelling evidence suggesting that lifestyles were closely linked to structural influences like social class, leading to a rethinking of micro-level conceptualisations of these phenomena (and initiating a shift away from his intellectual roots in symbolic interactionism). If health lifestyles were indeed a matter of free choice, then they should not cluster within particular social groups according to, for instance, class position. But in Germany they nonetheless did so, and subsequent research in the United States and other Western societies confirmed these trends. Then, at a conference in Vienna in 1994, Cockerham heard social scientists from the former Soviet bloc struggle to adequately explain the mortality crisis in these nations, so he began applying his early ideas on health lifestyles to these populations, eventually uncovering one of the primary mechanisms fuelling the twentieth-century explosions in working class male mortality in the former Soviet Union and eastern Europe. He did not fully develop and articulate his conceptualisation of health lifestyles until a 2005 paper published in the *Journal of Health and Social Behavior*, only one contribution among dozens in various areas of the sociology of health and medicine, including social causation, risk, mental disorder, ageing, theory and international health.

With a prolific and influential career thus far, Cockerham's life as a sociologist spans the decline of structural-functionalism through the rise of symbolic interactionism and other agency-oriented paradigms, and then into the re-emergence of structuralist explanations of human social behaviour. The lifestyles paradigm discussed in the pages that follow reflects this intellectual trajectory, as it seeks to forge a theoretical 'middle-ground' that avoids slipping into the upward and downward conflating tendencies of more purely agency- and/or structure-oriented explanations. It is to a discussion of this framework that I now turn.

The shifting landscapes of late modernity

At least three general trends are responsible for the rising significance of lifestyles in contemporary health and society, including (1) shifting disease patterns; (2) a new modernity; and (3) the transformation of self-identity. First, shifting disease patterns constitute the phenomenon that Omran (1971) first termed the 'epidemiological transition', which marks the shift from infectious to chronic disease as primary sources of morbidity and mortality. Importantly, this transition also signals an important change in how we conceptualise health. In pre-transition modernity, health was most often simply the absence of disease or injury. Social and economic factors strongly shaped disease trends even then, although typically by influencing where and/or when an individual might contract an infectious agent. At this time, infectious disorders were responsible for most morbidity and mortality, so avoiding these pathogens and the areas in which they thrived permitted one to enjoy a state of general health. However, economic changes, advances in public infrastructure and the progress of medical science eventually stemmed the threat of infectious disease and, in the process, set the stage for the chronic disease threats of late modernity.

So epidemiological trends are the first noteworthy trend in the rising significance of health lifestyles, where the burden of mortality moves from short-term, treatable and often curable disorders to more prolonged, sometimes manageable but rarely curable chronic illnesses. This is important not only from a demographic, epidemiological and biomedical perspective, but because social determinants of health, including lifestyles, become even more important to how, when and in what groups disease outcomes emerge (Link 2008). Put another way, before this transition individuals often looked to physicians or medical science (or the promise of scientific advancement and 'magic bullets') to 'fix' or eradicate disease, but the structures of clinical medicine are not well-suited to address many contemporary health threats. Instead, chronic disease is a long-term process emerging from the cumulative individual, yet structurally influenced, lifestyle decisions spread across the life course. Lifestyles thus become the most powerful predictors of health and mortality, and the diseases that emanate from them very often defy the curative logics of modernist medicine (see Wasserman and Hinote 2012).

Health today is not merely the absence of something undesirable (that is, disease, injury and so on). Rather, it is a more complete sense of not just physical, but also emotional, social and psychological well-being – a multi-dimensional concept. In addition, it is often something of an achievement, an outward projection of one's ability to navigate the increasingly complex terrain of contemporary threats to health and wellness. As this multi-layered definition suggests, health is something that we must deliberately and consciously work towards or, conversely, risk the chance of disease or early death by neglecting. In the end, these developments suggest that individuals are normatively assigned greater responsibility for their own health and bodies, but this does not mean that everyone is equally able to assume that responsibility effectively. Thus, while social factors certainly shaped disease outcomes in modernity, these influences become even more powerful during and after the epidemiological transition, with lifestyles one of the most important mechanisms through which these factors operate (Cockerham 2007; Wasserman and Hinote 2011).

The second significant development mentioned above refers to a new form of modernity (see Giddens 1991; Beck 1994, 1999; Hinote and Wasserman 2013 for more discussion of late modern shifts). The contemporary prominence of health lifestyles emerges from the shift into what can be characterised as late modernity, signalled in part by the epidemiological transition. Societies around the world are undergoing significant changes that undermine the logics of Enlightenment-based, industrial modernity, and we can observe the consequences of these various transformations in multiple domains. In health and medicine, we see declining status, prestige and authority among physicians, who formerly enjoyed great power, influence and autonomy during the 'golden age' of medicine, prior to the rise of the late modern medical marketplace. As both a cause and outcome of these trends, we may also point to movement towards a more equitable distribution of power and decision-making authority in the doctor–patient relationship, as well as the rise of Internet medicine and the increasing uncertainty surrounding health matters more generally. We see a fracturing of the previously monolithic power base of modernist medical knowledge, and in late modernity, medical science and the logic of the clinic become only one of many competing paradigms of promoting health and treating disease. As a result, perhaps the most critical outcome of these developments is a single paradox. The shifting tides of late modernity permit more individual responsibility for and active participation in health through lifestyles, but doing so requires the resources necessary to navigate a multi-dimensional and increasingly complex health landscape, where social factors are increasingly important and where the nature of disease pathogenesis is more uncertain and less well understood (Cockerham 2007; Wasserman and Hinote 2011).

Finally, the third development mentioned above refers to late modern shifts in the primary locus of self-identity. In modernity, work or occupational prestige was an important determinant of one's position in the socio-economic hierarchy. During the twentieth century, however, patterns of consumption began to displace mechanisms of production as markers of social position and group identification. The techno-economic progress of modernity (along with production shifts in global labour markets) facilitated easier acquisition of material goods, so that what one consumed, rather than produced, became a primary mechanism of distinction or similarity for many in the emerging late modern order. This further pushes lifestyles to the forefront of studies of human social behaviour, because they are themselves markers of consumption. So we can therefore conclude that in late modernity, lifestyles are important for self-identity, and they are also an important part of understanding contemporary social life. To be sure, lifestyles have also assumed a powerful position in our nascent understanding of health and disease at both the individual and population levels of analysis. But before fully unpacking contemporary health lifestyle theorising, the topic of this chapter, let us turn to a brief discussion of lifestyles in earlier sociological thinking.

The study of lifestyles in classical sociology

The work of Max Weber ([1922] 1978), Pierre Bourdieu ([1972] 1977, 1984, 1990) and Anthony Giddens (1987, 1991) strongly influenced Cockerham's contemporary formulation of health lifestyles (2005, 2014). These major intellectual influences constitute the bedrock of health lifestyles theory, and their work, especially that of Weber and Bourdieu, emphasises at least two philosophical and theoretical problematics that lifestyles theory seeks to overcome in the area of disease and health behaviour: the agency–structure problematic and the subjectivist–objectivist dichotomy. While he did not specifically address health practices, the sociological analysis of lifestyles probably begins with the work of Max Weber, who focused more generally on the connections between lifestyles and social status. While the long-standing concept of social class originated in the economic sphere, where class represented the economic component of life chances (Weber [1914] 1964), lifestyles for Weber were characteristic of status groups (that is, groups of individuals sharing, among other attributes, a special social esteem). These status groups come into being through shared 'styles of life' centred upon what is consumed by members of this or that group. Accordingly, classes are stratified, based upon their relation to the production of goods, whereas status groups are stratified according to principles of consumption, or in other words, styles of life (Weber [1922] 1978). So Weber's early discussions of lifestyle emphasise the idea of consumption, which would ultimately prove important in later applications to health, but he also describes the way lifestyles involve two major components: life choices and life chances.

Weber argued that sociology is a science focused upon the interpretive understanding of social action (see [1922] 1978), and life choices and life chances are two of his major intellectual contributions to the analysis of social life. Life choices refer to self-direction, or choosing from multiple behavioural options, while life chances refer to the structural probabilities of realising one's choices. It is through the dialectical interplay of these concepts that lifestyle emerges. In other words, chances constrain or enable life choices, and choices in turn either reinforce or modify life chances to generate a particular lifestyle profile for groups of people sharing similar status. Life chances are solidly anchored in structural conditions of social and economic stratification and generally refer to one's probability of attaining wants, needs, desires or choices (Dahrendorf 1979). Individuals thus have a range of freedom, but not complete freedom, to choose from options available to them by virtue of their position in broader systems of stratification, their chances in life. The notion of chance occupies a prominent role in Weber's work, but it is important to remember that life chances are far more than haphazard. They are assigned at birth, and while they are somewhat open to change, they are also quite durable (Cockerham 2014; Hinote 2014a).

In connecting the action of the agent (choices) to the larger social system (chances), Weber also provides a useful conceptualisation with which to analyse the long-standing agency–structure problematic, with choices a proxy for agency and chances a proxy for social structure. The relative roles of agency and structure in social behaviour have been the central focus of sociology since the beginning of the discipline (Cockerham 2007:55), because understanding these relations is critical to understanding what society actually is (Archer 1995). Somewhat surprisingly, many medical sociologists initially paid little attention to this age-old dilemma (probably due to the more applied roles the discipline played early on in psychiatry and medicine), but it is particularly important to discussions of health behaviour and lifestyles. That is, are these isolated, individual choices? Or are they somehow shaped by structural variables like social class, gender and so on? And how do we explain how lifestyle choices and, ultimately, patterns emerge? These are critical questions to understanding these phenomena, and critical to the way we explain aggregate epidemiological trends. Such questions also perplexed later thinkers, those analysing health behaviour as well as those dissecting social behaviour more generally.

The study of lifestyles in contemporary sociology

While Weber provides the classical sociological contribution to the study of late modern health lifestyles, Anthony Giddens (1987, 1991) and Pierre Bourdieu ([1972] 1977, 1984, 1990) specify the conditions and mechanisms associated with these important contemporary phenomena. More specifically, Giddens analyses the ways that social changes associated with the shift into late modernity undercut many of the traditional practices of simple modernity and, in the process, promote a diversity of choices for individuals. Agents' choices (shaped by structure) constitute a lifestyle that connects them to others through a stable set of behavioural practices. Building upon the idea of shifting social identities discussed above, lifestyles are integrated sets of practices that not only fulfil utilitarian needs, they constitute the narrative of a particular self-identity. In other words, consumption patterns help reify social identities, and because these choices are never detached from broader structural realities, Giddens emphasises that an agent's orientation relative to social structure can enable or empower, rather than simply constrain, lifestyle choices (Cockerham 2014). But while these ideas are important and influential contributions, Pierre Bourdieu arguably plays a bigger role in Cockerham's health lifestyle conceptualisation.

Although the idea did not originate with his own research, Bourdieu provides one of the cornerstone concepts of contemporary health lifestyles theory – habitus. As one of the most well-known and widely cited contributions of contemporary social theory, Bourdieu develops habitus to reconcile the behavioural implications surrounding the agency–structure problematic described above, and by extension, the connections between subjective experience and objective social structures (Maton 2008). At the level of experience, for example, individuals often feel that they are free in their choices, but they typically orient their action towards the predictable behaviour and attitudes of others around them. Similarly, at the level of structure, social action is carried out with regularity and consistency, not only in terms of repetition, but also because children of working class families tend to eventually get working class jobs, middle class people enjoy middle class entertainment and so forth. These dynamics unfold in a way that is quite predictable in the absence of explicit guidelines or as the product of solely social structures or subjective intention (Swartz 1997). Bourdieu explores the ways that behavioural choices are obviously regulated in the absence of clear rules to guide them, and he specifies habitus as the mechanism through which society is deposited into individuals through dispositions to think, feel, and act in particular ways that are sometimes creative, but typically predictable, responses to situations and surroundings (Wacquant 2006). Accordingly, habitus guides individual choices and social action in a way that reproduces preferences, tastes, behaviours and opportunity structures.

Bourdieu (1977, 1990) himself describes habitus in various ways (see Swartz 1997), but the processes surrounding and embodying this concept unfold as a system of circular relations, in which life chances are internalised and then translated into individual expectations, which are subsequently externalised through behaviour that tends to reproduce and/or express the very same life chances that originated social action. Accordingly, individual and group aspirations and dispositions tend to reflect habitus (that is, it is a 'structured structure' as well as a 'structuring structure'; see Bourdieu 1990:35) and, therefore, perpetuate existing social arrangements. Habitus originates through primary socialisation during childhood and generates deeply structured dispositions characteristic of specific class or status groups. Habitus explains how either advantage or disadvantage is internalised into behavioural dispositions that reproduce individual differences and structural inequalities across generations. It influences multiple domains of cultural consumption, and it is enduring but not completely static or unchangeable. Although somewhat adaptable, it nonetheless demonstrates an inherent inertia that tends to (re)produce practices patterned by the structures that give rise to them.

As part of Bourdieu's broader theory of social action, habitus provides contemporary lifestyle theorising with a critical link between agents' lifestyle choices on the one hand, and aggregate health behavioural trends on the other. This important concept overcomes the false dichotomy of agency and structure by accounting for behavioural regularities as well as creativity in social action. Further, individuals are inextricably linked to broader structures so that each is embedded in a distinct set of social influences. But those influences are by definition shared after all, so that even in our distinctions, differences are inevitably socially patterned. Finally, habitus resolves the behavioural problematics associated with subjectivist–objectivist dualism by explaining the ways that objective social facts are internalised into dispositions, and then how those dispositions are externalised as social action (Maton 2008; Hinote 2014b). What these seminal contributions share is an emphasis upon the myriad ways that the choices constituting one's lifestyle embody internalised dispositions shaped by the individuals' inescapable connection to broader structural arrangements. In this way, the ideas briefly outlined above set the theoretical stage for their application in medical sociology – a sociology of health lifestyles.

Towards a contemporary theory of health lifestyles

In large part due to the changes outlined above (for example, shifting disease patterns, a dissolving modernist order, and transforming self-identities), a distinct need for a sociological theory of health lifestyles arose by the early twenty-first century. This is not to say that researchers and practitioners minimised or overlooked the importance of lifestyle as a health concept. Rather, despite the extensive prior sociological analysis of social action more generally, the widely adopted definition of lifestyle in public health, epidemiology and related disciplines diverged from the conceptualisations of Weber, Giddens and Bourdieu. As noted above, these thinkers analyse and explain social action vis-à-vis the enabling and/or constraining nature of social structures. Much contemporary socio-medical discourse emphasises the individualist dimension of health lifestyle, thereby neglecting the inherently collective, structural nature of these phenomena (Frohlich et al. 2001). Such methodological individualism overlooks an important dimension of individual choices and fails to provide a deeper sociological understanding of health lifestyles. Not only are these approaches for the most part inadequate in explaining human social behaviour generally, they also unnecessarily restrict our thinking to individual behavioural interventions, rather than bringing into better focus the importance of contextual influences like environments, relationships and other critical social factors pertinent to health and well-being. In short, what was needed was a comprehensive framework that adequately accounted for determinants of health at multiple levels of analysis, as well as an explanation capable of explicating the roles played by these factors in generating health outcomes.

Cockerham (2000a) defines health lifestyles as collective patterns of health-related behaviour based on choices from options available to people according to their life chances. It is important to begin with this definition. Weber's influence in the dialectical interplay of choices and chances is already apparent, and the health lifestyles framework begins with this critical dynamic (for graphical depictions of the health lifestyles paradigm, see Cockerham 2005, 2007, 2014). As noted above, life choices are analogous to agency, with life chances a proxy for social structure and either enabling or constraining behavioural choices, eventually giving rise to a health lifestyle. In addition, health lifestyles are not the uncoordinated actions of atomistic individuals; rather, they are personal routines coalescing into aggregate patterns characteristic of specific social groups or classes, thus simultaneously constituting individual and aggregate health phenomena (Cockerham 2007).

Contrary to conventional lay thinking but probably not surprising to other social scientists, the genesis of health lifestyles begins with structure, or more specifically, life chances. Initially ascribed statuses like class, age, gender and race/ethnicity determine to what life chances we will typically have access throughout primary socialisation and childhood. We may extend the influence of socio-economic circumstances, ideologies and social relationships to collectivities and living conditions, all of which either constitute or directly influence our probabilities of finding the good things in life, or our chances of realising life choices. Class circumstances and other dimensions of life chances thus set the stage for initial socialisation and early experience. Individuals, during this period of life, effectively internalise their life chances and learn to orient their behaviour towards appropriate choices and aspirations, according to what their life chances deem possible or probable. In short, the early conceptual interplay of chances and choices, of structure and agency, (re)produces habitus, which is characteristic not only of individuals (that is, each possesses habitus) but also of collectivities (that is, groups of individuals sharing similar positions in social space share a group habitus). In these ways, Weber's choice–chance dynamic and Bourdieu's habitus conceptualisation constitute the bedrock of Cockerham's lifestyles framework.

To recapitulate thus far, multiple categories of structural variables (by constituting life chances) have the potential to shape lifestyle choices for individuals and groups, including but not limited to (1) social class circumstances; (2) age, gender and race/ethnicity; (3) collectivities; and (4) living conditions. These categories affect lifestyle choices by providing an *agenda of choices* (that is, a set of available options) and the *code of choosing* (that is, guidelines for what is appropriate) (see Bauman 1999). Accordingly, through life chances, structural considerations shape ranges of available options and provide the rank order of preference for those choices. Put another way, social structure (most notably social class) shapes what is available to choose from and what, in turn, should be chosen. The primacy of class, or socio-economic status, in health outcomes is well established (for example, Link and Phelan 1995; Cockerham 2007; Phelan and Link 2013); as a result, this concept occupies a similarly prominent place in health lifestyles theory. Still, the other structural variables listed above also play a role in shaping life chances – through age cohort effects, gender roles, shared norms and ideologies (that is, collectivities) – and neighbourhood, living and working conditions, among other influences. These opportunity structures, according to Cockerham (2005, 2014), shape choices with regard to lifestyle and are internalised as habitus through socialisation, thereby guiding behavioural dispositions to make this or that choice when faced with a range of health options.

Habitus, within the context of health lifestyles theory, is essentially a cognitive map or set of dispositions that simultaneously reflects and routinely guides an individual's health choices and options, generating behaviour that is not only normative but also habitual and intuitive. It also connects individuals to larger groups of similar agents. In health matters, these dispositions to act might focus upon health maintenance or promotion (for example, exercise, healthy diet and so on), or they might generate particular practices with little regard for health consequences (tobacco use, harmful alcohol consumption, unhealthy diet and so on). The practices emerging from habitus may be based on deliberate and rational calculation, or they might emerge from habit or intuition, so deeply integrated into routinised behaviour that they are enacted with little or no conscious thought. Agents tend to embrace behavioural repertoires and strategies in a way that they may be enacted without conscious aims, ends or analysis. As such, lifestyle practices, guided by habitus, are woven into the fabric of everyday life and are often guided more by pragmatic and habitual considerations than abstract logic.

Typical lifestyle practices generated from these processes include tobacco and alcohol use, dietary practices and exercise regimens, and extend to health maintenance (for example, routine check-ups and so on) and countless other behaviours. The individual practices themselves might be positive or negative in character, but they are organised into a lifestyle profile, which can become increasingly complex, that is characteristic of not just individuals but also of the groups of which they are a part. Accordingly, this framework successfully accounts for a diversity of health practices that emerge among individual agents, as well as aggregate lifestyle patterns that are observable among groups of agents sharing similar habitus and life chances. Finally, the enactment of a particular behavioural profile (a health lifestyle) tends to reproduce itself over time. There is room for behavioural modification, vis-à-vis selection of another available option according to life chances, but lifestyles are relatively consistent over time, open to some degree of change but remarkably durable (Cockerham 2014). And because lifestyles work through the structures of life chances and habitus, they are also transmitted inter-generationally, thus ensuring their durability across the life course of individuals and their cohorts, and across multiple generations as well. This is why lifestyle profiles are remarkably stable phenomena for individuals and social groups over time.

Discussion and applications

As mentioned previously, research (for example, Cockerham et al. 1988, 2002; Cockerham 1997, 2000a, 2000b) investigating health dynamics in the former Soviet Union and Europe provided momentum for the eventual development of a contemporary theory of health lifestyles. For example, studies conducted in West Germany and the United States (for example, Cockerham et al. 1988) lay the Weberian theoretical groundwork for health lifestyles by extending Weber's critiques of Marxist theory to the study of health behaviours. Cockerham and colleagues (1988) acknowledge the merit of the Marxist approach to health lifestyles advanced by Waitzkin (1983) and Navarro (1986) in its emphasis on the roles that structural and material considerations play in shaping health outcomes. But they also note major shortcomings in this line of thinking, pointing to the Marxist assumption that health behaviours are determined not by individual choices or decisions but by the economic superstructure of society and the ideology that underlies it (Cockerham et al. 1988:115). After all, people do indeed have choices regarding their health behaviour given their circumstances. Adopting a Weberian perspective of health behaviour overcomes the limitations of the Marxist analysis by introducing the notion of choice–chance interplay, and a focus on the relationships between consumption patterns, lifestyle choices and their connections with status groups.

Because the most prominent negative mortality trends affected primarily males in this part of the world, subsequent research in the former Soviet Union and eastern Europe (Cockerham 1997) focused more specifically on this group, especially those in the middle-aged, working class demographic. Competing hypotheses explaining these developments included the structure of Soviet state ideology and health policy, social stress associated with rapid social transition and, finally, health lifestyles. While the first two explanations likely played some role in mortality fluctuations, health lifestyles, including alcohol consumption, tobacco use, dietary practices and physical inactivity, appeared to be the major social determinants of health for these men. And even when various dimensions of life chances like, for example, state ideology (Cockerham et al. 2002) or stress/distress (Hinote et al. 2009b) negatively influenced health in these populations, these variables arguably did so in large part through the mechanism of health lifestyles, including drinking, smoking and dietary practices. Much of the research noted here not only provided more support for lifestyle explanations, this work also further emphasised the need for a theory of these very important behavioural components of health.

Later research (for example, Hinote 2009) refined these ideas and applied them to women as well as men (Abbott et al. 2006; Hinote et al. 2009a, 2009b, 2009c), providing still more evidence of the link between social conditions, life chances and health and mortality outcomes. Hinote and Webber (2012) explore the significance of gender constructions and habitus among men in the former Soviet Union, noting that at multiple levels of analysis, the 'construction of masculinities is intimately linked to specific behavioural dispositions and therefore exerts a profound influence on health and longevity' (Hinote and Webber 2012:305). They further note that behavioural dispositions pertaining to harmful drinking patterns are born of habitus, reinforced through social interaction in specific fields and collectivities, social institutions and the state. In other words, 'working class socialisation and learning to “do masculinity” are often deeply embedded in ritualised drinking practices, therefore sustaining the generational transmission of specific habitus configurations’ (Hinote and Webber 2012:306). These authors effectively explain the ways that health lifestyles persist in a relatively stable manner across generations and at multiple levels of social scale, thereby illustrating the utility of a health lifestyle approach. Cockerham also extends his ideas to Asian contexts (Cockerham et al. 2006) and in his on-going work on health trends in the United States.

While Cockerham’s framework is a quite useful way to theorise health behaviours in contemporary society, it nonetheless spawns some challenging methodological issues. For example, as Cockerham (2005) himself succinctly notes, measuring aggregate-level phenomena that are closely related to life chances (in a way that truly captures these variables’ structural attributes) is not an easy task. Conventional qualitative and quantitative approaches both possess inherent weaknesses that researchers must either overcome or, at the very least, minimise. Even appropriately measuring something as ubiquitous as social class poses a number of problems in this and other frameworks (see McQueen 2009). And with Bourdieu’s habitus as its core, the concepts that constitute health lifestyles theory may be quite difficult to operationalise with conventional research methodologies. Bourdieu (1984) himself utilised correspondence analysis to map his data and objects of study (see Bourdieu 1984; Hinote 2014a), but this approach does not permit probabilistic hypothesis testing directly. Because health lifestyles theory is a relatively recent development, many of these challenges remain for researchers. Cockerham (2005) specifically suggests the use of multi-level or hierarchical modelling to overcome some of these measurement issues, but as more and more research accumulates in the area of health lifestyles, we will hopefully gain a clearer picture of how innovative research methodologies might enable us to better measure these phenomena.

Still, one notable strength of health lifestyles theory involves overcoming the individualist conceptualisation of lifestyle dominant in much of the current biomedical discourse, but theorising health behaviour and outcomes in this way also pushes our thinking forward in the areas of practice and intervention at the individual and policy levels. Clearly, these ideas are relevant well beyond the Soviet and post-Soviet contexts within which they largely originate. For instance, Weitz (2010) cites Cockerham’s lifestyle theory as a way to overcome the weaknesses of agency-centred approaches to conceptualising health and illness. She remarks that this framework overcomes the upward conflating tendencies of many contemporary models of health and offers a ‘comprehensive analysis’ of contemporary health behaviours (Weitz 2010:41). In addition, Phelan et al. (2010) incorporate status group dynamics into the on-going development of fundamental cause theory, using Cockerham’s ideas to better frame the nature of structural-level health resources that operate over and above individual choices. These resources accrue and benefit higher status individuals whether they choose to deploy them or not, and are clearly important considerations in the analysis of health behaviours. Moving into the broader implications of Cockerham's lifestyles framework, Abel and Frohlich (2012) integrate these ideas and others into a much broader discussion of health inequalities, where research and practice must consider structural health influences and their interplay with individual health choices. Beyond largely theoretical discussions, however, health lifestyles theory has also inspired new ways to think about health behaviour and policy. Delormier et al. (2009) draw from this framework to discuss the social influences beyond individual eating practices and note that acknowledging these forces is key to developing more effective nutrition interventions. Further, Edison and colleagues (2011) similarly utilise Cockerham's ideas to push their thinking forward in the analysis of community health. That is, more thorough and thoughtful consideration of structural and community contexts is crucial to overcoming individual-level approaches to community health interventions, which are often less than successful. Finally, Fotaki (2010) uses these ideas and others to analyse socio-economic and social psychological factors germane to the notion of patient choice in the British National Health Service. She notes that choice is conditioned by so much more than individual-level considerations and emphasises the broader policy implications of a simplistic and one-sided conceptualisation of individual patient choice in discussions of equity.

Wasserman and Hinote (2012) also draw from Cockerham's (2005, 2007) lifestyle theory as well as Link and Phelan's (1995, Phelan and Link 2013) fundamental cause approach to emphasise the implications of contemporary sociological research and theorising on clinical practice, medical education, reimbursement structures and the medical division of labour. In short, many contemporary healthcare delivery structures are ill-suited to deal with health threats, as well as the nature of disease itself, in late modernity. As mentioned previously, health lifestyle theory explains the mechanisms by which individual lifestyle profiles come about, as well as the overall health profiles of large social groups and populations. Wasserman and Hinote (2011) similarly acknowledge that lifestyles tend to afford greater individual responsibility in health matters (that is, health is in many ways individuated in the late modern era), but because choices are very much structured by life chance configurations, not every individual is equally equipped with resources to effectively assume responsibility for those choices in late modernity. In other words, those best positioned to adopt healthy lifestyles most effectively are those with the social and economic resources to navigate the increasingly complex and multi-dimensional landscape of health and disease, and contemporary epidemiological trends tend to reflect this ubiquitous pattern of stratification. In summary, Cockerham's health lifestyles approach connects to various strands of contemporary research in the social, medical and health sciences in many health and policy discussions, only a small portion of which is discussed here.

Conclusion

The purpose of this chapter is to provide a concise yet thorough background, explanation and general application of the health lifestyles approach developed by American medical sociologist William Cockerham, whose career spans the decline of structural-functionalism, the rise of micro-paradigms, and the resurgence of neo-structuralist theorising in the social sciences. Accordingly, his lifestyles framework aims to link various scales of analysis from the micro to the macro levels to avoid the upward and downward conflating tendencies of many theories, and to overcome classical theoretical problematics such as agency–structure and subjectivism–objectivism, to analyse how health behaviour is predictably generated and patterned. This framework, and related strands of sociological thought, helps push research and thinking past individualist lifestyle conceptualisations, as well as similarly individualist approaches to disease pathogenesis, healthcare delivery and health policy. Cockerham draws upon and synthesises the insights of multiple sociological thinkers to explain precisely how lifestyle profiles and trends emerge in late modernity, and in doing so accounts for the dynamic connection between the individual agent and the social groups of which they are a part.

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Chapter 31

George Ritzer: Rationalisation, Consumerism and the McDonaldisation of Surgery

Justin Waring and Simon Bishop

This chapter introduces and explores the continuing relevance of George Ritzer's McDonaldisation thesis to contemporary healthcare reforms. In general terms, Ritzer's work revisits and extends Max Weber's analysis of modernity, especially the idea that social action is increasingly 'rational' or driven to determine the most efficient and practical means of achieving a desired end. For Weber, this type of 'instrumental rationality' was best exemplified by the growth of bureaucracy, which institutionalised the roles, rules and regulations of achieving efficient and effective modes of social action. In revisiting these ideas, Ritzer's work offers a counter-argument to more recent social theories that describe a late- or post-modern era characterised by more diverse and fluid types of action, including post-bureaucratic modes of social organisation. At its foundations, his McDonaldisation thesis, therefore, aims to demonstrate the continuing relevance of Weberian concepts of rationality and bureaucracy to contemporary society by showing how they have evolved to reflect additional social changes, especially individualisation, consumerisation and globalisation. In particular, Ritzer's work focuses on the mode of social organisation associated with fast-food chains, such as McDonalds, as exemplifying the hyper-rationalisation of everyday life. This includes rationalising the production of goods and services, and also transforming the material and symbolic modes of consumption. Importantly, he also reveals the inherent contradictions and irrationalities of this type of social action, especially latent risk and the illusion of choice.

In this chapter, Ritzer's ideas are explored with particular reference to on-going healthcare reforms, especially for advanced industrial democracies. Over the last three decades, healthcare systems around the world have been systematically 'modernised' and reconfigured to ensure effective use of increasingly limited public resources; to expand public access and, at the same time, patient choice; and to improve the standards and quality of care. For many healthcare systems, this has involved a move towards more managed and marketised modes of service organisation. These reforms have been framed, in many cases, by wider social and economic changes associated with the decline of post-war welfare regimes, cyclical economic crises, the rise of New Public Management and the individualisation and commercialisation of everyday life. In particular, many sociologists suggest healthcare, and other public services, are increasingly reorganised on the basis of bureaucracy and the market, rather than professionalism. In other words, healthcare systems around the world have, like many other aspects of social life, been caught up in the institutional logic of rationalisation. For scholars such as Freidson (2001), professionalism offered a third logic or alternative to the logics of the market or bureaucracy, but continuing health reforms suggest the convergence of these logics, via the mechanisms of McDonaldisation, at the expense of professionalism.

Our chapter develops this idea to describe the McDonaldisation of healthcare. We acknowledge that this is not entirely novel, with Ritzer offering a number of tentative examples in this arena, and other writers offering similar descriptions. That being said, many studies often draw narrowly on Ritzer and rarely explore how healthcare rationalisation is actively reconstructing the practices of both healthcare professionals and patients. As such, we describe the emergence of the 'McDoctor' and the 'McPatient', but also suggest that these changes are often characterised by contradiction and resistance, which become especially revealing where doctors and patients interact. To illustrate this view, we highlight on-going changes in the social organisation of surgery, especially the shift towards dedicated surgical centres to provide high-volume, low-risk procedures. These reveal the McDonaldisation of surgery and provide new insight into the challenges of rationalising healthcare.

Biography

George Ritzer is widely recognised as one of the leading social theorists and meta-theorists of the late twentieth century. It is interesting to note that Ritzer has no formal qualification in sociology, but came to the discipline through a circuitous tour of accounting, psychology and business studies. Unlike many of the writers profiled in this volume, Ritzer remains active and capable of easily challenging the account of his work depicted here. As such, we pay close attention to the details of his websites and recorded interviews. He was born in 1940 and raised in upper Manhattan in, what he describes in an interview with Dandaneau and Dodsworth (2006), as the upper lower classes with a 'pretty marginal economic existence'. After attending Bronx High School of Science, he attended Baruch Business School at City College New York in the belief that he 'wanted to go into business'. He initially planned to major in accounting, but eventually changed to a major in psychology. Following graduation, Ritzer decided to return to his interest in business and enrolled in an MBA at the University of Michigan, a decision which he suggested might have been shaped by a desire to avoid the military draft of 1962. It was during this time that Ritzer became interested in personnel administration, or what today might be understood as human resource management, human relations or organisational behaviour.

After graduation in 1964, Ritzer took a position at Ford in the area of personnel administration. This relatively short-lived experience became a 'defining moment' and set the backdrop for his future academic career. Upon arriving at Ford, Ritzer found two other applicants had been appointed to the same post. Not only did this provide a lesson in corporate mismanagement, but it also required that he '*look* busy' to safeguard his employment. To do this, Ritzer would tour the factory facilities and observe the everyday routines of the shop floor. Like many other sociologists, this ethnographic encounter seemed to spark his interest in work organisation. He noted the hostility of workers to his periods of observation and, more broadly, the underlying tension between 'workers' and 'management'. Significantly, Ritzer observed how the established processes of work organisation and management stifled the potential for creativity or innovation among staff.

Reflecting on these experiences, Ritzer decided to resume his studies with a PhD in the School of Labor and Industrial Relations at New York State University, which was in part based on his previous studies in personnel administration and experiences working at Ford. It was at this time that Ritzer became exposed to more formal sociological theories, including Howard Becker's work on workplace commitment, which were developed through his doctoral studies on role conflict and personnel administration (Ritzer and Trice 1969). After defending his thesis in organisational behaviour, Ritzer took faculty positions at Tulane University and the University of Kansas and within seven years was made full professor at the University of Maryland, where he continues to hold the post of Distinguished University Professor.

In his interview with Dandaneau and Dodsworth (2006), Ritzer reflects that his lack of formal training in sociology or social theory not only meant that he became self-taught, but also that he 'never had the blinders that a lot of social theorists have from buying into a particular perspective'. This arguably reflects a key feature of Ritzer's theoretical work, namely that it seeks to reappraise established perspectives and work towards an integrated paradigm. This can be seen in his first major theoretical work *Sociology: A Multiple Paradigm Science* (Ritzer 1974), his later work *Metatheorizing in Sociology* and his textbook *Classical Sociological Theory*. As well as 'theorising about theory', Ritzer has made a number of significant, arguably landmark, contributions to sociology and the social sciences more broadly through his related studies on McDonaldisation, consumption and globalisation. It is perhaps his McDonaldisation thesis (Ritzer 1996, 1998, 2004), however, that is most recognised. The origins of this work, he recounts in interview, stem from first-hand observations of McDonalds' rapid expansion through the 1960s and 1970s, first within America and then Europe. This was coupled with his teaching of Weberian social theory, where he reappraised and looked to extend Weber's ideas about formal rational and bureaucracy. Before detailing this work, it is interesting to note that it had its origins in an article written in 1983 which examined Weber's typology of rationality and explored the possibility of hyper-rationality. Ritzer suggests that this work was barely picked up at the time, and it was nearly ten years later when he presented the ideas at an American Sociological Association meeting in 1991 that the concept of McDonaldisation garnered interest from the audience, a concept he only 'mentioned in passing in talking about hyper-rationality'. Ritzer reflects that he 'got tired of writing books that nobody wanted to buy', and the apparent popularity of his new conceptualisation of hyper-rationality laid the foundations for the McDonaldisation thesis. Running through this and his other works on consumption and globalisation is a critique of contemporary society highlighting the threat to individual freedom and creativity posed by the institutional structures of production and consumption.

The McDonaldisation thesis

Although many readers will already appreciate the following point, it remains important to emphasise that Ritzer's McDonaldisation thesis is not really about the fast-food chain McDonalds. Rather, it uses this iconic global company to exemplify a broader process in the reorganisation of everyday life; where 'the principles of the fast-food restaurant are coming to dominate more and more sectors of American life as well as the rest of the world' (Ritzer 2004:2). What Ritzer effectively captures through the concept of McDonaldisation is the way in which social actions and modes of organising are increasingly guided by hyper-rationality, which has combined with other globalising and commercial trends to represent a powerful institutional logic. Before unpacking his thesis, it is important to trace the connections with the work of Max Weber.

Weber's sociology centres on the idea that social actions are inherently meaningful, within a given social and historical context (Weber [1922] 1970). Sociological enquiry should therefore seek to interpret these subjective meanings to explain and predict social processes. Weber elaborates different types of social action, including 'traditional' action where behaviour is habitual and based on convention; 'affective' action where behaviour is guided by emotion; and 'rational' action, which is premised on a calculated understanding of the relationship between means and ends. Rational action is further elaborated as 'value-rational' action where behaviour is guided by the belief that something is right or proper, and 'instrumental-rational action' where behaviour aims to achieve a desired goal through the most practical and efficient means. In making a distinction between non-rational and rational action, Weber elaborates four distinct types of rationality (Kalberg 1980). 'Practical rationality' describes the more pragmatic and direct means–end responses to prevailing 'everyday' circumstances, in so far as behaviour is produced to accept and adapt to the present reality, rather than seeking to transform it. 'Theoretical rationality' seeks to better understand the prevailing circumstances through developing a more detailed and abstract conceptualisation of reality, rather than necessarily trying to directly act upon it. 'Substantive rationality' captures social actions that directly seek to respond to social circumstances but based on 'value postulates' rather than means–end calculations, that is, what matters to the individual. Finally, 'formal rationality' describes the extension of instrumental, practical rationality through formal economic, political and legal institutions, especially through bureaucratic modes of organising action. For Weber (1970) bureaucracies are based on fixed jurisdictions of activity; they are administrated through hierarchies of super- and subordination; they are ordered through formal documentation; with management based upon expert or formal training; and are governed through generalised rules. Weber was particularly attentive to the negative consequences of rationality, especially what he saw as the 'iron cage' of bureaucracy, where the potential for individual expression becomes constrained by the confines of strict, formal rules and regulations. Weber's ideas clearly resonate with other sociological perspectives on modernity. For example, the organisation of work through highly specialised, segregated and managed division of labour echoes Taylor's (1911) 'scientific management' and more broadly Fordist modes of organising.

In basic terms, Ritzer's McDonaldisation thesis revisits and extends Weber's conceptualisation of formal rationality to consider how more and more aspects of modern life are subject to rational forms of organisation and control. This *hyper-rationality* not only manifests in production-type processes, but also in the cultural imperatives for everyday activities especially the contemporary significance of consumption. The origins of this hyper-rationality are located in radical social, economic and political changes evident in the late twentieth century, including the rise of neo-liberalism, the globalisation of Western capitalism, the commercialisation of everyday life and the individualisation of social relations (Giddens 1990, 1991). However, his works offer a counterpoint to many theorists who attempt to describe and explain these far-reaching social changes as the coming of a post-industrial, post-Fordist or post-bureaucratic age (Lash and Urry 1987; Amin 1994). Ritzer's work captures the possibilities for bureaucratic rationalisation to be extended within individualised and consumer-focused late modernity, rather than replacing it with an understanding of more personalised and postmodern cultures. In particular, his thesis examines how hyper-rationality continues to offer producers, consumers and managers more efficient, calculable, predictable and controlled means of achieving desired goals in an increasingly dynamic world (Ritzer 2004). It is along these dimensions that Ritzer elaborates his conceptualisation of McDonaldisation.

The dimension of *efficiency* captures the ability of rationalised processes to select the 'optimum means to achieve the given ends'. This is typically articulated in terms of the minimal or least wasteful use of available resources to achieve a desired aim, such as money, human capital, materials or time. In 'fast food', this is found in the way meals are prepared with the smallest possible number of simplified activities, as well as the way it is served and consumed with little waste or duplication, including the lack of cutlery or crockery which would require subsequent cleaning. This efficiency is typically achieved through using explicit work processes that are known to reduce waste and maximise outcomes. The emphasis on such efficiency is understood as commonplace in many traditional work organisations, but has now spread to other social activities.

The dimension of *calculability* highlights how quantitative aspects of social activities are emphasised by rationalised processes at the expense of qualities less open to straightforward measurement. On the one hand, this fosters the belief that 'bigger is better' in terms of the size or scale and, on the other hand, focuses social action on those activities that can be quantified, that is, 'what gets measured, gets managed'. The consequence being that more qualitative and intangible aspects of social activities tend to become devalued.

The dimension of *predictability* describes how rationalised processes tend to involve standardised processes and result in broadly similar outcomes, often regardless of spatial and temporal boundaries. With respect to McDonalds, the design of restaurants, the range of menus, the uniforms of staff, the method of ordering and the production of food is broadly similar regardless of city or country. This predictability is commonly achieved through reordering social processes so they become routinised, consistent and regular, typically through the use of standardised rules, operating procedures and outcome requirements. Although standardisation supports calculability and efficiency, it does necessarily equate to quality. In fact, Ritzer suggests the challenge for organisations is how to rationalise and retain quality, because quality tends to be sacrificed to measurable standardisation. Equally, standardisation constrains individual discretion and leads to questions against the idea that consumers really have choice given the extent of standardisation.

The dimension of *control* elaborates how the emphasis on calculability and predictability, as a means of achieving efficiency, requires more formal means of ordering and governing the activities of both producers and consumers.

Again, in the McDonalds' restaurant customers are organised through queues, menus and uncomfortable seats which encourage desired behaviours; similarly workers are required to follow prescriptive protocols and standardised rules for preparing, cooking and serving food. Increasingly, this control is premised on non-human technologies, such as the use of monitoring systems, alerts or automated processes that further limit individual discretion. As such, Ritzer sees McDonaldisation as micro systems of control, which introduce not just an iron cage, but a series of mini-iron cages where any vestige of choice invariable leads to another form of control.

Like Weber, Ritzer's thesis is clearly attentive to the dangers or *irrationalities* of rationality. As noted above, he describes the intricate and formal mechanisms of social control that constrain individual creativity. In particular, he highlights the new risks created by rationalisation, especially the threats to local cultures, the dehumanising effect for workers and consumers, the loss of traditional skills or capabilities, and the potential impact on the environment and other scarce resources. For example, McJobs tend to sacrifice expertise and skill to prescriptive protocols, or the pursuit for standardised food creates new environmental risks from mass farming (Ritzer 2004).

McDonaldisation therefore highlights the continuing relevance of bureaucratic rationality in a post-industrial, globalised and consumerist age. The elements described increasingly structure social life, and where novel or bespoke activities emerge, the likelihood is that their future success and exploitation will be premised on being McDonaldised, hence losing the qualities that made them special. These ideas have been popularly received both with academic and public audiences, where the phenomenon of McDonalds powerfully articulates a broader social change. Accordingly, these ideas have been applied to many aspects of social life where the principles of fast food have restructured fine-dining (Ritzer 2004), art and culture (Fine 1999), sport and leisure (Jary 1999; Bryman 2004), the family (Raley 2004), police work (Robinson 2004), higher education (Hayes and Wynyard 2006) and social work (Dustin 2007).

At the same time, Ritzer's work has attracted significant debate and criticism. First, many authors are quick to point out that the McDonaldisation thesis largely restates Weber's work on rationality and bureaucratisation (Kellner 1999; Smart 1999; Weinstein and Weinstein 1999; Turner 2004). Although some see merit in his account of hyper-rationality (the combining of rationalities), it has been commonly stated that his four dimensions offer little novelty or theoretical advancement. Further, where his work seeks to be more critical, it turns to other established critiques of industrial bureaucracy or modern forms of governance, such as those of Braverman (1974) or Foucault (1980). Second, and echoing the above, Ritzer's ideas are criticised for their popularism, especially the use of familiar or iconic social references to explain complex sociological propositions. As Weinstein and Weinstein (1999) argue, this form of metonym, in this case using McDonalds to illustrate a wider phenomenon, substitutes the precise conceptualisation of complex social processes with a more palatable and arguably McDonaldised sociology. Third, his work often downplays the significance of, and impact on, local cultures, especially the capacity for individuals and communities to actively resist McDonaldisation, in some circumstances (Munch 1999; Pieterse 2004). As Smart (1999) asks, however, it is not always clear what is being resisted, for example, rationalisation or the loss of local commerce to global actors. Finally, many have extended Ritzer's notion of irrationalities to highlight a further range of negative consequence of McDonaldisation. As noted above, these are often found in the negative impact on workers in the face of enhanced management control and de-skilling. Research also elaborates the paradox of choice which is often at the heart of McDonaldisation, specifically where consumers are seemingly offered more abundant opportunities, but these are inherently structured according to the principles of predictability and calculability (Smart 1999). A further dilemma concerns issues of quality and inequality. As outlined above, the reliance upon measurable standards and standardisation can neglect the intangible and more subjective aspects of social life, which in many instances are the basis of aesthetic experience, personal taste and subjective quality. As such, standardisation can have the effect of driving down quality in pursuit for quantity and efficiency. In turn, this can create new possibilities for inequality where the poor or marginalised tend to rely upon McDonaldised services and the more affluent are able to access more bespoke and high-quality services (Smart 1999). For public and healthcare services, rationalisation therefore creates new possibilities for two-tier services.

In our view, Ritzer's thesis offers something distinct and novel. Specifically, it captures the extension of formal rationality beyond the realm of production to that of consumption in a globalised context. Here it has a powerful symbolic and cultural influence, as well as its capacity to order materials and resources. More than this, it enrols everyday life into an individualised, self-authoring pursuit for efficiency, predictability and control as a means of countering the uncertainties of late modernity and maintaining a sense of ontological security (Giddens 1991). Further, it is the coming together of hyper-rationality with hyper-consumerism, and on a global scale, that distinguishes Ritzer's work from that of Weber.

Rationalisation, consumerism and the McDonaldisation of surgery

Healthcare has not been immune to the influence of McDonaldisation. It is important to recognise how the modern hospital, in many ways, illustrates Weber's view of bureaucracy, with its administrative hierarchies, clinical subspecialities and physical design and control structures, that is, the Nightingale ward. Moreover, Ritzer (1996) suggests bureaucracy and professionalism stem from similar processes of formal rationality; although he, like many others, recognise that professions such as medicine are often able to avoid the constraints of bureaucracy through securing relatively high levels of autonomy (Freidson 1970). In such instances, healthcare might be better understood as a professional bureaucracy (Mintzberg 1993).

Contemporary healthcare reforms suggest a demise of this professional autonomy and the creeping bureaucratisation of healthcare work (Scott et al. 2000). From the late 1960s, policy-makers have increasingly questioned the lack of political accountability in healthcare, as well as the excessive power of professionals to influence resource allocation. In the United States, this was particularly evident with publicly funded Medicaid payments and the introduction of Diagnostic Related Groups where doctors' monopoly interests seemed to run counter to those of administrators or patients (Alford 1975). In the United Kingdom, policy-makers since the early 1970s have questioned the autocratic power of doctors and the need for more bureaucratic control in service planning and delivery (Klein 1990). Since this time, the ascendance of neo-liberalism in the Western economies and its influence on New Public Management have led to further dramatic changes in the social organisation of healthcare. In the United States, for example, Starr (1982) described how the failure of the state to effectively control healthcare spending led to new forms of rationalisation based on market and corporate structures. This saw doctors increasingly working as salaried employees, the amalgamation of healthcare providers into larger corporations and the concentration of ownership within corporate firms or insurance funds. For some commentators, this signalled the end of the 'golden age' of medical professionalism with doctors experiencing enhanced forms of corporate and bureaucratic control in the form of 'assembly-line medicine' (Scott et al. 2000; McKinlay and Marceau 2002). In more publicly funded healthcare systems, similar processes are evident as policy-makers have extended rationalising and 'countervailing' powers (Light 1995) for management to better control professional practices, or similar forms of market mechanisms (Ham 1999). In the United Kingdom, the introduction of General Management in the mid-1980s and the internal market in the early 1990s demonstrates the simultaneous drives for bureaucratisation and marketisation as a means of rationalising healthcare and controlling professional work (Harrison and Pollitt 1995).

It is against this backdrop of change that the McDonaldisation of healthcare has occurred. In earlier work, Ritzer (Ritzer and Walcak 1988) explores how the increased use of protocols and operating procedures, such as clinical guidelines, challenge the discretionary expertise of professionals, such as doctors, and invokes new forms of standardised and rationalised organisational control. Later, Ritzer describes the rationalisation of maternity care and diagnostic services, where patient pathways are redesigned in ways that reduce the number of visits, procedures and interactions, because patients have come to expect healthcare service be more like their fast-food outlets, offering 'one-stop visits that include lab work, needed drugs and consultations with physicians' (Ritzer 1996:45). Research in New Zealand suggested similar developments where medical services are offered as one-stop shopping centres, where care is offered within 'fast-turnaround service hubs' (Kearns and Barnett 1997). This one-stop idea is further revealed in studies of day-surgery, where the patient experience is organised around a production-line process of short, structured clinical interaction (Mottram 2011). Germov (2005) similarly describes the hyper-rationalisation of healthcare in Australia in the context of far-reaching management reforms. Similarly, Harrison (2002) interprets the growth of evidence-based medicine, the extension of new regulatory procedures and the enhanced (but often illusionary) priority on patient choice as resulting in 'scientific bureaucratic medicine'. That is, where medical work is increasingly organised and governed in line with the principles of a McDonaldised bureaucracy to reflect the changing needs of patients and policy-makers. Returning to Ritzer's four dimensions, we can see how healthcare services are subject to hyper-rationality.

Efficiency

Healthcare services are increasingly organised to provide services in ways that maintains, or indeed extend the level of services, but through reducing the expenditure of financial and other human resources (Aday et al. 2004). Making efficiencies in healthcare is associated not only with increased margins or value for money, but also with the coverage of, or access to, services across the population. At the policy level, efficiency is at the heart of drives to change funding structures (payment linked to outcomes rather than populations), technologies (reducing effort and movement) and work systems (maximising utilisation of resources), with quality itself seen as supporting efficiency, for example, through reducing duplication of failed procedures. Moving employment, careers, work roles and skill-mix away from professional norms has been a particular target, seeking greater efficiency in human capital.

Examples of contemporary activity illustrate how efficiency concerns orientate daily practice within healthcare organisations. The recent proliferation of lean management methods among healthcare providers is testament to policy-makers' desire to reduce all form of 'waste'. In several countries, national programmes for Lean have made the tools and language of waste reduction commonplace in hospital wards and other service spaces (Waring and Bishop 2010; Radnor et al. 2012). In our own work in ambulatory surgery centres (also known as day surgery and treatment centres), we see 'assembly-line medicine' (Ritzer 1996) extended to surgical care. Treating only the lower risk routine cases allows the formation of services that, at least on the surface, closely resemble models of modernised service production in other sectors. Evidence of actual efficiency gains is mixed, however, as separating straightforward cases may reduce the efficiency in other parts of the system, with all complexity and unpredictability concentrated elsewhere (for example, Aaserud et al. 2001).

Predictability

Consistency and predictability of healthcare processes, as well as outcomes, has similarly become a common aim of healthcare reform. Government policy changes have led to clinical governance regimes that tie expectations surrounding performance and quality measures to formal reporting and management structures, so that boards of governors are accountable and responsible for clinical outcomes, as well as other aspects of healthcare organisational performance. This is supported through increased transparency of published outcomes and the widespread availability of data on all aspects of healthcare services (McGivern and Fisher 2010). Such explication of service outcomes goes hand in hand with the increasing standardisation of service process, as any variations are potentially evidence of inefficiency and disorder.

In day-to-day healthcare practice, this has resulted in the proliferation of best-practice or evidence-based guidelines, standard operating guidelines and systems of checking and monitoring for particular services and healthcare conditions (Harrison 2002). These may specify the order and spaces of action, use of equipment and roles and responsibilities that make up service production. To varying degrees, such guidelines are supported both by national frameworks as well as international circulation of evidence, so that forms of service can be standardised and predictable across locations. In ambulatory surgery centres, we find a proliferation of such guidelines for practice which break down the required actions of both clinicians and patients into individual steps and decision points, with each case expected to fit into the conveyor belt of care. In Mottram's (2011) work, the rapid, mechanistic nature of such care met patient expectations for modern convenient service delivery, despite the fact that this may ultimately require more work from patients in terms of responsibility for post-surgical care and in certain instances increase risk of complications during recovery.

Calculability

Accounting and quantitative measurement has become a central feature of healthcare work (Lapsley 1999), with contemporary payment systems requiring links to be made between patient classification, types of conditions, treatment processes and the expected costs of care (Pettersen 2001). Each of these may require new administrative systems of data collection and measurement, with such measures linked to an overall understanding of performance, as well as financial incentives or penalties. Accounting for each aspect of clinical practice is a particular focus of clinical activity where new contractual relationships are formed, and trust-based control is replaced by arms-length reporting systems, including the use of key performance indicators. League tables of outcomes at both the level of the organisation and the individual healthcare practitioner are increasingly common.

Within ambulatory surgery centres, the increased opportunity for measurement has been a central feature of efforts to explicitly manage professional work. Placing elective surgery into spaces where the likelihood of unexpected events has been greatly reduced allows the direct measurement and comparison of surgery times, use of resources and other aspects of process and performance. Within individual centres, data on how each surgeon has performed is often displayed on walls and message boards, illustrating the competitive performance expectations and work control increasingly typical within these healthcare services. This occurs regardless of the fact that many may be sceptical of the ability of such measures to capture important aspects of the 'real' quality of care. Further, as many have pointed out, measurement and calculation require significant amounts of additional work, potentially undermining the ultimate aspiration of increased efficiency (Pettersen 2001).

Control

In summary, we can see the above processes of McDonaldisation as aspects of the increased degree of control experienced in the sphere of healthcare. This extends to clinicians who are expected to meet the norms of optimal efficiency, adhere to standardised processes and open themselves to measurement, as well as patients who are required to fit within pre-determined modes of service delivery. The agenda of patient choice can similarly be seen in this light, with patients expected to control their own behaviour by acting as rational and informed consumers. As has been observed, while this may be welcomed by patients, their ability to choose between different forms of McDonaldised services may be against their own interests in terms of quality of care (Mol 2008). We can place increased use and capacity of information technology as supporting all of the above processes, providing a means of collecting and publicising data, supporting efficiency in decision-making and ultimately enabling new systems of control. In the design of many new healthcare facilities, including ambulatory surgery centres, comprehensive systems of IT are the focal point of systems redesign, with computer software ordering tasks according to standardised procedures, as well as subsequently collecting data on them for future analysis. In this environment, venturing outside of predefined forms of behaviour, at least in terms of 'front stage' service performance, becomes increasingly difficult.

Irrationalities

As illustrated above, the McDonaldisation of healthcare each also brings with it irrationalities. Expanding these, a number of additional irrationalities can be stated. First, we can see clear tensions between a focus solely on the measureable aspects of care and the ability of individual clinicians to offer high-quality and safe services to the individual. As Hewison (2004:344) states, a 'purely business' relationship between clinician and patient turns out to be ethically irrational as it does not allow for individual interpretations of human relationships. Second, while the negative consequences of workforce de-skilling has been a core critique of organising work according to economically rational principles in general, in the case of healthcare services this remains a particularly salient issue. This includes the high level of emotional and moral involvement required for healthcare work (Bone 2002) as well as the inevitability of complexities which require more than minimum levels of skill to cope. A third is the long-standing and on-going tension between medicine and management where rationalisation might further reduce the trust and cooperation needed between these groups. As such, the scope for apparently necessary clinical judgement and discretion to be exercised may be severely curtailed (Brownlie and Howson 2006). Finally and returning to the issue of patient choice, the requirement of the patient to act as a rational agent in an healthcare market appears to be particularly ironic, given that stimulating such a system limits the possibility of the average patient having any genuine involvement in the McDonaldised processes of their own care.

Concluding thoughts

George Ritzer's work remains controversial. It offers a powerful and persuasive conceptual approach for interpreting contemporary social change, including both positive *and* negative aspects of rationalisation. At the same time, it is criticised for restating well-established theories, over-simplifying the complexity of contemporary life and not fully addressing the limits and resistance to rationalisation. Ritzer's McDonaldisation thesis clearly has much to offer the analysis of contemporary healthcare reforms, especially as new expressions of hyper-rationality, continue to shape and reshape healthcare services. These can be summarised along two lines. First, we highlight the growth of vertical structures of hierarchical control through the 'rationalising' interests of management in relation to resource allocation, service planning and quality control (Light 1995). It can also been in terms of horizontal structures of control found in the standardisation and reconfiguration of healthcare practices through formulaic, evidence-based care processes (Ritzer and Walcak 1988; Harrison 2002). This often stems from corporate or government demands for more standardised and predictable care, together with concerns about sub-standard quality, which have led to a form of 'assembly-line' medicine (McKinlay and Stoeckle 1988; Harrison 2002).

However, McDonaldisation has not merely transformed the structural environment of healthcare organisation, but has had a more profound effect on the social meaning of both healthcare professionalism and the consumer-patient. Today, doctors, nurses and other carers are increasingly judged and seen as legitimate by virtue of the efficiency and predictability of their clinical interactions: where time and patient throughput become imperative; where performance is measured by compliance with standardised guidelines and evidence-based protocols; and where outcomes are measured and assessed in terms of league tables. At the same time, patients are expected to become pro-active and rational consumers of healthcare through actively reviewing available performance data, choosing services from available menus of service providers, and accessing care in more convenient and time-limited interactions. Yet, the benefits of more predictable and safe healthcare also entail a false choice on the part of patients, where services become less personalised and less patient-centred, because they are evermore uniform and standardised. Equally, the over-standardisation of professional practice puts at risk the capacity for professionals to respond effectively to dynamic, changeable and uncertain circumstances, that is, where guidelines are of little relevance. The inherent de-skilling of clinicians in the drive for standardisation threatens the capacity of professionalism to respond in relatively uniform, experienced and expert ways to the specific needs of individual patients.

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Chapter 32

Julia Kristeva: Abjection, Embodiment and Boundaries

Trudy Rudge

The purpose of this chapter is to explore how Julia Kristeva's approach to embodiment and boundary work extends understandings of how vulnerability, disgust, horror and uncertainty shape healthcare practices. Kristeva's oeuvre is based in Lacanian psychoanalytic theories and concepts as well as approaches from social and literary studies. In the case of this chapter, the focus is on her theorisation of the psychological defence mechanism of abjection – a response to the abject, where identity, order or system are thrown into disarray. The abject, which is our focus here, is the abject body, but the abject can also be social situations and activities that are polluting, betrayals of what is considered 'right', and social positions that are considered defiled, stigmatised or associated with what destabilises our sense of certainty. Such an analysis affords the possibility of voicing both the significance and incomprehensibility of bodies that leak, the chaos of illness and disease, and their sometime monstrosity. An analysis of abjection situates much that is deemed 'out of place' in healthcare. As this is the case, I draw on instances of health-related practices to show the relevance of the emotional defence of abjection to explanations about lack of boundaries, sullying of subjectivities and what is in operation when various attempts to regain boundedness and certainty are mobilised.

The first section will explore the detail of Kristeva's development of the ideas of abjection and how these fit into psychoanalytical theories of ego defence and embodiment. How these terms work and what view of health and illness are possible will be explored with this Kristevan lens through description of the abject, abjection and the 'powers of horror'. In focusing on the concept of abjection and the abject body, such analysis acknowledges what is both unknown and known, what is ambiguous and uncertain, and what is 'out of place'. In exploring what is uncanny and outside of societal norms, in the following section I provide analyses of embodiment using this lens to open up the possibilities such an approach makes possible. The focus will be on what falls out from encounters with the boundary work accomplished by patients, healthcare workers and researchers using such an approach. The final section explores alternative views and the contentiousness of Kristeva's work on abjection, critiques of her approach as well as an estimation of how this work begins to open up a radical ethics of care when they are positioned relationally in the in-between, and alert to the ambiguities and destabilisations that emerge in the processes of treatment. In taking up the position offered by Kristeva on the position of the abject, healthcare workers can rethink the cultural and social meanings of embodiment in health and illness as well as its accompanying horrors and fascinations so as to acknowledge, yet deface its profound effects.

Biography

Julia Kristeva was born in the Balkans in 1941, travelling to Paris for her doctoral studies, bringing with her eastern European studies of literature and literary studies. Her work in literary studies was influenced by Bakhtin and other linguists, but once in Paris her work became more revolutionary – as a member of the *Tel Quel* collective (Brandt 2005). Her views on feminism are said to have been influenced by her disaffection with Maoism after a study tour to China with that collective, with the penning of her critique of the treatment of Chinese women – a paper that brought the wrath of American Feminist scholars down on her (Rose 1993). This long-standing difference of opinion between Kristeva and Anglo-American feminism is best thought of as a difference in emphasis as to feminism and its political agenda. Such a framing these authors insist, most famously Judith Butler (1993a) and Elizabeth Grosz (1989), that Kristeva's reading of femininity is essentialist and biologically deterministic – all flowing from her use of psychoanalytic theories to explain a variety of emotional states, experiences and social situations such as the negation of motherhood.

Julia Kristeva is a practising Lacanian psychoanalyst, a Professor of Linguistics at the Université de Paris VII and a visiting professor at Columbia University, New York, whose university press continues to publish most of her work when translated into English, as well as the University of Toronto, Canada. She is a prolific author with continuous publication of books about psychical states, theories about gender, race, nationalism, revolt and activism as well as philosophical works on many of the concerns of contemporary Western societies. Her early work was in literary studies and many of her studies continue this framing, using cultural approaches to explore emotional states and personal conditions. Her work in literary studies continues along with these philosophical works about emotional states such as abjection, alienation and exclusion, depression and women, new maladies of the soul, the sense and non-sense of revolt, to name but a few. The position she has taken on how women's status in society is best confronted remains contentious for many feminist authors, yet she has found advocates in feminist scholarship, film studies, critical race studies and critical social analysis. She continues to write and lecture in both France and New York, where she provides lectures, seminars as well as practising as a psychoanalyst – work that provides her with salient and relevant examples and insights into the human condition. Julia Kristeva has been awarded the Hannah Arendt Prize for Political Thought and the first Holdberg International Memorial Prize for research in the field of the human and social sciences, law and theology (Kristeva 2009).

In this chapter, the focus will remain on her work on the emotional defence of abjection, the abject body and how this work pushes the boundaries of understandings about the civilised, civilising body. Kristeva has continued to develop the idea beyond its first application in the *Powers of Horror* (1982) into *New Maladies of the Soul* (1995) and other works such as *Black Sun* (1989), *Tales of Love* (1987), *Hatred and Forgiveness* (2009) and *The Sense and Non-sense of Revolt* (2000) where this thinking has been extended, developing into a more nuanced account of how emotions, bodies and social systems intersect throughout and in the accomplishment of a child's social development. Such an approach hints at the socio-cultural forces that shape our relations to our bodies and the social. In the next section, I provide a beginning survey of this work, in the section following that I bring the work on abjection to bear on the body, skin and its links to identity. In the final section, I discuss reactions to her work with some authors who find her work productive, as well as critics who highlight how her work continues to be problematic for feminists, and others who find psychoanalytic approaches to the social equally problematic.

Abjection, embodiment and the self

> It is thus not lack of cleanliness or health which causes abjection but what disturbs identity, system, order. What does not respect borders, positions, rules. The inbetween, the ambiguous, the composite (Kristeva 1982:4).

In these much-cited sentences from the *Powers of Horror* (1982), Kristeva lays out the framework with which to think about the emotional defence of abjection, its sources and social consequences. She grounds her analysis of the power of horror in her everyday sense of repugnance and visceral horror when she encounters the film of skin on the top of a milk coffee. Abjection is a response to this horror, as she shrinks from ingestion of the skin and the feel of it in her mouth. Boundaries, inside, outside, emotions and the self are hence foundational concepts for how we are to understand this emotional state and what it signals. Kristeva's argument is that this emotion is also a defence mechanism against its horrors and is foundational, acting as a primer for other emotional states and defences in the structure of the psyche. But at the same time, the abject is contaminated by the knowledge that its presence has the potential to challenge what is held as sacred, all that needs to be repressed in order for us to live:

> A wound with blood and pus, or the sickly, acrid smell of sweat, of decay, does not *signify* death. In the presence of signified death – a flat encephalograph, for instance – I would understand, react, or accept. No, as in true theatre, without makeup or masks, refuse and corpses *show me* what I permanently thrust aside in order to live. These body fluids, this defilement, this shit are what life withstands, hardly and with difficulty, on the part of death. There, I am at the border of my condition as a living being (Kristeva 1982:3).

Kristeva's psychoanalytic theories are based on Freud's (1856–1939), and later Lacan's (1901–1981) construal of a child's development, and the structures of psyche brought about through the child's psychosexual development; and in the later formulation by Lacan, the child's language acquisition. How Kristeva differs from these psychoanalytical theorists is important here. While Freud's ideas have provided insights for critical theorists and feminists alike in terms of offering a form of understanding of the unconscious and ego formation, both Freud and Lacan remain captive to the power of the male hegemony. In the *Powers of Horror* (1982), Kristeva brings her understanding of language and language acquisition, with her training as a Lacanian psychoanalyst to bear on the Oedipal myth which Freud used to account for our differentiation as sexed bodies, the psychical structures and defences emanating from the child's separation and civilisation by the mother as well as the child's emergence into the world of language. She argues for an approach that centres the primacy of the rejection of the mother as crucial in understanding how emotions, drives and desire compel the separation as well as drawing the child to language through its love for the paternal ideal (rather than the disciplinary paternal law and power that governs later psychosexual development), so as to present the child with a third way based in between power and its negation in the maternal function (Kristeva 1987; Oliver 2002a; DeArmitt 2005; Chanter 2008). While formed in the negation of the maternal function, and through the abjection of the maternal body, Kristeva nevertheless also presents a view of the development of the self (and its relation to the other) that predates the formation of subjectivity in language and paternal power. Hence, the child's foundational separation takes place in ambivalence, at the borders of linguistic understanding or the symbolic, while abjection's presence and power to horrify waits in-between and outside psychical structures (such as the ego or superego) developed in later struggles of becoming a 'self' (Oliver 2002a, 2005).

Moreover, as part of this process, various products of the body are acknowledged as not-me (or other), and their potential to defile the self recognised. Whereas Mary Douglas (1966), who Kristeva uses to analyse how bodily products and processes come to be viewed as polluting or as matter out of place, sees all such matter as polluting and therefore requiring ordering to reduce their danger, Kristeva (1982) categorises defiling products as different, dependent on whether these substances are external dangers or threats to the self, or internal threats to identity:

> Excrement and its equivalents (decay, infection, disease, corpse and so on) stand for the danger to identity that comes from without: the ego threatened by the non-ego, society threatened by its outside, life by death. Menstrual blood, on the contrary, stands for the danger issuing from within the identity (social or sexual); it threatens the relationship between the sexes with a social aggregate and, through internalisation, the identity of each sex in the face of sexual difference (Kristeva 1982:71).

In such a construal, Kristeva figures that dangers and threats to the self from matter out of place, or potential failures to maintain purity of body and self, are mapped onto the psyche and the body through its civilisation under the authority of the maternal function which is 'trustee' of the self's clean and proper body. The process of guardianship and civilising of the child confirms the ambivalence towards the abjected maternal role, replaced by the imaginary loving father (Kristeva 1995, 2009). Moreover, such mapping of what is excluded/included is affective and pre-symbolic located in the realm of meaning in the semiotic – present in drives and the body rather than in the linguistic logic of the paternal law – even as the abject defines what is clean and proper. To recognise how this primal activity operates to develop a sense of self, separate from the mother and the abject, one needs to:

> ... distinguish between the *semiotic*, which consists of drive-related and affective *meaning* organised according to primary processes whose sensory aspects are often non-verbal (sound, and melody, rhythm, colour, odours, and so forth), on the one hand and *linguistic signification* that is manifested in linguistic signs and their logico-syntactic organisation on the other (Kristeva 1995:104).

The picture obtained of the place of the defence and positionality of abjection is one where the socialisation of the child develops firstly from their rejection of the civilising and abjected mother, then drawn onwards to acceptance as 'social' by the figure of the imaginary loving father, into the full acquisition of language proper, separated from the maternal with a sense of civilised and appropriate social identity.

However, it is not a simple or finalised process. Not only does rejected matter vary as to its effects, be under voluntary control or not, remain attached, or dissociated with the body, such associations and meanings are not always available to the conscious mind (Kristeva 1995, 2009; McAfee 2004). In other words, although such matter may leave the body and be rejected, such rejections may not always obtain object status – they remain in the unconscious, their threat manifest in the semiotic and affective levels of language and meaning (Kristeva 1995:104; McAfee 2004). Hence, that which is rejected is manifest (concrete), a physical product of the subject (excrement, secretions, and so on), and imaginary (symbolic), existing metaphorically (and even metonymically) because of the cognitive process taking place in which the abject evokes filth and is affectively associated with pollution of the body and mind. Moreover, the mapping of what counts as proper and improper, clean and unclean, possible and impossible is accomplished through the work and authority of the maternal function (Kristeva 1982). Hence, the maternal function is associated forever with the civilising of the infant body, just as abjection places this function outside of the control of the symbolic order even as this paternal function positions the maternal as 'lack'. Paradoxically, such exclusion constitutes the basis of the maternal power – a power that both disgusts and pleasures. It is this duality of the abject that signifies why subjectivities that are abjected (such as women as mothers) fail to be adequately represented or controlled by the symbolic order of language. The abject remains outside of total control of patriarchal power, even as abjection limits and excludes the body and some of its products, its need for civilisation and its power to horrify remain.

Skin, boundaries and the abject

In this section, the problem of the body, embodiment and its theorisation will identify through an examination of skin in embodiment, where skin, in contemporary society, represents 'fashion', a materiality to paint, puncture or suggest plasticity of self as skin is moved around – drawing societal fascination and horror in equal parts – which Grosz (1993) points out may well be the same thing. In exploring skin (Connor 2004), the hope is to interrogate its silence in most analytical work on bodies, a cover left behind in our rush to uncover the hidden vitality of the body and biochemical mysteries. My argument lies in the assertion that our fascination with bioscience reaches deep into our bodies trapping us into going beyond our most primal relationship with our bodies, its boundaries and limits experienced through skin. Skin is an organ which begins our understanding of and communication with the world, and when analyses of the body proceed under our skin without recognition of this embodied boundary as central, aspects of personhood remain overlooked, as well as skin's socio-cultural import in how we understand the body as complete, emotionally and somatically.

From such a perspective, skin is a human tapestry that embodies our sense of self, containing our kaleidoscopic imagery of our sense of self from the first embodied connections with the world. It maps not only the self but our contact with others, and, as Anzieu (1989) suggests, carries these memories in the way skin remembers those important attachments to significant others. Skin is the largest organ and sense organ, and with its rupture there are dangerous sequels for people from the failure of its functions as a barrier. Moreover, skin has a considerable socio-cultural burden in contemporary society, being written upon by transgressive practices increasingly normalised as practices of freedom such as tattoos, cosmetic surgery and piercings (Anzieu 1989; Connor 2004). Connor (2004) asserts that Anzieu's idea of the *skinego* links skin to the mind/self, and from skin to the mind. In thinking through skin from the outside to the mind we open up possibilities to see how the body intersects with the mind, and then onto the identity as represented by skin. Skin, as a border, comes to represent how our identities are bounded to the unitary ego of Western metaphysics. Since skin works at the level of semiotic, as well as symbolic, it provides a strong sense of who we are. Anzieu (1989) asserts skin is mapped onto and is a direct representation of a person's psyche. Moreover, in a society that is increasingly 'epidermiologised' (Chanter 2008) through race and racial discrimination, our racial imaginary embodied by skin is metonymic (Grosz 1993; Pile 1996), crystallised by skin's dominant function as cover (Rudge 2009).

Kristeva's view on a child's socialisation is based on a series of incomplete rejections, where each new development is constitutive of a self under threat from its relations to bodily products that disgust and threaten. Hence the self remains reliant on emotional defences to maintain boundaries between the self and other – a subject in process (Kristeva 1984). Our sense of self is contingent on mobilisation of an on-going ordering of objects, practices and beliefs that contain the clean and proper body, its boundaries or systems. Moreover, as each excluded object or emotional threat horrifies, it as well fascinates us – containing as it does our sense of security and order from earlier connections between our bodies and the maternal function:

> The imaginary is a kaleidoscope of ego images [from the various sources of those images] that build the foundation for the subject of enunciation. Yet we must remember that the imaginary extends its effects through psychic modalities that precede specular identification, that is, through the psychic representations of affect that are subjected to the fluctuating rules of assimilation and rejection [negativity] as well as condensation and displacement (Kristeva 1995:104).

From Kristeva's position in linguistics and psychoanalysis, she asserts that our beliefs about objects (such as the boundedness of skin) are built through relations with our bodies and to senses of touch, smell and hearing before we come to organise our sense of who we are according to the dominance of the specular, or linguistic senses. For Kristeva, the young child (between 6 and 18 months of age), as part of the process of self-identification, begins to reject certain parts of his or her being, as well as symbolic representations of the child's relationship with their mother (Kristeva 1982). This process is asserted as necessary for any child striving to construct its own identity and become a speaking subject. However, central to Kristeva's portrayal of the role of the abject and abjection is the bringing of the child to language through the semiotic – the world of meaning mapped onto a body first understood through skin, orifices and senses of touch (Kristeva 1982:72).

Hence, skin can be asserted as a primal location where social structures and structuring effects are registered – skin is constitutive of the warp and weft of an identity made up of both self and other, as understood to Lacanian psychoanalytic thought (Kristeva 1991; Oliver 1993; Chanter 2008). In approaching the crossing of mind and body through the covering of our bodies, skin intersects with not only gender but race, class and other dividing structures, gets into our psyche in the body through metonymic or metaphorical relations with our skin (Brennan 1993) and is entangled with our acquisition of language. Moreover, skin as metaphorical cover tells more than what rightly resides inside and outside:

> ...the skin surface itself, as that which appears to contain us, but as where others impress upon us. The contradictory function of skin begins to make sense if we unlearn the assumption that the skin is simply already there, but begin to think of the skin as a surface that is felt only in the event of being 'impressed upon' in the encounters we have with others (Ahmed 2005:101).

In work undertaken in the case of people who have lost both the sense of what is contained and the ability to work out how they are to be impressed upon in the future, then it makes sense how the loss of this embodied boundary can be followed by a sense of loss and trauma deeper than one's looks, or image. The attachment to skin is, as Anzieu highlights, more than skin deep. For instance, when a person is burnt (Rudge 2009), their problems with identity are profound, going beyond issues of disfigurement into the fragility of embodied identity constituted as a tapestry of self/other, masculine/feminine and race. As the abject waits for such trauma and loss, our anxieties about skin as a boundary are defaced by emphasising coverings of technoscience of wound care products rather than the long-term care needed to cure the deep trauma of abjection and identity loss. To counter this focus, Anzieu (1989) asserts that skin has many psychoanalytical functions. He suggests nine functions: supporting, containing, shielding, individualising, connecting, sexualising, recharging, signifying and assaulting/destroying (Anzieu 1989:98–108; Connor 2004:50). Such a figuring of skin resonates with Kristeva's (1982) mapping of meaning and orifices, as well as Ahmed's (2005) more political idea of skin as impressionable. Similarly, research on burnt men showed how skin as boundary is embodied deeply into and a major part of social understandings about identity and masculinity. Hence, loss of skin integrity is an assault accompanied by a deep sense of loss and certainty that is both an actual as well as a figurative brush with death (Rudge 2009).

Lafrance (2010), in a paper exploring the biography of the first facial transplant, wonders at Dinoire's expression of the enormity of loss from her facial wounds and disfigurement, and her drive to regain a complete face/skin. Kristeva (1991, 1982) explains this situation, using Lacan's (1977) figuring of identity – identity as always already constituted with the shadow of the other within. Moreover, not only does identity or our sense of self obtained emotionally and socially contain the other but also has within it the Other as represented in major systems of differences such as race, class and gender. Hence, identity as portrayed in psychoanalytic theory assumes contingency of identity, requiring constant negotiation and reworking with each recognised and misrecognised threat to its sense of completeness, a sense obtained at a cost and only ever transiently – a more postmodern sense of self. Such a sense of identity framed by the abject confirms how we live in the shadow of our mortality (Kristeva 1982). Skin embodies much of the concerns of health and illness in the twentieth century, where skin represents symbolically our intensified concerns over ageing, has become the model for ageing and the very centre of embodied anxieties about how skin shows 'age' (Rudge 1999; Connor 2004).

> The skin is always written: it is legendary. More than the means of what we happen voluntarily or involuntarily to disclose to sight, it has become the proof of our exposure to visibility itself (Connor 2004:51).

Moreover, skin has become an unreliable border simultaneously as it is read anxiously for cancers, AIDS-related conditions such as Karposi's sarcoma and signals to others that a person is being treated for HIV through the distribution of adipose tissue under the skin (Gagnon 2010).

In thinking through what skin embodies for contemporary understandings about health and illness, Kristeva's notion of abjection affords a view of how our desires and horrors are carried by this boundary between the inside and outside of the self. Skin embodies social transgressiveness converted to skin artistry of tattoos and cosmetic surgery (Davis 2003; Connor 2004; Covino 2004), the abject of skin loss contained by second skins figured by the science of wound healing and visualised as second and enduring skin (Rudge 1999), as well as skin's disappearance into virtual realities, all sites where skin has become what Connor terms a 'transbodily hyperorgan' (2004:66).

Problems and advances with the abject and psychoanalysis

Psychoanalytic theories represent a site of intense debate and contention as to whether such theories have a place in the explanatory armoury of contemporary social sciences. Their development at a particular historical time and place suggests that the frameworks they use to explain personal and individual traumas and anxieties remain deeply problematic. Such theories, it is contended, are individualistic, embedded in patriarchy and fail to confront the powerful positioning of the therapist in such understandings (Frosh 1987; Lechte 1990; Beardsworth 2004). At this time, when the brain, and by association the mind, is increasingly constituted as an empirical reality through visual imagery of scans, and where its secrets are opening up through analysis of biochemical activity and processes, does a theory based in observational case studies, dated ideas about human development and neuroscience have a place in understanding human activity and social relations? (Frosh 1987). Worse still, in a time where biological determinism is confronted by feminist and other theories, is there utility in using a theory that universalises, yet individualises and is charged with essentialising human and more specifically women's experiences of their bodies and relationships? Kristeva has had a long-standing debate with Anglo-American feminism, acknowledged by many as arising from her falling back into a negation of motherhood, her construal of feminine powerlessness and silencing and feminine martyrdom to motherhood in her work about the abject and the emotional defence of abjection (Rose 1993; Butler 1993a; Mansfield 2000).

Such difficulties and contentiousness reside in the subject matter of the abject and abjection itself. The abject constitutes a threat insofar as it makes personal and social demarcating lines illusory. In constructing the self, the 'separateness of our individual bodies' (Mansfield 2000:82) is perceived as formative in the process of defining one's subjectivity. Kristeva argues, however, that this separateness is tenuous because it is born within our idealism and ideology (Mansfield 2000). Alienation is necessary in order to get a sense of separateness: 'I give birth to myself amid the violence of sobs, of vomit' (Kristeva 1982:3). An individual needs to reject subhuman matter (such as excreta, or other's matter) in order to strengthen his or her subjectivity and preserve the clean, proper, self-controlled body, yet continuously facing doubt about personal integrity and autonomy: 'The subject remains in process, forever trying to establish itself, forever pushing away at those things that relentlessly challenge its limits' (Mansfield 2000:83). More centrally for the argument about embodiment and skin, such theoretical positioning negates arguments which assert that the abject or abjection is essentialist or does not acknowledge difference arising from structures and their effects. Without a psychoanalytic reading, the depth of effects from skin loss or alteration disappears, with a corresponding failure to apprehend what skin signals about Western metaphysics and what is disturbed by skin loss.

Another criticism of psychoanalytic theories and Kristeva's writing in particular is its failure to confront normative, psychosexual development (Butler 1993a) where abjection, the role of motherhood and femininity are charged as biologically deterministic, bringing a sense of compulsory motherhood and hetero-normativity (Grosz 1989). Oliver (1993) is equally mystified by this implacable failure on Kristeva's part to address how women are defined as 'lack', through the psychoanalytic, paternalistic approach to therapy and human development. Much of this comes from Kristeva's position on certain forms of feminism and identity politics (Birmingham 2005; Chanter and Płonowska 2005; Chanter 2008), a position with which many feminists (including Butler 1993b) would agree. In a conversation with Rosalind Coward and others, Kristeva (2002) positions herself as a feminist who has moved from such identity politics, away from a belief in revolutionary change to a focus on her work as a therapist. This refusal of the political agenda of feminism mystifies Oliver (2002a), who instead highlights how central the understanding that the personal is political is to calls for social change and the social support of women in their maternal role.

However, another position can be taken to refute the charge that Kristevan theories essentialise (Butler 1993a). Using the abject body and ideas about identity formation from Kristeva's perspective, Butler recognises that not only is identity formation fragmentary and contingent (the subject in process) but also constitutes a tapestry of the embodied self/other/Other, whose identity is an incomplete project. Also, in the case of abjection, such a self is subject of, and subject to, its discursive effects (Holmes et al. 2006; Rudge 2009). In such a conceptualisation, the collapse of meaning associated with vulnerabilities is an effect (Oliver 2005; Chanter 2008; Bradbury-Jones and Taylor 2013), where a person is positioned as in-between a complex of intersecting vulnerabilities, all of which require recognition and support. Discourses of emotional states, such as abjection, indicate how the boundaries of inclusion and exclusion operate, how some positions are silenced, how structural effects such as racism continue to oppress and how economic rationalist policies that deny access to education, health and welfare are abject in their effects (Rudge 2009).

In agreement with this reading beyond the Freudian psychoanalytic heart of the family, Chanter (2008), Oliver (2002b), McAfee (2004) and Rose (1993) assert that an essentialist reading is less possible. Instead these authors argue that Kristeva's work challenges normative readings because Lacanian identity does not talk about men and women as fathers and mothers, males and females, but rather tapestries of maternal and paternal functions, where the sex/gender differentiation requires analysis of the other/Other in bodies, and where structure and agency are intermingled. Moreover, as the abject and its discourses are entangled with and implicated in how bodies, structure and agency operate, its presence can be traced into the larger register of the political (Rose 1993). Such a view affords the possibility for psychoanalytic theories to provide insights as to how social structures get into our bodies (Brennan 1993; DeArmitt 2005).

In the case of skin and its embodiment of identity, Kristeva (1982) offers a particular view of how we can think of forgiveness, forbearance and the absence/presence of social support for traumatised and oppressed persons (Oliver 2002b). In the case of trauma from skin loss, when skin's function as cover dominates the treatment regimes, its functions of shielding from, connection with and transmission of communications between people remain as unacknowledged background. Their long-term, emotional effects are not taken into account in the treatment of people with skin loss and disfigurement (Rudge 2009; Lafrance 2010). The saliency of our embodiment (through skin) structures how masculine/feminine, white/black, young/old are woven into, and integral to, understanding fragmentation of identity through the experience of skin loss or traumatisation, making recovery a longer process than the time taken to accomplish 'complete skin' by plastic surgery.

Moreover, contemporary society carries many of its anxieties and traumas on the surface. Chanter (2008) and Ahmed (2005) both emphasise that the abject is deeply implicated in epidermiologised society and its racialisation, particularly in post-colonial and settler societies. Our fascinated horror and disgust with growing old is projected onto the pages of advertisements of creams and potions that claim to hold back time on our faces (and perhaps other areas as well). Promoting such a view takes abjection beyond its location in societal myths and taboos, to the possibility of seeing the abject outside its forge of familial conflict. To better comprehend the lack of social support for mothers, the obsession to improve on nature in skin care, as well as the intransigence of racialisation of the black other, Chanter (2008:162) offers the consideration:

> Abjection is inherently mobile, as descriptive of a mechanism by which various others are stipulated as excluded, in particular raced, classed, and sexually deviant others . . . rather than seeing processes of constitutive differentiation as coterminous with socio-symbolic myths as Kristeva does, there is a need to reflect on their divergence from symbolic legitimation.

This call by Chanter (2008) and others suggests how we can go beyond fetishistic understandings about embodiment, and in particular, skin, to indicate what is at stake when we ignore how skin is always already embodied and more than mere bodily covering.

Skin is represented and fetishised in contemporary society because its loss compels us to acknowledge how threats of annihilation, alienation and mortality worry us. We go past our skins to abstractions about embodiment, ignoring what skin loss signals at our peril. Threats to sovereignty from how we organise the social can be analysed from within psychoanalytic theories such as those offered by Kristeva's conceptualisation of the abject and discourses of abjection. Using concepts such as abjection challenges the racialisation of others as structural only, instead race is embodied in how skin impresses us to contain/exclude the black Other; or how our focus on skin as surfacing 'ageing' disavows our abject lack of control over the future involving as it does an on-going betrayal of the elderly in the race to avoid the horrors of ageing (Latimer 2010).

Conclusion

Psychoanalytic work proffered by Kristeva affords glimpses into how the body, emotions and social structures are mutually implicated in the preservation of views of the social that disavow the way structural effects get into and shape our bodies. The abject body and abjection takes an analyst to locations where what divides and excludes are shown to be always already waiting in how bodies as variously sexed, gendered, classed and racialised are formed and reproduced from a very early age. For instance, from a psychoanalytical perspective, skin is an embodied tapestry that symbolises socio-culturally our legitimate and non-legitimised positions as abject when its security as a boundary is lost. Abjection and its theoretical exploration provides some insights into what is at stake when we focus on skin as metaphorical covering, and where it signals separation rather than connection with others. Moreover, in exploring the location where the civilising of infants both situates and also hides maternal power, we glimpse a location outside of symbolic legitimation that may translate into how skin, orifices and their symbolic meanings may be reconfigured as emotionally central. The figuration of skin as complete effects our position as individuals, just as the move passed its covering into our interiority of molecules and genes has brought with it an intensification of what skin conveys as a sign of fragmentary and contradictory subject formation.

Embodiment and subjectivity, either in health or illness, require analysis by researchers interested in uncovering the work of patients, consumers, their supporters or healthcare workers. Emotionality embedded in experiences of embodiment require that we take seriously how threats to self, identity and the politics of health are mutually implicated in what problems gain purchase in the sociology of health and illness. In this instance, exploration of the emotion of abjection (as defence and discursive position) affords a view of what is swept aside when we do not research the emotionality of illness experience, deny the centrality of embodiment and the abject positioning of death- and age-denying contemporary medical science. The power of analysing that which horrifies (Kristeva 1982, 1995, 2009) lies in the uncovering of exclusionary practices such as racism or ageism, the entrenched effects of stigmatisation in chronic illnesses such as cancer or hospice care, mental illness or obesity, and the on-going invisibility of trauma and its effects on the health professionals who work in these locations. Such a focus may go someway in accounting for the unaccountable, the uncanny, the repressed in bodies, identities and boundaries.

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Chapter 33

Magali Sarfatti Larson and Anne Witz: Professional Projects, Class and Gender

Ivy Lynn Bourgeault

One of the key problematics in the sociological study of health and healthcare is the stratification of the healthcare division of labour, with the profession of medicine holding a dominant position: a feature particularly notable in Anglo/American societies. How this was achieved historically and what have been and continue to be the consequences of these dynamics has been the focus of many sociological treatises and scholars from Talcott Parsons (1951) to Everett Hughes (1958) to Eliot Freidson (1970) and others. Two key theorists who address this problematic in a particularly novel way are Magali Sarfatti Larson and Anne Witz. They do so by drawing on the neighbouring literature of the sociology of professions and advancing the concept of *professional projects*.

Larson was particularly concerned with how the medical profession achieved its privileged status within the healthcare division of labour. In explicating the historical journey of modern medicine in England and the United States from pluralism to dominance, Larson proposed the concept of the *professional project*. This project entailed two interacting dimensions of a collective project of upward mobility among this emerging segment of the petit bourgeoisie and the controlling of a market for scientific medical expertise. It is in this way that she attempted to reconcile a tension in the literature between neo-Weberian concerns with the development and exercise of professional power and neo-Marxist concerns linking to the ultimate sources of this power within modern capitalist society.

Witz builds upon Larson's concept of professional projects through an application of an explicit gender lens to the analysis of the professions of medicine, nursing, midwifery and radiography. In doing so, she stresses the importance of gendering the actors of professional projects and situating their efforts and activities within the context of patriarchal capitalism. She argues that men and women, particularly at the turn of nineteenth-century Britain, had differential access to the tactical means of achieving the goals of their professional project. This resulted in different strategies and outcomes for various efforts of health professional groups.

This chapter explores these theorists' presentations of the different dimensions of the professional project concept (that is, class and gender); the heuristic value of their conceptualisations to explain key historical dimensions of the healthcare division of labour; and the relevance of the concept for the contemporary context; by drawing on their application to case studies of the midwifery and dental hygiene professions.

Biography: Magali Sarfatti Larson

Magali Sarfatti Larson was born in Italy, travelled extensively with her family (particularly between France and Argentina), but lived most of her adult life in the United States. She received a BA from the University of Paris, an MS from the University of Buenos Aires, and her PhD from the University of California, Berkeley (in 1974). Subsequent to this, Larson taught at the University of Pennsylvania, Harvard University, and Temple University (where she is now professor emeritus); she held a Distinguished Professor position at the University of Urbino, Italy. She married in 1968 before commencing her doctoral work in 1970, and had a son in 1974 (the year she completed her dissertation). Her book, *The Rise of Professionalism*, published in 1977 was a culmination of her doctoral thesis work. Larson has written books and articles on the sociology of development in Latin America before turning to professions, architecture and postmodernism, that is, *Behind the Postmodern Facade,* and many articles published in several countries.

Larson's conceptualisation of *Professional Projects*

> Profession appears to be one of the many 'natural concepts', fraught with ideology, that social science abstracts from everyday life ... Many elements of the definition reproduce the institutional means and the sequence by which the older professionals gained their special status ... And yet empirical studies of medical practice challenge the validity of the sociological model at almost every step ... The contradiction is resolved if we recall that the 'organic' or 'traditional' character of a category of intellectual workers is not a static feature, but the outcome of a complex historical situation and of on-going social and political efforts (Larson 1977:xi–xv).

Larson's concept of professional projects, first introduced in her 1977 book, *The Rise of Professionalism: A Sociological Analysis*, advanced scholarship in the sociology of health and the sociology of professions by attempting to reconcile the tension in the literature between the neo-Weberian and neo-Marxist schools of thought. The neo-Weberian scholars stressed the importance of power in the development of the professions and in the professionalisation process more generally. Initially working within this perspective, Johnson (1972) argued that professionalism is a means of controlling an occupation, or as Freidson (1970) described, controlling the content and context of professional practice: 'a profession is distinct from other occupations in that it has been given the right to control its own work'. Within this 'power' perspective, professions were regarded as monopoly seeking, self-interested groups.

Professions scholars from a neo-Marxist tradition pursued an analysis of the wider sources of power underpinning professionalism. In his later work, Johnson (1977), for example, criticised the neo-Weberian approach he earlier drew upon, arguing that it is inadequate to theorise professional power as stemming from its knowledge base alone. Neo-Weberian scholars, he asserted, do not adequately explain what specifically is necessary about the esoteric knowledge base of a profession that garners it such significant social power. The issue became how to reconcile the power that certain, particularly dominant, professions secured in their division of labour by paying attention to the relationship of this knowledge base to existing and wider sources of power in capitalist society.

Larson reconciles the differences between the neo-Weberian and neo-Marxist approaches through a comparative, historical analysis of the development of the medical profession in England and the United States. She introduces the concept of a *professional project*, which involves two interrelated processes. The first involves control over a market for expertise and the second a collective conquest of social status:

> I see professionalisation as a process by which producers of special services sought to constitute *and control* a market for their expertise. Because marketable expertise is a crucial element in the structure of modern inequality, professionalisation appears *also* as a collective assertion of special social status and a collective process of upward social mobility . . . Professionalisation is thus an attempt to translate one set of scarce resources – special knowledge and skills – into another – social and economic rewards (Larson 1977:xvi–xvii).

Larson argues that an upwardly mobile occupation must create a need for its services (that is, there must be a use value for their otherwise intangible services), and at the same time create a scarcity of the resources to deliver these services, that is, restrict its own membership. These strategies are accomplished by controlling the 'production of producers' (Larson 1977:210), in terms of both the numbers of students/trainees and the professional licensing and certification process, and the standardisation of the content delivered through a mandatory system of professional training. This managed scarcity serves to create a monopoly of expertise in the market, and in turn a monopoly of status in a system of social stratification:

> The focus on collective social mobility accentuates the relations that professions form with different systems of social stratification; in particular, it accentuates the role that educational systems play in different structures of social inequality . . . the two dimensions – market control and social mobility – are inseparable; they converge in the institutional areas of the market and the educational system (Larson 1977:xvii).

Market conditions, however, are insufficient to guarantee professional power, and it is here where Larson highlights the critical linkages to the system of capital. She argues that as a profession attempts to rise upward, it:

> . . . must form 'organic' ties with significant fractions of the ruling class (or of a rising class); persuasion and justification depend on ideological resources, the import and legitimacy of which are ultimately defined by the context of hegemonic power in a ruling class society (Larson 1977:xv).

In the case of medicine, for example, she asserts that its collective rise was facilitated by the fit between its emerging doctrine – the individualising ideology of Western biomedicine – and capitalist ideology. The consequent reductionism of biomedicine could divert the gaze of practitioners away from the broader negative influences of the increasing power of the corporate capitalist class on growing social inequality on health (or at the very least not call it into question).[1] Thus, according to Larson, professionalisation results when an occupational group seeks upward mobility by controlling and aligning its knowledge base within a socio-political context defined by capitalist relations of production.

These two interelated processes entail the core activities of a professional project.

Larson situates professionalism broadly in the historical phase of capitalist rationalisation. As such, the ideology of professionalism both justifies the inequality of status in the healthcare division of labour and also enables the creation and control of a professional 'market' which is not structurally subordinated to a pure capitalist market of employers (Witz 1992). This is due to the esoteric, but at the same time socially valuable, nature of the knowledge behind the professional services. This, she would argue in a subseqent article, is largely true of the 'historic' professions:

> For the older professions that organised in relative independence from capitalist relations of production, monopoly of expertise was the road to

> surplus privilege . . . For the younger specialities that are either spawned by the capitalist process of production or absorbed into it, attaining profesional privileges appears as the other side of the loss of skills and control suffered by the majority of workers (Larson 1979:623–4).

In other words, more contemporary professions are more suceptible to pressures towards fragmentation and trends towards proletarianisation.

Although Larson focuses largely on the civil society elements of the professional project, she also emphasises the symbiotic relationship between professions and the state, observing that 'organisational professions are generated . . . by the expansion of the bureaucratic apparatus of the state' (1977:179). This is particularly related to the state's role in the system of education: 'the creation of professional exchange value ultimately depends upon the state – or more precisely, upon the state's monopolistic appropriation and organisation of a social system of education and credentialing' (Larson 1977:211). Nevertheless, her choice of profession – the medical profession – and countries – England and the United States – Anglo-Saxon, laissez-faire capitalist industrial societies, does not enable a broader analysis that would have been possible if she had included other societies with stronger central government control and long-standing state involvement in the development of the professions, which more closely align to civil service.

Critical analysis

Larson's historical analysis of the rise of professionalism in the case of medicine in England and the United States and in particular her conceptualisation of the professional project have had a profound impact on the fields of the sociology of professions, work and organisations more broadly. As one of the reviewers of her book noted, this 'is a work of major significance that cannot be ignored by historians interested in the role of the professions in modern society' (Rimlinger 1979:858). The extensive number (greater than 4,500) and range of citations is evidence of a far-reaching influence. What is particularly interesting is to see how in the aristocratic context of England and the democratic context of the United States, similar trends are revealed regarding the focus on cognitive skills and the tight control of the training of professionals (Rimlinger 1979).

One of the phenomena that remains unclear from Larson's analysis, however, is whether it is mainly through the efforts of an upwardly mobile occupational group organised around a certain knowledge base with ties to the ruling class that leads to professional power and status, or whether it is simply the logic of capitalism that enables an occupation with a knowledge base that fits with capitalist ideology to become powerful. This leave us with the long-standing 'chicken and egg' debate of which is more important in the success of certain professional projects – structure versus action – or which is necessary but insufficient. Certain professional projects will be inherrently more successful than others not only because of the actions of their advocates but also because of the influece of the broader structure of society. The analysis of the role of the state in the professionalisation process, under-conceptualised by Larson, may enable us to better understand how would-be professions attain power in a capitalist system. In addition to expanding upon the role of gender in both the context and activities of actors undertaking professional projects, the work of Anne Witz described below also offers additional insights into the role of the state.

Biography: Anne Witz

Anne Witz was born in 1952, and with the exception of extensive travel, lived her life in Britain. She graduated in sociology from Exeter in 1977 and after taking time to teach, completed her PhD in 1987. Witz had a long-standing interest in social theory addressing patriarchy and women's labour, with an early analysis of coal-mining and later the healthcare division of labour and organisations/bureaucracy. As one of her colleagues stated:

> Anne was committeed to feminism and to re-envisioning sociology through a feminist lens, but she was also committed to sociological theory and to ensuring that feminist sociologists did not simply throw the theoretical baby out with the patriarchal bathwater (Scott 2007:498).

Witz taught at Lancaster, Exeter, Birmingham (1990), Strathclyde (1996) and finally Leicester (from 2001). Witz died in 2006.

Witz' gendering of professional projects

> 'Professions' and 'patriarchy', despite having a splendidly alliterative ring, are two words that are rarely put together . . . Both traditional and critical approaches to the professions continue to reproduce at the level of sociological knowledge professional men's own construction of their gender self-image (Witz 1992:1–3).

In her doctoral thesis research, published as *Professions and Patriachy* in 1992, and an earlier article in 1990, Anne Witz advanced theory in this area by gendering the concept of professional projects. In doing so, she drew upon both Larson and also upon advances in the Neo-Weberian literature on the professions that had developed in the interim (for example, Parkin 1979 and Crompton 1987).

Parkin (1979) expanded upon the theory of social closure that was implicit in previous 'power' focused neo-Weberian work on the professions. Max Weber employed the concept of 'closure' to refer to the monopolisation of opportunities by various social groups in order to maximise their own rewards and privileges by limiting access to them. Parkin (1979:45) stated:

> ... [t]he distinguishing feature of exclusionary closure is the attempt by one group to secure for itself a privileged position at the expense of some other group through a process of subordination.

He identified two generic types of closure action: *exclusion*, power directed downwards through the subordination of socially defined inferiors, usually through legalistic procedures; and *usurpation*, power directed upwards oriented at improving the position of a subordinate group at the expense of a dominant group, usually through solidaristic tactics. Usurpation is a consequence of and a collective response to exclusion. A third form of closure, *dual closure*, involves both exclusionary and usurpationary strategies. Exclusionary strategies are based predominantly on property ownership and academic or professional qualification and credentials but can also be based on other factors such as gender or race. Parkin (1979:54) defined professionalism as a particular type of exclusionary closure based on credentials 'designed ... to limit and control the supply of entrants to an occupation in order to safeguard or enhance its market value'.

In drawing upon Larson and Parkin, the primary focus for Witz was on the influence of gender on professional projects. Early theorising about the influence of gender on professional status tended to take either an uncritical or sexist view of professions dominated by female members.[2] Etzioni (1969:vi), for example, argued that 'the cultural value of professions, organisation and female employment are not compatible'. Simpson and Simpson (1969) asserted that women are less likely to maintain a high level of specialised knowledge and less able to attain societal support for professional autonomy as they are more likely to defer to [male] authority. According to these arguments, female-dominated professions are not full professions because they are largely made up of women. There was, however, no effort made to detail why this was the case; the impact of gender on the status of a profession was taken as a given rather than its influence fully explicated and theorised.

The status of female professons and of female professionals within traditionally male-dominated professions is what Witz explores through four illustrative case studies – medicine (a historically predominantly male occupation), midwives and nurses (both predominantly female occupations that struggle against subordination to male doctors), and radiologists (a less clearly male- or female-dominated profession). Across these four cases, Witz addresses the various positions of women within and between the professions in the healthcare division of labour. But beyond the issue of status, she is also interested in the gendering of closure strategies: what it was that people do to achieve greater professional status and privilege.

Witz defines professional projects as projects of occupational closure, and proposes a model which genders the agents of these projects, locating them within the structural and historical parameters of patriarchal capitalism. She argues that 'gendered actors engaged in professional projects . . . will have differential access to the tactical means of achieving their aims in a patriarchal society within which male power is institutionalised and organised' (Witz 1990:677). Thus, Witz, like Larson, attempts to reconcile neo-Weberian and neo-Marxist theories of the professions by drawing on a neo-Weberian closure model and on a (feminist) neo-Marxist model as a structural and historical framework. Witz explicitly brings a gender lens to her analysis by referring to gendered strategies and patriarchal structures. Strategies are gendered, she argues, because the strategic actors within the professions are gendered and because gendered criteria of exclusion or inclusion are built-in features of closure strategies. Successful professional projects are largely of class-privileged male actors in particular societies at a particular point in time.

Witz' gendered occupational closure model is modeled after Parkin (1979). She elaborates four elements of occupational closure, *exclusion*, *inclusion*, *demarcation* and *dual closure*, to identify their gendered dimensions (refer to Figure 33.1). Exclusionary and demarcationary closure strategies are adopted by the dominant occupational group, whereas inclusionary and dual closure strategies are the responses of subordinate occupational groups. Exclusionary strategies aim for *intra*-occupational control of the internal affairs within an occupation, and demarcationary strategies aim for creating and controlling boundaries with adjacent occupations in the division of labour, or *inter*-occupational control.

First with respect to exclusionary strategies (the top left hand cell of Figure 33.1), Witz (1992:46) describes as serving to:

> . . . create women as a class of 'ineligibles' through excluding them from routes of access to resources such as skills, knowledge, entry credentials, or technical competence, thus precluding women from entering and practising within an occupation.

This is undertaken through the use of two key types of strategies – *credentialistic* and *legalistic*. Credentialistic strategies involve exclusion through organisations in civil society, university and other training or certifying institutions. Legalistic strategies involve state legislatures where exclusionary licensure laws are created and courts of law where they are applied. The gender-based exclusion

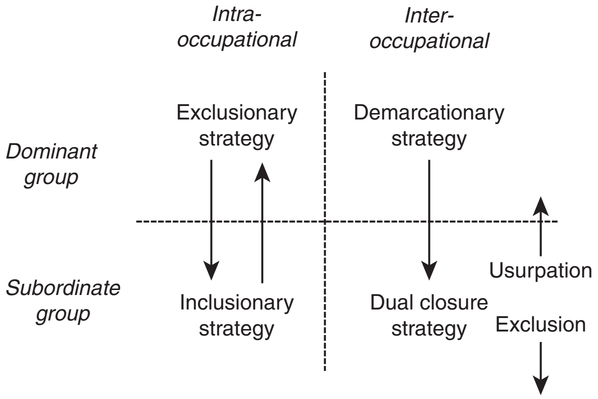

Figure 33.1 Witz' model of gendered professional projects/social closure
Reprinted from patriarchy and professions by Anne Witz, page 43, 1992, with permission of Taylor and Francis.

of women from medicine in England is elaborated as an example of this form of professional closure.

A demarcationary strategy (in the top right-hand cell) does not rely upon exclusion but on the:

> ...encirclement of women within a related but distinct sphere of competence in an occupational division of labour and, in addition their possible (indeed probable) subordination to male-dominated occupations (Witz 1992:47).

The profession remains distinct and separate from the dominant group, typically through the use of gendered ideology of women's societal role as 'carers' as opposed to 'curers', thus in a position of subordination. This also involves an under-valuing of the skills these largely female health professionals possess, reflective of the broader societial undervaluing of women's work. The gender-based subordination and devaluing of the professions of nursing and midwifery by the medical profession in England are elaborated as examples of demarcation.

The bottom left-hand cell of Figure 33.1 identifies inclusionary strategies which are a response to exclusion; that is, where a subordinate group seeks inclusion within the structure of an occupation from which they are collectively excluded. Witz cited the example of women seeking entry into medical school as an example of inclusion. Finally, the bottom right-hand cell situates dual closure strategies which are of particular interest to Witz. Dual closure includes both usurpation, a countervailing, upwards exercise of power on the part of the subordinate groups in response to the demarcationary strategies of the dominant profession; and exclusion, when members of the subordinate group seek out their own position within the division of labour rather than pursue inclusion into the ranks of the dominant group. The form of exclusion engaged by the subordinate group here is similar to that adopted by the dominant group (in the top left hand cell) in that it involves legalistic tactics of seeking state-sponsored systems of registration, and the credentialist tactic of restricting ranks into professional training programmes. This strategy of dual closure used by elites heading aspiring female professions, Witz argues, better describes intra-professional relations and the two-way exercise of power of female professional projects than could be explained by inclusion or exclusion separately.

Witz then draws a link between the gendered closure strategies in which aspiring female professions are engaged and the larger patriarchal societal context; she does so by highlighting the role of patriarchal civil society and the role of the state in fostering gender-based exclusion. She argues that 'it is in the sphere of civil society within which male power is organised and institutionalised and where gendered exclusionary strategies operate to sustain patriarchal modes of occupational closure' (Witz 1990:680). She asserts that credentialist exclusionary strategies employed through institutions in civil society (that is, university and professional associations) prove to be more effective at excluding women from the professions than legalistic exclusionary strategies employed through the state. Alternatively, female professional projects such as nursing and midwifery have been more successful in achieving legitimacy by legalistic means via the state than by credentialist means via civil society. Thus, she argues that the state is the 'weaker link in the chain of patriarchal closure' (Witz 1990:681). As others have noted:

> Witz . . . refutes monolithic versions of the state as an agent of male social control, suggesting, for instance, that women's professional ambitions have historically been more often frustrated by credentialist struggles and satisfied in legal challenges (Walkowitz 1993:187).

Thus, she offers a more nuanced gendered analysis of the role of the state in these female professional projects.

Critical analysis

> [Witz] . . . establishes the centrality of gender to the history of professionalism [and offers] a theoretically rigorous, sophisticated, and insighful paradigm for understanding the relationship between gender and professional strategies (Walkowitz 1993:186–7).

With over 1,000 citations on Google Scholar, it is clear that her incisive analysis has had a profound impact on the fields of gender, work and the professions as well as the sociology of health and healthcare.

There are a few interesting strands which are promising to be more fully explored. First, it is not clear whether new professional projects must operate within this structure and with similar dynamics or whether there is an 'opting out' strategy. The case of the lay midwifery social movement in North America, where midwives at least initially worked outside the bounds of the legally sanctioned healthcare system to promote and attend women in childbirth at home (Bourgeault and Fynes 1997), could be seen as a case of such opting out. As I note below, however, the ultimate evolution of this social movement into a professional project did succumbe to similar dynamics as those noted by Witz.

Second, Witz' analysis fails to fully explicate why it is that the state is less effective in maintaining patriarchy than institutions in civil society. As Clarke (1993:142) similarly notes in her review of *Professions and Patriarchy*:

> Witz argues that the state is the weak link in patriarchal relations, because it has a constellation of competing interests. It therefore should be the target of any new professional projects. She does not however, give concrete examples of how this can be achieved. Nor does she show whether there are similar problems with credentialism and legalistic tactics in the present day or whether we have moved beyond.

Moreover, in her focus on patriarchy, Witz relatively neglects the role of capital (and class), and how that might intersect with patriarchy in gendered professional projects. An analysis of the continuation of the midwifery professional project in England undertaken at roughly the same time that Witz was working on her book (that is, Heagerty 1990), added a very interesting class dimension – a dimension which was acknowledged in *Professions and Patriarchy* but not fully extended. Specifically, Heagerty (1990) described how the two-tier system of midwifery that resulted from midwifery elites' incomplete professional project at the turn of the century, 1902 – which included both the upper middle class, educated midwives and the lower class, 'untrained' handywomen – was ultimately reversed through exclusionary reform efforts that resulted in legislative changes some 30 years later with the passage of the 1936 Midwives' Act. Further analysis of this and other similar cases could have added some depth to the intersectionality of gender and class on health professional projects.

The application of Larson and Witz to contemporary professional projects

Although focused on the historical developments of the health professions in England and the United States, Larson and Witz' conceptualisations of professional projects have resonance in the contemporary era. I describe here a select number of analyses that have recently been undertaken which draw upon these theorists.

Beth Rushing's (1993) study of the use of the ideologies of science and feminism by contemporary midwives in their drive to legitimate midwifery practice in the United States and Canada draws upon both Larson and Witz. While the medical profession has long drawn on the ideology of medical science to achieve and maintain their status, those in pursuit of the recent midwifery professional project have similarly and successfully drawn on science to refute medical claims that midwifery care is unsafe and to lobby its benefits. In a similar vein, Rushing argues feminism, with its support of women's control over their reproductive lives and its emphasis on female empowerment, has also been drawn upon by midwifery legitimation efforts. Although ascriptions to feminist ideology have helped the popularisation of midwifery, Rushing notes that midwifery's ascription to the more mainstream ideology of science is perhaps more influential in their professional project.

Similarly, Tracey Adams' work on the dental division of labour draws upon Larson's emphasis on the role ideology plays in professional projects and Witz' gender-based analysis (Adams 2000; Adams and Bourgeault 2003). Adams has detailed how the male-dominated profession of dentistry, like medicine, has relied on the ideology of science to legitimate their claims to expertise, and thereby attain professional status. The dental profession also drew on gender ideology to assert their professional authority over other workers in the dental division of labour, notably dental hygienists, similar to the demarcationary efforts Witz describes. In their recent usurpationary efforts, dental hygienists draw upon feminist ideology that challenges women's subordination to men and supports dental hygiene's professional goal of challenging their subordination to the male-dominated dental profession. Here, professionalisation becomes a feminist project.

I have drawn extensively from the work of Larson and Witz in a number of studies examining the changing role and status of female health professions including midwifery and nursing/nurse practitioners (Bourgeault 2000, 2005). First, with respect to contemporary midwifery, I have highlighted how they have, as Larson and Witz have described, explicitly undertaken a professional project. One cannot accurately describe the midwifery integration process in Ontario and elsewhere in Canada without highlighting the tenacity, insight and political astuteness of the midwives and their supporters. These women astutely manoeuvred within the health and legal systems so as to ensure their integration and the maintenance of their unique model of practice. They employed a number of credentialist and legalistic tactics, similar to the gendered historical efforts described by Larson and Witz.

Contemporary female professional projects have been particularly successful in seeking change by legalistic strategies through the state (Bourgeault and

Fynes 1997; Adams and Bourgeault 2003; Bourgeault 2005). Midwives, dental hygienists and nurse practitioners, intent on expanding their scope of practice, have been able to appeal to the state for legislative privileges and recognition previously denied to them. What differs from the historical era examined by Witz is that feminism and the pursuit of gender equality have been influential in shaping the state's reaction to female-dominated professions. One of the key differences between the historic and contemporary eras of these projects is women's right to vote and the increasing trend towards a correspondence between their voting patterns and their gender. Moreover, in the case of midwifery's recent professional project efforts in Canada, many key bureaucrats and state officials are female, feminist and supportive of midwifery. These state actors help to promote the integration efforts of the midwives. This creates an even more conducive structural environment for female professional projects. Perhaps we are coming to a point where the state is not only the weaker link in the chain of patriarchal occupational closure, as Witz (1992) argues, but may be the stronger link in the promotion of the integration and professionalisation efforts of female professional projects.

Conclusion

To briefly conclude, these pivotal theoretical works by Larson and Witz have had a profound impact on the field of the professions, and gender and work more broadly. Both link the professionalising efforts and strategies undertaken by professional actors to the broader structure of society. This helps to address the continuing interplay between the agency of professional actors and the structure or context of society within which their efforts are situated. The form of the strategies undertaken by the professionalising group – particularly those targeting an evolving state – is a critical conceptual link between the two. Explicitly unpacking the role of the state in professional projects and the reshaping of the healthcare division of labour are worthy of continued examination.

Although it seems out of vogue now to undertake an analysis of professional projects, the reason for that may be an incorrect assumption that there is an end point in the analysis – that is, that the achievement of professionalisation is the end of the story. But the contributions of Larson and Witz if not explicitly, at least implicitly suggest that the dynamics evident in professional projects continue beyond what might be regarded as this typical end point. The class and gendered hierarchy of the healthcare division of labour is continually being reshuffled in response to a range of internal and external pressures. New professions such as case managers, doulas and lactation consultants have emerged, and the professional projects of more established professions evolve. The few contemporary analyses that draw upon their theoretical concepts suggest they continue to reveal similar dynamics of agency, structure and strategy. Further explorations which draw upon and expand upon the professional project concept remain fruitful.

Notes

1. Navarro (1976) also described a similar 'congruence thesis'.
2. When I refer to 'female-dominated professions', I am referring to the numerical domination of women rather than to the control women have over the profession.

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Chapter 34

Raewyn Connell: Hegemonic Masculinities, Gender and Male Health

John Scott

Males are one of the largest population groups of interest to health researchers. Male experiences of and attitudes towards health and illness are different to those of women. These differences have both a biological (sex) and social basis (gender). In Western societies, high rates of specific illnesses, such as heart disease, lung cancer, prostate cancer, depression, higher rates of physical injury (typically sustained at work or in motor vehicle accidents) and risk-behaviours, such as binge drinking, violence and drug taking, have been cited to indicate a relative lack of attention to or understanding of male health and well-being. The difference is usually articulated in terms of higher male death rates at all ages and higher rates of premature mortality. Also highlighted are lower rates of males using health services. In particular, a debate has emerged regarding the relative health disadvantage of males, with regard to its substance, causes and remedies.

Sex-specific factors may explain health conditions that only males will experience, such as prostate cancer, while gender-related factors are valuable in explaining masculine stereotypes and societal expectations and how these influence the experience of health and engagement with health services. This noted, too often the focus of research and intervention has been to change and remedy male behaviours through individualistic health promotion interventions, as opposed to understanding how such behaviours are produced and sustained in the context of broader social regimes. Further, the uncritical reproduction of monolithic and static gender binaries has tended to suggest that all men are disadvantaged, which abstracts the experiences of specific groups of men. Recently, a body of work has emerged which attempts to document and explain health inequality from the prism of gender relations (see Sabo and Gordon 1995; Watson 2000; Robertson 2007; Broom and Tovey 2009). This gender relations approach highlights how gender interactions facilitate and constrain health and illness. Through a critical sociological approach that focuses on power relations, the most well-known proponent of this school, Raewyn Connell, has developed the concept of *masculinities* (plural emphasised) and, in particular, *hegemonic masculinity*, to demonstrate how the experiences of some groups of men and relations between men and women, and between men, may best explain health inequalities. Connell's research has helped show that understanding social inequality and power relations is important to identifying the social contexts and social structures that create and sustain healthy and unhealthy practices.

Biography, context and major works

Raewyn Connell (born 1944, Sydney) is an Australian sociologist. She is currently Professor Emerita at the University of Sydney, having previously held positions as Founding Professor of Sociology at Macquarie University (1976–1991), Visiting Professor of Australian studies at Harvard University (1991–1992), Professor of Sociology at the University of California at Santa Cruz (1992–1995), Professor of Education at the University of Sydney (1996–2004) and University Professor at Sydney (2004–2014).

Connell is Australia's most prominent sociologist and, arguably, the only Australian sociologist whose theoretical work could be considered to be of international standing, to the extent that she has developed a comprehensive theory of her own society (Baldock 2005). She has written or co-written over 20 books and more than 150 research papers. Her work has been translated into 16 languages. A 2003 survey conducted by The Australian Sociological Association voted four books by Connell in its top ten most influential books in Australian sociology, with Connell's *Ruling Class, Ruling Culture: Studies of Conflict, Power and Hegemony in Australian Life* (1977) being the top ranked.

Connell initially became known for research on class dynamics in Australian culture, politics and history (*Ruling Class, Ruling Culture* 1977; *Class Structure in Australian History* 1980, with Irving). She considered class as a set of relations, as opposed to abstract categories, and the working class as an active agent of history, as opposed to passive victims of class dynamics. These ideas would also inform her later work on gender. Another important aspect of Connell's thought was her emphasis on childhood socialisation and the role of intellectuals in shaping class consciousness (Baldock 2005).

In the 1980s, Connell became increasingly interested in gender, and there is undoubtedly much continuity between her early work on class and later work on gender. In *Making the Difference* (Connell et al. 1982), Connell examined how gender is reproduced in the everyday life of institutional settings (for example, schools). Although not a dominant concern, gender is a focus of *Which Way Is Up* (1983), with a chapter of the book exploring the way in which masculinity is embodied and linked to power structures. An interest in both feminist thinking and creating practical programmes to address the HIV/AIDS epidemic prompted Connell to develop a theory of gender relations in *Gender and Power* (1987), which examined gender as a large-scale social structure, as opposed to its then common conceptualisation, in fields such as health, of gender as a personal identity (Connell 2014). A seminal paper of this period, 'Toward a New Sociology of Masculinity' (Carrigan et al. 1985), provided a manifesto for a critical account of masculinity. While focusing on men, this paper broke from the men's liberationist writing of the period by drawing on feminist writing, which, in contrast, was attuned to relations of power and the influence of socio-structural conditions on gender relations. Rather then presenting men as an homogenous and reified group, the paper turned attention to historically and culturally specific masculinities.

Masculinities (1995) secured Connell's reputation as one of the founders and key theorists in the study of masculinity and as a major international social theorist. The work was intended to provide an empirical basis for ideas regarding gender developed during the preceding decade, and brings together Connell's longer-term interest in class, psychology and sociological theory (Wedgwood 2009). The work challenged the prevailing social determinism of sex role theory, which had dominated social scientific accounts of gender since the 1950s. In 2005, the book was voted by The Australian Sociological Association as one of the ten most influential books in Australian sociology, being ranked at number five. At the time of writing this chapter, it has over 7,000 citations – the most cited text in its field. A recent study estimated that the book has been cited in 246 different journals across 110 fields as diverse as women's studies, education, clinical neurology, public administration and forestry. However, its greatest impact has been in the field of gender studies (Wedgwood 2009).

Connell's more recent research (for example, *Southern Theory* 2007) has involved developing a sociology of intellectuals in the context of neo-liberal globalisation. This work developed through an appreciation of the way in which gender research from the Global South challenges European and North American approaches and assumptions. It not only problematises Northern theory, but indicates there are alternatives which have been produced in colonised and post-colonial societies. *Southern Theory* has also extended the interest in intellectual labour and the way in which it is institutionalised, asking questions about what world power means for intellectual work in the global metropole, and where most social theorising has emerged. Rather than see neo-liberalism as emerging from a crisis in Northern economies, driven by free market ideology and managerialism, Connell's recent work sees it as a product of global dynamics of trade and investment (Connell 2014). In this respect, she extends a longer-term focus of how historically and culturally specific social relations construct inequalities.

Main concepts, perspectives and theories

Connell's research has consistently engaged with structural theories of the Left. Connell has stated that her style of sociology attempts to 'combine empirical research, structural theory, social criticism and relevance to practice' (Connell 2014). Her early research was neo-Marxist in orientation, much of it concerned with cultural hegemony in Australian society. Austin Broos (2005), writing on Australian sociology in 1989, observed that class, social inequality and the state were central problematics for Australian sociology, and Macquarie University, where Connell worked during the 1980s, was the centre of Marxist sociological analysis. Following Connell, work in the Marxist tradition has been largely historical and qualitative in Australia. On a broad level, her research provides a critique of positivist social analysis, which dominated sociology during the early 1970s. Her essay, 'The Concept of Role and What to Do with It' (1979), argues that questions of power and change have been under-theorised in sociology. This was especially true of gender, where sex role theory had been grounded in biological determinism. Nonetheless, Connell's understanding of gender is materialist in orientation, understood in terms of practices, or what people actually do, rather than what is expected of them or imagined. In this way, gender is not a fixed set of values or norms that are socialised or internalised, but something produced and reproduced in everyday practices (Demetriou 2001). The focus on power and change would remain a constant throughout Connell's work.

Connell's interest in gender might be couched in the broader context of second-wave feminist debates, which prompted feminists to theorise gender and patriarchy. Critical feminist analysis of men and masculinity emerged during the 1990s as a response to the narrow focus of sex role theory on gender identity, socialisation and conformity to role expectations. The new research stressed the importance of power in understanding social life, including health outcomes. It also argued that gender identity and practices are not merely imposed on people through processes of socialisation, but people actively construct gender identities and practices which are immersed in socially and historically constituted webs of power relations (Sabo 2000). Sex role theory fostered the notion of a singular of male personality, but in the newer approach, rather than being a static category, gender is constituted through social interaction and best understood as a verb as opposed to a noun. As such, gender does not reside in the person, but in social transactions defined as gendered (Courtenay 2000b). Connell (2014) states:

> ...gender is about how bodies enter history. Gender is a social structure, not a reflex of biology, though it's a structure that relates to and organises,

> human reproduction. It's a complex, changing structure, and the notion it can be understood through simple dichotomies is sadly mistaken.

As with other major sociological thinkers of her generation, such as the British social theorist Anthony Giddens, a major concern of Connell's work has been accounting for the influence of structure *and* agency on social life. For example, in *Masculinities* (1995), Connell is able to cite the development of historically specific masculinities while at the same time show how men reproduce masculinity through everyday practices. Methodologically, much of Connell's recent work has been grounded in empirical research, especially biographical or life history interviewing (see *Making the Difference* 1982 and *Masculinities* 1995). This approach draws from a longer-term interest in psychoanalysis, dating back to her PhD study and undergraduate training in psychology, especially the work of Freud (Wedgwood 2009).

Aside from Freud and Marx, the most profound influence on Connell's work has been the Italian Marxist Antonio Gramsci (1891–1937). 'Hegemony', a term developed in the *Prison Notebooks*, was used by Gramsci to highlight how a ruling class obtains and holds power by ideological means. Especially influential and much debated in Connell's work on gender has been the concept of *hegemonic masculinity*, which provides an explanation of the legitimacy of patriarchy and how men maintain global dominance over women. This concept was first coined in *Ockers and Disco-maniacs* (Kessler et al. 1982) and later refined in the paper 'Toward a New Sociology of Masculinity' (Carrigan et al. 1985).

Hegemonic masculinity refers to the most idealised and valorised forms of masculinity in a specific cultural and historical setting. It is not the only pattern of masculinity, or even the most common form of masculinity in everyday practices.

Gender is a product of cultural and subjective meanings that are dynamic and in constant flux. Nonetheless gender stereotypes are produced which define characteristics believed to be desirable in men or women. For example, in many Western contexts, masculinity may accentuate male dominance over women through reference to physical strength, emotional and physical control, violence, competitiveness and rationality. Traits, identified in sex role theory as masculine, are conceived as ideological manifestations, which inform hegemonic masculine constructs. Hegemonic masculinity is embodied in men who are heterosexual, white, well-educated and middle class. Donaldson (1993) identifies the influential agents of hegemonic masculinity as a cultural elite, including the clergy, artists, sportsmen and academics. These groups comprise organised intellectuals who regulate and manage gender regimes by articulating upon experiences, fantasies and socio-cultural perspectives. The 'hero' might be considered an embodiment of hegemonic masculine ideals. Often, in contemporary Western societies, heroes are sporting figures, representing models of true manliness. While few men embody the ideals of hegemonic masculinity, many men invest in maintaining these ideals. In this way, hegemonic masculinity is at once a collective and individual project.

Hegemonic masculinity is produced in relation to other men and masculinities, as well as in relation to women and femininities. Hegemony is both external (in relation to women) and internal (in relation to other men). An example of internal hegemony would be the way in which straight males have a higher social status and gay males are subordinated by practices which discriminate against them politically, economically and socially. In contrast to hegemonic masculinities, marginalised and subordinate masculinities include the poor, ethnic others and queer men. Homosexuality may be considered to be counter-hegemonic in that it is fundamental to heterosexuality, is associated with femininity, and homosexual pleasure is considered socially subversive. Antagonisms and hostility to gay men is a standard feature of hegemonic masculinity and integral to contemporary articulations of the masculine, despite homosexuality being compatible with hegemonic masculinity in other historical periods (Donaldson 1993). Indeed, anthropological research indicates that masculinity is highly culturally and historically variable in its articulations. The related concept of *emphasised femininity* refers to cultural ideals that are celebrated for woman, such as sociability, fragility, passivity, compliance and receptivity. Emphasised femininity is constructed in a reciprocal and subordinated relation to hegemonic masculinity in order to perpetuate masculine power and domination (Sabo 2000).

Connell's account, which conceptualises the production of gender through the intersection of culture, social class and history, has been labelled a 'gender relations' approach, given the way it highlights interactions between men and women and among men, and how these inform various inequalities experienced in social life, including health outcomes. Two important spheres of such interaction are the family and the workplace. If we are to understand differential health outcomes, we need to understand the gendered organisation of work, especially access to work and the hierarchical organisation of work spaces. The gendered division of labour is, thus, important in explaining sex differentials in health status (Schofield et al. 2000). Connell is concerned not only with meaning and interpretation, but with the material conditions which produce inequalities and perpetuate them. The concept of hegemonic masculinity assists Connell in clarifying three related structures of gender relations, first outlined in *Gender and Power* (1987): labour (the sexual division of labour), power (the subordination and oppression of women and the dominance of men) and cathexis (practices that shape emotional attachment and desire). The three social institutions which correspond to these structures of gender relations are, respectively, the labour market, the state and the family (Demetriou 2001).

Gender and male health

Gender is a significant socio-cultural factor which influences health outcomes. Inequality, between and within the sexes is seen as a significant explanation of variable health outcomes. Women have typically been the focus of research into health disadvantage. They have generally been regarded as suffering from more adverse health than men, to make more frequent use of health services, and as the custodians of health for their partners and families (Cameron and Bernardes 1998). However, Courtenay (2001b) observes that being a women may be the strongest predictor of preventative and heath promoting behaviour. Further, research suggests that men who adopt 'traditional' or dominant forms of masculinity expose themselves and those around them to greater health risks and poorer health outcomes.

Statistics present evidence to show that men suffer from a range of poor health outcomes. In Western countries, for every age group, male mortality is higher than female (Cameron and Bernardes 1998). Creighton and Oliffe (2010) note that in Western countries, males aged 15–29 have a 2.6 times greater risk of dying than females, are 3.5 times more likely to experience accidental death, have higher mortality rates for the top 15 causes of death, and more likely to suffer chronic illness at an early age. In the United States, for 14 of 15 leading causes of death, men and boys have higher death rates than woman and girls. Men's age-adjusted death rate for heart disease and cancer are 1.5 times higher than women's. Men are also more likely to suffer severe chronic conditions and fatal diseases and experience these at an early age. Similar patterns can be observed in other anglophone societies (Courtenay 2000a). For example, men are more likely than women to engage in a range of risky behaviours, such as unsafe motoring practices or the consumption of illicit substances. An extensive review of North American data shows that men of all ages are more likely than women to engage in over 30 behaviours that increase the risk of disease, injury and death (Courtenay 2000a). Excluding reproductive healthcare visits, adult men are less likely to undertake healthcare visits than women and are more likely to postpone seeking assistance when they are ill (Cameron and Bernardes 1998; Courtenay 2000b).

Early attempts to explain differences in men's and women's health drew on biological sex. This research explained adverse male health as a product of hard-wired psychology or biology that predisposed them to risk-taking behaviours. The biological argument holds that factors such as higher testosterone can explain male risk-taking and aggression, which in turn results in higher mortality and morbidity rates.

Socio-cultural explanations were first developed to challenge biological thinking during the 1960s and 1970s. Early research in this vein focused on the hazards of sex roles (Goldberg 1976; Nathanson 1977; Harrison 1978). It soon intersected with the growth of feminist research, which studied how gender stereotypes influenced the diagnosis and treatment of women and patterns of sex discrimination in healthcare and medical education. This early research centred almost exclusively on women (Ehrenriech and English 1973; Corea 1977). When male health was investigated it was done according to a 'deficit' model, which posited that male conformity to traditional masculinity produced poor health outcomes. These theories, which often provide an account of the male propensity for risk-taking, offer insights into processes by which gender is learned and performed. There was, however, no analysis of gender relations or evaluations of masculinity itself. Further, change was conceptualised at an individual level in terms of norms or personality traits or as something which came from without to constrain roles, rather than as something that occurs within gender relations (Donaldson 1993).

Male health issues were advanced during the 1980s, alongside the growth of men's movements in many Western countries, especially the United States. Gay rights activism in this period increasingly adopted a health focus in response to HIV and the awareness of the health risks associated with some sexual practices. Heart disease and lung cancer were an early focus in male health, while later prostate cancer and mental health attracted increasing attention (Waldron 1983). The arrival of the 'new man' during the 1990s saw increased public attention given to men's health. The term 'men's health' itself came into popular use during this period to account for a range of health problems, from baldness to impotence (Sabo 2000). Male health also became the subject of specialised media, such as magazines, media reports and specialist services. Some of this attention was transferred to health projects specifically addressing men, and hospitals and medical centres now often direct portions of their clinical services and health promotion to male health needs.

One of the difficulties of this early period was the eagerness of some researchers to translate health differences for males as a generalised crisis of men's health and masculinity, suggesting a disorientation for men and boys over their collective loss of place and identity. This argument positions men and boys as victims of a society that privileges femininity and women's issues above a healthy and strong masculine culture. Yet, to posit male ill-health as a product of the symbolic subjugation of males misses the material reality of global male domination and female oppression (Creighton and Oliffe 2010). Further, a finding of difference need not necessarily imply a difference between all males and all females (Schofield et al. 2000). In response to figures which emphasise gender inequality in health, rather than produce a competing victims discourse, whereby male and female health are pitted against each other, it is more useful to understand the causes of such outcomes, most of which are amenable to change. For example, when understanding higher mortality, male risk behaviours are significant for common conditions such as liver disease and cardiovascular disease (Creighton and Oliffe 2010).

If we are to adopt Connell's account of gender, it would have it that just because males are exposed to health risks does not negate their privileged social position, for it is in the pursuit of power and privilege that men often do harm to themselves and others. Micro-level practices, such as aggressive behaviour, are linked to broader relations of power that reproduce inequalities. Males and females act and think the way that they do because of cultural influences, which posit specific configurations of masculinity and femininity. Connell emphasises the plurality of masculinities, highlighting hierarchies among males and females and among men themselves.

Conformity to hegemonic masculinity can present health risks for males, just as conformity to emphasised femininity can pose health risks for females (for example, bulimia). Resistance to hegemonic masculinity can also produce negative health outcomes. Marginalised males may attempt to compensate for their inferior status by defying hegemonic masculinity and adopting alternate or hybrid forms of masculinity in order to reconstruct their position as embodying 'true' masculinity. These have been variously labelled: oppositional compulsive, protest and compensatory forms of masculinity. Often these are hyper-forms of masculinity, which are exaggerated and frequently dangerous and self-destructive (Courtenay 2000b).

In exhibiting hegemonic masculine ideals through health practices, cultural beliefs regarding the nature of masculinity and the male body are reinforced, such as the view that male bodies are more robust and efficient than female bodies. For example, a man boasting he has not been to visit a health professional in years situates himself in a masculine arena (Courtenay 2000b). In this way, hegemonic masculinity idealises men as autonomous and robust. This can disallow engagement with 'feminised' self-care practices. Further, enacting masculinity can involve practices such as binge drinking, which while aligning men with masculine ideals, can impact on immediate physical health and that of others through dangerous activities, such as acts of aggression. Masculinities are constructed through the adoption of masculine ideals, but also through the rejection of feminine ideals. Often healthcare utilisation and positive health beliefs are constructed as feminine and associated with idealised femininity. To deny healthcare needs is a practice by which males can demonstrate masculine affiliation while asserting difference from females (Courtenay 2000b).

Other approaches to male health

Connell's work, especially the notion of hegemonic masculinity, has directed attention to gendered power structures and the role these have in generating and maintaining health outcomes. The concept of hegemonic masculinity provides a critique of role theory by emphasising power and change. Power is considered an essential feature of relations between genders and within gender. Connell's work has been quickly taken up and developed by theorists attempting to move away from social role theory. Writers such as Hearn (2004) and Kimmel (1987) follow Connell in advocating a critical approach to male health studies. The approach may be firmly situated in the 'new public health', which highlights how social practices and environments shape health and illness. Where power and the male body had been largely invisible in research into gender and health prior to the 1980s, there is now an increasing awareness among health scholars of how notions and practices about heath and the healthy body may support and reproduce specific structures and practices of masculinity.

While early feminism tended to constitute men and women as homogenous groups, the strength of the concept of hegemonic masculinity is its ability to account for the multiplicity and fluidity of masculine expression, revealing how gender impacts on various subgroups of males, be they dominant or marginalised. In this way, Connell's work helps to identify specific groups of males with unique health risks and needs, such as adolescents, ethnic minorities, homeless, gay and bisexual men (Sabo 2000). Connell's work moves us away from the notion that different health outcomes for men mean that men *as a sex* require a sex-specific public response in terms of services and policies, instead drawing attention to specific groups of marginalised men (Schofield et al. 2000). This understanding can have significant benefits in terms of efficiency of service delivery to those groups most needing care. The gender relation framework provides for clarity and effective action, for it suggests that it is the social disadvantage of *some* males which reproduce the health differences often cited in empirical research (Schofield et al. 2000).

Connell highlights how inequalities between men may be as significant as those between men and women. Her important contribution to theories of gender inequality is to extend feminist analysis to include intra-gender relations. Significantly, relationships within genders are largely explained by the relationships between genders (Demetriou 2001). Petersen (2009) has observed that just as feminists from the developing world became critical of the universalising of concepts such as 'women' and 'sisterhood' developed by white Western feminists, the essentialist frameworks produced by (mostly) white, heterosexual identified writers regarding 'men's' experiences have been challenged by men and women from minority ethnic and gay communities, who have experienced intra-gender inequalities. Connell's work has also informed current inter-sectionality studies, which seek to understand how race, ethnicity, class and sexual orientation inform gender relations and shape health outcomes.

The concept of hegemonic masculinity has been utilised widely in recent years in a range of studies on specific male health issues, including arthritis

(Gibbs 2005), prostate cancer (Chapple and Ziebland 2002; Broom 2004), impotence (Oliffe 2005), sexual health (Oudshoorn 2004; Rubin 2004; Knight et al. 2012; Persson 2012), fertility (Throsby and Gill 2004), alcohol abuse (Hinote and Webber 2012), men's experience of depression (Emslie et al. 2006; Valkonen and Hänninen 2013), mental health (Addis and Cohane 2005) and suicide (Cleary 2012). Research has also examined how material and symbolic representations of maleness and male bodies influence health (Robertson 2006) and risk-taking (Mahalik et al. 2007). Finally, there have been studies examining measures to address male health inequalities, focusing on treatment for drug addiction (Ezzell 2012), health promotion (Smith 2007; Sloan et al. 2010) and health-seeking behaviours (Möller-Leimkühler 2002; Galdas et al. 2005; O'Brien et al. 2005; Noone and Stephens 2008). There have also been attempts to create a more intersectional account of masculinity that incorporates ethnicity and class (Lohan 2007).

Concluding thoughts

It has been argued that the concept of hegemonic masculinity has been 'over-emphasised' by those utilising Connell's work and that the concept is sometimes 'misunderstood', being reproduced unproblematically and inevitably, despite having been developed to critique essentialist or deterministic accounts of gender. Specifically, the concept is often presented as free-floating, rather than being situated relationally at the top of a hierarchy of specific masculinities, including those which are complicit, subordinated and marginalised (Wedgwood 2009). Earlier battles between positivists and Marxists have been eclipsed by more subtle distinctions between those who have adopted Connell's structuralist account of masculinity and post-structuralist accounts, which advocate closer attention to the work of the French social theorist Michel Foucault. Crawshaw (2007, 2009) and Petersen (2003) have argued that men's health research still lacks a critical understanding of the complex relationships between men, their health and wider social, political and economic factors. Following from this, Petersen (2003) has advocated an historical deconstructionist project, highlighting the need to question the sex and gender binaries that uncritically reproduce the categories of male and female.

Further, much work following Connell has fallen into the trap of compiling lists of what are seen to be the characteristic qualities of hegemonic masculinity and comparing these with espoused feminine qualities. In this way, although the theory of gender relations was developed to move away from essentialist accounts of masculinity, research drawing on the notion of hegemonic masculinity still refers to masculinity as though it has some definable, distinctive essence. As such, this approach to research continues to uncritically reproduce Enlightenment binaries, rather than, for example, examining similarities between males and females (Peterson 2009). Such work fails to capture the contradictory, temporal and fluid aspects of masculinity which Connell's work originally sought to highlight, instead coming full-circle to reproduce 'trait'-type accounts of masculinity similar to those associated with sex role theories. Some of the secondary literature also tends to present hegemonic masculinity as essentially heterosexual, violent and, even, criminal. It is always viewed as negative in orientation. It is also considered to be unified and coherent (Demetriou 2001). Sloan et al. (2010) show that men adopting healthy behaviours, such as drinking less, also draw on discursive elements of hegemonic masculinity, suggesting that its effects on health practices are diverse and complex. For example, to choose to have a healthy body involves positioning oneself as rational and autonomous, which are traits often identified with hegemonic masculinity, which, as noted above, is rarely considered as something which has contradictory and complex impacts on health behaviours.

Connell has acknowledged the need to reformulate and extend the concept of hegemonic masculinity. Writing with James Messerschmidt, who has worked extensively with the concept in research on delinquency and crime, the authors suggest reformulation of the concept of hegemonic masculinity in four areas: a more complex model of gender hierarchy, emphasising the agency of women; explicit recognition of the geography of masculinities, emphasising the interplay among local, regional and global levels; a more specific treatment of embodiment in contexts of privilege and power; and a stronger emphasis on the dynamics of hegemonic masculinity, recognising internal contradictions and the possibilities of movement towards gender democracy (Connell and Messerschmidt 2005). A more sophisticated account of the variability and complexity of masculinity will undoubtedly require a global appreciation of gender relations which contests the intellectual hegemony of the Global North. Connell's most recent work, captured in *Southern Theory* (2007) recognises this challenge.

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Chapter 35

Raewyn Connell: Gender, Health and Healthcare

Maree Herrett and Toni Schofield

This chapter explores the contribution of Raewyn Connell's theorisation of gender for understanding policy, research and practice in health and healthcare. It focuses on several interrelated, high-profile global health issues: gender as a social determinant of health disparity, gender-specific health policy and research and gendered health movements (men's health and women's health). By way of introduction, the chapter presents and explains the core concepts she has developed and applied in social research over the last 25 years. *Gender and Power* (1987), *Masculinities* (1995) and *Gender* (2009) are the main sources for analysis and discussion. These are supplemented by reference to other texts and the large collection of papers Connell has published internationally in relation to gender since 1987. As the chapter explains, at the heart of Connell's prolific contribution is a plain-language critique and rejection of category-based understandings of gender as a world of dimorphic bodies and social roles to match. Her theory demands a seismic conceptual shift whereby gender is understood as a specific domain of embodied social process; a dynamic enacted around the sexual reproductive distinction that brings us into being as gendered individuals, groups and institutions. We do gender but always through structures of practice that both constrain and transform our experience of it. The chapter then turns to the gender-related health and healthcare issues outlined above. It draws on and applies Connell's approach to gender to understand the limitations of prevailing approaches to them.

R.W. Connell

In 1979, a provocatively titled article appeared in a scholarly but internationally obscure publication, the *Australian and New Zealand Journal of Sociology*. It was called 'The concept of role and what to do with it', and it was written by R.W. Connell. As it transpired, it was not only the title that challenged prevailing social science orthodoxy. Connell mounted a head-on theoretical attack on one of the shibboleths of the field – the concept of *role*. Several years later, the paper was re-published with a short preface in a collection of essays on class, sex and culture (Connell 1983). The attack, our theoretical warrior explained, had rattled no social scientific cages: ‘The criticisms were just ignored’ (Connell 1983:189). This critique nevertheless served a pivotal role in advancing an original and dynamic understanding of one of the most significant and challenging concepts in sociology’s theoretical repertoire: gender. Theorisation of gender in sociology is one of the most animated and contested of all theoretical discussions in the field. Understanding Raewyn Connell’s contribution to it, we believe, is best begun by returning to the role theory challenge of 1979.

Sex roles, sex difference and what to do with them

The concept of a social role to explain human behaviour is a relatively recent sociological development. It was developed in the 1930s, and was a well-established sociological concept by the 1950s. The link with gender occurred when earlier research on sex differences, dating back to the late nineteenth century, ‘met’ and meshed with the concept of social role. The distinction between sex differences and sex roles became blurred with the result that the terms are now often used interchangeably. The idea of sex roles – the enactment of masculinity and femininity as two distinct realms – has had an enduring influence on thinking about gender. The concepts of socialisation, stereotypes and role models, are part of the explanatory framework.

Connell critiques sex role theory on both empirical and theoretical grounds. ‘Role’ might be adequate to explain certain performances enacted in our occupations or public lives. However the ‘dramaturgical’ specificity implied by it cannot encompass something as expansive and complex as gender (Connell 2009). It would be comparable, argues Connell, to having a ‘race’ role or a ‘class’ role (Connell 1987). Role enactment cannot account for the persistently unwieldy, and contradictory realities of men’s and women’s lives. Further the idea of ‘roles’ has little to offer in an analysis of power. While women’s liberation in the 1970s was an impetus for challenging sex role norms, parallel arguments about the equally oppressive impact of sex roles on men have since been advanced for different purposes.

The socialisation process described in role theory is an inherently conservative process of accommodation of the individual and the social. The socialisation agencies, including family, school, media, churches, social groups and institutions, are responsible for transmitting appropriate sex-role norms. The developmental trajectory throughout childhood then is towards finding one’s gendered place in the social jigsaw puzzle. Connell argues in the groundbreaking text, *Gender and Power*, that such a view assumes a consensus between the individual and these socialising agencies that is not matched in practice. The socialisation paradigm is ‘. . . all too mild for the fierce pressures generated in such settings' as the family and the school, where 'deviance' is often met with violence (Connell 1987:196). Gender is more accurately characterised by radical conflicts, at both a personal and a social level. Such a view is much more aligned with a psychoanalytic understanding of the interplay of nature and culture.

A landmark Australian study (Connell et al. 1982) challenged the taken-for-granted notions of the school or home as socialising agencies that simply reproduced privilege or inequality. They were sites of struggle and contestation rather than accommodation to social norms. The long-term significance of this study for Connell's theory is the recognition of dynamic and multiple gendered practices.

It is not surprising then that the idea of 'difference' underpinning sex role theory is rejected by Connell. A 'sex role' only makes sense if understood in terms of contrast or opposition between male and female. Difference is the starting point then for understanding gender in this theory. 'Sex role theory and sex difference research constantly collapse into biological dichotomy' (Connell 2009:59). However 'maleness' and 'femaleness' do not fall neatly on either side of a divide. Human life is much more complicated than that. Connell argues that sex difference is only one pattern of bodily difference; trajectories based on age, ethnicity, or size for example will produce multiple patterns. Depending on our cultural and social contexts, patterns of similarities and differences vary.

Sex-difference research is consistent in its failure to identify cognitive, psychological and behavioural differences of any significance (Hyde 2005). The persistent focus on sex differences obscures the patterns of similarities as well as the differences among men, and among women. Historical and ethnographic research cited by Connell in a number of her works, as well as the life study projects she conducted (Connell et al. 1982; Connell 1995), puts paid to the idea of a 'unitary' or categorical understanding of gender.

The idea of gender difference is not specific to sex-role theory. Changing views of difference as either natural, social, historical or discursively produced is a persistent feature of the landscape of gender knowledge. The elusive search for the 'riddle' of femininity espoused by Freud has been overtaken in recent years by a focus on masculinity. Populist accounts of masculinity contained in 'backlash blockbusters' (Mills 2003) resort to a mythopoeic view of 'deep manhood', while sociobiologists look for a Darwinian explanation of contemporary behaviour. Connell argues that in either case the notion of an 'essence' rooted in biological patterns of genomes, hormones or so-called 'hard wired' brain differences is fundamentally flawed. The 'essence' itself is arbitrary and not much more useful than the childish mantra 'what are little boys/girls made of'?:

> The most striking problem about sociobiology and evolutionary psychology, given the constant appeals to 'science', to evolution and to Darwin,

> is that the entire argument is based on speculation. Not one sex difference in psychological characteristics has actually been *shown* to result from evolutionary mechanisms (Connell 2009:54).

Goodbye to categories and hello to embodied social process

The influence of post structuralism disrupted the idea of difference as categorical or essential. The human subject is not a fixed, unique or coherent self but constantly being reconstituted in discourse. The subject is ‘positioned’ by conflicting discourses; different subject positions are neither equally powerful nor equally available depending on social and cultural contexts. By deconstructing discourses, power and privilege can be revealed and subverted. The subject is a ‘text’ signifying social and cultural meaning that does not have an origin in ‘the body’, but in textual practices. Connell argues that the focus on texts and signification is a case of throwing the baby out with the bathwater. The body is jettisoned as part of a wide-reaching rejection of structure.

Yet the idea of natural difference, of the sexes as opposites but complementary, is a beguiling cultural ‘myth’. In developing a theory of gender that does not collapse into sex difference, Connell requires us to make a seismic mental shift, and to grapple with gender beyond ‘his’ *n*’ hers’. She has not developed an abstract model but has worked, indeed sweated ‘to put together a coherent theory of gender’ (Connell 2004:9) with the focus on gender relations rather than gender difference. Connell builds on sociological concepts of social structure, psychoanalytic insights of internal conflicts and contradictions, and a rich vein of life history research.

Before analysing the model of gender relations, a key issue to highlight is the significance of the body. Though Connell rejected theories that were tied to categorical or essentialist notions of difference based on biological sex distinctions, she also stated that the materiality of the body matters crucially in understanding gender. Connell uses the term ‘social embodiment’ to represent the relationship between the biological and the social. Neither can be reduced to the other as is often portrayed in the ‘nature versus nurture’ dichotomy. The biological cannot be understood as a priori to the social context. Connell draws on developing understandings in neuroscience (Rogers 2001) and biology (Kemper 1990; Fausto-Sterling 2000) to demonstrate ‘a loop, a circuit, linking bodily processes and social structures’ (Connell 2009:67). The ‘natural’ is impossible to disentangle from social conduct and context.

The malleability of bodies ‘artificially’ sculpted to match culturally valued ideas of beauty or strength blurs any distinction between the natural and the social. Whether it is cosmetic surgery, performance-enhancing drugs, or examples of anorexia, the gendered body is socially produced in specific cultural and historical contexts. In the contemporary Western world, ‘the body’ and its transformation is big business. The differential 'wear and tear' on bodies, and costs of repair, depends on where you are located in the social structure. Access to safe and affordable maternity and child care provisions are similarly reflective of differential privilege. The 'making' of gendered bodies is inextricably interconnected with social practices.

Gender is a *particular* form of social embodiment related to reproductive bodily differences between male and female, but not reduced to them. Connell uses the term 'reproductive arena' rather than reproductive differences to convey that this is both a social as well as a biological site. Within this site, gendered cultural categories are created and not 'caused' by reproductive differences. The reproductive arena is shaped and reshaped in response by social processes such as, fertility practices and interventions; pregnancy; contraception and abortion; nurturing of children; sexual health; and an array of legal and political constraints or support. Breastfeeding provides an example of social embodiment in the reproductive arena. Such a purportedly 'natural' bodily function is a site of conflicting social attitudes and practices. It is brought into the public realm in discussions about where breastfeeding should 'be allowed' to happen. Women are subject to a spectrum of judgment whether they do or do not breastfeed, how long they breastfeed for, and even their 'schedules' for feeding. Workplaces and practices may or may not support breastfeeding women. The sentimental image of the 'nursing mother' collides with nasty images of 'breastfeeding Nazis' (those women who are seen to be ideological warriors), or simply ugly images of 'breeders' and 'cows'. Such social practices related to gender cannot be reduced to the body. Indeed 'gender exists precisely to the extent that biology does not determine the social' (Connell 1995:71).

However social practices change and it is this dynamic nature of gender that is crucial to Connell's theorising. Gender does not exist prior to the practices of men and women as social agents, and developing a gendered identity is not a straightforward developmental journey from birth to adulthood. The dynamic interplay of the personal and social is best described as configurations of practice that are divergent over time and in different cultural contexts.

Connell's study of the dynamics of masculinity (Connell 1995) reveals gender practices that are historically and collectively shaped. Connell applied the model of gender relations in a detailed study of the dynamics and trajectories of masculinities. Based on a life history approach, Connell mapped divergent gender practices among groups of Australian men, located in different social contexts. This study reveals why the term 'configurations of practice' is so apt in describing gendered trajectories. The study of the lives of four very different groups of men revealed 'a divergence of gender projects coming out of the same situation' (Connell 1995:120). The title of the study *Masculinities* represents the multiple and contested landscape of gender within which there is agency, as well as social constraints.

While gender is constituted by social practices, these are neither random nor unlimited. Connell's model brings coherence to the otherwise unwieldy, expansive field of gender that operates at every level of human experience from the personal, to economic arrangements and institutional organisation. Connell refers to a social structure of gender relations that is dynamically constituted in everyday life. The idea of structure is one of patterns and interconnections that, when linked in larger patterns, become organisational structures. However, structure is also more than these patterned interconnections; it refers to the constraints, the 'intractability' of the social world – in other words what we are up against. This does not mean that structures are fixed but they do have durability. Connell stresses that it is 'the *effects* of what people do that constitute history and remake structures through historical time' (Connell 2009:59, emphasis original). This historicity of social structures renders them dynamic and generative. Connell refers to them as structures of practice.

The gender order and gender regimes

Connell proposes that the broad pattern of gender relations produced by the combination of a society's structure of practices constitute its overall gender order. Gendered structures of practice, however, are enacted in four main ways involving power relations, production relations, emotional relations or cathexis, and symbolic relations, as the following explains. Connell uses the term 'gender regime' to describe the combination of these four gender relations and proposes they operate in particular sites such as workplaces and other social institutions associated with specific contexts such as healthcare and education. Thus they vary in numerous ways including in response to different class, ethnic and national contexts. This is particularly relevant in health and healthcare fields where men and women, boys and girls, are often treated as dichotomous and distinctive categories.

Power relations operate both institutionally and discursively. A gendered power analysis is concerned with who wields power, at a personal and an institutional level. The 'battle of the sexes' is more than a populist cliché. It also represents personal, organisational and political power struggles. Power is not always direct; it can operate 'discursively, through the ways we talk, write and conceptualise' (Connell 2009:59). But power is rarely monolithic; it is resisted and contested by countervailing power.

Production relations refers to the gendered division of labour. They encompass both the division of labour in the paid workforce, and also the division between the public sphere of paid work, and the private sphere of unpaid work. The gendered division of work is not a 'natural' consequence of reproductive differences. This is obvious when we consider that the division of labour means different things in different cultural and historical contexts. However the gender divisions have material consequences beyond the type of work done; unequal pay, accumulation of superannuation benefits and access to positions of responsibility are part of the effect of gendered production relations.

'Emotional relations' or 'cathexis' refers to the social structuring of the continuum of attachments, from positive to negative, towards others. It includes sexual attachments. While we may think of emotional relations primarily in terms of relations between individuals, they also are part of wider sets of relations within and between groups and organisations, from workplaces to sporting and leisure activities, political engagements and community-based participation. Common expressions in any of these settings of solidarity, support and mutual recognition both among men and women, and between them, for example, suggest the operation of emotional relations that are conducive to co-operative relations of gender equality (Schofield and Goodwin 2005). Gendered emotional relations also produce material and embodied effects beyond the emotions expressed. On-going harassment and bullying by men of women in workplaces and other social settings such as team sports and recreational activities, for example, often result in serious 'mental injury' such as depression and/or anxiety. Such hostility and aggression can also be played out against other men because of their sexuality or age, for instance – an example of the ways in which gender relations inextricably involve the production of our sense of ourselves as masculine, feminine, a combination or neither. Exclusion from participation in the group or organisation as a result, can involve a loss of income or other valued social resources, such as physical activity and social relaxation.

Symbolic relations structure meaning and interpretation, and help us 'read' the world in gendered ways. When we read gender – whether through language, film, dress or other forms of signification – we bring into play a vast range of representations and understandings. These 'are enormously greater than the biological categories of male and female' (Connell 2009:83). The world of sport – often held up as a realm of health-promoting activity for men and women – is a distinctive site for representing gender. Connell argues that the 'growing institutional, media, and business complex of commercial sports . . . is something new, welding exemplary bodies to entrepreneurial culture' (Connell 2005:1816). Here there is a renewed focus on men, and a particular version of masculinity involved that celebrates 'force, domination, and competitive success' (Connell 2005:1816) and at the same time ignores or demeans women. The world of healthcare is a further site offering influential gender representations. Though numerically dominated by women it is organisationally dominated by men who are over-represented in medical specialties and senior management. Employment in healthcare is less gender segregated than it used to be but operation of the reproductive difference in symbolic relations about it remains very powerful. When we think of nurses and others in the 'helping professions', we think women. When it comes to doctors and hospital CEOs, it's men.

While conceptually these four structures of practice are represented as distinct, in reality they overlap and impact on each other. Changes can occur in one area that are inconsistent with developments in another. This can be seen when increased numbers of women enter the paid workforce, for example, but encounter the intransigence of male-dominated power. The 'glass ceiling' is really the 'bricks and mortar' of past gendered practices that define access to power (Connell 2006).

The sets of relations that constitute gender are not limited to direct interactions between men on one side and women on the other; hierarchical gender relations can exist, for example, in an all-male environment. The conflict connected with it can be played out through different kinds of *masculinities*. These involve the ways in which men think and feel about themselves and others as men, enacting these in their own practices and relations with others. Some versions of being a man are more dominant or 'hegemonic' than others, and often linked to extreme and explicit differentiations from women and femininity. The distinction between hegemonic and subordinated masculinities has been a crucial contribution to understanding the conflict within the gender order. However it depends on the social context and the specific possibilities available for how participants can *do* masculinity within it.

Connell's model of gender relations shifts the debate on gender equality beyond a 'Mars and Venus' understanding of relationships. It demonstrates the multidimensional structure of relationships between men and women that operate at every level of human experience. 'Moving towards a gender-equal society involves profound institutional change as well as change in everyday life and personal conduct' (Connell 2005:1801). As her turn to the global dynamics of knowledge production and distribution suggests, this project can only be adequately understood through a social scientific approach that recognises the relentlessly divisive relationship connecting the global 'metropole and periphery' and the polarised social fortunes that characterise it (Connell 2007).

Gender as a social determinant of health

Connell's dynamic model of gender provides a critical lens through which to understand how health policy, research and service provision approach the issue of gender. This section examines how gender is represented and understood in global *policy* that addresses the social determinants of inequality, particularly related to health. There are a number of international agencies involved in the field but the World Health Organization (WHO) and the United Nations (UN) are the most significant and influential.

The WHO's Commission on the Social Determinants of Health (CSDH) released its ground-breaking report in 2008 and the UN announced its '8 Millennium Development Goals' at the end of 2000 (updated, UN 2013) in order to arrest deepening global inequality and its impacts on health. Both the UN and the WHO recognised gender as a major determinant of social inequality and proposed the advancement of gender equality and the empowerment of women as a goal in its own right. The WHO identified the latter as a crucial method for intervening in *gendered* health disparities (CSDH 2008:149).

In 'representing the problem' (Bacchi 2012), both policy documents referred to the consistently greater barriers of access experienced by women worldwide, but especially in Africa, South Asia and West Asia, to two main social goods. The first encompassed social resources – income, education, housing and the capacity to influence one's everyday life – and the other, participation in social institutions that play a critical role in generating access to such resources, primarily, sustainable and adequately paid employment and public or state decision-making. Identifying and representing social concerns as 'problems' through *public policy* is critical to how these concerns are transformed into issues for government attention and action, including allocation of public funding (Schofield 2011). *How* policy represents the problem shapes the ways in which public agencies understand and respond to it (Bacchi 2012). It plays an integral role in the making and unmaking of social inequality, including gender disparity.

Both UN and WHO policies have proposed that women have less power as the sex-differentiated distribution of critical social goods described above demonstrates. Resolution of the problem depends on women having more power, or being 'empowered', especially in the 'global south' or 'periphery' as Connell describes the regional collection of societies beyond the wealthy metropole of Europe and North America (Connell 2007). Gender inequality, then, is a problem of injustice arising from the relations between men as a group and women as a group, and the measurable differences between them with respect to social resources and participation. Such a formulation appears to reflect a category-based approach to the problem of gender disparity. Yet its identification of wide-ranging institutional mechanisms by which gender disparity is produced advances an understanding that recognises a gendered power dynamic; one in which the reproductive difference has been operationalised on a worldwide basis in such a way that it has advantaged men at women's expense. Significantly, however, both policies recognise that the division between the 'global north' and the 'global south' structures the process of gender division on a global basis producing its unequal regional impacts, especially in relation to the health of women and their children.

Gender and health policy

Connell's approach to gender provides a conceptual basis upon which to critically appraise a further international policy current and much of the research that informs it: national and international gender-specific health policy. From this perspective, while gender is a distinctive kind of embodied social process, health can be understood as one of the specific realms of its effects, manifesting itself in diverse ways depending on the mixing and merging of gender dynamics with other domains of social practice such as class and ethnicity (Schofield in press). However, gender-specific health policy has generally represented gendered health through sex differences in medically and epidemiologically defined health conditions. Gendered health as a consequence is generally understood to involve men as a group and women as a group, and the statistically measurable health differences between them (Schofield 2004, 2008; Connell 2012). This approach typically assembles and presents sex-differentiated statistical rates of mortality, life expectancy, injury, chronic conditions, drug and alcohol abuse, harm from violence and so on to depict the gendered health pattern of the world as one of thoroughgoing sex-based 'dimorphism'. A difference in the magnitude of the statistical rate indicates a problem of gendered health disparity (Schofield 2004, 2008). For example, women's higher rates of depression and anxiety have been consistently interpreted as demonstrating their worse mental health, suggesting a problem of gender inequality (Busfield 2012). Greater rates of injury, chronic poor health conditions and deaths from domestic violence and abuse among women further illustrate the disparity. At the same time, the higher rates of men-on-men violence-related health damage, suicide and all-cause mortality have been cited as evidence of the ways in which gender disadvantages men and their health as much as it does women's (Schofield 2012).

Gender ostensibly operates in such a way, then, that it causes poor health among *both* men and women but in *distinctive* ways – in other words, same but different, but not unequal. Lending support to and legitimation of this framing of gender-specific health policy is the emergent discipline of gender-specific medicine. It has developed in the context of a substantial critique of biomedical research and practice as having been gender-*in*sensitive (Schofield 2012). In other words, it has routinely excluded women from its studies. Gender-specific medicine seeks to redress this exclusion by advancing knowledge of sex differences in systems medicine and treatments for addressing them (Schofield 2012). It has been foundational to the advancement of men's health in the US.

One of the most powerful statistical 'facts' mobilised to support this approach is that women live longer than men. A plethora of medical and epidemiological research confirms it (Waldron 1983; Austad 2006; Eskes and Haanen

2007).The World Bank's recent 'development indicators' on global male and female mortality rates by country further attest to it. According to these indicators, the global mortality rate in 2013 for men aged 15–60 was 196 for every 1,000 men and 140 for every 1,000 women in the same age range (World Bank 2013). These figures mean that if you are a man aged between 15 and 60, the probability of you dying between these ages is 196/1,000, while a woman's chances in the same age range are 140/1,000. Clearly, your chances of longevity are increased by being 'female' in almost every country.

Closer examination of the World Bank's 'development indicators' on mortality, however, raises serious questions about this story. For example, if you are 'female' and live in Botswana, your chances of a long life are considerably more diminished than the average for men as a whole because the probability of death for women there between the ages of 15 and 60 is 733/1,000! (World Bank 2013). This does not apply only to women in Botswana. Being a woman in Sub-Saharan Africa more generally pretty much ensures that the 'average global man' will likely outlive you – and by a considerable number of years. The dramatically increased probability of death among these women is even more pronounced by comparison with men in Qatar in the Middle East where the male adult mortality rate is 66/1,000. The World Bank's sex-differentiated adult mortality rates for all of the countries of the world in fact reveal remarkable variations in men's and women's chances of dying before age 60. So much so that it is simply not true to say that women live longer than men or that men die earlier, unless we are talking about a statistical fabrication that asks us to believe that men and women are two distinct categories of human beings.

From the sex-differentiated statistical perspective, then, men's and women's health are necessarily exclusive of each other since they are brought into being by a division or binary that is intrinsic to its own thinking (Schofield 2008:146–7). Informing it is the category-based conceptualisation of the 'two-realms' story of gender discussed above: gendered health disparity is essentially generated by a combination of biological sex differences plus 'dimorphic' sex roles. As already explained, Connell's analysis of category-based approaches exposes their major flaws and limitations. It suggests that the 'two-realms' model of men and women as distinct categories of human beings is empirically and theoretically unsustainable and, therefore, not up to the task of informing research and policy to address gender inequality and health. It captures no sense of the dynamic, relational and multidimensional nature of gender as a social process. Nor does it provide any coherent explanation for the ways in which gender produces multiple and complex forms of health disparity that do not and cannot derive from sex differences.

The sex-difference approach to gender expressed in most gender-specific health policy throughout the world (Schofield 2011), sits uneasily with the recent twenty-first-century global policy story of gender inequality as a social determinant of health disparity. The latter frames the problem in terms of *global* social inequality between men and women but, as explained previously, emphasises the differential severity of its impact between the global north and global south: the costs of gender fall most onerously on women in Africa, South Asia and West Asia. WHO policy on the social determinants of health in particular recognises gender as a social division that interacts with other political social dynamics such as the bloody ethnic nationalism of Sub-Saharan Africa and class and caste in India, though such recognition is not usually made explicit. As significantly, it acknowledges the organisational mechanisms by which gender inequality is generated in both business and political arenas, with the exclusion and marginalisation of women in high-level decision-making in both.

By contrast with most policy and research-based symbolisations of gendered health, recent global policy on gender inequality and health does not represent health as a collection of sex-differentiated, statistically measurable medical and healthcare conditions. Rather, the facts of gender division and its interaction with other powerful forces of social conflict are foregrounded to portray a process that exacts enormous *embodied* human sacrifice, mainly of women and their children, and more commonly in the world's poorest and/or most violent national precincts. Certainly appalling rates of maternal and infant mortality and chronic diseases such as HIV are marshalled to quantify the extent of the embodied damage. But these are contextualised alongside rates of education, employment, income, access to clean water and sanitation, and to adequate and appropriate primary healthcare, especially for pregnancy and birth, that document the depth and breadth of the social impoverishment and immiseration rolled out by the juggernaut of global division and competition.

Gendered health movements: Men's health and women's health

A further health-related area in which Connell's model of gender sheds significant theoretical light is that associated with gendered health movements: men's health and women's health. The relationship between gender inequality and health, and demands for social institutions such as healthcare to do something about it, was pioneered by the women's movement of the 1960s and 1970s in the world's rich, Anglo and European, democracies (Broom 1991; Schofield 1998). The 'women's health movement', as it represented itself, was avowedly feminist and overwhelmingly middle class, at least in the United States. It identified medicine as a form of 'patriarchal oppression' of women through its control over women's bodies (Boston Women's Health Collective 1971). This control was exerted in various ways but chief among them were the constraints women experienced in regulating their own fertility and gaining access to birth control technologies such as contraception and abortion. Hospital-based, clinically managed pregnancy and childbirth, and frequently ineffective and clumsy therapeutic management of women's gynaecological maladies related to menstruation, menopause and vaginal infections, were also identified as important.

For renascent, metropole-based feminism of the early 1970s, then, one of the main institutional sites by which men controlled women was medicine. The relationship between women's health and medicine was seen as a critical mechanism by which gender inequality was produced and perpetuated. Women's health activists and commentators viewed medicine as propagating its own power at women's expense. Its agents had wrested control of the knowledge and practices related to women's reproduction from the 'wise women and midwives' who had previously assisted women (Ehrenrich and English 1973). As a consequence, women had become estranged from their own bodies and sapped of a major source of power in their lives (Rich 1976). From the outset of the movement, women's mental and emotional health was also singled out as a source of control over women by patriarchal medicine. Women's emotional distress in the face of the struggles they encountered as women in a gendered society, according to trans-atlantic and Australian feminist criticism (Schofield 1998), was medically pathologised, a development evident in the widespread prescription of tranquillisers to women in the 1960s and 1970s.

Drawing on Connell's dynamic model of gender, the twentieth-century women's health movement can be understood as an expression of organised resistance by predominantly white, middle class women to a powerfully controlling, male-dominated social institution. It actively challenged one of the foundations of gender inequality at the time, proceeding to establish in various parts of the wealthy world at least, women's health centres run by women, with women and for women. In Australia, and in contrast to how this development worked in the United States, government policy and funding provided most of the resources the movement needed. By the 1980s, policy and funding commitment to women's health programmes was assured with feminist bureaucrats able to maintain a watchful eye on potential political and administrative attacks (Schofield 1998). Such a development had been made possible by gender regime changes that involved challenges to male-dominated participation, and political and symbolic relations, within state organisations. This was closely associated with an increased representation of women and the formation of feminist policy machinery in state bureaucracies (Franzway et al. 1989).

In the 1980s, however, women's movements among the Anglo democracies at least, began to attract sustained opposition by organised men's movements. According to Connell (1995), they represented a 'masculinist backlash', attacking many of the gains of feminist activism waged through organised women's movements. The attack was played out on various fronts including, as Connell (1995:206) wrote in *Masculinities,* the development of a 'masculinity therapy' movement for 'healing the wounds done to heterosexual men by gender relations'. Spearheaded in the US, this therapeutic strategy was supported by a plethora of publications basically bemoaning the damage wrought among men by feminism and feminists.

This backlash politics began to gain ground elsewhere in the 1990s. The emerging men's movement focused its attacks on the most visibly successful advances of the women's movement, among which women's health policy and programmes was a prominent target. This occurred through a proliferation of men's health policy development and research, especially in Australia, England, Ireland, Scotland and the United States (see Smith and Robertson 2008). In Australia, the 'men's health movement' focused on penetrating state health bureaucracies and pressing policy-makers to recognise and respond to the serious poor health of men as a group (Schofield 2004). The women's health movement and feminist bureaucracy appear to have seriously ruffled the feathers of 'hegemonic masculinity', at least in the Australian setting. The only redress, it appears, was a men's national health policy that would reinstate some gender balance. No such policy ever eventuated. What did transpire was wide-ranging national debate and discussion about men's health, supported by state-based health agencies, and resulting in some policy papers in various States.

Central to the men's health discourse that developed in the process was the advancement of the 'two-realms' model of gender in understanding gender and health, with sex-differentiated statistics the evidentiary bedrock of men's health claims. Connell's dynamic model of gender has been mobilised by a number of feminist scholars, both men and women, in exposing the shaky theoretical and empirical foundations of this approach (see, for example, Schofield et al. 2000). Yet men's health policy and politics have persisted in affirming that gender inequality adversely affects the health of both men as a group and women as a group but in different ways. This perspective has made significant inroads in framing gender-specific health policy in a number of local contexts such as Australia and the United kingdom. It is evident, however, that such an approach has had limited impact in shaping global policy on gender, inequality and health in the early twenty-first century.

Conclusions

Theorisation of gender is one of sociology's most significant projects and among its most controversial discussions in the field. Connell's contribution to it is built on a thoroughgoing critique of the determinacy of reproductive sex differences and sex role theory on both empirical and theoretical grounds. Gender is not about static categories but dynamic social process that makes the reproductive distinction matter in diverse ways, particularly access to social participation and resources. The process is inextricably embodied and constituted in everyday life through interactions with others. This does not happen afresh every day but, rather, is structured or patterned, creating constraints on and opportunities for action.

At a big-picture level, the combination of a society's gendered structures of practices constitutes its overall gender order. How these structures – or regimes – are configured establishes the limits on and possibilities for gender equality. Connell's model of gender relations shifts the debate on gender equality beyond a 'Mars and Venus' understanding of relationships, advancing a multidimensional structure of relationships between and among men and women that operate at every level of human experience. Such a process, the model suggests, is enacted on a global basis and subject to geo-political and economic forces that impose greater costs on women of the global south than their counterparts in the metropole. Connell's theorisation of gender provides a fresh and critical lens through which to understand how health policy, research and service provision approach the issue of gender disparity in health and healthcare, both in local and world contexts.

In relation to the latter, early twenty-first-century global policy has identified gender inequality as a major determinant of health disparity, reflecting a growing understanding of the dynamic, political nature of gender and how it works as a global social process. Gender division and its interaction with other powerful forces of social conflict generate enormous *embodied* sacrifice, mainly of women and their children, and more commonly in the world's poorest and/or most violent national precincts. In contrast, gender-specific policy and research have generally represented gendered health as a world of dimorphic bodies with correspondingly sex-differentiated health conditions that are medically and epidemiologically defined. Gendered health as a consequence is generally understood to involve men as a group and women as a group, and the statistically measurable health differences between them. From this perspective, gender operates in such a way that it causes poor health among *both* men and women but in *distinctive* ways – in other words, same but different.

Despite the apparent complementarity of gender-specific health policy, no consensus prevails in gendered health movements regarding the nature of gender and how it works in relation to health. The women's health movement of the twentieth century can be understood as an expression of gendered resistance predominantly by globally privileged women to a powerfully controlling, male-dominated social institution. It actively challenged one of the foundations of gender inequality. Men's health movements by comparison represented a metropole-based, masculinist reaction to the gains of feminist activism, especially in health. Connell's dynamic model of gender exposes the shaky theoretical and empirical foundations of 'men's health', posing a major challenge to its suitability as a framework for informing the development of policy, research and practice to understand and redress gender inequality and health. The global dynamics involved in this relationship render the local medical and epidemiological focus of much men's health bereft of relevance for tackling the fundamental sources of the problem.

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Chapter 36

Donna Haraway: The Digital Cyborg Assemblage and the New Digital Health Technologies

Deborah Lupton

This chapter introduces the work of the influential American feminist techno-science studies writer Donna Haraway and shows how it may be used to theorise the new digital technologies used in the health and medical sphere. Haraway's concept of the cyborg has particularly inspired cultural theorists who have written about the implications of technologies for human embodiment and subjectivity. She argues that all individuals in contemporary Western societies have become cyborgs (a term that melds 'cybernetic' and 'organism') in their interaction with technologies, blurring the distinction between human and machine. She further uses concept of the cyborg as a metaphor for political contestation and action.

Haraway's writings on the cyborg and her other work extending these ideas have been particularly influential in theorising the interaction of the human and the non-human in sociology, science and technology studies, feminist theory, cultural studies and race/ethnicity studies. Her ideas are introduced in this chapter to demonstrate the continuing relevance of this work for contemporary theorising in relation to the new digital technologies that are currently being positioned as offering innovative ways of promoting health, improving healthcare delivery and reducing healthcare expenditure. Human bodies now interact with medical technologies in a variety of ways, not only using comparatively old-fashioned technologies such as limb prosthetics, heart pacemakers, hearing aids, insulin pumps and the like, but more recently by digital technologies embedded with tiny sensors and data-processors. Many functions of the body can now be monitored, recorded and rendered into data using these new digital health technologies. These data can be readily downloaded into a digital database and interpreted using complex algorithms to produce statistics on one individual or thousands of users. Some digital devices, such as smartphones, may easily be carried around as part of everyday life; other, even smaller devices may worn on or even inserted within the body or swallowed.

Digital technologies are employed in telemedical systems as part of self-care and self-monitoring regimes for people with chronic medical conditions. They are also adopted voluntarily by individuals keen to track their biometric data in the interests of learning more about their bodies as part of attaining optimal health, in what is termed 'self-tracking', 'body-hacking' or 'the quantified self'.

In this chapter, I discuss aspects of digital technologies as they are employed in medicine and health promotion through the lens of the ideas of Donna Haraway. I begin with an overview of Haraway's work, and then focus on her writings on the cyborg. Then follows an account of the new digital health technologies and discussion of how the concept of the cyborg and other aspects of Haraway's thought may be used to theorise the role, influence, possibilities and limitations of these technologies for conceptualising health, medicine, illness, disease and the body/self in the Web 2.0 era.

Biography

Donna Haraway is an American scholar, born in Denver, Colorado, 1944, who has become renowned for her writings in science and technology studies, particularly in relation to post-Marxist feminism and human and non-human relations. She sometimes uses the term 'techno-biopolitics' to describe what she writes about and also characterises herself as an historian of science. Haraway is now retired from the position in the History of Consciousness Department at the University of California, Santa Cruz: a post she held for many years. She retains the title of Distinguished Professor Emerita at that university.

Haraway was brought up as a committed adherent to the Roman Catholic faith (although she relinquished her religious belief as an adult) and her academic training was in philosophy, theology, biology and literature (Schneider 2005). Haraway has remarked in many forums that this combination of influences has contributed to her work in profound ways, giving her a unique intellectual perspective as an historian of science. She contends that her training in biology has contributed to her perspective on bodies as not just signs or symbols, as a focus on semiotics or discourse may have it, but as fleshly objects with distinct histories (Haraway in Gane 2006). Haraway has also been influenced in her own thinking by prominent science and technology theorists such as Bruno Latour (Haraway in Schneider 2005). Her work draws upon and contributes to cultural studies as well as feminist theory and race/ethnicity studies, all of which she views as interrelating to the others as part of a 'knotted analytical practice' (Haraway 1994).

Haraway has a distinctive writing style that makes constant use of metaphor, the vernacular, the poetic, story-telling and her own personal experiences, at the same time as employing sophisticated and original philosophical insights into the nature of the human and the non-human and the many complexities and ambiguities that exist between these categories. She is the author of six books (Haraway 1976, 1989, 1991b, 1997, 2003, 2008). She has also published a collection of her articles and essays (2004) and a book-length interview with Thyrza Nicols Goodeve (Haraway and Goodeve 2000). Several other interviews or conversations with Haraway have been published as academic journal articles or book chapters. These are useful sources of clarification and further exposition of her thought (see, for example, Bhavnani and Haraway 1994; Schneider 2005; Gane 2006; Williams 2009).

The various topical areas addressed by Haraway in these works and others attest to the primary focus on her theory: to draw attention to the blurriness of boundaries between categories such as human/non-human, human/animal, human/machine, living/dead, mind/body, nature/culture and female/male. Haraway's writings on the cyborg are the central focus of this chapter. Her essay 'Manifesto for cyborgs: science, technology, and socialist feminism' (1985) is a particularly influential piece of writing, having been re-published in collected works a number of times in later years and in revised form in *Simians, Cyborgs and Women* (1991b). (I refer to this revised version throughout this chapter rather than the original.)

Haraway also often refers to her concept of the cyborg in her later books, where it continues to work for her as a way of thinking through the complexities of the ontology of human and non-human actors and possibilities for political action. In fact most of the scholarship throughout Haraway's career contributes to her project to call into question the fixed or essential nature of identity and embodiment. The themes of humans, animals and technologies and their intersections dominate her writing.

Haraway's cyborg theory

Haraway did not coin the term 'cyborg'. It was first used in a 1960 article by two NASA engineering researchers, Clynes and Kline, writing about the concept of the cybernetic organism in the context of adapting to space travel (Haraway 1995). Clynes and Kline referred to the cyborg as 'self-regulating man-machine systems' (quoted in Haraway 1995:xv). Their definition included the idea that the cyborg is a human who 'deliberately incorporates exogenous components extending the self-regulatory control function of the organism in order to adapt it to new environments' and that these components may include 'suitable biochemical, physiological, and electronic modifications' (quoted in Appleby 2002:104). Haraway took up the term 'cyborg' in her own writing to denote what she originally described as 'a cybernetic organism, a hybrid of machine and organism, a creature of social reality as well as a creature of fiction' (1991b:149). However, as I point out below, her conceptualisation of the cyborg has changed in more recent writings.

In her 'cyborg manifesto' essay, Haraway argues that there are two types of cyborg that operate at different ontological levels. The cyborg is represented both as a metaphorical and a literal configuration of human bodies and new technologies; or as she puts it, the cyborg is 'a creature of social reality as well as a creature of fiction' (Haraway 1991b:149). One type is the material cyborg that is configured via the military–industrial–entertainment complex: the cyborg of science fiction films, the warrior macho human-machine, the medicalised body that is normalised by technologies and earns profits for pharmaceutical and medical device companies. The second type is the metaphorical cyborg, or the 'creature of fiction': the figure that challenges assumptions and binaries, that is politically disruptive, progressive and oppositional in its hybridity and liminality.

One of Haraway's oft-quoted phrases is that 'we are all chimeras, theorised and fabricated hybrids of machine and organism; in short, we are cyborgs. The cyborg is our ontology; its gives us our politics' (1991b:150). Here she is trying to express the idea that no human bodies/selves are stable or natural. Rather, we are multiple bodies and multiple selves, depending on the context in which we find ourselves and the other bodies and non-human entities with which we interact. Haraway contends that human bodies cannot easily be categorised as one thing or another in a static binary opposition; nor can technologies be singled out as separate entities from the human. Each contributes to the other: we understand our bodies/selves through technologies and our bodies/selves give meaning and configure technologies through the enactments of everyday life.

Haraway's concept of the cyborg brings the body and its permutations, differences and ambiguities, as well as its performative configurations, into focus as an object for political critique and action. She argues for a view of the subject/body that is inevitably split and contradictory, providing for ambivalence and ambiguity, and she sees this approach as important for feminist and technoscientific critique (1991a, 1991b). As she notes, 'If the cyborg is anything at all, it is self-difference' (1991a:22).

Haraway is not anti-technology; nor is she anti-science (her doctoral thesis was in biology). She acknowledges that she has an ambivalent attitude to technoscience (or a 'simultaneity of love and rage', as she puts it) (Haraway in Williams 2009:139). However, she views technoscience as participating in a culture in which science is viewed as offering salvation for the messiness, suffering and disease to which humanity is exposed. While the cyborg is the product of technoscience, its transgressive liminality also poses a challenge to the myths of technoscience: its project to establish the perfect, whole body and to reproduce cultural binary oppositions as if they are essential and natural (Haraway 1991b). Haraway's cyborg theory, therefore, offers a way of valorising the monstrous, hybrid, disabled, mutated or otherwise 'imperfect' or 'unwhole' body (Gottleib 2000) and is relevant to other types of social and cultural differences.

Many scholars interested in the social and cultural analysis of health and medicine have found Haraway's cyborg theory to be a fruitful and intriguing approach. Her writings have been taken up by other writers to analyse a diverse range of biotechnologies, medical issues and health conditions, including Prozac (Lewis 2003), disability (Gottleib 2000), menopause (Leng 1996), female reproduction (Handlarski 2010), foetal surgery (Casper 1995) and stem cells (Jetté et al. 2007). However, as with any other cultural theorist, Haraway also has her critics. Her writings can be difficult to penetrate at times, in her love of the poetic turn of phrase and the metaphor. Some critics have challenged Haraway's model of the disruptive, transgressive cyborg by suggesting that it has not been used to effect political change or to support difference, and that instead the figure of the cyborg has continued to be used as a symbol for the escape from the body and as representing aggressive masculinised technophilia (Squires 2000; Jensen 2008). The novelty of Haraway's concept of the cyborg in cultural theory has also been called into question (Jensen 2008). Other critics have contended that stating that 'we are all cyborgs' is in itself the kind of essentialism that Haraway is attempting to avoid, and find her definition of the cyborg confused (Soper 1999).

Many of the critiques above focus on the material rather than the metaphorical interpretation of the cyborg. Haraway herself has expressed concern about how her cyborg theorising has been simplified in some approaches to hardly more than 'blissed out techno-bunny babbling' and that its radical political project has often been overlooked (Haraway in Schneider 2005:118). I would contend that Haraway's cyborg theory has much to offer a continuing critique of essentialism and dualism as it is expressed in relation to the body. As I observed earlier, Haraway's perspective can be taken up in relation to many kinds of social or cultural difference. By acknowledging human difference, her cyborg theory has contributed to feminist critiques of essentialism, and has also been taken up by scholars interested in sexual identity, ethnic/racial difference and post-colonial politics (Bhavnani and Haraway 1994; Handlarski 2010).

Particularly relevant to the concerns of this chapter, Haraway's cyborg theory also constitutes a major contribution to contemporary theorising about the interaction of human flesh and technology. The concept of the assemblage has been used increasingly in socio-material theory to encapsulate the idea that human bodies are complex and dynamic configurations of flesh, others' bodies, discourses, practices, ideas and material objects. This perspective is also found in Haraway's work, particularly her more recent formulations of the cyborg. In an article published in 2012, Haraway notes that she no longer views cyborgs as machine-organism hybrids 'or indeed hybrids at all', but rather as 'imploded entities, dense material semiotic "things" .... articulated string figures of ontologically heterogeneous, historically situated, materially rich, virally proliferating relatings of particular sorts' (2012:301). Haraway's reference to 'string figures' relates to the cat's cradle game, played using string manipulated on the hands to produce complicated patterns, and which can be swapped from one pair of hands to another as part of sharing the creation. She employs this metaphor in her later work as a means of emphasising the intertwinings, complicated patternings, knottings, webbings and collaborations of technoscience and the bodily assemblages it configures (for example, Haraway 1994, 2008; Haraway and Goodeve 2000). I would argue that in bringing together the concept of the assemblage with that of the cyborg, the term 'cyborg assemblage' may usefully be adopted to highlight the sociomaterial theoretical underpinnings and the constantly changing character of this phenomenon.

The digitised cyborg assemblage

Now, over half a century on from Clynes and Kline's invention of the concept of the cyborg and their pioneering experiments attempting to construct 'man-machines systems', the new digital health technologies have become very close to their original vision. While the cyborg of science fiction – the Terminator figure that is more machine than human, robotic, lacking human emotions – has yet to eventuate, the kind of cyborg first envisaged by Clynes and Kline has become a reality. The cyborg assemblage, understood as a melding of body with technologies that are able to provide cybernetic (feedback) mechanisms, is now configured via the new digital health technologies. This digital cyborg assemblage is not the organism with super-human powers that is so beloved of science fiction fantasy as portrayed in popular culture. Nor is it the disembodied, virtual avatar that moves around cyberspace with little thought of its fleshly reality. Rather, it is the ordinary person who uses digital technologies to monitor her or his bodily functioning or movements or perform medical self-care tasks.

Twenty years ago, four types of cyborg technologies in relation to the human body were identified: those that are restorative (restoring lost functions or limbs), normalising (re-establishing normal functioning), reconfiguring (constructing new combinations of humans and technologies) and enhancing (extending human capabilities) (Gray et al. 1995). The new ubiquitous digital health technologies are capable of all these functions, but also perform others: specifically surveillance, monitoring and communication. In addition to smartphones, digital technologies include devices that may be worn upon the body, such as smartwatches, wristbands, headbands, augmented eyewear (Google Glass), laminated strips and clothing, as well as tiny devices that may be implanted or inserted into the body or swallowed, monitoring the body from within. These devices have embedded sensors that can record biometric data which are then sent wirelessly to other digital technologies for storing and algorithmic processing.

Thousands of apps (the shortened term for 'applications') for smartphones and tablet computers are now available that assist with uploading and interpreting the data collected by body sensor devices, or which can be used to manually upload data about one's bodily functions and activities. Such body functions and indicators as blood glucose, body temperature, heart function, breathing rate, body weight and fat levels, blood chemistry, blood flow volume, the electrical activity of muscles, lung function, physical movement patterns and activity levels, mood, pain and even brain activity can all be monitored using digital devices. The data collected can then be uploaded to apps or websites by users for their own monitoring purposes, rendered into visual form such as graphs and tables and transmitted to their healthcare providers or shared with others via social media platforms or patient support websites.

The techno-utopian visions of what biotechnologies can offer humans identified in Haraway's writings in the 1980s are clearly evident in contemporary representations of digital health technologies. These devices and the data that they are able to gather are viewed as having great potential for improving human health and reducing healthcare costs (Swan 2009, 2012; Topol 2012). As an article published on the *Scientific American* website claims, these devices represent '[t]he wearable, implantable, personalised future of medicine' (Reed 2013). It is routinely suggested in the medical and health promotion literature that these technologies provide particular opportunities for people from disadvantaged socio-economic groups or those who live in rural or remote regions or in developing countries, where healthcare provision may be limited, thus supposedly overcoming geographical and socio-economic barriers to healthcare access (Chib 2013).

The new digital health technologies contribute to the creation of a new form of patient – the 'digitally engaged patient' (Lupton 2013a). This idealised patient builds upon a growing orientation in healthcare since the 1970s in developed societies to viewing patients as 'informed' and 'empowered' consumers, willing and able to challenge medical authority and participate as partners in their own healthcare (Henwood et al. 2003; Bury and Taylor 2008). The newest manifestation of this 'empowered' patient is portrayed as an individual who undertakes to engage in healthcare and health promotion as an 'engaged', 'incentivised' or 'activated' participant who seeks to 'digitise' herself or himself (Topol 2012) as part of 'personalised preventive medicine' (Swan 2009). Information as it is realised in digital data is represented as the dominant means by which disease and early mortality can be conquered and states of good health achieved and maintained.

As part of the focus on the information or data that digital devices and software can collect on the human body, the digital cyborg assemblage produced is another version of what Haraway described as a combination of 'text, machine, body, and metaphor – all theorised and engaged in practice in terms of communications' (1991b:212). In her 'cyborg manifesto' essay, Haraway makes some comments about the ways in which communication and biotechnologies are central to concepts of bodies and selves, embodying new forms of social relations and ways of thinking about the body. These include understanding bodies (and indeed the world) as a problem of data coding. Haraway develops these thoughts further in another essay, entitled 'The biopolitics of postmodern bodies: constitutions of self in immune system discourse', first published in 1989 and reprinted in *Simians, Cyborgs and Women*. In this essay she asserts that in the context of contemporary immune discourse in Western cultures, '[t]he biomedical-biotechnical body is a semiotic system, a complex meaning-producing field' (1991b:211). Disease has become viewed as 'a subspecies of information malfunction or communications pathology; disease is a process of misrecognition or transgression of the boundaries of a strategic assemblage called self' (1991b:212).

This notion of the body as a system of data codes and disease as information malfunction is central to contemporary discourses on digital health technologies. These technologies are represented as providing ways for people to overcome their bodies' ills (current or potential) by providing them with the capacity to gain self-knowledge of their bodies via the data produced: indeed, even before disease makes itself known through symptoms or signs. Digital data and the algorithmic calculations that make sense of these data and provide recommendations ('exercise more', 'test your blood glucose levels', 'eat less', 'visit your doctor') are viewed as objective and pure sources of knowledge of disease and the body. The apparently clean orderliness of digital data appears able to contain and control the inherent and mysterious tendency towards disorder (disease, disability, pollution and early death) of the human body.

Here the concept of the digital cyborg assemblage harkens back to the science fictional cyborg or the disembodied fantasies of cyberspace by evoking the pleasures and potential of using technologies to discipline the body and transcend the ills of the flesh. Yet paradoxically, as part of this project of disciplining and transcending the flesh, digital health technologies also bring the body sharply back into focus (Lupton 2012, 2013c). Now, more than ever, digital technologies have made it possible to peer inside the body, to monitor its functions and render them into visual form. The digital cyborg assemblage in the context of medicine and health promotion is focused on monitoring the signs and signals of the body, its patterns and its data. These technologies make their users constantly aware of the fleshly nature of their bodies: how high their blood pressure or glucose levels are, how happy they feel, how many steps they have walked that day. They therefore promote a self-reflexive, hyper-awareness of the body and its weaknesses and frailties as well as its strengths and capabilities (Lupton 2012, 2013a, 2013c).

The digital cyborg assemblage that is configured via these technologies is truly a cybernetic organism in its attempts to create a closed regulatory system, in which data are produced which then affect behaviours that then create further data and so on. Self-knowledge, as an integral dimension of taking responsibility for maximising one's good health, is part of this system. These technologies also provide the means by which this information may be shared across an unprecedented number of viewers using social media. Users can tweet their daily statistics to their followers, or upload them to Facebook, and by doing so invite their followers and friends to participate in their self-examination and self-surveillance strategies.

Willing and unwilling digital cyborgs

The digital cyborg assemblage as it is portrayed in discourses on 'digitising the self' as part of achieving efficient medical care or promoting health is not the radical, split subject proposed in Haraway's writings. On the contrary, it is inherently conservative, well-behaved, civilised, seeking perfectibility and wholeness, championed in the interests of self-knowledge and personal and fiscal responsibility. There is little that is transgressive or disruptive about this idealised body, despite common references to digital health as 'revolutionary' and 'creatively destructive' of the dominant medical paradigm (Swan 2012; Topol 2012). We see in the figure of the digital cyborg assemblage in the context of medicine and health an urge towards a single, unified body, a body that is configured and intimately understood by data and self-knowledge. This concept of the body is a central underpinning of medicine and health promotion: indeed, the tasks of these fields are to reunify or discipline bodies that are viewed as unruly, out of control, impure and unregulated; whether this is because of disease or illness or because the bodies' owners lack appropriate self-discipline (Crawford 1980; Lupton 1995; Petersen and Lupton 1996; Bunton and Coveney 2011).

'Digitally engaged' lay people, in 'digitising' or 'quantifying' themselves, are conforming to the idealised citizen of neoliberalism: the individual who voluntarily takes up the imperatives of health in her or his interests rather than being coerced to do so (Lupton 1995, 2012, 2013a; Petersen and Lupton 1996). Those who use these technologies also participate in the promotion of the healthiest discourse, in which good health is valued above many other priorities and those who take up this discourse are represented as ideal citizens (Crawford 1980). Digital health technologies are represented in this discourse as allowing citizens to participate in the assumed shared ideal of good health above all by providing the tools to facilitate responsibility for one's health. They are portrayed as enhancement technologies, able to correct apparent deficits in the body by providing information and thus extending the capabilities of the body to monitor itself and allowing users to represent themselves as capable, responsible, illness-avoiding subjects.

The ideal digital cyborg assemblage domesticates digital technologies, incorporates them into its body unproblematically. It hardly sees itself as a cyborg, although others might. Instead the digital cyborg simply views these technologies as part of its everyday world, its usual habits and its mode of operating. Some people find the opportunity to track their biometrics using digital devices or to use telemedicine at home a comforting means of taking control over their bodies (Lupton 2013b). That is not to say, however, that people are always willing to take up the practices of 'digitising' the self that are championed in digital health discourses. Several sociologists of science and technology have drawn attention to the lived realities of using digital technologies in the home as part of telecare arrangements. They have highlighted the emotional and physical dimensions patients experience of bringing the clinic into the home, of having to continually use technologies to check their blood glucose levels, heart function or body weight. Using self-monitoring and self-care technologies can be hard work and force people with chronic illness to constantly be aware of their bodies when they may prefer to forget that they are ill (Oudshoorn 2008, 2011; Mol 2009; Hortensius et al. 2012; Mort et al. 2013). Some patients prefer face-to-face interactions with their healthcare providers rather than digitally mediated encounters or self-care strategies. Some find the responsibility of self-monitoring and self-care overwhelming, and simply wish to allow their healthcare provider to take control (May et al. 2009). Patients may also challenge healthcare providers' encouragement to engage in self-monitoring and self-disciplining strategies predicated on internal motivation, and call on their providers to be more involved in helping them achieve health-related goals (Pii and Villadsen 2013). Yet there may be little choice offered to people who are released from hospital with telecare plans in place (Mort et al. 2013) or who are coerced by their health insurers' financial penalties to engage in self-tracking as part of preventive health ('wellness') programmes (Zulman et al. 2013).

Even if digital health technologies are taken up willingly or voluntarily, there are moments when users become aware of their dependence on technologies, or find the devices annoying or difficult to use, or lose interest in them. For example, some people using self-tracking digital devices have reported finding them cumbersome or frustrating, or worrying that engaging in self-tracking promotes an overly anxious or obsessive approach to their bodies, or have observed that they simply have become bored with using them (Lupton 2013b).

A significant proportion of people simply lack access to the requisite technologies. A Pew Research Center report published in 2013, for example, found that 15 per cent of Americans do not use the Internet, and a further 9 per cent did use it but did not have Internet access at home. Older Americans and those with lower levels of education and income, in particular, were less likely to use the Internet than other Americans (Zickuhr 2013). These findings are supported by other studies in the United States (Bobkowski and Smith 2013) and elsewhere (Fuchs and Horak 2008; Halford and Savage 2010; Frederico et al. 2012) that demonstrate that social disadvantage and geographical location are significant factors in shaping access to digital health technologies and the ways in which they are used.

A range of factors, therefore, influence the willingness with which people may embrace the 'digitally engaged patient' ideal or attempt to participate in voluntary self-tracking of biometric data using digital technologies. Sociodemographic status and geographical location are important structuring elements, but so too are people's existing states of health, the extent to which they prefer to engage with technologies rather than healthcare professionals, their familiarity with digital technologies and, importantly, their vulnerabilities and emotional dependencies. As Freund (1998:273) puts it, there are 'seams in the cyborg', or disjunctions or incontinuities where flesh and machine rub up against each other, fail to work together successfully. Human–technological interactions and intersections are not always manageable, despite the constant employing of the discourse of control that pervades discussions of the potential of digital health technologies.

Together bodies/technologies may be erratic and unpredictable. Bodies/selves may be spontaneous, creative, emotional, irrational and irregular (Freund 2004); technologies can be messy, fail to work as expected and confound expectations about offering control of the vagaries of the body (Mol 2009). People do not always conform to the rational imperatives of tight self-discipline and self-control demanded of them in contemporary discourses on risk avoidance, preventive medicine and medical self-care. At least on some occasions, they may prefer the pleasures of lack of containment and loss of control offered by the grotesque body over the disciplines of the regulated civilised body (Lupton 1995, 2013d; Bunton and Coveney 2011). Haraway's figure of the metaphorical cyborg, therefore, in its insistence on resistance, ambivalence and difference, its recognition of imperfections and multiplicities, serves as a challenge to the material cyborg that is idealised in dominant representations of the digitised, responsibilised patient. Both are elements of the digital cyborg assemblage that participates in (or resists) digital health technologies.

Conclusion

I have argued in this chapter that Haraway's cyborg theory offers a unique and intriguing perspective that can be employed to analyse the social and cultural meanings of contemporary digital health technologies; or what I have dubbed 'the digital cyborg assemblage'. Her approach to the cyborg body offers a way both to acknowledge the potentialities of these new technologies but also their limitations and to express ambivalence towards them without feeling the need to indulge either in technophobia or technophilia, itself the kind of dualism against which Haraway warns. Given the current move in medicine and public health towards digitising the body as part of configuring the responsibilised lay citizen (Lupton 2013a), it is important for sociologists to continue to challenge the discourses that privilege certain types of bodily assemblages. While the digitised cyborg assemblage is inherently conservative, seeking the ideals of wholeness, purity and self-responsibility espoused by medicine and public health, the metaphorical cyborg as articulated in Haraway's work continues to offer a means of disrupting this ideal. Haraway's two-faceted cyborg – the literal and the metaphorical – allows us to recognise the potential of the digital cyborg assemblage for enhancing and improving human well-being, health and medical care while simultaneously maintaining a critical distance, in order to identify the ways in which some social groups or individuals may be coerced, stigmatised or disenfranchised by these technologies and how the rhetoric and practice of digital health serve powerful interests.

The figure of the digital cyborg assemblage as it is championed in digital health discourse may be challenged by Haraway's fictional disruptive cyborg for political purposes. The spirit of this latter cyborg, in calling into question accepted technoscientific and techno-utopian assumptions and truths, in focusing on the operation of power and agency and provoking ambivalence and contestation, conforms closely to the project of a critical sociology of health and medicine. As I observed earlier in this chapter, discourses on the digitally engaged patient/lay person suggest that those who take up the imperatives of digital engagement as part of the project of good health are ideal, responsible citizens. Those people who do not conform to these expectations tend to be marked as lacking knowledge or the ability to engage in self-management and self-enhancement, or as simply not well enough 'incentivised' or 'activated' (Lupton 2013a). Such assumptions are invariably constructed using categories: the technophobic, those on the wrong side of the 'digital divide', the ignorant, those who are too old, too little educated or lacking the language ability to master or attempt use of the new digital technologies. It is these material and diverse aspects of embodiment, and the social and economic inequalities that they perpetuate and in which they participate, that Haraway's cyborg theory is well placed to question and critique.

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Chapter 37

Mike Bury: Biographical Disruption and Long-Term and Other Health Conditions

Louise Locock and Sue Ziebland

The insight that a diagnosis of chronic illness disrupted the structure of everyday life came to Mike Bury during his late 1970s fieldwork with people diagnosed with rheumatoid arthritis (Bury 1982). His analysis draws attention to the way illness interrupts 'the expectations and plans that individuals hold for the future', requiring 'a fundamental rethinking of the person's biography and self-concept' (Bury 1982:169). Always alert to the effects of socio-economic circumstances, Bury (1982:177) explores how people may engage in a process of mobilising their resources to 'normalise in the face of disruption'. Below we provide a summary of this initial elaboration of the concept, in the context of other contemporary work tending towards similar ideas about the impact of chronic illness: notably Strauss and Glaser on chronic illness (1975), Anthony Giddens on 'critical situations' (1979) and Kathy Charmaz (1983) on 'loss of self'. The concept of biographical disruption has proved durable and continues to inspire and challenge. We examine its legacy in four ways:

- how Bury himself developed and refined his original work;
- how other theorists have applied and adapted the concept in the field of chronic illness, including the recognition that biographical disruption may sometimes *cause* chronic illness;
- challenges to the assumption of biographical disruption, including notions of biographical flow, continuity and reinforcement, 'narratives of unconcern', and the suggestion that disrupted and normal identities may co-exist; and
- the extension of biographical disruption to a wider range of conditions and topics (including acute or self-limiting conditions, terminal illness and cancer, and the experiences of family members).

Biography, Mike Bury and British medical sociology

Simon Williams (2000), in his reflection on the 'core concept' of biographical disruption, points out that any discussion of the sociology of chronic illness will soon refer to Mike Bury. Indeed there is ample evidence of the centrality of Bury's work in our citation search which yielded nearly 900 items (see below). We enjoyed re-reading the core papers, discovering new applications of biographical disruption and were also pleased to have the opportunity to talk with Mike Bury as part of our preparation for this chapter. We refer to this conversation as 'personal communication 2013'.

Bury's career can be seen as mirroring the development of British medical sociology. The medical sociology section of the British Sociological Association started as an offshoot of mainstream sociology; Bury was born in 1945 and studied sociology at the University of Sussex in the 1960s. The sociologists who were based in medical schools were often teaching the social causes of disease. Before the 1970s sociologists had little interest in studying health experiences, (physical) illness was regarded as a purely biological issue. Bury's early career included posts in the Department of Psychiatry at the University of Bristol, and the Arthritis and Rheumatism Council Epidemiology Research Unit at the University of Manchester. At Bristol, he worked with an anthropologist (Vieda Skultans) and a psychiatrist (Oliver Russell), doing field work in a small mental handicap hospital that had been the subject of a government enquiry into deaths on the wards. Looking back, in a 2005 chapter, Bury traces the origins of much of the sociological interest in medicine to the anti-psychiatry movement (Bury 2005).

The first UK chair of medical sociology was held by Margot Jefferys at Bedford College, University of London; Bury joined Professor Jefferys in this mainstream sociology department (subsequently merged with Royal Holloway), where he remained until retirement. In 1991 he was awarded a personal chair in sociology at the University of London and he has had a major influence on the development of medical sociology. Throughout his career, Bury has brought a cool, sociological gaze to the enduring topics of chronic illness, disability and ageing, gently reminding the discipline about the importance of scholarly reflective work with a sense of history:

> At the heart of sociological reasoning lies its desire to take a step back from the immediate pressures of events and headlines, and to look beneath the surface, or at least to set the issues involved in their wider social and political context (Bury 2005:41).

In this chapter we are concerned with an early contribution, from Bury's years at Manchester, of the concept of *biographical disruption*, which was published in a landmark article in the journal, *The Sociology of Health and Illness* (Bury 1982).

The climate and context in which biographical disruption was born

By the 1970s, the changing patterns of disease and death had contributed to a shift in focus from the study of mortality and morbidity to considering how chronic illness and its treatment affect people's lives. This shift moved attention away from the causes to the consequences of illness and disability. Better living standards, improved healthcare interventions and increased longevity in developed nations during the twentieth century created the conditions in which living with chronic illness became a common experience. While treatments (such as inhalers for asthma or insulin therapy for diabetes) allowed people to live longer with conditions which might previously have led to an early death, the lack of cure remains a defining feature of chronic illness. As Bury himself (1991), following Gerhardt (1990), later notes:

> Expectations of medicine can thus be raised, paradoxically, in a context which is often perceived as one where medicine is often of only limited effectiveness. In fact, the expansion of treatment in a wide number of areas may be associated with the reduction of fatal outcomes and the increase in the prevalence of chronic illness (Bury 1991:457).

As a child of 1960s sociology, Bury's thinking was influenced by American sociologist C. Wright Mills. In *The Sociological Imagination*, Mills (1959) distinguishes between 'personal troubles', as individual vagaries of life, and 'public issues':

> An issue is a public matter: values cherished by publics are felt to be threatened . . . It is the very nature of an issue, unlike even widespread trouble, that it cannot very well be defined in terms of the everyday environments of ordinary men. An issue, in fact, often involves a crisis in institutional arrangements (Mills 1959:8–9).

Health and illness was not a particular focus of Mills' thought in relation to personal troubles and public issues, not least because sociologists were still viewing illness as an essentially biomedical topic. But clearly illness, healthcare organisations and treatments provide excellent examples of a public issue that encompass many seemingly personal troubles. Drawing on Mills, Bury saw a role for medical sociology in illuminating the intersections of history, personal experience and the social structure. Researching experiences of chronic illness, in a working class area of northern England, allowed Bury to examine these very intersections.

Sociology has a longer history in the United States, and American sociologists were rather ahead of their British colleagues in turning their attention to the experience of living with a chronic illness (for example, Strauss and Glaser 1975) or disability (Davis 1963). Bury was of course aware of Anselm Strauss's work on illness trajectories and the meanings people attach to chronic illness (Strauss and Glaser 1975), and also Davis' work on the impact of polio (1963) and visible disabilities (1964). Bury also drew on Anthony Giddens' (1979) concept of the 'critical situation', previously described in relation to war and displacement, to understand how people respond to an unexpected diagnosis that may challenge their former expectations and require them to re-orientate. Bury (1982:177) pointed out that depending on people's social, familial and economic positions, they may be able to mobilise inter-personal, structural and material resources to 'normalise in the face of disruption'. This may seem a more hopeful prospect than Charmaz's 'loss of self', although it should be remembered that Charmaz had studied people with severe and disabling chronic conditions, some of whom could not leave their homes. In later work, she too explored how people may achieve a 'restored self', which may be restoring an unchanged past identity (an 'entrenched self'), but may also encompass reassessment as a 'developing self' (Charmaz 1987). Gareth Williams, working in Manchester after Bury, interviewed people who were 'seasoned professionals' (Williams 1984:176) with rheumatoid arthritis (RA), and notes that his respondents, interviewed in their own homes, narrated their experiences to introduce some sense and order, some explanation and coherence into their accounts of the causes and impact of their illness. Williams (1984) describes this as process of 'narrative reconstruction' in his own very influential paper.

Conrad and Bury noted in their 1997 appreciation of Anselm Strauss that he 'and his collaborators moved from studying patients to studying how people experienced and managed their illness in everyday life. Managing chronic illness needed to be understood in the context of people's lives'. These largely empirical studies may have made little overt contribution to theory, but the shift in focus to the person living with the condition rather than the *patient* in the clinical setting was highly influential for several decades of sociologically informed research on the lived experiences of illness.

Bury worked in Manchester with rheumatologist Philip Wood, who developed the influential WHO taxonomy of impairment, disability and handicap (Wood 1975). Wood was an enlightened colleague, aware of the potential for social science to contribute to clinical understandings as well as to the parent discipline. Through his sponsorship, both Mike Bury and his successor Gareth Williams were given the opportunity to observe and interview patients at the Manchester arthritis clinic. This opportunity was not lost on Bury; looking back he marvelled about the ready access he had to observe consultations, talk to people at the clinic or as hospital in-patients and also visit them at home for interviews (personal communication 2013).

The fieldwork Bury drew upon to develop the concept of 'biographical disruption' was with patients who were first-time referrals to a rheumatology clinic in Manchester, in the north of England. He interviewed 30 patients (25 were women, reflecting in part the gender distribution of the disease), nearly all of whom were from working class backgrounds. His exposition of biographical disruption examined how chronic illness disrupts personal expectations, and the plans and the structures of everyday life, leading to 'a fundamental rethinking of the person's biography and self-concept' (Bury 1982:169). Among influences from this time was the anthropologist Clifford Geertz who explained the importance of making sense of data through layering observations and interpretations to develop a 'thick description' of a culture rather than the 'thin' descriptions of facts and events (Geertz 1973). Yet, in common with many other research articles of the period, Bury's paper omits any description of the analytic method; it includes only five extracts from the interviews. While his approach would probably now be seen as 'mixed methods', at that time it was simply using his access to the clinic to apply the ethnographic skills of observation and semi-structured interviews. Bury reflected that:

> No doubt today a thousand forms and ethical committees would have to be dealt with in order to undertake such observations, but I don't think I did any harm, and I learned a great deal (Bury 2005:33).

In our conversations, Bury told us that after about four or five interviews he started to become aware there was something interesting, perhaps important, and maybe transferable, about the way an RA diagnosis affects people's assumptions about their future lives. He described, in perhaps remarkable detail for encounters that took place nearly 40 years ago, the key interviews that helped shape his thinking. These included the man, interviewed in his sitting room in the fading light of a winter's afternoon, who described how his social life was now limited to the local club where 'everybody knows me' due to his reluctance to go to other pubs or clubs where he felt people would wonder what was the matter with him and refuse to meet his eye. There was also the husband who lamented, after his wife had been interviewed, that he had bought a new car which he feared would no longer be used to take his wife out for drives now that she found getting in and out of the car too difficult. These were not the issues that clinicians were attuned to hearing in the 1970s clinic, where alleviating pain and improving physical mobility were the dominant concerns (personal communication 2013).

Bury became aware that the patients he was meeting had been brought face-to-face with 'worlds of pain and suffering... normally only seen as distant possibilities or the plight of others'. This insight has some parallels with Charmaz's (1983) idea of the 'loss of self' arising from chronic illness, which she observes as affecting one's identity, self-worth and social interactions, as well as the better recognised physical aspects of suffering. Bury's interview participants had been diagnosed recently. He observed that dependence on others can disturb the 'normal rules of reciprocity' and potentially lead to the loss of social networks and growing social isolation.

Biographical disruption has become part of the landscape of medical sociology. When Bury first presented his idea in relation to chronic illness (which, he suggested to us, is perhaps more a heuristic than a concept), it had both resonance and novelty for patients, clinicians and social scientists. It was a new way of thinking about the impact of a diagnosis, but was not an outlandish idea – it was recognisable to people who worked in field and to many of those who had experienced chronic illness. Later, the 'social' dimension in arthritis became a topic of research, measurement and clinical focus in rheumatology in terms of 'quality of life' as well as a well-recognised component of managing a long-term condition.

In subsequent work, Bury (1991:451) noted that sociologists:

> . . . tend to be more interested in problems than in people's responses to tackling them. In the field of chronic illness, the documentation of problems faced by patients, and to a lesser extent their families, has usually dominated the research agenda.

In his later explorations of biographical disruption, Bury (2001) has focused in more depth on how people use individual agency to respond to and overcome disruption through narrative, seeking 'the repair and restoring of meanings when they are threatened'.

How biographical disruption has been applied, adapted and challenged in chronic illness

The concept of biographical disruption has proved remarkably durable. An electronic database search in early 2013 of papers referencing Bury's key articles (1982 and 1991) yielded nearly 900 items on the topic, including both papers which support the original idea and extend it to other areas, and those which challenge or adapt it. The flow of references shows no sign of slowing. In this section we highlight how biographical disruption has been applied and adapted within chronic illness, before considering how it has been extended to other types of condition or experience.

Bury's original conception of biographical disruption was particularly focused around the early stages after a diagnosis of chronic illness, and the process of adjusting to a changed long-term trajectory. The sociology of health and illness is not a field in which simple replication is encouraged; therefore articles accepted in the best peer-reviewed journals are likely to test, refine, adapt or challenge existing work. Given that journal submissions are reviewed according to their likely contribution of something novel to the field, it is perhaps not surprising that there are few papers offering simple re-endorsements of the concept in other types of chronic illness, though several find it resonates strongly with the experience of some people in their samples, or with some aspects of their experience.

Here we take a few key papers in the field to explore the range of ways in which biographical disruption has inspired other researchers and helped them consider ways to make sense of participants' accounts. Other review papers which reflect on the contribution include those of Simon Williams (2000), while both Julia Lawton (2003) and Bury (1991) himself have reviewed the contribution of biographical disruption to the sociology of chronic illness. In the 1991 review, Bury extends his observations by considering how people try to impose meaning on their situation through a 'legitimation' process which seeks to repair the disruption 'to maintain a sense of personal integrity and reduce the threat to social status, in the face of radically altered circumstances' (Bury 1991:456). In our discussions about this chapter, Bury reminded us that while the problems of pain, discomfort and growing disability may be pressing, questions about who to tell, how much to tell and in what ways and contexts, are often major preoccupations when dealing with disruptive symptoms, or diagnoses:

> The sense of trying to establish a 'negotiated order' in everyday life in the face of disruption may have wider implications for how social order is established more generally – explanation, legitimation and so on (personal communication 2013; see also Rogers et al. 2009).

Biographical disruption has been challenged on the grounds that it does not fully represent everyone's experience of chronic (or other) forms of illness, a point with which Bury himself is in agreement. He suggests it is more useful to think under what conditions it does or does not hold, rather than assume it invariably applies (personal communication 2013). The idea of 'disruption' implies a negative experience, indicating what we have described as 'a destructive breach in the fabric of life' (Locock et al. 2009:1075). Kathy Charmaz (1983) explored chronic illness in terms of the negative 'language of loss'. A counter position, argued by Frank (1993), is that the disruptive effect of illness can be positively life-affirming, creating 'epiphanies' or 'moments that are privileged in their possibility for changing your life': though Frank (1993:42) acknowledges the existence also of ' "reluctant Phoenixes" who claim little if any self-change following illness'.

Others have argued that chronic illness may not necessarily be either positively or negatively disruptive, but may instead be accepted as biographically anticipated 'normal illness'; terms such as 'biographical flow', 'biographical anticipation' or 'biographical continuity' have been coined to express this (Williams 2000). Sanders et al. (2002), for example, found that older people especially interpreted the pain and reduced mobility of osteoarthritis as a normal part of ageing, consistent with their expected biography rather than disruptive of it (even if at the same time it disrupted practical daily living in quite a major way). In explaining their findings, they draw on Bury's (1988) own distinction between 'meanings as significance' (in this case the significance of the condition for one's sense of self), and 'meaning as consequence' (in this case the practical activity restriction and social disadvantage resulting from the condition) (Bury 1988:91). As their article title suggests, normal and disrupted biographies may co-exist for older people who see osteoarthritis as normal but nonetheless limiting. However, Sanders et al.'s sample also included some younger participants for whom this degree of pain and disability was in no way anticipated and who therefore experienced it much more as biographical disruption on all fronts.

Simon Williams (2000), in his reflections on Bury's concept, draws attention to the 'less well documented' idea that biographical disruption (life events) can be the precursor, rather than the sequel, of a chronic illness. While the causal link between life events and mental illness has been widely acknowledged since Brown and Harris' (1978) work on the social origins of depression, Williams suggests this could be a fruitful area for further empirical work – especially in the sociology of the emotions.

The meaning of chronic illness is dependent partly on age, but also on co-morbidity and wider social factors such as class, poverty and poor housing. Faircloth et al. (2004), in a study of experiences of stroke among White, Hispanic and African Americans, argue that their findings:

> ... suggest a biographical flow more than a biographical disruption to specific chronic illnesses once certain social indicators such as age, other health concerns and previous knowledge of the illness experience, are taken into account (Faircloth et al 2004:242).

Thus the authors counsel against 'treating all stroke survivor experiences as universal' (Faircloth et al. 2004:258).

Pound et al. (1998:502), in a study of older working class people in the East End of London, suggest that they may have 'lower expectations of health and may anticipate illness as *inevitable* in old age, or meet it with a greater sense of acceptance'. The participants in this study described witnessing death at a relatively early age among family and friends, alongside experience of other hardships; in this context, illness may simply be seen as a normal part of working class life. While cautioning against any simple 'face value' interpretation of narratives, they are concerned that where narratives do not fit with biographical disruption this is sometimes taken as evidence of denial, or a wish to present oneself as conforming to a socially expected form of stoicism. They encourage us to pay attention to 'the straightforward possibility offered by the interviewees themselves' that 'chronic illness may be anticipated and experienced by some older people as normal' (Pound et al. 1998:502).

Bury has recognised this as a valuable qualification of the original idea (Bury and Holme 1991). As Williams (2000:51) puts it:

> Prejudging the issue of illness as biographical disruption cannot, from this viewpoint, be justified. Instead, *timing* and *context*, *norms* and *expectations*, alongside our *commitment* to events, anticipated or otherwise, are crucial to the experience of our lives, healthy or sick, and the meanings with which we endow it.

Many studies of chronic illness have been in a single illness population – an exception is the work by Carricaburu and Pierret (1995). Through studying two different groups of men with HIV (homosexual and haemophiliac men) they developed the idea of 'biographical reinforcement'. Patterns of difference in the impact of a diagnosis of HIV infection emerged between the two groups of men. Carricaburu and Pierret stress that difficulties recruiting homosexual men may affect the generalisability of their findings, but they note that the homosexual men in their sample (mostly young and previously healthy) *all* experienced biographical disruption at diagnosis. This contrasts with the haemophiliac men, in whom the pattern of responses was more mixed. Some did report it as disruptive:

> These interviewees had organised their lives to win the battle to 'lead a normal life'. . . . Being HIV positive had disrupted this normalcy because haemophilia could no longer be kept at a distance (Carricaburu and Pierret 1995:82).

Other men with haemophilia, however, had always 'organised their biographies around their illness trajectories' (Carricaburu and Pierret 1995:81). They already had one condition that severely restricted their lives and were in a sense already defined by that illness. The addition of HIV to the equation simply resulted in further biographical reinforcement of their ill self and caused no disruption (though the authors stress that this did not mean they did not feel 'menaced' by HIV infection).

Harris (2009) chooses the term 'narratives of unconcern' to explain the accounts of people in New Zealand and Australia with a diagnosis of hepatitis C virus. She found (Harris 2009:1028) that study participants were 'almost evenly divided between those who reported being distressed by diagnosis and those who described contracting hepatitis C as "no big deal"'. Again, contextual factors may help explain why some people offer a 'narrative of unconcern'.

The varied nature of participants' narratives about their hepatitis C diagnosis indicates that the experience of biographical disruption is contextual: dependent upon previous experiences of illness, marginalisation or hardship, and the extent to which hepatitis C is an unknown entity or normalised within community networks. Similarly, Olsen et al. (2013) have argued that hepatitis C virus is a low priority for people who inject drugs and found evidence of biographical reinforcement. In their study, most women who used drugs did not experience hepatitis C as disruptive, but rather 'incorporated the disease experience within their life story, confirming their identity as a person who injected drugs and as someone with constant and serious life stressors' (including poverty) (Olsen et al. 2013:531).

A common theme in many of these adaptations or challenges to biographical disruption is that where other problems loom large, the impact of a (or another) chronic illness may assume less significance than the concept of biographical disruption might suggest. In a different take on the importance of context, Shostak and Fox (2012) point out how improvements in treatment for a condition over time may lessen the perceived disruptive effect of an illness. In their study of the changing experiences of epilepsy, participants contrasted the 'Dark Ages' of epilepsy care with current narratives of hope and steadily improving treatment.

Larsson and Grassman (2012), on the other hand, have recently taken issue with notions of biographical continuity and biographically anticipated 'normal' illness and provide clear evidence in support of biographical disruption. They draw on two studies, one a 30-year prospective study of people aged 30–45 at first interview who had both a chronic illness and visual impairment, and the other a retrospective study of people aged over 55 who had been living with a physical impairment for anything between 30 and 66 years. Two key findings emerged: First, that biographical disruption occurred not only as a reaction to initial diagnosis but that there were 'recurring disruptions' (Larsson and Grassman 2012:1164), 'repeated transitions due to bodily and functional losses over the life span in chronically ill and disabled people – losses that may have been both unexpected, feared and expected at the same time' (Larsson and Grassman 2012:1157). Second, they dispute the suggestion that disruption is less relevant to older people and to those who have experienced difficult lives, noting that:

> We found hardly any support for the notion that bodily changes in later life or after many years with a disability are experienced as less painful or less disruptive than at an earlier age or closer to the onset of chronic illness or

> impairment. Instead, we argue that the risk of experiencing a complication or bodily or functional loss as disruptive in some respects might be even greater after many years of living with a chronic condition than it would be earlier in the process (Larsson and Grassman 2012:1157).

Wilson (2007), in her study of Scottish women, also re-emphasises the value of biographical disruption as an analytical device, demonstrating how the discovery of HIV infection, the associated stigma and the threat of dying prematurely, disrupts women's identities as mothers; yet their responsibilities and desire to protect their children provides a reason to cling to this identity (in effect a kind of biographical reinforcement in the face of illness). She too queries the suggestion that illness may be less disruptive for people who have already had hard lives. In her sample, women had carefully constructed an identity as good mothers against a background of marginalised communities characterised by low incomes, unemployment and drug use; to then have this one key identity threatened was a profound form of biographical disruption.

Extension to other conditions

Thus, within studies of chronic illness, biographical disruption has been both embraced and challenged, and inspired a range of more nuanced reflections on what it means to people to have a long-term condition. Researchers have also found it a fruitful way to shed light on a range of other areas of health for which it was not originally intended, including acute, self-limiting conditions, life-threatening events or diagnoses, social experiences, and also the absence of diagnosis (and indeed it has even crossed boundaries to studies of housing and migration).

This last point may seem counter-intuitive – how can the absence of disease be seen as disruptive? We take three examples here. Seeley et al. (2012) report the experiences in Uganda of a group of people who had previously been told they were HIV positive, and adapted, to varying degrees, to living with a stigmatised and life-threatening condition. During the roll-out of anti-retroviral therapy in 2004, they were retested and found to be HIV negative. Paradoxically, the rediscovery of a healthy identity resulted in further biographical disruption, requiring 'biographical work . . . in both the personal and the social dimensions of their lives in order to manage their new-found HIV-uninfected status' (Seeley et al. 2012:330). A particular form of disruption was having to leave the AIDS support group to which they had belonged and which had been a source of great friendship. People were often reluctant to tell other support group members of their new status, and as a result:

> . . . the identity reversal or change was often handled privately. Compared with their transition to an HIV-positive identity, they now lacked a social

> dimension to their identity transformation as they managed their new identity in the face of self- and public doubt (Seeley et al. 2012:330).

Our second example of biographical disruption in the absence of a diagnosis is Gillespie's (2012) analysis of living with risk, specifically in men, told they are at risk of prostate cancer following a prostate specific antigen or PSA test. Many of Gillespie's respondents talk of a loss of identity as a healthy person following their test result, even though they are not (yet) ill; living with constant vulnerability, anxiety and uncertainty about the future led to a fundamentally altered health identity.

Finally, Shepherd (2010) reports the impact of advances in genetic testing which have enabled some people with diabetes previously regarded as insulin-dependent to switch to a different treatment (sulphonylureas). Even though this can lead to improved blood glucose control and quality of life, some people in their study chose to stay with insulin or to go back to it after trying the new treatment. The author explored how the practice of injecting insulin had become fundamental to individuals' self-identity and how the possibility of stopping insulin injections posed a major challenge.

Cancer is a field in which biographical disruption has been increasingly explored. Cancer has in many cases shifted from a life-threatening acute event to something more akin to living with chronic illness – though as Hubbard and Forbat (2012) suggest, cancer survivors may still see the condition as a permanent threat to life and thus a continuing source of disruption. As one example among many, McCann et al. (2010) use a framework of biographical disruption to examine the experiences of women diagnosed with breast cancer, how they make identity transitions between health and illness as they progress through diagnosis, treatment and follow-up, and how they seek to restore identity while facing continued future uncertainty.

Biographical disruption has been applied also to more self-limiting or acute conditions. One of the authors of this chapter has applied it to experiences of nausea and vomiting in pregnancy (NVP) (Locock et al. 2008). While NVP is regarded both by women and health professionals as a normal and expected part of pregnancy, its intensity and duration can be profoundly unexpected, and result in disruption of normal daily life, parenting and social functioning, as well as loss of an expected pregnant identity (not blooming, but 'blooming awful'). Here biographical disruption may be a very temporary response to a transient condition.

Reproductive health provides further examples of the application of biographical disruption. From a feminist perspective, Sevon (2012) examines transition to motherhood and identifies two main transformation narratives: either turbulent or smooth. The turbulent transformation narrative 'demonstrates how the transition to parenthood may lead to biographical disruption in first-time mothers' lives' (Sevon 2012:60), as women negotiate roles with their partners and struggle with 'contradictory cultural narratives of intensive mothering and shared parenthood'. The intersection of identities is explored by Fisher and O'Connor (2012) in their study of how a breast cancer diagnosis disrupts women's biography as mothers.

Exley and Letherby (2001:112) provide a fascinating comparison between involuntary childlessness and terminal cancer, arguing that both 'have a disruptive effect on daily lives and future expectations'. They explore how individuals manage this disruption to both their sense of self and the self in relation to others.

We, too, have examined biographical disruption in the context of terminal illness (Locock et al. 2009), specifically motor neurone disease (also known as amyotrophic lateral sclerosis). We argue that motor neurone disease sits uncomfortably between terminal and chronic illness, with no cure, a strong likelihood of rapid progression and death with a matter of months, yet a degree of uncertainty about the form progression will take and the speed at which it will happen. We suggest for many people the initial diagnosis is not only disruptive but constitutes what we term 'biographical abruption':

> ... whereas ... 'disruption' implies disturbance and unwelcome change, 'abruption' is intended to convey a sudden ending, literally a 'breaking off'. It encapsulates a commonly reported feeling that the diagnosis was a 'death sentence', that life was in effect already over and that individuals had been denied a future ... Biographical abruption imagines life simply not happening at all – the story is already over (Locock et al. 2009:1047–8).

This may not be a permanent or predictable response; we also report numerous examples of processes of biographical repair and reconstruction as people realise they have months or even a few years left to live and need to move beyond the initial paralysis of 'existential shock' (Brown 2003).

Another area of application for biographical disruption might be described as more social or family experiences. Tower, Rowe and Wallis (2012) argue that the needs of women affected by domestic violence have too often been viewed by healthcare practitioners through a biomedical lens, and that biographical disruption offers an alternative way of exploring how women experience a dislocation of their sense of self as a result of domestic violence. Owens et al. (2008) extend the concept to the experiences of those bereaved by a son's suicide, which they characterise as 'biographical disintegration', as an anticipated family future collapses and parents struggle to repair both their son's and their own 'shattered biographies'. Becoming an informal carer for a person affected by illness or disability can also be profoundly biographically disruptive, as Greenwood and Mackenzie (2010) identify in their meta-ethnography of literature on informal caring for stroke survivors. In a different twist, Jenkins et al. (2013) explores how individuals having genetic testing for familial hypercholesterolaemia interpreted the results as variously disruptive or reinforcing in the context of an overall familial disease biography. Where test results unexpectedly did not show that the person's high cholesterol was conclusively familial in origin, this could disrupt previous assumptions and leave the person feeling dissociated from the rest of the family network.

On a different level of application is Gay Becker's (1998) wide-ranging review of how Americans respond to many different forms of unexpected life events, including not only illness but migration, bereavement, divorce, transition to residential care for older people and other personal crises. She argues that in developed societies such as the United States, our expectation of social order and predictability mean such sudden moments of crisis or chaos are experienced as especially disruptive.

Concluding remarks

When we talked with Bury, he said he could not possibly have predicted, in the early 1980s, that his paper on biographical disruption in chronic illness would be such a highly cited contribution to medical sociology, but that he was of course very pleased if the idea had been of some use to fellow researchers. We hope this chapter reflects our conviction that there are ample grounds to suggest that Bury has contributed an enduringly core concept to sociology. The literature includes a few criticisms and many welcome expansions, modifications and adaptations in a procession of illuminating articles that bear ample witness to the usefulness of the concept. We agree with Lawton that this early work of Bury's has enhanced our understandings of 'the overlapping and interdependent nature of body, self and society' (Lawton 2003:27). And while we can see no immediate sign that the flow of references is likely to cease, we are aware that biographical disruption has almost reached such an accepted, even taken for granted, status that its origins might have started to be overlooked and under cited. We suspect Bury would be more amused than offended if so.

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Chapter 38

Bryan S. Turner: Bringing Bodies and Citizenship into the Discussion of Disability

Gary L. Albrecht

Disability is increasingly being recognised as a universal human condition with enormous social and economic consequences. The World Health Organization and The World Bank (2011) estimate that 15 per cent of the global population, or over one billion people, live with some form of disability. Nations have responded to this problem with disability legislation, providing health and welfare services to people with disabilities and ensuring their rights. Emblematic of these efforts on an international level are the United Nation's Convention on the Rights of Persons with Disabilities declared in 2007, with 155 nations as signatories as of 2013, and the European Union's Disability Rights Convention of 2008. Taken together, these treaties pledge to reduce discrimination and provide people with disabilities with protections and services designed to facilitate their full participation in society.

In this chapter, I enlist the theoretical work of Bryan Turner on the body and citizenship to inform our understanding of the disability experience, how individuals make sense of and respond to disability, and the place people with disabilities have in society. I show how Turner built on the work of previous theorists to address our evolving appreciation of the body in society and the shifting notion of citizenship in a multicultural, global world. I then apply these insights to the study of disability considered from the perspectives of the sociology of disability, disability studies and rehabilitation sciences. In terms of the sociology of the body, Turner builds on the work of Descartes, Foucault and others in considering the body as a method of classification, the body as metaphor, parts of the body as symbols, the body as power, sex and difference, the technological reshaping of the body, the body experience and the self, control and government of the body and the body and vulnerability. I demonstrate how these ideas pertain to the study of disability by examining how people with disabilities are categorised, labelled, experience disability and are treated as real and symbolic objects by communities and the State in considerations of social welfare and determinations of human worth. Then, based on Turner's analysis of citizenship, human rights and vulnerability, I explore what citizenship means for people with disabilities in terms of legal status, human rights, participation in society and having a sense of belonging.

Biography

Bryan Stanley Turner is a contemporary social theorist with a global perspective, having held university positions in England, Scotland, Germany, Finland, Holland, Australia, Singapore and the United States. He received his D.Phil. from the University of Leeds and honorary Doctor of Letters degrees from Flinders University in 1987 and the University of Cambridge in 2009. He was a Professor of Sociology and Head of Department at the University of Cambridge (1998–2005), and Research Team Leader of the Religion Cluster at the Asian Research Institute at the National University of Singapore (2005–2008). He is currently Presidential Professor of Sociology at the City University of New York and Professor of Social and Political Thought and Director of the Religion and Society Research Centre at the University of Western Sydney. He is a founding editor of the journals *Body and Society*, *Citizenship Studies* and *Journal of Classical Sociology*. Born in 1945 in Birmingham, England, Turner was a member of the post-war generation, who keenly observed the reconstitution of world wealth and power, the rise of Islam, the emergence of developing countries and shifting of power to Asia from different vantage points in Europe, Australia, Asia and the United States. Geography, religion and culture influenced his view of the world and theoretical interests. In each location, he was exposed to theorists who wrote from their own cultural and historical perspectives. Grounded in classic sociological theory, Turner engaged with the work of Derrida, Foucault, Bourdieu, Husserl, Heideigger, Habermas, Beck, Bauman, Goffman, Geertz, Robertson, Nussbaum, Taylor and Woodiwiss. Turner's work has evolved over the years, taking into account fundamental changes in social institutions and globalisation. His work has a currency which is particularly applicable to vulnerable people in multicultural societies. Hence, his relevance to people with disabilities across the world.

The body and society

Turner invigorated medical sociology by refocusing attention on the body interpreted in the tradition of European social theorists such as Descartes, Heidegger, Foucault and Bourdieu. At the same time, he acknowledges that these earlier theoretical contributions need to be recast in terms of advances in the new genetics, bio-technology and neuro-biology. Through his book, *Body and Society:*

Explorations in Social Theory, first published by Blackwell in 1984, and leadership in founding the journal *Body and Society*, in 1995, Turner contended that the abstract concepts of structure, class and function miss something of the human experience that can best be captured by placing the body at the centre of sociological analysis.

The body typically refers to the entire structure of the human organism. When an individual is alive, the body is seen as the integrated, tangible, material locus of the self. Hence, the feminist saying and title of an influential book, *Our Bodies, Ourselves*. In this sense, the body is conceived as the focal point of corporeal, mental and spiritual experiences. By extension, the body is a symbol, a metaphor, a lived, organised experience. Thus we speak of embodied experiences, feelings, memories, fantasies and dreams. Recent work, such as the *Histoire du Corps (History of the Body)* (Corbin et al. 2005), traces our understanding of the body from being grounded in religious symbols and meanings, suffering and redemption, to contemporary notions of the body as an object of study, site of disease, sexual locus and source of mystical transformation. Likewise, *The Oxford Companion to the Body* (Blackemore and Jennett 2001) expands these notions of what the body is and represents in an interdisciplinary review of what it means to be human, ranging from the genetic and neurophysiological, sexual, physically active, thinking, sentient being to the creative, social animal and member of society. To many philosophers, the body is the centre of discussions about what it means to be human and social. For example, Descartes raised questions about the split and conjunction of body and mind. Serres (1985) is concerned with how perceptions and common sense are employed to integrate and give meaning to being embodied. Bourdieu (1977), a sociologist deeply influenced by French philosophers, offers his theory of practice as an attempt to transcend conventional forms of dualism between the body and mind. Within this context and tradition surrounding the study of the body in society, disability has a singular importance.

Disability is composed of the interplay of physical and mental conditions, perceptions, environments and social experiences. According to the World Health Organization's International Classification of Function (ICF) model (WHO and World Bank 2011), impairment is the loss or abnormality in body structure or physiological function, where abnormality means significant variation from established statistical norms. Thus, impairment is directly rooted in bodily structure and function. Disability, on the other hand, occurs at the intersection of the body and society. Disability refers to activity limitations and restrictions on participation in society that occur when impaired individuals interact with their personal, physical, political, economic and social environments. For example, impairments such as the loss of a lower extremity by British soldiers serving in Afghanistan due to explosions of improvised explosive devices (IEDs) is a structural abnormality but may not result in a permanent disability if they receive comprehensive medical rehabilitation, are fitted with a prosthetic, have accommodated living and working space, a suitably fitted van and a supportive social network. On the other hand, degenerative neurological conditions like advanced multiple sclerosis or mental conditions such as serious depression, even given full and competent care, often imply activity limitations and physical or emotional restrictions that degrade a person's ability to attend school, hold a job or live an active social life. These conditions would constitute a disability which may or may not be acknowledged by the individuals themselves or by others in society. In such situations, the goal of rehabilitation is to help individuals enhance their body functions and encourage the larger society to break down or modify environmental barriers so that disabled individuals can act independently and participate as fully in society as they are able (Faircloth 2012). Turner's ideas on disability developed over the years. In *Regulating Bodies* (1992), he recognises the socially constructed nature of disability but equally emphasises the corporeal, experienced aspects of disability that lead to later appreciation of impairment and disability and their experience (Turner 2008).

Turner and the body

Turner was deeply influenced by classic and contemporary European theorists (1992, 1993, 2008, 2012). He is less interested in the current empiricism of analysing large, nationally representative data sets, studying the epidemiology of a condition, evaluating the effect of a medical or social intervention or examining the effect of disparities in society than he is in understanding, from the actor's point of view, what it means to live the human experience in local or global communities. In terms of the sociology of the body, he believes that social scientists had abstracted themselves from what it means to be embodied (Turner 1992, 2008, 2012). Over time, influenced by theorists such as Durkheim, Weber and Parsons, sociologists cast their attention on structure, function, institutions and social networks, surveys, intervention studies and disparity research, while under-emphasising what this meant from the embodied viewpoint of the actor-subject.

Turner (2012) appreciated these advancements in theory, concepts and analysis but began rethinking the body in terms of the work of Descartes, Heidegger, Bourdieu and Foucault. During the Enlightenment, Descartes represented the idea that the definition of a human is based on the quality of consciousness. His analysis of the relation of body and mind concluded that persons exist because they think: 'I think, therefore I am'. He judged that the senses were often unreliable, so indubitable knowledge comes from the thinking person, the mind. He argued that the mind interacts with the body at the pineal gland and that the body can influence the rational mind – such as when individuals act out of passion – but that ultimately the mind is what makes people human and helps shape their behaviour. According to this argument, bodies are of secondary importance to the intellectual life of the mind. Turner found this dualistic argument wanting and was impressed with theorists who reintroduced the materiality of lived experiences as a significant focus of analysis. Turner (2012:62) reflects:

> In place of such dualisms, sociological interest in the body, especially in medical sociology, has promoted the holistic idea of the embodied person as a unity of organism, consciousness, emotions and actions. The unity of body and practice is referred to simply as 'embodiment'.

Heidegger's *Being and Time* (1962) influenced Turner's reflections on the body by rejecting Cartesian dualism and positing that *Dasein* (being there; existence) is the fundamental entity in each of us. His philosophical analyses centred on what it meant to be bodily in the world and in time. From a sociological perspective, this meant studying the practical activities of individuals in their everyday lives as embodied beings. Olafson (1995:198) had a significant impact on Turner's (2012) interpretation of embodiment when he commented:

> To say that something acts is to say that it makes a change in the world, and that it is possible only for an entity that is itself in that world and is in it in a way that permits acting on it. We know of no way in which that can be done in a world of material things like ours unless the entity in question is or, as we also say, has a body.

The work of Bourdieu further expanded Turner's thinking on the sociological concept of embodiment. Bourdieu took exception to the rational actor school of sociology and economics, where the mind, economic calculations, reasoning and market forces shape individual behaviour. Bourdieu emphasises the importance of the body and practices where social actors do not behave on each occasion according to some rational calculus but typically according to their 'feel for the game', their 'habitus' or usual way of doing things. Bourdieu passed on two important concepts employed by Turner: 'hexis' and 'habitus'. 'Hexis' refers to an individual's comportment, encompassing gait, gesture, posture or countenance by which they carry and present themselves. 'Habitus' refers to the dispositions through which taste is expressed (Bourdieu 1977). Turner (2012:69) concludes about Bourdieu:

> His emphasis on practice and habitus lends itself conveniently to an appreciation of culture as an ensemble of social practices. We can define habitus as an assembly of attitudes, dispositions, and expectations that individuals

> share as members of a particular environment for which he employs the terms ‘field’.

These concepts are important to Turner for they are useful in distinguishing and portraying social class and the corporeal expression of the hierarchies of social power. In England and the United States, for example, slim, flexible and pliant bodies used in tennis, golf, yoga and mountain climbing are preferred to the thicker working class bodies of football players, weight lifters and bowlers. As we will see, these concepts also carry over to analyses of disabled bodies.

Foucault also had a major influence on Turner and the entire field of the sociology of the body through his myriad efforts to demonstrate how various institutions like hospitals, prisons and even sexuality exercise power over the body. In his works, *Discipline and Punish* (1995) and *Abnormal* (2003), Foucault contended that public executions, judicial proceedings and punishment for aberrant behaviour demonstrated that the State sought to exercise compliance from its citizens. He argued that the power of the State and larger society was organised to regulate the body and subjugate individuals by expanding the number of human characteristics regarded as abnormal. This was especially evident in the diagnosis and classification and treatment of people with disabilities, particularly the mentally ill. Turner (2008) thought that this analysis was important for it portrayed the body as a material entity and an object of power which can be identified, controlled and reproduced. While deeply appreciative of Foucault’s insights, however, Turner was concerned that Foucault envisioned the body in passive terms. The body was seen as an object subjected to institutional practices and discourses. Turner prefers Frank’s (1991) interpretation of Foucault, whereby there is an attempt to ‘bring the body back in’ by directing attention away from the body as a problem for society and instead forcing a consideration of the body in itself. For instance, Frank focuses on the notion of illness as suffering and being vulnerable. Being sick for Frank entailed pain, weakness, the body being out of control and feelings of vulnerability. Turner thought that suffering and vulnerability were key to understanding the human experience of the body. This work builds on Foucault’s (1988) concept of care of the self in focusing on the active experiences of embodied people with disabilities.

Based on assimilation of the work of previous theorists and influenced by in-depth interviews about the body experienced by dancers, athletes and the sick and disabled, Turner laid out a framework for developing a sociology of the body. He writes (2008:39–40):

> To write a sociology of the body is thus not to write a treatise on society and physiology. It involves the historical analysis of the spatial organisation of bodies and desire in relation to society and reason.

Turner enunciates four principles that should shape studies of the body. First, the body is at once a material, organic part of nature, existing in a specific environment and at the same time a medium of the self, expressing culture through language, writing, religion, feelings and social relationships. Second, the body expresses the tension between being an individual and yet a member of society subject to struggles over wants and desires. While individuals are singular microcosms, society acts through social networks, institutions, laws and customs to regulate the individual's desires and behaviour. Third, the body is the centre of political struggles. The body is the vehicle where struggles over identity, sex, reproduction, legal age to drink and vote, serve in the military and age (youth, retirement and senior citizen, for example) are concentrated. The body is also used as a metaphor amidst political and legal battles over inheritance, paternity, right to life, mental competence, legal power of attorney, membership in the 'body politic', gender, race and immigration. Fourth, the self is represented through the performances of the socially interpreted body. In this sense, the body is a vehicle of the self. In sum, Turner sees the body at the centre of the struggle of oppositional forces: those of civilisation and desire. The study of the body, then, examines the struggles of necessarily subordinating passion to reason in order to have social stability and social order.

In thinking about the body, Turner has recently reconsidered the social constructionist arguments that have driven much sociological research during the last 40 years (2008:11–13; 2012:9–11). In part, he argues that while social construction perspectives dominated sociological thinking, 'research on the phenomenology of the body, embodiment and bodily practices languished' (Turner 2012:9). Explanations of socially constructed categories and social movements drew attention away from the material body with its attendant illnesses, suffering, pain and vulnerability. This position 'presupposes a distinction between the socially constructed body and the lived practical reality of embodiment' (Turner 2012:10). He then reaches even further in observing that the body is in a sense disappearing in contemporary society: 'it is being converted into an information system whose genetic code can be manipulated and sold as a commercial product in the new bio-technological economy' (Turner 2012:14). From this perspective, the body is being deconstructed into an information system, bio-organism and genetic set of codes that have been commodified. This thrust of theory and research points to the growing work on the merger of information technology, social network theory and biological sciences in understanding humans and people with disabilities at once as social and biological animals (Kurzweil 2005; Christakis and Fowler 2009).

Turner's key contributions have been to build upon the work of earlier Western philosophers and social theorists. He helped create a field of the sociology of the body that returns to what it means to be individually embodied; not abstracted into some social movement or socially constructed reality. In other work, he explores what being materially grounded in a body means in terms of religion, values and globalisation (Turner and Khondker 2010). For disability studies, Turner's contributions turn our attention to the body as a unit of analysis, to issues of illness, suffering and vulnerability.

Turner and citizenship

Turner makes a second major contribution to the sociology of disability and disability studies in his work on citizenship and human rights. Given his academic positions in multiple countries and cultures, he naturally began to ask what it meant to be a citizen in a global, multicultural world. He traces the historical roots of citizenship from membership in a city state rising in early European civilisation through the Greek polis, the Church and Middle Ages, diffusion of the concept to China, Japan and other Asian societies to the present (Turner and Khondker 2010). He points out how the English Civil War, the American War of Independence, the French Revolution and Russian Revolution nurtured modern nationalism. In this context citizenship came to encompass the corresponding rights and duties of a person who is a member of a national community. In this historical development, two aspects of citizenship emerge: juridical status, which confers civil rights and political liberties on members of a nation state, and social membership in the nation-state, which allows citizens to enjoy the social and economic benefits of being a constituent through residence or birth.

During these times, being a citizen of a nation-state conveys a legal status and entitles one to personal security, freedom of expression, the vote, the opportunity to acquire an education, to work and have access to social welfare benefits. Reciprocally, being a citizen of a nation-state implies that an individual would try to become educated, to be knowledgeable in the cultural affairs and language of the country, try to work, pay taxes and in some cases serve in the military or civil service. Citizenship was signified through birth certificates, immigration papers, passports, national identity cards, records of military service, tax statements paid and cards to access social welfare benefits. Yet, the concept of citizenship was not static. Turner recognised that the classic considerations of citizenship evolved after the Second World War, placing increasing attention on the concepts of 'multicultural citizens', 'global citizens' and 'human rights'.

In studying the classic, post-war notions of citizenship, Turner (1990) noted that citizenship can be passive or active depending on whether it was developed from above by the State or from below in terms of belonging to a colony, being an immigrant or children of legally recognised immigrants, resident of merged territories or even of trade unions. He also observed that citizenship can be forcefully expressed in both the public and private arenas within civil society. ‘A conservative view of citizenship (as passive and private) contrasts with a more revolutionary idea of active citizenship (active and public)’ (Turner 1990:189).

Over time, Turner realised that the traditional notions of citizenship were eroding, given the rapid development of capitalism, mobility, globalisation and the loosening of tight familial, social and community ties. He remarked:

> With the erosion of national citizenship, Marshall’s three forms of rights (legal, political and social) have been augmented by rights that are global, namely environmental, aboriginal and cultural rights. These are driven by global concerns about the relationship between environment, community and body such that the quest for social security has been replaced by concerns for ontological security (Turner 2001:189).

While deeply interested in the fundamental duties and obligations of citizenship, Turner found increasing promise in adding ‘human rights’ to bolster the concept of citizenship to protect individuals and ensure their place in the world, where the idea of citizenship based on membership in a nation state was altered and weakened (Turner 1993, 2006; Turner and Khondker 2010). The argument for human rights is grounded in the concept of human frailty, particularly the vulnerability of the body, the precariousness of social institutions, moral sympathy and the capabilities view of development as freedom. These arguments are based on the theoretical work of Turner (2006a, 2008) on the body, Beck (1992) on the dynamics of the risk society, Scheler (2008) on the phenomenology of sympathy and Nussbaum (2006, 2011) on the capabilities approach to justice. From this perspective, human rights recognise human vulnerability, inherent uncertainty and risk in a global society, the moral foundation of sympathy and basic principles of social justice.

For Turner (2010:166):

> Human rights may be defined as the entitlements of individuals qua human beings to life, security and well-being. They are said to be universal, incontrovertible and subjective, that is, individuals possess them because of their capacity for rationality, agency and autonomy.

His thinking about citizenship and human rights developed over time as he was immersed in different cultures and national settings and continued to think more deeply about the body and medical sociology. Not only was the traditional notion of citizenship being attenuated because of the diminishment of enforced duties and obligations in nation states as the world globalised, but he realised that often ill or impaired people cannot be expected to serve in the military or civil service, engage in mainstream education, hold a permanent job or even realistically be able to pay taxes (Turner 2001, 2006a). He saw that the seriously sick and impaired were not able to engage in the reciprocal exchange of rights and duties demanded of citizenship. Turner (2006) therefore began to think of protecting and supporting the most vulnerable members of society from a human rights perspective because, in the case of human rights, there are no explicit obligations. This exposes the inherent tension between arguments of citizenship and human rights. The major question raised is who is to support, fund and enforce human rights (Beckett 2006). Nation states do not want to give up part of their sovereignty to international organisations like the United Nations, a World Court or non-government organisations (NGOs). Citizens are reluctant to be taxed to support human rights activities in their own and, even more so, in other countries or failed states. The effective enforcement of human rights requires state stability and the institutionalisation of national citizenship. Most human rights abuses seem to occur in weak or failed states or to the poor and most vulnerable in stable states. To expand these ideas to support human rights in a global civil society is a hard sell. While acknowledging these difficulties, Turner persistently argues for a worldwide acceptance of fundamental human rights based on the universally shared vulnerability of being an embodied person.

In his book *Vulnerability: Human Rights* (2006), Turner applies a human rights argument to impaired and people with disabilities. He concludes:

> Hence human rights discourse has an obvious appeal to the disability movement: human rights do not require a close or necessary connection between entitlements and contributions and are not inevitably connected with the narrow contributory model of national citizenship (Turner 2006b:97).

(Also see Bickenbach (2012) for an extensive discussion and evaluation of the different arguments for disability rights.) What is evident from the analyses of Turner and Bickenbach is that disability can be considered in the context of citizenship but is more fruitfully addressed from a human rights perspective. In the arena of disability rights, much of the early activity took place on a national level, but beginning in the twenty-first century, the disability movement has taken off with the encouragement and support of powerful international actors like the World Health Organization, World Bank, Rehabilitation International, Special Olympics and Disabled People International. The future of the disability movement and people with disabilities seems to be more promising based on theories of human rights and economic development than centred on citizenship arguments.

Disability, the body, citizenship and human rights

Disability is at once an intimate part of the human experience and a major demographic and political force in the world. Given the global rise in obesity, chronic diseases and increasing life span, most people will experience disability at some point in their lives (WHO and World Bank 2011). From the *World Report on Disability* (2011), based on an analysis of representative data sets from over 100 countries representing every level of economic development, we know that the global prevalence of disability is higher than previously estimated, the numbers of people with disabilities are growing, every nation has people with disabilities, the 'disability experience' is diverse and varies according to the interaction between type of health condition, personal factors and the environment, and that disability disproportionately affects vulnerable populations. Individuals who are poor, female, older, live in risky environments and have limited access to health and social welfare systems are more likely to be disabled. On a personal level, people with disabilities often feel vulnerable, experience pain, are subject to stigma and discrimination, are isolated due to physical and social barriers to mobility and have difficulty accessing proper healthcare and social support programmes (Albrecht and Devlieger 1999).

In applying Turner's contributions to the study and understanding of disability, it is important to distinguish between the sociology of disability, disability studies and rehabilitation sciences (Albrecht 2010). The sociology of disability focuses on the social causes, experiences and consequences of physical and mental disability. This field was invigorated by the efforts of social scientists who were often themselves disabled and who began to advocate for participative action research where people with disabilities would be included in the design, execution and reporting of disability research. The general approach was research-driven, using epidemiological, quantitative, qualitative, case study and narrative methods. Disability studies is an interdisciplinary field that arose from the efforts of social scientists, scholars in the arts and humanities, disability activists and social movement experts to create a discipline that centred on understanding disability in an historical and cultural context, and emphasised the personal viewpoint of people with disabilities, activism and political advocacy. Rehabilitation sciences is an agglomeration of health-related disciplines that uses different but inter-related measures of physical and social function, medical condition, social, psychological and vocational status to design interventions to help people with disabilities regain their highest possible level of independence and participation in society (Seymour 1998). The interventions used are typically based on medical, biological, genetic and bio-technical understandings of disease, impairment and disability. Turner's work makes contributions to each of these different approaches to understanding disability.

Strengths and limitations of Turner's contributions to understanding disability

Turner's analysis of the body, citizenship and human rights applies to each of these disciplines but in different ways. His work raises important questions to be addressed by each of these perspectives, provides a theoretical base for research and discussions, generates a reorientation of perspectives of those working in more traditional disciplines and suggests how science, cultural traditions, philosophy, human experience and morality can be combined to inform our knowledge and experience of disability. His work also represents the multicultural, multidisciplinary, global viewpoint of a widely experienced international scholar who is grounded in European history and intellectual traditions. This approach is in contrast to the research method, mathematical model, evidence-based and outcomes-oriented research that represent much of Anglo-Saxon empiricism. His work also gives reason for impassioned activists to pause and rethink the theoretical, moral and political bases of their arguments and interventions.

The strengths of his work include a re-conceptualisation of what it means to be embodied and his presence as a founding member of the field, the body and society. His attention to personal experience undergirds studies of classifying, experiencing and making meaning of the body. Today's lively discussions of the importance or inadequacies of the *American Psychiatric Association's Diagnostic Manual of Mental Disorders* (DSM V 2013) are a case in point. As the understanding of illness and disability becomes more informed by bio-genetics and psychopharmacology, some argue that the DSM V should not have been published until a stronger and more informed research base could be established for the biomedical causes of diseases and behaviour. Others point out that illness will never be fully explained by understanding the biology and neurology of disease. They point out that we need classifications like the DSM V to grasp the varieties of human behaviour and the complexity of being embodied. They argue that a strictly biological approach to illness leaves out the patient, the person and the essence of what it means to be human – that this knowledge only comes from talking to people about their lives and observing their behaviour. Turner's contribution to this debate is to acknowledge both the biological nature of human beings and the experience of being embodied. This contribution prompted research into understanding what constituted high quality of life for people with and without disabilities alike (Albrecht and Devlieger 1999).

Turner also expands our appreciation of the body by focusing on parts of the body as metaphors (2008, 2012). Employing this insight provides new awareness of what the breast means in history, culture and society, for example. The breast is a symbol of passion, motherhood, nurturance, cancer and dying

(Yalom 2010). In the disability arena, the symbol of the wheelchair represents people with disabilities who need prostheses to move and take their place in society (Stiker 1982; Zola 1991). Images of tortured civilians or sexually abused women evoke the power of individuals to violate the body in disturbing and amoral ways and the manner in which society uses institutions to control people's bodies. These viewpoints can be extended into discussions of sexuality and reproduction.

Turner also reminds us that there are bodily conditions, quality of life, avoidance of suffering and pain and isolation that money cannot buy nor alleviate (Sandel 2012; Goosby 2013). He underlines that it is the nature of the human condition to be inter-dependent and vulnerable.

In terms of citizenship and human rights, Turner promotes a more refined and theoretical understanding of the mutual obligations and benefits of being a member of a local community or nation. His emphasis on vulnerability as being a key to appreciating the importance of human rights encourages more analysis of what it means to be human and to stimulate the debate over whether or not all human beings are to be respected and in what ways with what rights. This discussion also brings new understandings to what it means to be a member of a society, to be civil and civilised.

Turner's theories and research are a rich work in progress but have shortcomings and lacunae. The theoretical foundation of his contributions is solidly European but does not directly address the intellectual contributions of North American pragmatism (Albrecht 2002), nor obviously deal with the enormous body of empirical research on the body, social behaviour, shared opinions and values, immigration and citizenship. An example would be focusing on the nature of stigma, cross-national research in this area and how it relates to disability and vulnerability in general (Pescosolido 2013). He suggests that genetics and bio-computer research will alter our understanding of the body and human behaviour, but he does not indicate how this knowledge may be integrated with insights from the social sciences and humanities to form a full picture of the human. He also is appreciative of the fragmentation of society (Rodgers 2011) in the last 40 years but does not point to the social glue that might bind individuals together in communities and global society supported by shared human rights. On an individual level, this would explore how individuals' sense of belonging could be enhanced. In this context, it is difficult to see where people with disabilities stand and how they will be integrated fully into society. His work would also be strengthened by a fuller consideration of stability and change across the life span in terms of the body and citizenship and human rights.

His work is grounded in a Western context where emphasis is on individuals in developed countries with full-blown state institutions and health and welfare systems. It would be interesting to apply his concepts and thinking to African, Asian, Middle Eastern and some Latin American societies where emphasis is more on the group, local communities, tribes and kinship groups – where health and welfare systems are less developed or for the wealthier and more privileged. Turner is also working in a time frame in which concepts of disability, the body and citizenship have changed considerably. Notions of disability have adapted to changing views of stigma and normality and the more visible participation of people with disabilities in public life. Citizenship has taken on different meanings as membership in a global society has become an everyday experience. Therefore, the concepts of disability and citizenship require adjustment to these changing environments.

Social theorists and scholars cannot be expected to address every issue and solve every profound problem. The next step in applying his work to disability is to attempt to expand and test his ideas with empirical studies, seek an integrative framework that includes his insights with those emerging from medicine, genetics and psycho-neurology, combine moral and philosophical arguments with the work in political science on citizenship and human rights and to reach to the future in anticipating what will happen as power shifts from the West to the East in the world. Winter's (2011) studies on global, interlocked oligarchies that operate within and across national boundaries, Touraine's (2010) concern with what happens to people after the latest financial crises, Bloemraad's research on citizenship and immigration (Bloemraad et al. 2008), Klandermans, van der Toorn and Stekelenburg's (2008) research on the mobilisation of vulnerable people, Hochschild's (2011) thinking on the interface of emotional life and capitalist markets and Solomon's (2012) and Heller and Harris's (2012) analyses of how diverse identities and life courses can be formed by children from the same families are promising steps in these directions. In sum, Turner's work suggests that disability scholars be more theoretical in the European tradition in asking their questions and approaching their work. An infusion of more theoretical thinking and the development of an integrative, multidisciplinary framework in the study of disability would advance the field.

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Chapter 39

Peter Conrad: The Medicalisation of Society

Simon Williams and Jonathan Gabe

Medicalisation has been a much-debated issue since the 1970s, not simply within medical sociology, but within medicine, popular culture and society at large. Peter Conrad has been and remains a key sociological figure in these developments and debates regarding the 'medicalisation of society'. This chapter therefore pays fitting tribute to Conrad's valuable sociological contributions to these developments and debates since the mid-1970s. It includes both a necessarily selective sketch of his many writings on these matters, and a critical appraisal of other recent contributions which seek to question, if not go 'beyond', medicalisation in order to capture the changing dimensions and dynamics of health and biomedicine in these increasingly technoscientific and biopolitical times.

Biographical and intellectual context

Peter Conrad was born in 1945 and completed his doctorate at Boston University in 1976 on the identification of hyperactive children. The study was originally conceptualised as one about labelling hyperactive children, but as it progressed, turned into a project about the medicalisation of deviance. As such, it represented Conrad's first attempt to develop his argument about medicalisation and was published in book form in the same year as he received his doctorate (and reprinted in an expanded form in 2006) (Conrad 1976, 2006). Conrad had already taken up a teaching position at Drake University at this point and went on to join the staff of Brandeis University as an assistant professor in 1981. He became the Harry Coplan Professor of Social Science in 1993, a position he still holds.

In 1980, Conrad co-authored with Joseph Schneider *Deviance and Medicalisation: From Badness to Deviance*. This seminal text won the Charles Horton Cooley Award from the Society for the Study of Symbolic Interaction for 'its outstanding contribution to the study of symbolic interaction', and was subsequently republished in an expanded form in 1992. As the title confirms, the authors saw medicalisation as a form of deviance. They took an avowedly interactionist position, in contrast to the predominant positivist approach which still held sway at the time, and asked how the definition of medicalisation as deviance was constructed, how deviant labels were attached to certain people and what were the consequences for the labelled and labellers? Unusually for interactionists, they placed the medicalisation of deviance in an historical context and tried to understand how deviancy labels developed over time. Thus, for example, they described how opium addiction was conceptualised as a disease in the nineteenth century, criminalised in the early twentieth century and re-medicalised in the 1950s. Conrad and Schneider were thus interested in problematising how medical knowledge was applied to social problems like mental illness and alcoholism and did not question the basis of medical knowledge like social constructionists.

Paralleling other early proponents of medicalisation such as Zola (1972) and Illich (1975), Conrad and Schneider gave particular attention to the ways in which medicine operates as an institution of social control, redefining aspects of everyday life as a medical matter. Marxists and feminists have made a similar point, although, in contrast to Conrad and Schneider, have attributed the actions of the medical profession more broadly to satisfying the interests of capitalism (Waitzkin 1983) and patriarchy (Oakley 1984) respectively.

Since *Deviance and Medicalisation* was published in 1992, Conrad has gone on to make a series of important observations about medicalisation, which have resulted in his being awarded the Leo G. Reeder Award for a 'distinguished contribution to medical sociology' by the American Sociological Association Medical Sociology Section in 2004. His 2007 book, *The Medicalisation of Society*, was also shortlisted for the C. Wright Mills Award by the Society for the Study of Social Problems in 2008. Below we explore his contribution to the debate about medicalisation in more detail.

What is medicalisation?

Conrad's contributions on the medicalisation of society, as we have seen, are concerned with the creation, promotion and application of new medical categories, treatments and solutions to human conditions or problems and associated sociological questions of medical jurisdiction and social control. In order to develop our account of Conrad's work, we need to ask how he defines and delineates its characteristics and contours, drivers and dynamics, costs and consequences, and what cases he uses to illustrate these processes in practice. It is to these matters that we now turn.

Definition and dimensions

Medicalisation, Conrad states, 'describes a process by which non-medical problems become defined and treated as medical problems, usually in terms of illness and disorders' (2007:4). The key to medicalisation therefore, Conrad stresses, is 'definition': a problem, that is to say, which is 'defined in medical terms, described using a medical language, understood through the adoption of a medical framework, or "treated" with a medical intervention' (2007:5). To 'medicalise' something then, in short, is quite literally 'to make medical' (Conrad 2007:5).

Conrad makes a number of other equally important points in seeking to further define and delineate what exactly medicalisation is and is not. First, and perhaps most crucially of all given common misunderstandings, medicalisation simply 'describes a process' (Conrad 2007:5) and does not automatically assume or presume that any and all cases of medicalisation are cases of 'over-medicalisation'. Assumptions of 'over-medicalisation', in other words, are 'not a given in the perspective' (Conrad 2007:5). Medicalisation moreover is not necessarily a negative process. It may indeed bring benefits in terms of much-needed medical recognition and validation of suffering and vital help in alleviating it: a case of the 'brighter' as well as the 'darker' sides of medicalisation, as Conrad (1975) noted long ago.

Second, medicalisation is not an all or nothing process or state of affairs. Rather it is matter of *degree*, whereby some conditions such as childbirth are more medicalised than others such as menopause, or contested conditions like chronic fatigue syndrome (CFS), Gulf War syndrome or multiple chemical sensitivity. Medical categories moreover may expand or contract over time.

A third closely related point concerns the fact that medicalisation, despite the general trend towards expansion during the past century, is a *bidirectional* process, in the sense that there can be 'both medicalisation and de-medicalisation' over time (Conrad 2007:7). Masturbation and homosexuality perhaps are the most obvious cases of de-medicalisation over time, although re-medicalisation remains possible, as Conrad notes, following any such process of de-medicalisation. Indeed, Halfmann (2011) argues that medicalisation and de-medicalisation can occur simultaneously and that even when one of these processes seems to be dominant it is often incomplete.

This in turn alerts us to the fact that to medicalise something involves a number of steps or stages. The first stage, according to Conrad and Schneider, involves behaviour such as chronic drunkenness being defined as deviant, often before the emergence of a modern definition like alcoholism. At the second stage, the medical conception of deviant behaviour is proclaimed in medical journals. The next stage is crucial and requires claims-making about a new medical deviance category by medical and non-medical interest groups like self-help groups. The fourth stage involves the legitimation of the claim, with medicalisation occurring at stage five, when the medical deviance label is institutionalised. The latter is illustrated when a deviance designation is codified within a medical classification system. The value of this sequential model is that it highlights how attempts to define deviance as a medical problem are hotly disputed and the outcomes uncertain.

Fourth, medicalisation may occur simultaneously or separately at three distinct levels, namely, the conceptual, institutional and the interactional. Conceptually, a medical vocabulary may be used to define a problem; institutionally, organisations may adopt a medical approach to treat a problem in which they specialise; and interactionally a doctor and patient might interact to define a problem as medical and agree on a form of medical treatment. The process thus often involves a physician directly, but this is not always the case. For example, in the case of alcoholism, the medical profession may be only marginally involved or not involved at all. Conrad and Schneider's typology can be mapped onto the distinction between macro-, meso- and micro-level actors, with macro-level actors involving researchers and governments, meso-level actors referring to local organisations and micro-level actors focusing on doctors and patients. Halfmann (2011) suggests that a medical vocabulary, for example, may be employed by actors at all three of these levels (for example, researchers, hospital managers and patients). He also notes that medicalisation at the micro level may include clinical workers other than doctors and non-medical actors like teachers and counsellors. And he argues that micro-level medicalisation may occur through the identity construction of various actors, with doctors, for example, meeting cultural expectations to varying degrees about what 'being a doctor' involves.

A fifth equally important point, as Conrad emphasised early on in these debates, is that medicalisation cannot and should not be equated or conflated with charges of medical imperialism. To do so is to mistakenly bring questions of medical intent into debates about medicalisation. Medicalisation, in other words, may occur regardless of the intentions of doctors or the medical profession and should therefore be evaluated as such. Doctors, for example, in some cases, may be reluctant or resistant to medicalise a particular problem, even if it does eventually become defined and treated in these terms. The same goes for misplaced charges regarding sociology's own intentions, 'imperialist' or otherwise, in advancing arguments regarding the medicalisation of society, as Conrad and Schneider's (1980) rejoinder to Strong's (1979) critique makes clear. Once again, any such claims of medicalisation need evaluating on a case-by-case basis, irrespective of the sociological intentions or imperialist ambitions of those who make them.

A final, closely related point, which is equally important to stress, is that de-medicalisation and deprofessionalisation are also far from synonymous processes. Something may be de-medicalised for instance, without any deprofessionalisation of medicine. Deprofessionalisation, in contrast, may occur without any de-medicalisation of existing or future medical problems.

Drivers and dynamics

If medicalisation simply describes a process, then this by definition means that medicalisation is not an explanation but itself needs explaining. What are the factors that account for or drive medicalisation and to what extent have they changed over time?

Conrad, once again, has been at the heart of these debates over decades, including what he terms the ‘shifting engines’ or ‘drivers’ of medicalisation over time.

‘When I first began studying medicalisation in the 1970s’, Conrad tells us, ‘the most important forces behind medicalisation were physicians, social movements and interest groups, and various organisational and interprofessional activities’ (2007:133). Significant changes in both medical knowledge and medical organisation nevertheless have taken place over the past three decades or so; changes which Conrad claims have ‘engendered a shift in the engines that drive medicalisation in Western societies’ (2007:133).

Three major changes in medical knowledge and organisation, in particular, are singled out by Conrad for further attention. First, the pharmaceutical and biotechnology industries, he claims, are now becoming ‘major players in medicalisation’. Pharmaceutical companies, for example, in the case of the United States and New Zealand, can now advertise directly to the public through direct-to-consumer advertising on television. Such advertising is designed to create a market for drug company products by encouraging consumers to ask their doctor to prescribe the company’s drug. Biotechnology companies are set to become more important with the prospect of genetic tests for particular diseases enabling patients to see themselves as ‘potentially ill’, and biomedical enhancements for bodily characteristics and mental and social abilities. Second, consumers have become major players in our changing medical and healthcare systems as health and healthcare have become commodified. The body has become a site for various degrees of ‘makeover’ with medicine as the vehicle, and patients have been turned into consumers who have allegedly become much more vocal about the kind of healthcare they want. A third and closely related factor, Conrad stresses, concerns the emergence of managed care organisations, or their successors, which have now come to dominate US healthcare delivery. Managed care requires that medical treatments are pre-approved and limits set on the type of care available. This has constrained the care offered by doctors and received by patients. In terms of medicalisation, it is both an incentive and a constraint. In the case of mental health, it has reduced insurance cover for psychotherapy while encouraging the use of psychotropic medications in its place.

Cases, counts and costs

Numerous cases of medicalisation have now been extensively documented and detailed – from childbirth to obesity, alcoholism to anorexia, baldness to erectile dysfunction, female sexual dysfunction to menopause, sleep problems to death and dying – many by Conrad himself, of course in collaboration with colleagues.

Three case studies nevertheless will suffice here for illustrative purposes. The first concerns the case of adult attention deficit/hyperactivity disorder (ADHD), which, as Conrad (2007) comments, may have been an 'oxymoron' 30 years ago but now provides a clear case of how medicalised categories can 'expand' over time to include a wider range of troubles within their remit. The medicalisation of ADHD was primarily accomplished, he argues, by 'refocusing the diagnosis on inattention rather than hyperactivity' and by 'stretching the age criteria', which therefore allowed for the 'inclusion of an entire population of people (and their problems) who were excluded by the original concept of hyperactive children' (Conrad 2007:66). Lay groups and lay-professional alliances, exemplified by children and adults with attention deficit/hyperactivity disorder (CHADD), as well as media presentations, were key here too, as Conrad shows; collaborations which contrast sharply with other more contested cases or conditions such as multiple chemical sensitivity and chronic fatigue syndrome, where medical backing and legitimacy have proved problematic. The case of adult ADHD therefore illustrates a process of expansion pertaining to what is now regarded as a 'discrete disorder that can be claimed and diagnosed' through a 'feedback loop among professionals, claims-makers, media and the public in terms of the creation, expansion and application of illness categories' (Conrad 2007:67).

The second case of human growth hormone (hGH), in contrast, takes us from medicalised matters of diagnostic expansion to the problems and prospects of biomedical enhancement. While humans in this regard, as Conrad rightly notes, have always tried to improve or enhance themselves in various ways, and while the treatment–enhancement distinction is itself of course a socially constructed, changing and contested matter, the promises and prospects of biomedical enhancement now extend far and wide, from cosmetic surgery to performance-enhancing drugs.

The development and myriad uses of synthetic hGH since 1985 are particularly good examples of different types of biomedical enhancement and the social dilemmas with which they are associated. Initially approved as a medical treatment for growth hormone deficiency, other possible off-label medical uses now include hGH as a treatment for children with 'idiopathic short stature' and as an 'anti-ageing' therapy. A third use, while not medically approved or sanctioned, is also supposedly common, namely to enhance athletic performance.

Here we glimpse, then, the way in which social problems, such as shortness, ageing and performance edge, become amenable to biomedical solutions. We also, of course, glimpse what Conrad terms the different 'faces of biomedical enhancement' (2007:86). Thus the treatment of idiopathic short stature perfectly illustrates the use of biomedical enhancements to 'bring the body into line' with what doctors or patients deem to be the 'normal' or 'socially expected standard' – what Conrad terms 'normalisation' or 'standardisation' (2007:87). Resort to hGH in order to relieve some of the effects of ageing, in contrast, is more a matter of repair than normalisation: an attempt, that is to say, to use biomedical interventions to 'rejuvenate the body or restore it to a previous condition' (Conrad 2007:87). Finally, resort to hGH as a biomedical enhancement in the sporting arena in order to improve athletic performance is neither a case of normalisation nor of repair or rejuvenation of the body but of what Conrad terms 'augmentation' or 'performance edge': the use of a prescription-only drug, beyond its licensed medical purposes, as a way to improve life performance (2007:88). This example in turn underlines another critically important sociological point, namely, that in many if not most such cases, context is crucial, given 'enhancement inheres not in the biomedical composition of the intervention but in when and how it is used' (Conrad 2007:89).

Moving on from cases of medicalisation, we turn next to consider how medicalisation is to be measured, including the degree or extent as well as the costs and consequences of medicalisation for society. If claims are to be made about the increasing medicalisation of society, then it is surely incumbent on those making them, as Conrad rightly remarks, to quantify them in some way in order to substantiate them.

Conrad, for example, examines hormone replacement therapy, breast implants, prescriptions of psychotropic medications for adolescents and the National Comorbidity Survey (a once-a-decade nationally representative survey of the state of American's mental health), concluding that 'Clearly, by all standards, categories, treatment rates and measures of pathology, medicalisation is continuing to increase' (2007:132). The *National Comorbidity Survey* for example, Conrad notes, suggests that nearly half of all Americans will become mentally ill with a diagnosable mental disorder at some point in the lives – thereby illustrating, he claims, 'how psychiatric research itself can potentially medicalise more of life's problems' (2007:132). Such findings indeed, Conrad continues, 'could spur an actual increase in medical treatments for minor life difficulties and serve as a rationale for extending psychotropic treatments to larger portions of the population', including new DTC advertisements to this effect, through a 'medicalisation-amplifying feedback loop' (2007:132).

As for the costs and consequences of medicalisation for society, another recent paper by Conrad and colleagues (2010) estimates the direct US medical spending on 12 medicalised conditions – anxiety and behavioural disorders, body image, erectile dysfunction, infertility, male pattern baldness, menopause, normal pregnancy and/or delivery, normal sadness, obesity, sleep disorders and substance-related disorders. Direct US medical costs for these 12 medicalised conditions, they report, amount to around USD77 billion in 2005 or 3.9 per cent of total domestic healthcare expenditures. While this of course, as Conrad et al. readily acknowledge, still leaves open the question as to whether this spending is 'appropriate' or not, it nevertheless sheds new light on the economic impact of medicalisation on healthcare, particularly when comparisons are struck with other dollar spends on conditions such as heart disease (USD56.7 billion) and cancer (USD39.9 billion) in the United States in 2000.

Beyond medicalisation?

For all the decades of developments and debates regarding the medicalisation of society, a critical question has increasingly been raised, namely, whether or not medicalisation has outlived its usefulness as a sociological concept, if not become a victim of its own success, within and beyond sociology (Clarke et al. 2003; Rose 2007a,b; Bell and Figert 2012; Williams et al. 2012).

In part this has taken the form of claims regarding other more appropriate or specific concepts that better capture these dynamics and developments today: positions which we might, for short-hand purposes, term the 'supplementary' agenda. We see this clearly, for example, in the case of writers such as Moynihan and colleagues (Moynihan 2002; Moynihan and Cassels 2005; Moynihan and Henry 2006), who claim that many instances of so-called medicalisation are better seen as cases of outright 'disease mongering', given the huge profits to be made from convincing 'healthy' people they are 'sick': a case of 'selling sickness', in the words of Moynihan et al. We also see this clearly in the development of other distinct yet related sociological concepts such as geneticisation (Martin and Dingwall 2009) and pharmaceuticalisation (Williams et al. 2011) over the past decade or so, each of which has a complex and contingent relationship to medicalisation. Geneticisation, for example, as Conrad and colleagues (Shostak et al. 2008) have themselves demonstrated, may or may not result in medicalisation, while medicalisation may or may not involve pharmaceuticalisation. Pharmaceuticalisation in turn, however, may arguably extend 'beyond' medicalisation, where drugs are used for non-medical 'enhancement' or 'lifestyle' purposes.

Consider sleep for example, which at most is a partially medicalised matter, depending on the problem or issue in question. Insomnia, for instance, is a prime case in point, particularly in the United Kingdom, where psychological interventions such as cognitive-behaviour therapy (CBT) are now increasingly recommended, resources permitting, as a first line, cost-effective treatment of choice. Here, moreover, we see the way in which other more specific sociological concepts like pharmaceuticalisation and de-pharmaceuticalisation may better capture some of these dimensions and dynamics, given the long-standing history of prescription hypnotics in the United Kingdom and elsewhere on the one hand, and recent attempts along the aforementioned lines to encourage other non-pharmacological forms of intervention on the other.

In part however, these developments have also taken the form of attempts not simply to supplement medicalisation through related concepts of this kind, but to go 'beyond' medicalisation in a more concerted or sustained fashion: positions which we might, for short-hand purposes, term the 'alternative' agenda.

Clarke and colleagues (2003, 2010), for example, from a more postmodern stance, argue that developments in technoscience have ushered in a new era of what they term 'biomedicalisation' – a multi-stranded, multi-sited technological and scientific process focused on health and the 'elaboration of risk and surveillance biomedicines', which is no longer simply about the 'control' but the 'transformation' of bodies through new 'individual and collective technoscientific identities' (2003:161). While processes of medicalisation continue therefore, they stress, they are now increasingly eclipsed, if not replaced, by this new more technoscientific phase of biomedicalisation.

Rose (2007a) too, in similar and different ways, makes a number of critical points in his call to go 'beyond' medicalisation. For Rose (2007a), it seems, medicalisation has become something of a 'cliché' which fails to adequately capture or convey the multiple ways in which medicine, both past and present, has made us who we are, or the kinds of persons we take ourselves or wish to be. Hence the need, in Rose's view, to go 'beyond' medicalisation and to think more broadly in terms of biomedicine's own morphing and mutating ('molecular') thought styles, and its multiple roles in the governance or biopolitics of life itself in the twenty-first century (2007b): a vital politics in short, including new more biosocial relations and forms of personhood and citizenship.

Conrad, in response, remains critical of biomedicalisation as being too broad a concept, and while he would also no doubt see many of Rose's wider biosocial and biopolitical points as indeed 'beyond' medicalisation, these recent debates do nevertheless represent a significant series of challenges to conventional or orthodox sociological stances on medicalisation. They are therefore best viewed perhaps as part and parcel of an evolving series of developments within and beyond sociology, regarding the changing dimensions and dynamics of biomedicine, health and society and the place of medicalisation within them.

At the very least we suggest medicalisation remains a useful sociological concept to think both 'with' and 'beyond' in the twenty-first century. Future sociological work in this regard, building on Conrad's own recent efforts along these sorts of lines, might further profitably develop a more fully fledged 'integrated' approach to the medicalisation of society. An approach, that is to say, which

(i) spans different micro, meso and macro levels of medicalisation, including implications for citizenship, governance, selfhood and social relations; (ii) is explanatory rather than descriptive; (iii) further explores relations between medicalisation, disease mongering, geneticisation and pharmaceuticalisation; (iv) traces and tracks forms of ambivalence or resistance to medicalisation and (simultaneous) processes of de-medicalisation or re-medicalisation over time; (v) estimates the costs and consequences of (de-)medicalisation through more quantitative as well as qualitative work; and (vi) relates all these foregoing issues to changes in medical knowledge, organisation, practice and trust relations in the twenty-first century.

Two further important dimensions and dynamics of medicalisation may also be mentioned in this regard as worthy of future sociological research in the coming decades.

First, while there has already of course been much sociological discussion and debate about the role of the media in processes of medicalisation, both old and new, greater sociological attention clearly needs to be paid in future to the role of *new information and communication technologies* as both *cause* and *consequence* of these processes. To what extent, for example, are we witnessing the dawn of a new phase of medicalisation in the digital information age? Consider for instance developments in the new so-called m-Health arena. The 'm' in question stands for 'mobile', as in new mobile digital apps for our smartphones, tablets and the like, to help monitor and manage our bodies and our health ourselves. Use of these apps provides opportunities to share this information with healthcare professionals as well as family, friends and others with similar health interests or concerns, through interactive Web 2.0 platforms and social media sites such as Facebook or Twitter. Already there is much discussion and debate if not 'hype', within medical and public health arenas, about the power and promise of these digital developments to 'transform' or 'revolutionise' medicine and healthcare in the twenty-first century, including the launch in the United Kingdom of a new National Health Service (NHS) 'health apps library' of officially approved and rated health apps. While these developments therefore raise a host of critical sociological issues 'beyond' medicalisation (see Lupton 2012, 2013, for example), they also raise an equally important series of sociological questions regarding their power or potential to reconfigure processes of medicalisation in more or less significant ways in the decades to come: the dawn of something akin to '*medicalisation 2.0*' and/or another significant manifestation of so-called '*e-scaped medicine*' (Nettleton 2004) in the information age perhaps.

Second, while a sizeable and significant corpus of sociological work now exists on the medicalisation of society, old and new, there is clearly a need to go beyond existing studies – many of which are North American in focus – in order to explore more fully the *global* dimensions and dynamics of these processes today in the global 'south' as well as the global 'north': part and parcel of what Turner (2004) terms a 'new' medical sociology for the twenty-first century perhaps, given the changing forms of biomedicine, health and illness today in the global era. A similar point has been made by Bell and Figert (2012), who suggest that while pharmaceuticalisation has been most useful in understanding developments in the West, it has as yet not been applied to resource-poor societies of the Global South. They suggest that anthropologists have provided a useful way forward by focusing on the 'pharmaceuticalisation of public health'. This approach has generated case studies of pharmaceuticals that connect global dynamics between states, non-governmental organisations and pharmaceutical companies with local communities.

Conclusions

Three main conclusions may be drawn here in this short chapter on a key concept and a central figure in medical sociology since the 1970s.

First and foremost, as we have seen, Conrad has been and remains a central sociological figure in medicalisation developments and debates over the past four decades. Since his early forays into the area in 1976, his contributions have been critical to these sociological discussions on the medicalisation of society. His seminal text with Joseph Schneider in 1980, linking medicalisation to deviance, through to his 2007 book which explores the new drivers of medicalisation, have made path-breaking contributions and along with his other writings have established him as a world leader in the field.

Second, while many criticisms of medicalisation are well made, others are partial or problematic, given the evolving complexities and sophistication of sociological approaches to medicalisation today. Medicalisation in this regard remains a delimited yet useful sociological concept to think both 'with' and 'beyond' in the twenty-first century. It is able to capture the changing nature of medical knowledge and power and to take account of the growing influence of pharmaceutical and biotechnology companies and consumers as drivers of medicalisation independent of the medical profession. At the same time we have seen that medicalisation's relationship with pharmaceuticalisation and geneticisation has become increasingly contingent, so that these processes may occur without medicalisation necessarily taking place. In this way it is possible to go 'beyond' medicalisation and fashion an 'alterative agenda' as we have noted.

Finally, as far as the future of sociological work on medicalisation is concerned, there is a need, building on Conrad, for the development of a more integrated approach in the decades to come, including both its *digital* and *global* dimensions and dynamics. In this way medicalisation will retain its value as a key sociological concept and vital human issue in the twenty-first century.

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Chapter 40

Eva Feder Kittay: Dependency Work and the Social Division of Care

Michael Fine

Having been long ignored, care has finally become a key critical concept in contemporary social theory. This chapter reviews the emergence of sociological theories of care and the disputes and controversies that have accompanied them. It is focused on an exploration of the approach to care as a relationship of power, introduced by the philosopher Eva Feder Kittay. Her contribution needs to be understood in the context of broader debates about care and the division of labour, both of which have their origins in the awaking of interest in care associated with feminism and the contested viewpoints of disability activists.

As health sociology developed over the twentieth century, its primary focus was on the medical care system, especially the systems of service delivery, the professions and the institutions of medicine. Despite the repeated use of terms such as 'healthcare' and 'nursing care', the pervasive and general phenomenon of the provision of care was taken for granted and effectively ignored, not just within the specialty sub-discipline of health sociology, but by those working in the wider discipline of sociology and across the social sciences, including the discipline of economics, until the final quarter of the twentieth century (Folbre 2001:1). The long-standing neglect of care, I argue, came about because it was regarded as a familial responsibility, a duty and role ascribed to women as a natural extension of maternal nurturing (Fine 2007). Responsibility for providing non-professional support on an unpaid basis was readily confined to the private sphere of the home and its importance ignored or glossed over (Graham 1983). But emergence as a field of research and as theory owes much to the rise of feminism, as feminist scholars from the mid-1970s onwards sought to politicise the private familial duties and responsibilities of women.

As access to formal healthcare services grew over the twentieth century, they provided increasing employment for women and men outside the home. In turn, the increase in formal care services, especially childcare, disability support and aged care, provided substitute care provisions that served to release women from the home (Fine 2007). In the process, care was transformed from what C. Wright Mills might have called a 'private worry' into a public issue (Mills 1959), eventually becoming a social problem requiring political solutions as well as academic research.

Biography

Eva Feder Kittay is Professor of Philosophy at the Stony Brook campus of the State University of New York, where she has taught since 1979 following the award of her PhD from The Graduate School at the City University of New York the previous year. The daughter of reunited Polish holocaust survivors, she was born in Sweden in 1946, immigrating to the United States when she was six. Kittay attended public schools in New York, then Sarah Lawrence College (a women's college famous for its progressive approach to education). She is married to Jeffrey, her 'life partner' and husband, and is a mother of two children. Her daughter Sesha remains 'profoundly dependent' as a result of intellectual disability from birth, and Kittay's experience as her mother has, in turn, deeply shaped her work. Writing alone, as a joint author and as an editor, she has published extensively and taught and written on issues pertaining to women throughout her career (Kittay 1984, 1999a, 2001; Kittay and Meyers 1987; Kittay and Feder 2002; Kittay and Alcoff 2006).

Kittay's early work focused on questions of feminism, language and the mechanisms of domination (Kittay 1984, 1987), but from the mid-1990s she turned to writing on care, linking her concern with disability and feminism. One of the important critical concerns and frameworks of her work has been liberal philosophy, while her critique of the deficiencies of Rawls' theories of justice, in particular, helped identify the crucial gaps in his approach that led him to be accused of a blindness to issues of gender and dependency (Kittay 1999b). This is a concern she shares with a number of other important American feminist philosophers, including Martha Nussbaum, Martha Fineman and Dietmunt Bubeck, with whom she is in dialogue in much of her writing and who, in turn, have contributed to her edited collections (Kittay and Feder 2002).

Kittay's approach to the topic of care and an ethic of care is also based on feminist moral and political philosophy, but draws also on her own experience as the mother of a daughter who is significantly disabled, as well as on other empirical research in a way that distinguishes her account from others that are largely (or exclusively) confined to abstract theorising. Her approach places dependency and considerations of power in the relationship between care-givers, care recipients and their broader social context at the centre of the analysis. In contrast to the approach of defining care as an all-encompassing orientation to the world, in Kittay's approach the concept of care is writ small, its scope confined to specific activities embedded in concrete relations between specific individuals. The broad social implications of this approach, however, are no less profound.

One of the most striking and appealing features of Kittay's approach to care, for me, is her approach that links personal experience with hard-nosed philosophical analysis. Unlike much of the most influential social theory which often seems to have been written without empathy or acknowledgement of the visceral and poignant dilemmas of human experience, her work speaks of engagement with life. While refusing to escape into theoretical, abstract philosophy, Kittay also resists the temptation to reduce her work to the subjectivism that characterises so much of postmodernist thinking. Her reflections on dependency, she wrote in 1999 in the preface to what has proven to be her most important and influential work, *Love's Labor: Essays on Women, Equality and Dependency*, were:

> ... prompted in part by a personal situation that made questions of dependency especially salient for me. My daughter is a lovely young woman who is profoundly dependent and will always be. Her conditions of severe mental retardation and cerebral palsy have meant she can never carry on a life without constant assistance. I have lived with my daughter's dependency for twenty-eight years and have had a long time to absorb the meaning and extent of dependency (Kittay 1999a:xi).

Kittay's work is remarkable for the manner in which it combines the personal with the theoretical. Interspersed between chapters of complex philosophical and political argument are personal descriptions of life and events. Her intimately confessional account of the exhilaration and love she and her husband felt when she gave birth at the age of 23, when the nurses returned her daughter to her and she 'melted into my arms', is developed into a maternal narrative that captures the compelling emotional processes of personal bonding and the gradual development of an awareness of the extent and significance of her daughter's disability as well as her humanity. In the work she lets the reader do more than glimpse her own, at times awkward and troubled, responses to the situation in which she finds herself – as feminist, mother, philosopher and career academic. She hired a personal attendant and learnt to rely on her and trust her in the daily care for her daughter, without surrendering her deep personal involvement or responsibility for her daughter's care. In the United States, her options were not those available to someone in an equivalent situation living in Scandinavia, the United Kingdom or even Australia. It would be wrong to give the impression that the analysis is any way sentimental or emotional. Kittay's sharp analysis of her own relatively privileged position and her capacity to draw on her personal experience to inform her account, her refusal to abandon either her daughter or her knowledge of the importance of powerful ideas and ways of understanding, give her work a depth and complexity that few other authors have been able to achieve.

Defining care

Care has proven to be a remarkably slippery concept, its meanings at once both emotive and contested. It is difficult to define not only because the accepted approaches to care change over time but because the concept signifies activities and phenomena that are inherently value-based. Historically, in the European languages, care has been a word associated with a sense of concern or worry: as in the phrase 'full of cares'. It has also been used to refer to monitoring and keeping something dangerous under control. This latter sense is evident today in phrases such as 'take care' or 'to place in the care of her majesty', meaning to place someone in prison. In times of infectious epidemics, care of the sick involved the isolation of those who would infect others. In common usage today, the term may refer to a mental disposition (to care about someone), to an activity that constitutes a form of work (to care for them), or to a relationship between specific individuals or groups (a caring relationship) (Rønning 2002; Rummery and Fine 2012). As Arlie Hochschild has pointed out, the ideals of care may be used in ways that invoke warmth or coldness, covering a range of quite distinct approaches, from traditional images of maternal nurturance to more contemporary service types such as childcare (Hochschild 1995). Although it is desirable for all these elements to be present for the term 'care' to be used comprehensively, each aspect may be used in an exclusive way as an expression of care.

For many feminist writers in the late 1970s and early 1980s, interest in care arose as a concern with the unpaid work carried out by women within the family. Care came to be seen as a burden that arose because it was the particular and unique responsibility of women. In the United Kingdom, for example, feminist activists had already pointed to the way responsibility for childcare prevented women from pursuing careers outside the home. Subsequently, the housekeeping and home duties expected of wives and mothers came to be understood in much the same way (Oakley 1974; Land 1978). In this feminist research literature care came to be equated with the household duties of married women, which included, according to Land, 'caring for their children, their elderly or sick relatives and, of course, their husbands' (Land 1978:360). This analysis was extended to other forms of care, such as care of the elderly and of children with disabilities, as well as to community care policy (Finch and Groves 1983). In this view, care came to be considered in Hilary Graham's (1983) deservedly famous description as the 'labour of love' provided at home, informally, by unpaid and recognised female relatives of the recipients.

In this discourse, care was defined in quite specific and focused terms as a form of burdensome responsibility involving tasks undertaken by women on behalf of others. This applied even with the acknowledgement that care could also be undertaken in a paid capacity, a case put clearly nearly a decade later (Graham 1991). A parallel development is evident in the writings emerging from the profession of nursing from the 1970s onwards. In these, care was seen in a focused, specific way (Watson 1979; Benner 1984; Leininger 1988; Lawler 1991) as a specialised professional skill that attracts women and predisposes them to nursing, where they develop further expertise through their education and experience.

The definition proposed by Joan Tronto provides an alternative and contrasting approach to the more focused definitions that saw care as a form of interpersonal support or linked it to women's domestic work. Tronto, a political scientist and moral philosopher, extends the concept of care and caring to a wide spectrum of activity, so that it denotes 'a species activity', an orientation to the world. She argues:

> On the most general level, we suggest caring be viewed as a species activity that includes everything that we do to maintain, continue and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web (Tronto 1993:103).

Rather than defining it narrowly, this definition extends the concept of care to the level of a philosophical ideal, an alternative, feminist-inspired goal to that of (the masculine one of) competitive individualism. In this, Tronto builds on the ethics of care approach that grew from the work of Carol Gilligan (Gilligan 1982; Noddings 1984; Tronto 1993). As Tronto explains in a more recent publication, while caring remains a 'subordinate activity and value within the framework of a competitive, *winner-take-all* society', addressing caring at the individual level or within the framework of one's own family will lead not to enhanced collective support but to increasing inequality, as men and women from well-off families seek to optimise their own opportunities by relying on exploitative care arrangements. What is required is for care to be elevated to become a central shared value, the result of which would be a profound social transformation (Tronto 2002).

Productive disputes around the use of the concept of care by feminists and others in the final decades of the twentieth century arose from the tension between these two approaches – the focus on defining care narrowly as the property or virtue of a particular group, or broadly as a widespread and necessary 'species activity'. Yet there is also much common ground in the identification of the way that care is undervalued in both the private sphere of the family and in paid care. A complicating, critical voice was introduced into the discussion, however, by disability-rights authors, including, importantly, sociologists Jenny Morris and Colin Barnes (Morris 1993a, 1996; Barnes 1998; Shakespeare 2000), who contested the use of the concept of care on the basis that the valorisation of the concept privileged the perspective of those providing care at the expense of those receiving it. People with disabilities in particular, they pointed out, were represented in the research on care not as people, active agents in their own rights, but simply as a burden:

> Care – in the second half of the twentieth century – has come to mean not caring about someone but caring for in the sense of taking responsibility for. People who are said to need caring for are assumed to be unable to exert choice and control. One cannot, therefore, have care and empowerment, for it is the ideology and the practice of caring which has led to the perception of disabled people as powerless (Morris 1997:54).

Some care advocates attempted to respond to this attack by acknowledging the receipt of care. Building on Hilary Graham's (1983) distinction between *caring about* and *caring for* another person, Joan Tronto, for example, set out a concept of care that sought to link separate elements of care together as a process with four distinct yet linked phases (Tronto 1993, 1998):

- *Caring about*, the development of an awareness of, and attention to, the needs for care in another;
- *Taking care of*, responsibility for these needs is assumed and plans are made about to respond;
- *Care-giving*, which involves meeting some or all of the needs for care through physical work, usually requiring direct contact between what Tronto called 'care-givers' and 'the objects of care'; and
- *Care-receiving*, the final phase, which necessarily entails a response from the recipient, linking the two parties.

This approach served a number of purposes. The first stage acknowledges the care that a male breadwinner may have for his children and family, while distinguishing it from the actual taking of responsibility for daily, hourly plans, as set out in the second stage. Each of these remained conceptually distinct from the third stage, the visceral hands-on physical work involved. Few if any male breadwinners took on this work, as it was usually the responsibility of women. Yet only in the final stage is the care recipient identified as the 'object of care'. Despite Tronto's attempt to acknowledge the importance of care receiving, and her attempt to define caring as a broader, social and shared orientation rather than as a dyadic relationship in which the care-giver attends to the needs of the recipient (Tronto 1993:103), there is a sense in which this approach locates care as a process and activity initiated by care-givers and undertaken on their terms. The recipient or object of care is portrayed as a relatively passive participant in the process, almost as an afterthought.

Selma Sevenhuijsen and a number of European care researchers have more recently sought to acknowledge care as part of a model of citizenship rights in a way that would recognise the right to *receive* as well as the right to *give* care, as well as acknowledge the importance of the care-giver having the time and opportunities to care for herself (or himself) (Sevenhuijsen 1993; Knijn and Kremer 1997; Williams 2001). Through its engagement with the rights approach favoured by the disability movement, their argument is important in that it recognises the reciprocal and embodied nature of care and support as well as the importance of those who require care. The contribution of disabled people *giving* care, as parents, grandparents, spouses and as children of older parents, in particular, is typically ignored in much care theory (as Morris and others had pointed out), but recognising care as a right of citizenship helps bridge this gap, as later work by Morris acknowledges (Morris 2001). Caring relationships are often complex, reciprocal and mutually supportive rather than simple relationships of dependency, in which an active carer takes all responsibility for a passive and dependent care recipient (Fine and Glendinning 2005). In response to the critique, care theory developed to recognise the agency and personhood of the care recipient, or better said, care partner (Lloyd 2000, 2004; Rostgaard 2006; Yeatman et al. 2009; Needham 2011).

Gender and dependency work

In many, perhaps most of the feminist accounts of care, gender is the key explanatory concept. Care, so the argument goes, is de-valued in economic, political and ethical terms because it is an activity undertaken by women. This explanation is intuitively correct in that it helps explain the lived experience of millions of women and men in different historical periods and diverse social contexts. There are, however, problems with this essentialist approach – not the least of which is that it offers little prospect of change. As a feminist, Kittay does not reject the gender-based explanation but seeks to go deeper. Her starting point is the concept of dependency:

> Dependents, require care . . . questions of who takes on the responsibility of care, who does the hands-on care, who sees to it that caring is done and done well, and who provides the support for the relationship of care and for both parties to the caring relationship – these are social and political questions . . . How a social order organises care of these needs is a matter of social justice (Kittay 1999a:1).

Her analysis of care is based on understanding dependency, exploring and helping to explain the effects and construction of gender without collapsing into essentialism. The starting point for this is an examination of the ideal of equality in Western political and legal theory – the philosophical underpinnings of liberal democracies. Equality, she contends, has been an important goal for women, but despite a raft of achievements that can be linked to it – including women attaining senior positions once deemed beyond them 'from astronaut to CEO', equal or greater numbers of women than men attending college and the recognition of sexual harassment claims in law – policies based on the principle of equality have failed women in the public as well as private arenas. Rejecting the explanations offered by what she labels as the *difference critique*, the *dominance critique* and the *diversity critique* (Kittay 1999a:5–11), Kittay argues that it is the invisible impact of dependency that has led to equality eluding care-givers, and by extension women who selflessly assume it.

For Kittay, dependency is a fundamental part of, and condition for, human existence. Physical dependency on actions by others is evident in early childhood, as well as in periods of illness, in disability and as a result of frailty in old age. These are points in the life course that Martha Fineman has called the 'inevitable dependencies' of life (Fineman 1995, cited in Kittay 1999a:30). Prolonged periods in which we are unable to attend to the necessary conditions of our own survival arise from our embodied existence. Political, socio-cultural, economic and moral conditions at different points in history and in different social contexts shape these dependencies and the social response to them (Kittay 1999a:29).

Attending to dependents by providing care is what Kittay calls 'dependency work'. This is a neutral and less emotive term than care, a term chosen quite deliberately to emphasise that 'care of dependents is work . . . traditionally engaged in by women' (Kittay 1999a:30). She identifies those who directly provide such support (whether paid or unpaid) as 'dependency workers'. Those they assist are termed a 'charge', a term suggestive of passivity and an incapacity to attend to their own needs and requiring another to take responsibility for providing the necessary care.

Having defined her key terms, Kittay proceeds to identify a paradigmatic form of dependency work as an analytic device which she uses to explore its complexities. In the paradigm case, the well-being of the charge is the responsibility and primary focus of the dependency worker. Importantly, notes Kittay, while the worker has responsibility for the charge, the dependency relationship does not authorise the exercise of power unless it is for the charge's benefit. In real life, dependency work takes the form of a specific practice such as maternal care of an infant, care for an older family member or caring for the developmentally disabled. Each has its own requirements and appropriate responses. While there are common elements across practices, there are also important differences. Care for the elderly, for example, requires recognition and fostering self-esteem, while maternal care involves nurturing growth. Such practice fields help define culturally appropriate forms for understanding and meeting the needs of those who require care. They also provide a standard by which the appropriateness of the response can be assessed (Kittay 1999a:32–3).

Care and power

The significance of Kittay's approach to care as the management of dependency is made clear as she extends the analysis to examine the operation of power as it is shapes the care relationship. In doing so, Kittay makes the useful distinction between power and domination. Inequality of power is inherent in dependency relationships, she points out, but this does not inevitably amount to domination. As a consequence of a lack of capacity, the charge (the care recipient) requires assistance from someone who has the capacity or power to do what is required. In this way, the charge is vulnerable to the abuse of power by the care-giver. In turn, though, the charge may also be able to exert power over the dependency worker as a result of social position, wealth or control of employment. These inequalities of power do not necessarily mean that abuse is inherent in the relationship, as a successful care relationship is built on mutual trust and responsibility. Domination can, however, occur when either the worker or the charge abuses this trust. Kittay observes:

> Domination is an illegitimate exercise of power. It is inherently unjust. The moral character of a dependency relation and its nature as a caring or uncaring relation is determined, at least in part, by how the parties in the dependency relation respond to one another, both with respect to the vulnerabilities of the dependent *and* to the vulnerabilities created for the dependency worker. Inequality of power is compatible with both justice and caring, if the relation does not become one of domination. That the relation be a caring one is largely the obligation of the dependency worker. That the relation not be one of domination is an obligation that equally befalls the dependency worker and the charge (Kittay 1999a:34, emphasis in original).

There is widespread recognition of the vulnerability of the care recipient that arises from her/his lack of physical or mental capacity. The extent of this is evident in the extensive moral sanctions and legal protections in all jurisdictions against such domination or exploitation. Less widely acknowledged is the vulnerability of the worker/care-giver which arises for a large part from her identification with the charge, her readiness to assist, her concern for the well-being of the charge and by her inability to express annoyance or vent frustration in ways that would normally be acceptable in human relationships between equals. The recipient of care may exert a 'certain tyranny' by advancing false needs, making exaggerated demands on the worker or by 'exploiting the worker's concern and need for the connection forged through the relationship'. Kittay (1999a:34) notes how a care recipient may (in the words of Marilyn Frye 1983) 'graft the substance of another to one's own', failing to recognise her own interests and the boundaries of her own integrity as a person. The special vulnerability of care-givers, in this view, arises as a result of the ties of duty, of identification with the other and the sense of self-sacrifice formed through the recipient's dependence on her. It is through this that the dependency worker/care-giver experiences her own self and substance as grafted onto the other (Kittay 1999a:34–5). In such cases, the care-giver is unable to assert an independent sense of self and effectively becomes over-identified with the charge.

Kittay's analysis is comparable to Weber's 'ideal type' approach, setting up a pure or abstract model based on generalised characteristics observable in real life. It establishes a point of comparison to be used in further assessment. Her approach is intended to apply to work that caters in a sustained way to the bodily and cognitive needs of another. It focuses on repetitive, routine daily caregiving rather than highly prestigious professional care. Dependency work explicitly excludes housework and 'wifely duties' undertaken as a more or less voluntary division of workplace or household tasks between consenting adults. Similarly, although Kittay argues that professional care work may be considered as dependency work in an extended sense, her analysis is not meant to apply in its entirety to professional care provided by practitioners who have been specially selected and admitted to a powerful professional elite and are able to benefit from collegial systems of self-regulation, command over a body of specialised knowledge requiring extensive training, systems of support by peers, an orientation of service to the community and the availability of symbolic rewards and social recognition outside the dependency relation. Although ordinary dependency work and the care provided by professionals share a common orientation towards compassionate action that is 'other-directed', medical and high-status health professionals typically enjoy high levels of recognition and reward. Their involvement in dependency work is also typically based on short-term, task-specific interventions that are distinct from the sustained and generalised commitments required of a dependency worker who sustains her charge only through on-going daily work. Nonetheless, by focusing on on-going, routine, everyday care in her analysis of the paradigm types of dependency relationships, issues pertaining to the extended case are also identified and addressed.

The dyadic interpersonal relationship between dependency worker and charge is essential to the identification of dependency work, but is only part of the picture. More important is the fact that the dependency worker is herself also made dependent on others by virtue of her dedication to this work and her need to rely on resources that others control. It is as a result of taking on this work that dependency workers – including women as mothers, sisters, wives, personal nurses, nannies and other personal care attendants – 'have been made vulnerable to poverty, abuse and secondary status . . . and often suffer psychological, sexual and other physical abuse as well as economic exploitation' (Kittay 1999a:40–1). Kittay explains this situation as involving a second, socially created level of dependency. This is the result of the fact that both the charge and the dependency worker are sustained and protected by their reliance on a third party, whom she calls 'the provider'. In a familial situation, the dependency worker, as wife, mother or maid, may be dependent on the male provider, who assumes the position of breadwinner and head of the household. In a welfare state, the worker may be an employee and the provider the state, just as, in other situations, the worker may be a domestic employee of the household, or of a private employee in a market-based care corporation or small business. This dependence has not been reduced by the increasing participation of women in the labour market in recent years. In contrast, much of this increasing participation is shaped by, and perpetuates, this socially created form of dependence. As Kittay (1999a:45) points out:

> In the case of the dependency worker, the provider's control of resources combines with a general social devaluation of the work of dependency to thwart the possibility of a comparable autonomy for the dependency worker. To speak of this diminished autonomy is another way of speaking of the dependency worker's unequal relation to the provider.

We may think of this as a dual system of dependency. The first component looks inward and involves two people – the dependency worker and charge – bound together through the relationship of physical or embodied dependency in which the charge depends on her care-giver for daily assistance with essential life tasks (ADLs, or activities of daily living). The second component is the system of support through which the dependency worker is maintained in the larger world, that is through which the care-giver is dependent, in turn, for her own support (Fine 2005). The primary dependency – that of the charge on the dependency worker – arises in the case of the object from the charge's lack of capacities for daily survival and maintenance. This is a form of physical or embodied dependence, clearly recognisable, too, as a form of interdependence. The dependency worker, committed to the well-being of her charge, in turn experiences a secondary dependency as a result of her dependence on the provider, which can be described in terms of her bargaining position in respect to the provider. This dependency is a socially constructed form of dependency because it arises from the social arrangements in which the dependency worker uses her time supporting the charge rather than producing an independent income or product. To overcome the disadvantage and limited autonomy experienced by those who take on responsibility for the support of those who are dependent, Kittay extends her project to develop what she terms a *doulia*, or 'public ethic of care' (Deacon 2007). Here the concept of care is writ large, not as an alternative or challenge to prevailing theories of justice and individual autonomy (and as it appears in the writings of a number of the early care theorists discussed in the opening section of this chapter), but as an amendment and extension to them. The recognition of the vital importance of care for human life as a response to dependency, which she has come to call 'the elephant in the room' (Kittay et al. 2005), provides Kittay with a rationale for public policy supporting care, and through it, the individuals who take responsibility by caring.

Conclusion: Kittay's contribution to contemporary social theory

Kittay's work can be understood, in part, as a dialogue with some of the leading public philosophers of the day. In addition to her extensive engagement with feminist philosophers and social scientists, her approach draws together a critical approach to John Rawls' concept of social citizenship (Rawls 1971, 1982) with the work of Amartya Sen concerning human capabilities (Sen 1997). Kittay argues that in a democracy in which equality is taken seriously, if we lack the capability to care for ourselves and therefore need support, we should be able to receive it without those who provide the assistance being penalised. Rather than presuming or asserting that everyone is independent or at least has the capacity for autonomy, as liberal theorists since J.S. Mill have done, recognition of the inevitability of dependence at some stage of each of our lives and of the need for care of those who are dependent must involve an acknowledgement of human interdependencies. Such a concept is not so much an assertion of interdependency as an alternative or negation of dependency, but rather one based on the recognition of 'nested dependencies' which link those who need support with those who help them, and in turn link the helpers to a set of broader supports. She terms this a notion of *doulia*, from the Greek word for service:

> Just as we required care to survive and thrive, so we need to provide conditions that allow others – including those who do the work of caring – to receive the care they need to survive and thrive (Kittay 1999a:133).

The approach to care taken by Kittay in the United States in which there is only a poorly developed set of social care programmes may therefore be properly regarded as one based on a concern for issues of justice. It can be usefully compared with that of the Dutch care theorist Selma Sevenhuijsen (1998, 2000), who argues similarly that contemporary social democratic theory in Europe, despite its support for social programmes, has ignored the sacrifices of women who provide essential care. Justice is not served if those who provide care in response to dependency are penalised, either directly or indirectly, in the process of supporting those who are not, of their own, capable of full participation in society. But whereas Sevenhuisjen focuses strongly on the issue of recognising the fundamental importance of care and women's rights, Kittay's focus is on understanding dependency and the manner in which it has been hidden and denied. Her focus on the issue of mental retardation, in which dependency cannot be understood as a cultural construction or by-product of some social convention (such as the failure to provide wheelchair access to buildings) that could be readily reversed given the right sort of social intervention, helps highlight the need to place the management of dependency at the centre of concerns for justice. Thus, she argues, a conception of justice is required that goes beyond the liberal conception of equality which eschews dependency and relies on a notion of reciprocal recognition extended between reasonable and rational adults:

> Those who are dependent (at least when, and to what extent they are) cannot reciprocate the care that they receive. In our dependence, we cannot pay back our care-givers and compensate them for their labour. Another must do so. I have called this form of reciprocation doulia, after the doula, the contemporary postpartum care-giver who cares for the mother so that the mother can care for her new infant. I have called for a public conception of doulia, by which the larger society supports those who care for the 'inevitably dependent' (dependent because of age, infirmity or severe disability). I conceive of this as a principle of justice, in fact, a principle of justice that embraces those excluded by the contractual model of reciprocation. We need a principle of doulia for a caring that is justly compensated, and a justice that is caring (Kittay 2002:270).

Her analysis makes issues of power central to an understanding of care, just as it makes an understanding of the need for, and provision of, care a basic consideration for understandings of human society. By understanding the goal of care as the nurturing and development of the charge's capabilities by the dependency worker, Kittay shows how a recognition of the complex nature and character of power is essential to understand the dynamics of inter-personal interaction between carer and recipient, and the injustice of exploitation and dependency experienced by carers, and, she is quite explicit on this point, by women more generally.

Care, for so long, has been invisible, regarded as a private matter, an unseen exchange that occurs within the intimacy of the domestic sphere, but has now become a global concern. With the rise of ageing populations, the increasing prevalence of disability and the increased reliance on formalised childcare arrangements to support working mothers (Kittay et al. 2005; Fine 2007), it is increasingly important that what Kittay has called 'a global ethic of long term care' be recognised. The movement of low-paid care workers from the third world to advanced wealthy countries (Ehrenreich and Hochschild 2002), as much as the persistent inequalities within care relationships, are issues of vital concern for health sociologists, as they are for others concerned with issues of global equity. Kittay's approach to dependency and care provides a powerful and original analysis, offering many of the tools necessary for investigating and critiquing the cultural ideologies that serve to ignore the significance and extent of dependency, and as a result to penalise, and exploit, those who provide care.

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Chapter 41

Gøsta Esping-Andersen: Welfare Regimes and Social Inequalities in Health

Mikael Rostila

This chapter focuses on Esping-Andersen's theory of 'the three worlds of welfare capitalism' and its contribution to the understanding of population health and health inequalities. Although several recent empirical studies have examined how population health and health inequalities vary within welfare states, it seems important to thoroughly discuss these issues from a theoretical point of view. This chapter starts with a discussion of some central aspects of Esping-Andersen's theory. Recent modifications/additions to Esping-Andersen's welfare regime theory will also be touched upon, together with some critiques of his ideas. Furthermore, some of the potential pathways through which welfare states can influence health and health inequality are discussed, and some empirical studies that have examined such relationships are presented. Finally, some concluding remarks on the usefulness of including Esping-Andersen's theory within health research are provided.

Biography

Gøsta Esping-Andersen is a sociologist born in Denmark in 1947 whose primary focus is on the welfare state and its place in capitalist societies. He studied demography, economics and sociology at Copenhagen University, received his PhD from the University of Wisconsin-Madison and is currently a professor at Pompeu Fabra University in Barcelona (Spain). He is a member of the Scientific Committee of the Juan March Institute and of the Board of Trustees and the Scientific Council at the IMDEA Social Sciences Institute, both in Madrid (Spain). His scientific work currently concerns life-course dynamics, social stratification and comparative social policy. His most cited book titled *The Three Worlds of Welfare Capitalism* was published in 1990. His other publications include *The Social Foundations of Postindustrial Economies* (Oxford University Press) and *Why We Need a New Welfare State* (Oxford University Press).

Theoretically, the work of Marshall (1950) and Titmuss (1958) laid the foundations for Esping-Andersen's typology (Arts and Gelissen 2002:138). For instance, Titmuss (1974) made a distinction between 'three contrasting models of functions of social policy' with some similarities to Esping-Andersen's typology. It has also been suggested that Esping-Andersen benefited empirically from the comparative research by, for instance, Wilensky (1975), Flora and Heidenheimer (1981) and Mommsen (1981) (Arts and Gelissen 2002:138). He is a member of the British Academy and the American Academy of Arts and Sciences, and Doctor *Honoris Causa* at both Roskilde University and Copenhagen University. Esping-Andersen has been actively engaged in international organisations, including the United Nations, the Organisation for Economic Co-operation and Development, the International Social Security Association and the European Union. Outside academia, he has been writing and recording music over the years with different bands. He is also a bee-keeper (http://dcpis.upf.edu/~gosta-esping-andersen/; Wikipedia 2013).

The 'three worlds of welfare capitalism'

Esping-Andersen's (1990, 1999) theory of the 'three worlds of welfare capitalism' is part of a long sociological tradition rooted in the use of ideal types (Esping-Andersen 1990; Ferragina and Seeleib-Kaiser 2011). Max Weber (1949) deals with two different kinds of ideal types: individualistic and holistic. Esping-Andersen's ideal types of welfare state regimes are holistic. They propose a bird's eye view of the broad characteristics of a social or historical situation (Arts and Gelissen 2002:139). His work is motivated by the belief that previous theoretical models of welfare state are inadequate and that re-conceptualisation and re-theorisation are necessary. He argues that for a long time, too little empirical and theoretical attention has been given to cross-national differences in welfare state structures (Arts and Gelissen 2002:138). He created today's best-known and most frequently used typology of welfare states. Most importantly, Esping-Andersen (1990) provides strong empirical support for the three-regime clustering of welfare states in the Western democracies based on cross-national quantitative analysis. The fact that he uses social data and empirically tests whether distinct welfare states that resemble his ideal types can be observed has been suggested as a major reason for the theory's enduring popularity (Arts and Gelissen 2002:141). His typology has three important advantages that may also explain its endurance: it is parsimonious, countries are clustered in a manner that allows scholars to study the underlying logic of categories, and it facilitates the development and testing of new hypotheses about the causes and consequences of social policy (Arts and Gelissen 2002:154).

Esping-Andersen addresses the question of whether the welfare state is merely the sum total of a nation's social policy repertoire or whether it is an institutional force above and beyond a given policy array. He argues that the welfare state cannot be regarded as the sum of social policies; it is more than a numerical calculation of discrete programmes (Esping-Andersen 1994). Welfare states are clustered around three highly diverse regime types, each organised according to its own discreet logic of organisation, stratification and social integration. These ideal types owe their origins to different historical forces and follow qualitatively different developmental trajectories. He emphasises that history and politics matter:

> . . . the historical characteristics of states, especially the history of political class coalitions as the most decisive cause of welfare variations have played a determinate role in forging the emergence of their welfare-statism (Esping-Andersen 1990:1).

Esping-Andersen suggests that three historical and political forces are behind regime differences: the nature of class mobilisation (especially the working class), class political action structures and the historical legacy of regime institutionalisation. He (1990:26) distinguishes between three ideal types of welfare state regimes according to two dimensions: the extent of de-commodification and stratification. These two dimensions have decisive implications for population health and social inequalities in health within different welfare regimes.

De-commodification in social policy

In capitalist societies, the welfare of individuals has come to depend on the market and cash nexus. Esping-Andersen (1990:21) suggests that stripping society of the institutional layers that guaranteed social reproduction outside the labour market means that people have become commodified. De-commodification occurs when a person can survive without reliance on the market. However, social assistance or insurance may not necessarily bring about significant de-commodification if they do not substantially emancipate individuals from market dependence. Means-tested poor relief will, for instance, offer a safety net of last resort according to Esping-Andersen. However, when benefits are low and associated with social stigma, the relief system will compel all but the most desperate to participate in the market. Esping-Andersen (1990:22) suggests that de-commodified rights are differently developed in contemporary welfare states. In social-assistance-dominated welfare states, rights are not so much attached to work performance as to demonstrable need. Means-tests and typically meagre benefits service to curtail the de-commodifying effect. Thus, in countries where this model is predominant, the result is to strengthen the market since all but those who fail in the market will be encouraged to contract private-sector welfare. In contrast, de-commodifying welfare states are, in practice, of very recent date. A minimal definition of these states, according to Esping-Andersen, is where citizens can freely, and without potential loss of job, income or general welfare, opt out of work when they themselves consider it necessary. The degree of de-commodification is, according to my view, the first important basic feature of welfare states with consequences for health and health inequalities since it buffers the negative consequences of inequalities, marginalisation and social exclusion.

The welfare state as a system of stratification

Welfare states also differ considerably with regard to social stratification and stratification processes. Esping-Andersen (1990:23) suggests that the welfare state is not just a mechanism that intervenes in or corrects the structure of inequality; it is, in its own right, a system of stratification and an active force in the ordering of social relations. The organisational features of the welfare state help determine the articulation of social solidarity, divisions of class and status differentiation. Esping-Andersen (2002) identifies three models, or ideal types, of stratification and solidarity that parallel the regime types. What unites models of traditional conservatism in continental countries is that traditional status relations must be retained for the sake of social integration while the goals of liberalism can be best understood as opposing the vestiges of conservative stratification. Liberalism stresses emancipation, freedom, equal opportunities and healthy competitiveness. By withholding aid, or helping eliminate traditional systems of social protection, and by refusing to place nothing but the market in their place, the liberal state attempts to grant the market a hegemonic role in the organisation of social and economic life. As an alternative to means-tested assistance and corporatist social insurance, the universalistic system promotes equality of status. According to Esping-Andersen (1990:25), all citizens have similar rights irrespective of class or market position. The result is that the egalitarian spirit of universalism often turns into a dualism in which the poor rely on the state and the remainder on the market. To conclude, the various worlds of welfare capitalism contribute to different stratification processes and levels of inequality in society, and these, it is argued below, are important determinants of health.

The three regime types

Esping-Andersen (1990, 1999) clusters countries into three distinct welfare regime types. In this section, the more distinctive features of these regime types are presented, demonstrating how the effects on population health and health inequalities vary. Some examples of additional regime types that have been added to the theory by scholars following ideas by Esping-Andersen's (1990) are also provided.

The ideal typical *social-democratic* regime has a policy of emancipation that addresses both the market and the traditional family. Esping-Andersen included the Scandinavian countries, Sweden, Norway, Finland and Denmark, in the social-democratic regime type. These countries are characterised by the highest levels of social security, with mostly universal social benefits, and are internationally unique in their emphasis on the government pillar (Esping-Andersen 2002:13). The underlying principle of the regime is not to wait until the family's capacity for aid is exhausted, but pre-emptively socialise the cost of family-hood. Hence these countries minimise dependence on the family and encourage capacity for individual independence (Esping-Andersen 1990:28). Esping-Andersen emphasises that the crowding out of markets in the pursuit of welfare is attached to a 'crowding in' policy of maximising citizens' employability and productivity. The result is a welfare state that, compared with other regimes, largely takes direct responsibility for caring for children, the aged and the marginalised (Esping-Andersen 1990:28). In other words, this model is characterised by universalism and solidarity. Esping-Andersen (2002:14) suggests that the broad and generous income safety net protects vulnerable citizens against poverty. Compared with the other two regime types, levels of inequality and poverty are hence low (Fritzell 2001). Furthermore, activation policies diminish long-term unemployment, and care services to families have provided a double bonus, enabling women to have children and careers while maximising employment levels. Since the welfare regime is effective in mobilising the more vulnerable, such as single parents, older workers or people with disabilities, it manages to maximise inclusion and minimise exclusion. Accordingly, the social-democratic welfare regime is inevitably costly for government and high taxes are necessary to cover public expenses.

In *corporatist* regimes rights are attached to class and status. Esping-Andersen (1990) suggests that Austria, France, Germany and Italy belong to the corporatist regime type. The state only interferes when a family's ability to serve its members is exhausted, and it then provides social benefits based on its previous status in society. This regime also focuses on the preservation of the traditional family and the position of the male breadwinner (Esping-Andersen 1990:27): a familialist bias additionally reinforced by the dominance of a form of social insurance (Esping-Andersen 2002:16) linked to employment and primarily protecting those with stable and lifelong employment. Countries with these regimes have traditionally introduced strong employment guarantees and protection for the stably employed. This, in combination with significant barriers to labour market entry, has nurtured a deepening abyss between privileged 'insiders' and precarious 'outsiders'. The fact that this regime type has a strong reliance on the family for limiting the risks of social exclusion negatively impacts women's search for economic independence. This regime also appears to create average levels of inequality and de-commodification in comparison with other regimes.

In the ideal typical market-dominated *liberal* regime, means-tested assistance, modest universal transfers or modest social insurance plans predominate. Countries belonging to this regime type, according to Esping-Andersen, are the United States, Canada, Great Britain and Australia. Here the state mainly encourages the market – either passively, by guaranteeing only a minimum of benefits, or actively, by subsidising private forms of the welfare system. With the exception of national healthcare, the dominant thrust is towards targeting benefits to the demonstrably needy (Esping-Andersen 2002:15). The middle classes have been encouraged to opt into the private welfare market in the liberal countries while government has sought to strengthen income testing. These countries are also characterised by a shift from means-tests towards work-conditional benefits which do not help unemployed citizens. This type of regime entails independence from the state and forces citizens to rely on family and friends for help and aid in situations of personal crisis. The consequences of this type of regime are high levels of income inequality, high levels of poverty and low levels of de-commodification compared with the social-democratic and continental regimes. The model also creates high levels of class dualism.

Three worlds of welfare capitalism or more?

However, as several countries cannot be categorised into the three welfare regimes described above, some additional regime types have been suggested. These alternative classifications originate from important criticisms of Esping-Andersen's (1990) classification (Arts and Gelissen 2002). First, it has been argued that Esping-Andersen's theory includes misclassification of the Mediterranean welfare states. The second criticism refers to labelling the Antipodean welfare states as belonging to the liberal welfare state regime. Finally, some scholars argue that the former European communist societies should be considered a separate regime type (Aidukaite 2004, 2009). The following section gives an overview of some features that characterise these additional regime types.

One important criticism of Esping-Andersen's typology is that he did not systematically include the Mediterranean countries (Ferrera 1996; Arts and Gelissen 2002). According to Esping-Andersen, Italy belongs to the corporatist welfare regime whereas Spain, Portugal and Greece are not covered by his typology. Those who support the notion of a *Mediterranean* regime suggest that it has many similarities with the continental regime, with its forced dependence on family and friends. However, while the Mediterranean countries could be considered an under-developed species of the continental model, they differ in as far as they have a less developed system of social security accompanied by a very high degree of familialism (Ferrera 1996; Bonoli 1997). Moreover, Ferrera (1996:17) suggests these countries are characterised by a highly fragmented income maintenance system, displaying a marked internal polarisation, including peaks of generosity accompanied by macroscopic gaps of protection. The Mediterranean regime also has a low degree of state penetration of the welfare sphere and a highly collusive mix between public and non-public actors and institutions.

The *post-socialist* regime has also been suggested as a specific regime type by some scholars. It consists of some of the countries located in central and Eastern Europe and is still only moderately theorised and analysed. The Czech Republic, Hungary, Poland and the Baltic countries are examples of countries that have been added to this regime type. Aidukaite (2004, 2009) proposes that the Baltic countries, as examples of post-socialist states, cannot be accurately placed in any model developed to study social policy. This supports the idea that the Eastern European countries constitute a separate kind of welfare regime. The results also indicate that the benefits of social security are very low in the Baltic countries and this has resulted in high levels of income inequality and poverty. Moreover, the post-socialist countries are characterised by high coverage of the social security systems, but low benefits, and therefore citizens still, to a high extent, have to rely on family or the market for support (Aidukaite 2009).

Another criticism concerns the Antipodean countries, suggesting there has been a misclassification of these in Esping-Andersen's theory (Arts and Gelissen 2002). Esping-Andersen argues that Australia and New Zealand are representatives of the liberal welfare state regime because of their marginal commitment to public welfare and strong reliance on means testing (Arts and Gelissen 2002:146). However, it has been suggested that these countries have a more particular and a more inclusive approach to social protection than the standard liberal form (Castells 1998). Thresholds are set at comparatively high levels, so that a large part of the population receives some means-tested benefits (Arts and Gelissen 2002:146). The result is that these countries exhibit the world's most comprehensive systems of means-tested income support benefits. Redistribution has been traditionally pursued through wage controls and employment security rather than social programmes. Income guarantees realised through market regulation thus play an important role in the institutional set-up of these welfare states. Accordingly, it seems that the Antipodean countries represent a separate social policy model (Arts and Gelissen 2002).

There have also been critiques which do not concern the classification of countries in regime types. One of the most serious criticisms of this kind is that Esping-Andersen's original theory (1990) is gender blind (Lewis 1992; Orloff 1993). Specifically, the concept of de-commodification fails to acknowledge the role of women as women, and the family is not included as a welfare provider.

Moreover, there is insufficient consideration given to gender as a form of stratification (Bambra 2007). Esping-Andersen responded to this critique in his more recent work (Esping-Andersen 1999:9). He acknowledged that his initial analysis lacked a gender/family perspective, so he extended the scope by focusing on the changing role of women (Dahl et al. 2006:197). For instance, he studied family policies and additional welfare outcomes, including fertility rates. Esping-Andersen's conclusion was that with respect to family policies his original typology fits neatly. The social-democratic countries have also developed family-friendly policies that are more or less absent in the two other regimes.

Another critique in this category concerns the idea that the actual operationalisation of welfare in Esping-Andersen's theory is rather narrow. This implies that important welfare benefits and services are left out, such as childcare, education, elderly and healthcare (Dahl et al. 2006:197). On the other hand, Nordic countries seem to score medium or high on childcare, education and healthcare expenses, and all have universal health insurance founded on the principle of equal access (Rostgaard and Lehto 2001; Gornick and Meyers 2003).

Esping-Andersen's seminal work (1990) has also been criticised for being not entirely clear about the countries belonging to each welfare state regime type. The classification of countries seems to depend on the outcome studied (for example, de-commodification, stratification, employment, pensions and so on). This may explain some of the diversity of interpretations and empirical decisions about how to classify countries into welfare regimes among later scholars.

Finally, some argue that institutional changes, especially in the Nordic welfare states during the 1990s, have altered the nature of the Nordic welfare state architecture (Dahl et al. 2006:198). There has been a shift 'toward work-oriented policies, privatisation of social welfare, increased targeting of benefits and a shift from an emphasis on the social rights of citizenship to the civic duties of community members' (Gilbert 2002:5). This may have changed the position of the social-democratic regime when compared to the liberal and corporatist. However, the vast majority of all recent research effort indicates that the Nordic model is still fairly distinct (Huber and Stephens 2001; Kautto et al. 2001; Dahl et al. 2006).

Esping-Andersen, population health and health inequalities

Comparative research on the welfare state has generally developed in isolation from comparative research on health inequality (Dahl et al. 2006:193). However, recently there has been an increased interest in studying whether population health within a country and the magnitude of health inequalities could depend on social policy and the generosity of its welfare system, that is, the welfare state regime type (Dahl et al. 2006; Eikemo et al. 2008a; Bambra et al. 2009). Thus, the next part of this chapter discusses the potential links between welfare systems and health.

Modern research on health inequalities has emerged since the early 1980s and an important starting point was the British 'Black Report' commissioned by the British government (Townsend and Davidson 1982). It was the first government-commissioned report anywhere to systematically collate data on social inequalities in health (Bambra 2012:146). The report revealed alarming differences in health by social position in the United Kingdom, and these inequalities tended to increase rather than decrease over time. Moreover, where in the world we happen to be born is still of significance for our health and longevity. Life expectancy differs by more than 30 years between the poorest countries in the world and the richest industrialised countries (WHO and Commission on Social Determinants of Health 2008). The global health gaps that are large and unacceptable are certainly well known. But there are large differences in health also between and within relatively rich countries (Kunst et al. 2005; Mackenbach et al. 2008; Rostila and Toivanen 2012). Health inequality refers to the systematic differences in health that exist between socio-economic groups that are politically, morally and economically unacceptable (Graham 2007, 2009). Since the Black Report, several studies have been conducted in the field. In 2005, the World Health Organization (WHO) set up the Commission on Social Determinants of Health to analyse the major global health gaps that exist around the world (WHO and Commission on Social Determinants of Health 2008).

It has, however, been argued that much epidemiological research has focused attention on risk factors that are relatively proximal causes of disease and that individually based risk factors should be contextualised by examining what puts people at risk of risks (that is, the fundamental causes of disease) in order to improve the health of nations (Link and Phelan 1995). Welfare state regimes could be considered fundamental causes of disease, in other words, as macro-level structures that put people at risk of risks, and the next section looks at this matter of the pathways between regime types and health.

Mechanisms linking welfare regimes, health and health inequalities

There are various possible pathways through which a welfare regime might influence health and health inequalities (Dahl et al. 2006; Lundberg et al. 2008a). These are closely related to the degree of de-commodification and stratification of the welfare state regimes.

De-commodification draws attention to the opportunities for 'all' citizens to opt out of work or fall ill and still be able to access sufficient material means to prevent additional negative health effects in a vulnerable life situation (Dahl et al. 2006:201). Welfare states can be important determinants of health as they mediate the extent and impact of one's socio-economic position on health (Navarro et al. 2003; Eikemo et al. 2008a; Eikemo et al. 2008c). Public health and health inequalities between and within countries are determined by income inequalities, the distribution of wealth and other aspects of socio-economic inequalities such as access to resources (Lundberg 2008). Welfare provision (social transfers and welfare services) is intended to address inequality and should therefore also influence health (Navarro et al. 2003). Eikemo et al. (2008c) suggest that welfare states provide a variety of social transfers (such as housing-related benefits, unemployment benefits, pensions, and sickness and disability benefits) as well as key welfare services (healthcare and social services). Welfare state social policies can also affect stratification by giving people the same opportunities for education, reducing discrimination in the labour market, reducing economic and ethnic segregation, and influencing the distribution of income. Family policy and pensions that ensure decent economic conditions in phases in life that are otherwise marked by deteriorating economic conditions contribute to better health in groups covered by such welfare policies (Lundberg et al. 2008b). These transfers and services should together mediate the relationship between socio-economic position and health and also contribute to higher overall health levels as poorer segments of the population get better overall health.

The implications of universalism in generous welfare states of the social-democratic model may be important according to Dahl et al. (2006:199). In these states, every citizen is ostensibly of equal worth and entitled to the same material benefits and social services. Hence, universalism may foster social integration and social capital among the least privileged groups in society. It may also foster general support for the welfare state. Assuming that social integration, social capital (Rostila 2013) and less anti-social behaviour are beneficial for health, universalism should bring about better health and smaller health inequalities than other welfare regimes.

Strong labour movements may also play an important role for health and health inequalities in different welfare regimes (Dahl et al. 2006:202). The labour movements have a strong position in the social-democratic welfare states, while a weaker position in liberal and corporatist countries. It seems reasonable to expect that this positively influences workplace characteristics and the work environment which, in turn, are important determinants of health and health inequalities (Toivanen 2007). Strong labour movements may especially improve physical and psycho-social working conditions among groups with low occupational status.

Welfare state institutions might also play an important role for health throughout the life course. If so, this should have a bearing on the life course approach to health inequalities, suggesting that risk exposures, health hazards and social disadvantages may have long-term effects on adult life and that risks might be accumulated throughout life. Approaches in this perspective take into account the fact that one's biological imprint in early life may have long-term effects on health, the accumulation of good or bad social circumstances, exposures and behaviours, and social and biological pathways (Dahl et al. 2006:203). Comprehensive arrangements of medical rehabilitation, activation measures and opportunities for education and life-long learning suggests that unfortunate life events like job loss and impaired health may have less severe consequences for well-being and life chances in social-democratic welfare states than in liberal or corporatist countries. For instance, universal welfare states have been characterised by developed maternal and childcare services since the early 1930s. Healthcare for children is also free, which means that parents have access to the same care regardless of social position (Lundberg et al. 2008b).

However, the literature suggests that it is unlikely that there is one particular facet of universal welfare models that leads to better health outcomes; rather it is the interaction and combination of a variety of policies (for example, universal access to welfare services, higher replacement rates, higher levels of employment among both men and women, and so on), over a sustained period of time, which has led to a health-enhancing reduction in material and social inequality (Navarro and Shi 2001; Chung and Muntaner 2006).

The paradox of absolute and relative inequalities in health

Rather few studies have examined whether health and health inequalities vary by welfare state regime, and the empirical evidence is fairly mixed. Some have examined the overall health and mortality by welfare regime type. Lundberg et al. (2008a) found that increased generosity in family policies supporting dual-earner families is linked with lower infant mortality rates, and Popham et al. (2013) showed that Nordic countries have the highest life expectancy and smallest inequalities in mortality for men but not women. Eikemo et al. (2008b) observed that people in the Scandinavian and Anglo-Saxon welfare regimes (comparable to the liberal regimes) have better self-perceived general health in comparison to Southern and East European welfare regimes. Nevertheless, some empirical studies that have focused on relative health inequalities suggest these are at a similar level – or even worse – in the social-democratic countries, while inequalities are lower in countries such as the Mediterranean. For instance, Eikemo et al. (2008a) found that the Scandinavian countries do not have the smallest or the largest health inequalities by income level. The Anglo-Saxon countries have the largest inequalities in health by income while countries with Bismarckian welfare states (comparable to the corporatist welfare states) have the smallest. Eikemo et al. (2008c) showed that South European welfare states have the largest educational inequalities in health while the Scandinavian welfare regimes are placed less favourably than the Anglo-Saxon and East European. Finally, Bambra and Eikemo (2009) revealed that relative inequalities in self-rated health are largest in the Anglo-Saxon, Bismarckian and Scandinavian regimes.

There are a range of possible explanations for why health inequalities are not the smallest in the social-democratic countries. First, it has been argued that the 'paradox' is not real but rather an artefact. There are differences depending on which socio-economic measure is used, how it is calculated and what health outcome is studied. There are also issues in terms of making cross-national comparisons of health inequalities as it is not clear whether the bottom groups are the same in each regime or country (Bambra 2012:156). Accordingly, limitations in our statistical modelling contribute to false conclusions. Second, it is possible that the social consequences of ill-health are greater in the Nordic countries and that people who have ill-health are more likely to be concentrated in lower socio-economic positions. Third, socio-economic inequalities in smoking are much higher in the Nordic countries than in other welfare regimes, and this could lead to poorer health among lower socio-economic groups (Bambra 2012:157). Fourth, it has been suggested that the effects of relative deprivation may be more extensive in social-democratic welfare states because of high levels of expectation of upward social mobility and prosperity generated among the less privileged: expectations that are seldom met (Huijts and Eikemo 2009). This may increase health inequalities especially with regard to stress-related conditions.

Concluding remarks

Because of the rather mixed findings on the relationship between welfare regimes, population health and health inequalities, some argue that Esping-Andersen's (1990) theory is not fruitful for the study of health. For instance, some suggest that the welfare regime typology as a tool for analysing the impact of policies and institutions on the determinants of health is simply too crude and imprecise (Lundberg 2008). Few studies in practice also adopt the same regime approach (although many use the same labels). This could explain why results produced are diverging and even conflicting. Esping-Andersen's theory is also focused on the principles behind the welfare states rather than the consequences for their citizens (Lundberg 2008). An important shortcoming as an analytical tool is therefore the one-dimensional nature of the typologies, given that they focus, for example, on general aspects of the cash-transfer system, while other more specific and health-relevant welfare services (such as pensions, sickness insurance, unemployment insurance or family policies) do not necessarily cluster according to welfare regime types. Furthermore, principles adopted in other areas of the welfare state, such as social care services and healthcare, are not necessarily the same as those adopted for transfer programmes. A recent review of the empirical evidence linking welfare regimes and health suggests that we should instead use the institutional or expenditure approach when studying the influence of welfare state features on health (Bergqvist et al. 2013). The *institutional approach* focuses on how welfare institutions and specific social policies and programmes are designed and how these, in turn, influence health and health inequalities, while the *expenditure approach* focuses on welfare state effort and generosity by studying public spending on social protection and services. Hence, it has been argued that they provide much more detailed information on how specific welfare policies influence health but they can be also easily applied to study the total welfare effort by combining different rights/spending patterns.

Although there are reasons to believe that different welfare regime types could have important consequences for health and health inequalities from a theoretical point of view, the empirical evidence is rather mixed and difficult to assess. This could lead us to question the usefulness of Esping-Andersen's regime types in health research. Nevertheless, 'The three worlds of welfare capitalism' theory has received its fair amount of criticism also in other research fields. In this context it is important to emphasise that contrary to the ideal world of welfare states, the real world is likely to exhibit hybrid forms (Arts and Gelissen 2002:153), and that every country presents a system mix. As long as we regard welfare state regimes as ideal types, we must also acknowledge and accept that there is variation between regimes and between countries within regimes. The contribution of Esping-Andersen's theory to the health field rather lies in simplifying complex processes and characteristics which could guide further research on more specific welfare programmes and services and their contribution to population health and health inequalities. Accordingly, Esping-Andersen (1999) argues that it is still fruitful to construct ideal types for the sake of economy: to be able to see the forest rather than the myriad of unique trees. As a theory, it has facilitated the development and testing of new hypotheses about the causes and consequences of social policy. More research on health consequences by welfare state regimes is needed before we discharge the value of 'the three worlds of welfare capitalism' in the health field.

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Chapter 42

Bruno Latour: From Acting at a Distance Towards Matters of Concern in Patient Safety

Su-yin Hor and Rick Iedema

If there is anything that is unique about Bruno Latour's body of work, it is his inclination to question not just others' practices and assumptions (notably that of scientists), but also his own. In that regard, Latour's philosophy differs markedly from that of *The Pink Panther*'s Inspecteur Clouseau:

> Housekeeper: You've ruined that piano!
> Inspecteur Clouseau: What is the price of one piano, compared to the terrible crime that has been committed here.
> Housekeeper: But that's a priceless Steinway!
> Inspecteur Clouseau: Nyot Anymeur (*The Pink Panther* 1963).

Comparing Clouseau's philosophy to that which underpins academic research may seem unwarranted, but the general point is important: research investigations too often ignore and sometimes even destroy the richness and fullness of what they confront out of deference for their favoured analytical manoeuvre or taken-as-given investigative principle.

Is it not a bit irreverent to open a chapter on Bruno Latour's prominent contribution to health sociology with a quote from the 1960s movie *The Pink Panther?* On the contrary, there are several good reasons for doing so. Latour does not just resemble Clouseau; he also sounds like him, and he is as funny, if not more so. During a plenary talk he gave at the 2008 *What Is an Organization?* conference in Montreal,[1] for example, he made reference to the probing gaze of a bust positioned behind him as Chair of the institute's research meetings. The bust represented the founder of the Sciences Po Ecole des Arts Politiques, where Latour was Vice-President of Research (from 2007 until 2012). Throughout his talk, Latour referred to the bust's gaze burning into his back, and imagined that gaze to act as a compass for determining what was the right thing to do. A reflexive sensitivity was thereby woven into the presentation, rendered all the more powerful and touching by being construed to issue from a dead person's sculpture's critical gaze – not from some philosophical, moral, pedagogic or investigative high ground.

The above anecdote also serves to emphasise the point that Latour's work needs to be read and understood as always in tension with itself, to prevent material reality – 'the priceless piano' – being destroyed in our overly fervent pursuits of and obsessions with theory, method and truth. In that regard, of course, Latour departs from Clouseau in his orientation to how truth and knowledge are to be pursued. Indeed, Latour's chapter in the 1999 book *On Actor Network Theory and After* argues for a complete 'recalling ANT', to prevent it from overtaking 'the real':

> There are four things that do not work with actor-network theory; the word actor, the word network, the word theory and the hyphen! Four nails in the coffin (Latour 1999a:15).

Hence Latour's ultimate caveat: no theory should ever be allowed to overshadow that which it is designed to illuminate (Latour 2004).

Against this introductory background and with this caveat in mind, our chapter now proceeds to address in more detail the principal aspects of Latour's theory, his philosophy and his methodology *within and around* actor network theory (ANT), and the relevance of his work for health sociology, and in particular the area of healthcare. We start with explaining Latour's main contributions, centring on rethinking the agency of material objects, expanding the field of material semiotics and applying the notion of networks and centres of calculation to social analysis. After setting out these key themes of his work, we explore their implications and application to the field of patient safety, specifically with regard to how the current modality of health service accountability appears to be shifting from numerical-calculative-rational methods operating to produce certainty 'from a distance', towards more narrative, local and multi-modal approaches allowing for complexity and 'heteroglossia'.

Biography and Latour's contributions to (social) science

Bruno Latour is a philosopher and anthropologist with an interest in scientific research practice. He was born in 1947 and taught at the École de Mines de Paris before being appointed Professor at Sciences Po Paris in 2006. Latour first became well known through his and Steve Woolgar's publication of *Laboratory Life: The Social Construction of Scientific Facts* (Latour and Woolgar 1979). In this book, Latour and Woolgar describe scientific labour conducted in a neuroendocrinology research laboratory. Besides involving all kinds of technical procedures and processes, this scientific labour is described in the book as constructing scientific facts by moving through different stages of certainty, from 'it's a personal story', via 'it's a laboratory artefact', towards 'it's probably a fact' oriented to gaining the support of peers and status within the scientific field more generally (Latour 1990). In constructing and realising this trajectory of 'fact construction', scientists enrol all kinds of actors and technologies (collectively referred to as 'actants' to acknowledge their agency) to lend importance and persuasiveness to their findings and conclusions.

Latour's approach has since defined the field of science and technology studies, demonstrating the dependence of scientific research and technological development on the progressive construction of facts and networks of actants supporting or confirming those constructed facts. Perhaps not surprisingly, for this reason his views became heavily contested by those seeking to defend a conventional appreciation of scientific achievement based on empirical rigour, truth and discovery (Boghossian 2006). Critics read Latour's work as equating the social construction of techno-scientific phenomena with relativism, reducing his accounts of how science unfolds to the position that any story about how things are in reality is as good as any other (Searle 1992).

In subsequent books, such as *The Pasteurization of France* (1988a) and *Aramis or the Love of Technology* (1996a), Latour elaborated his views and analysis of how science and technology are inevitably imbricated in social practices and networks. These books demonstrate that even effective scientific and technological solutions are unlikely to survive and persist unless scaffolded by a wide range of supportive practices and sociopolitical networks.

Latour's work further contributed in an important way to the formulation of ANT (Latour 2005). ANT marked a significant development in the social sciences. It emphasises three critical things: the potential agency of non-human actors (think about the impact of a virus on a population), the 'action from a distance' made possible through the translation of human agency into technological or bureaucratic agency realised through maps, machines and regulations, and the performativity or on-going activity that we need to engage in to maintain our social reality (Latour 1996b).

Latour arrives at these guiding principles by traversing different disciplines, including philosophy, anthropology, semiology (Greimas 1974) as well as ethnomethodology (Garfinkel 1967). Semiology, or the study of sign-making practices, enables Latour to trace the ways in which particular phenomena 'resemiotised' from one materiality into another (Iedema 2001). For example, people wanting to make sure their door was closed might ask individuals every time they come in to close the door, post a note on the door asking people to close it or install a mechanical door-closing device (Latour 1992). The latter two are translations, or resemiotisations, of what came before: the spoken request is 'translated' into the note; the note into the mechanical door closer.

Influenced by Gabriel Tarde's theory of social imitation, and in line with Garfinkel's ethnomethodological arguments, Latour regarded the social not as something 'out there' impacting on individuals as advocated in dominant sociological theory (Durkheim 1964). Instead, Latour adopts Tarde's perspective on the social (Tarde 2012), positing that the social both is and needs to be performed into existence (cf. Judith Butler's use of the term 'performativity', see (Butler 1996)). This performative perspective is prominent in the title of Latour's 2005 overview book explaining his general approach and ANT in particular, titled *Reassembling the Social*.

As already noted, Latour never shied away from calling his own theories into question, and even 'recalling ANT' in the late 1990s (Latour 1999a). Latour did clearly not subscribe to Inspecteur Clouseau's view that destroying a perfectly good piano is justified to get to the truth. For Latour, a theory or method should not ride roughshod over what is before us. On the contrary, a theory or method needs to be discarded if it turns out to be reductive of the complex circumstances in which we find ourselves. For him, a theory or a method should not become a distraction and risk complex material realities (the expensive piano) being sacrificed in favour of a promissory 'truth'.

Far from adopting a grand theoretical and rigid methodological stance that would lead us to miss what is evident and right before us, then, Latour prefers to work with a small number of investigative principles or what we could term 'minimal specifications' (Latour 2005). In what follows we examine two of these. The first is Latour's explanation of networks and centres of calculation, and how they enable 'action at a distance'. The second principle pertains to Latour's privileging of 'forums of engagement'. We finish with applying these principles to a specific aspect of health research: patients' safety.

How networks and centres of calculation allow for action at a distance

The publication of *Science in Action* in 1987 offered a new way of understanding technoscience as the production of 'knowledge' that is extracted, mobilised, maintained and collected through *networks* of practices and artefacts. Latour vividly describes how ideas move back and forth from being statements under contention, characterised as contingent, uncertain, fragile, to becoming 'facts' – black boxed explanations and knowledge that enjoy stability and become taken for granted. He points out that what we call scientific knowledge (theories or facts) is produced through 'trials of strength' that depend greatly on the density of the networks mobilised to bolster this knowledge – collections of literature, complicated laboratory set-ups, equipment, supporters in science or in other domains and so on.

The certainty of scientific knowledge therefore is not some cognitive absolute. Instead, certainty is a function of the socio-material networks that sustain and perform it. An important consideration here too is that the status of statements of fact always depends on subsequent statements and how these represent earlier ones. This process of 'translation' is critical to whether statements of fact will travel – whether subsequent translations accept or posit earlier ones as given, or treat them as uncertain and contentious. This means that no fact or account or statement can by itself sustain its own strength or credibility; instead, Latour teaches us that credibility always needs to be performed and constantly confirmed.[2] Credibility, factuality and certainty are never achieved once and for all, and in and for themselves: they ultimately depend on how and where and with whom translations align, where and how far they travel, and how much (economic, social) investment they can garner.

Further expanding on the ability of accounts to travel, in *Science in Action* Latour demonstrates how scientific methods address the challenge of acting *at a distance* – the desire to know about and to be able to act on what happens in other contexts (Latour 1987). He describes, for instance, the early explorers – tasked to search out distant lands and to 'bring them back' in the form of maps, meticulous records and knowledge about the depths of their channels, and about the peoples who live there and their willingness to trade (Latour 1986). This desire to act at a distance is the impetus for creating accounts, what we call information – scientific facts, knowledge or explanations of the world, which can travel distances through well-connected networks. This information is then brought together in 'centres of calculation', allowing those who populate these centres to control or at least influence what happens in multiple other, distant contexts.

In explaining how action at a distance unfolds in centres of calculation, Latour differentiates between 'knowledge' and 'practice'. For him, 'practice becomes whatever people do in the setting acted upon; knowledge becomes whatever is mobilised in [one setting] to act upon the other setting' (Latour 1988b:160). This differentiation enables Latour to outline the overarching features of knowledge that successfully traverse distances. Such knowledge has *mobility*, *stability* and *combinability*. This knowledge is portable rather than unwieldy, durable rather than fragile, and the information it transports is comparable or commensurable with other kinds of information. Knowledge that is mobile, stable and combinable relies on 'inscriptions' or 'immutable mobiles'. One example of such knowledge is the geographic map, enabling sailors and traders to plan voyages and trades (Latour 1986). Another example is the use of quantification in accounting which demonstrates how well numbers act as inscriptions. Whether we count diseases or treatments or payments, these accounts translate diverse and heterogeneous collections of qualities into equivalent quantities, making them transportable across time and space, and comparable with other kinds of (ac-)counting (Robson 1992).

The critical move in Latour's work therefore is his consideration of how specific and local phenomena (say, an island's landmass contours) become formalised into mobile, durable and commensurable kinds of knowledge to be used by others elsewhere. His analysis in effect enables us to understand the genealogies that produce these formalisms and the controversies that surround them, especially the power implications of the networks and practices that buttress such formalisms.

Drawing again on his studies of science – but applying them to multinational corporations, infrastructure and databanks, Latour also elaborates his views on how actions and decisions are *explained*. He refers to this as 'the politics of explanation' (Latour 1988b). Every time we offer an explanation of the world, he says, we are engaged in empire-building – that is, in network-building. The achievement of a strong explanation – one that has many allies and is difficult to counter or defeat – requires the tying together of 'as many settings as possible to as few elements as possible through as few intermediaries as possible' (Latour 1988b:160). This is where the combinability of phenomena into new immutable mobiles becomes critical. This is because immutable mobiles engender familiarity with (that is, afford knowledge of) things, people and events that were once distant:

> Nothing is unfamiliar, infinite, gigantic or far away in these centres that cumulate traces; quite the opposite, they cumulate so many traces so that everything can become familiar, finite, nearby and handy (Latour 1987:230).

Latour's analysis now reveals an important practical problem. The knowledge thus produced, rendered formal and defining of a centre of calculation and intention, now 'stands for' the distant context(s) that it represents. Its formality renders the un-represented invisible, and hence secondary, and potentially negligible. Made up of formal inscriptions, this knowledge risks losing its connection to what originally gave rise to it. Backgrounding the complexities of the contents that they represent, numerical data that translate specific aspects of practices and locales may turn into an end in themselves for people pursuing advanced kinds of calculation.

Here, we turn full circle: no fact, no account made formal and mobile in order to structure action at a distance is irrefutable or certain *in and for itself*. The strength of any fact (and the strength of the centres of calculation that mobilise and utilise it) is anchored in the associations and allies that support its claim on truth and knowledge.

We explore below the far-reaching implications of these considerations for health research, and particularly its more objectivist and statistical variants. Before we do so, we turn to a more recent and equally exciting development in Latour's thinking: his shift from 'matters of fact to matters of concern'.

From critique to engagement

The deconstruction of the certainty of scientific facts earned Latour much criticism. He readily acknowledges, and laments, this criticism (Latour 2004). One criticism he rejects outright however is that his work has the objective of debunking scientific certainties and thereby inviting 'mob rule'. In countering this criticism, he argues that the risk of 'mob rule' evaporates when we stop wishing for 'a transcendent force against the unruly mob' (Latour 1999b:15):

> The fight for or against absolute truth, for or against multiple standpoints, for or against social construction, for or against presence, has never been the important one. The program of debunking, exposing, avoiding being taken in, steals energy from the task that has always seemed much more important to the collective of people, things, and gods, namely, the task of sorting out the 'cosmos' from an 'unruly shambles' (Latour 1999b:22).

What Latour says here is that there are more interesting and fruitful things to do and discuss than the search for absolute facts. We do not need to engage in the war between Might and Right. There is an alternative, Latour suggests: 'the collective'. In *Pandora's Hope* (1999b), for instance, he contrasts the different ways in which we can describe the activity of scientists. One is as 'Science': activity that is cold, aloof, objective and distant, detached from politics, finance, ethics and values. The other is as 'Research': activity that is uncertain and open-ended, and deals with the everyday materialities and necessities of time constraints, budgets, personal relationships and rivalries, malfunctioning instruments and technical know-how.

To describe scientific activity as Research means acknowledging it to be a messy enterprise, and not giving in to political or marketing pressures to idealise scientific practices out of respect for their achievements:

> Take some small business-owner hesitatingly going after a few market shares, some conqueror trembling with fever, some poor scientist tinkering in his lab, a lowly engineer piecing together a few more or less favourable relationships of force, some stuttering and fearful politician; turn the critics loose on them, and what do you get? Capitalism, imperialism, science, technology, domination – all equally absolute, systematic, totalitarian. In the first scenario, the actors were trembling; in the second, they are not. The actors in the first scenario could be defeated; in the second, they no longer can. In the first scenario, the actors were still quite close to the modest work of fragile and modifiable mediations; now they are purified, and they are all equally formidable (Latour 1993:125–6).

Here, Latour challenges those who debunk science by caricaturing it as pure, detached and objective. In contrast, his own accounts of science as Research portray it as ‘a *collective experimentation* about what humans and non-humans together are able to swallow or to withstand’ (Latour 1999b:20). Framed within the terms of the discussion we presented earlier, after achieving peer recognition for a particular facet of knowledge and its explanation, scientific practice also involves pursuing the detachment of that knowledge and its explanation from their original sites and practices, such that the knowledge and explanation can intervene in new sites and practices. In sum, a Research approach to scientific activity and knowledge construction foregrounds the minutiae of labour involved in scientific network-building that goes on both within and beyond science.

In a seminal 2004 paper, Latour extends this argument about the contrast between idealised and more forgiving portrayals of scientific activity. In this paper, he differentiates between ‘matters of fact’ and ‘matters of concern’. The former – matters of fact – refer to knowledge entities that have become decontextualised and detached from their sites and practices of production, and are now taken for granted, no longer scrutinised. The latter – matters of concern – refer to knowledge practices involving multiple actants, complex gatherings and negotiations, which require our attention and scrutiny.

Latour foregrounds this distinction to enable him to analyse the sociologist’s and the science critic’s points of departure. Generally, critics of science justify their challenge on the ground that science lays claim to objectivity, certainty and factuality, or truth. What such a stance renders invisible, Latour suggests, is that science critics adopt their stance because they too are taken in by the apparent significance, objectivity, certainty and factuality of science’s claims, instead of recognising the complex and arduous labour that science expends on producing this significance, objectivity, certainty and factuality. For Latour, this means that not just science but also *social* science (and hence sociological critiques of science) are held hostage to the contestation over matters of fact, rather than recognising that (social) scientific practices are ultimately all about, and arise from, struggles over matters of concern.

This is why Latour suggests that we as social scientists should moderate our tendency towards traditional critique – which is harsh and makes fools of its subjects, to inquire instead into how things are assembled – how it is that multiple ‘actants’, human and non-human actors, gather together to produce relevance and maintain their existence:

> The critic is not the one who debunks, but the one who assembles. The critic is not the one who lifts the rugs from under the feet of the naïve believers, but the one who offers the participants arenas in which to gather. The critic is [...] the one for whom, if something is constructed, then it means it is fragile and thus in great need of care and caution (Latour 2004:246).

In concluding this section, we should mention that in 2010, Latour 'came out' as a philosopher, reflecting on his body of work and proposing to conduct a full-scale positive and constructive anthropology of the modern. He suggested that we start thinking not of a project of modernity but rather of *ecology*, which he defines as 'not the science of nature but the reasoning, the logos, about how to live together in liveable places' (Latour 2010:605). For scientists, he argues that the stubborn defence of Science (with a capital S) actually obfuscates the development of networks that allow a multi-directional transfer of immutable mobiles. Yet herein lies the value of science: giving us ways 'to live together, in liveable places', to 'sort out the cosmos' from the 'unruly shambles'.

These points are relevant for the discussion that follows about the ways in which researchers, clinicians and policy-makers have tried to sort through the 'unruly shambles' of healthcare delivery. In this section, we reflect on how Latour's thinking can help us make healthcare liveable and workable for patients, as well as staff who are currently under constantly rising pressure to improve the efficiency and safety of their practices.

Latour and patient safety improvement

Patient safety came on to the radar of researchers, healthcare professionals and policy-makers in the 1990s following a rash of publications announcing unexpected and excessive levels of health-service-caused harm – that is, avoidable harm to patients caused by healthcare delivery. What sparked alarm was that this harm occurred in some of the most trusted hospitals and health services in developed countries such as the United States, the United Kingdom and Australia (Wilson et al. 1995; US Institute of Medicine 1999; Vincent et al. 2001). Moreover, such harm is extremely costly both in human and financial terms (US Institute of Medicine 1999). Hence, patient safety has become an increasingly prominent concern, resulting in the widespread adoption of safety research findings into policy and practice, alongside a rise in the use of monitoring systems and reporting technologies promoted by safety experts and associations bolstered by specialised patient safety journals and international conferences (Wachter 2010).

Within these networks of activity, the main approach has been to find out why so much harm occurs, and what can be done to reduce it. The ever-increasing complexity of healthcare provision is consistently cited as an underlying factor, and one major response has been to 'tame' this complexity by increasing standardisation. Standardisation is pursued through the dissemination of policies, protocols and guidelines, designed around the principles of evidence-based medicine (Timmermans and Berg 2003). Accordingly, a significant body of patient safety literature is invested not only in the success of these formal and formalising principles but also in uncovering 'barriers' to their implementation (Pfeiffer et al. 2010). The two principal objectives that define these patient safety endeavours are the simplification of clinical work and the alignment of individual professionals' knowledge, actions and intentions to formal rules.

Let us consider these objectives through the lens of Latour's philosophy, particularly his work on centres of calculation, the politics of explanation and the shift from matters of fact to matters of concern. Doing so will help us to understand not just the popularity of these objectives, and the formal accountability approaches favoured among professionals and policy-makers, whose primary objective is to control and reduce *in situ* clinical and organisational complexity from a distance. It will also help us appreciate the shortcomings inherent in these objectives and approaches. Applying Latour's thoughts on moving from matters of fact to matters of concern, and from positioning ourselves as critics on the side-lines towards facilitators of forums of engagement, we become able to envisage alternative strategies that counter-balance the practices of concentrating knowledge in distant centres of calculation and excluding frontline professionals and patients from these centres' forums and processes of calculation (Iedema et al. 2013).

Accounting for safety

Latour's thinking helps us understand the work that policies, protocols and guidelines do in healthcare – enabling 'centres' such as the various departments of health, government quality and safety bodies, and even trans-national bodies such as the WHO, to act on the many different and varied staff and wards in every hospital, in every area health service, state and country – that is, to act on multiple settings from a distance.

Policies and their various translations – grouped together here as written documents that structure action by prescribing 'what to do' in specific situations (Berg et al. 2000) – travel to and traverse these distant sites where work happens 'at the coalface'. This work at the coalface is now also measured against the units set out in this documentation: for example, the number of staff who have washed their hands according to the protocols, or the time it takes to admit patients into the emergency department (ED), discharge a patient from a ward or enable a patient to undergo surgery. These aspects are measured, or rather, translated into numerical and material inscriptions through audits, record-keeping, reports and so forth. These translations, in turn, then travel along various paths to return to their centres of origin and legitimation for further decision-making.

These centres target and foreground specific aspects of clinical work, which can result in the privileging of certain dimensions of care over others – especially that which is more easily counted – and which can then often become 'what counts'. In what follows, we look at an incident reporting system as one such example of an inscription-generating system. We examine how the complex and multifarious elements of practice, politics and emotion that play through incidents causing harm are reduced to formal inscriptions (incident reports), and how these reports are then mobilised across large distances. We draw on Latour's work outlined above to explain both the popularity and the shortcomings of these processes.

Incident reporting

Incident reporting systems are designed to allow organisations to record and monitor incidents where patients have (or could have) been harmed. Staff are asked (or required – although comprehensive reporting of all incidents remains elusive) to translate these unexpected and undesirable events into carefully structured categories and forms (for example, a medication error, a fall). These inscriptions are then fed into databases collecting incident information, where they are aggregated geographically and analysed for patterns and trends. One of the assumptions underpinning incident reporting is that 'experts elsewhere' will be able to identify safety risks and translate these findings into guidelines that are then disseminated across multiple sites, compliance with which is understood to obviate such risks (Runciman et al. 2002).

Incident reporting thus enables action 'at a distance', using an online network of computers with reporting software, flowcharts of how reports are to 'travel', manuals on how to use the software, policy directives for staff on what kinds of incidents to report and charts of severity codes. Throughout this technologically driven process, complex and sometimes ambiguous or disjointed incident genealogies are transformed iteratively by staff into accounts that become more and more mobile, stable and comparable (Waring 2009). These accounts conform to structured drop-down lists of incident options, such as the type of error, severity of the incident, time, ward in which the incident occurred, and so on, down to the specific medication given in error. Although there are also free text sections, the fixed-option categories provide powerful comparative opportunities for safety experts and agencies.

In many ways, incident reporting fulfils our desires for accountability and 'transparency', for people outside being able to 'see' into the world of frontline work. However, incident reports inevitably reduce the complexity and ambiguity surrounding specific incidents, and our reliance on such reports, used at a distance, can inhibit the work done locally to negotiate and understand the complex confluence of factors that result in unsafe incidents. In that regard, a distanced use of incident reporting may assist those at a distance, but they may very well also detract from learning *in situ*. Learning is obviated when our attention is prevented from focusing on the messy events and disjointed narratives 'at the scene' shared among staff, patients and relatives, and is instead trained on these events' *transmogrification* into structured and formal incident reports and abstracted and generalised categorisations (Waring 2009). This transmogrification strips incidents of their complexity and politics in how incidents are recounted, in how incident solutions are formulated, in how professionals understand incidents to happen and in how practice improvement is achieved (Hor et al. 2010).

That said, research has revealed that incident reports can usefully elicit local discussions among clinicians about adverse events (Hor et al. 2010). For instance, a multidisciplinary medical team in a metropolitan teaching hospital in New South Wales, Australia, were found to use incident reports to initiate discussions and learning during scheduled meetings about incidents involving their patients (Hor et al. 2010). In these meetings, what were sometimes miscoded or insufficiently detailed reports were fleshed out by team members, including junior and senior doctors and senior nurse consultants who had first-hand experience of the incidents reported. Here, besides seeking to report on unexpected events to others elsewhere and to enable action at a distance, the reports buttressed the team's own attempts to recollect the detail of unexpected events, in effect treating them as matters of concern. The team discussed the messy detail of how the incidents happened, who was involved and even how the reports were constructed and why, by whom, and what was left out and/or included. Team members also disputed the categorisation or coding of incidents, and seemed able to resolve these discussions with actions to prevent similar incidents from occurring (Hor et al. 2010).

Using incident reports experts can spot rare but dangerous drug combinations, for example, or especially risky times for particular procedures, and this is valuable. There is however also valuable learning to be done by clinicians using these accounts locally, treating them not as matters of fact but as matters of concern, opening single accounts up to alternative interpretations and exploring their complexities and tensions. It is this latter strategy in fact that has informed recent new approaches to researching and accomplishing local safety in healthcare.

Video-reflexive ethnography, for instance, is a method that has been developed with the guiding principle of treating clinical practices always as matters of concern. Here the researcher's role is to harness and facilitate an exploration of local assemblages and local matters of concern (Iedema et al. 2013). The method uses video footage of everyday practices, collected collaboratively with participants, which researchers then show back to participants in group reflexive sessions. The process is uniquely tailored towards encouraging both researchers and participants to grapple with the complex realities and tensions of clinical work, away from simple linear or 'factual' explanations, and giving participants (including the researchers) the opportunity to reimagine new ways of working, sensitive to the messy socio-political, technical, material and emotional realities of their particular workplace environments.

Conclusion – Latour's safety

Latour's work presents an uncompromising account of how facts are produced from knowledge and network construction. In our present-day world, he contends, we should not satisfy ourselves with allowing existing centres of calculation to determine what is true and right. Instead, we should partake in forums of engagement, acknowledging that facts, instead of automatically issuing from transparent realities, scientific methodologies, and distant authorities, are no more than the outcomes of what people decide together and choose to do together. This idea is significant, as the complexity of our present-day world forces us to focus more closely and more frequently on how we do things together in the here-and-now. Local forums of engagement are important therefore for counter-balancing the traditional influence of distant centres of calculation whose interests and concerns may not be sensitive to rapidly shifting realities at the frontline.

We applied these elements of Latour's thinking to the approaches that prevail in patient safety research and policy-making. Here, we find that safety is predominantly construed as professionals' compliance with facts issued by distant centres of calculation. This construal of safety downplays the significance and legitimacy of actively grappling with complexity and local stakeholders producing emergent kinds of safety at the frontline (Iedema et al. 2013).

Most importantly, the shift from matters of fact to matters of concern, and from critique to engagement – exemplified in team-led initiatives at the frontline, and by research methods such as video-reflexive ethnography – together herald a more humble approach to science, knowledge and agency, and has a critical bearing on how we study, portray and accomplish patient safety into the future. Here, Latour's approach departs in a critical sense from that of Inspecteur Clouseau, alerting us to the priceless piano that is before us, and warning us not to be overly distracted by the promise of truth and certainty from beyond the here-and-now.

Notes

1. The full title of the conference was: '*What Is an Organization? A Tribute to the Work of James R. Taylor'* Montreal, 21–22 May 2008.
2. Latour's stance is cognate with ethnomethodology's notion of 'sequential implicature', pointing to the meaning of meanings being contingent on how these meanings are taken up in subsequent interaction (Garfinkel and Sacks 1970).

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Chapter 43

Paul Farmer: Structural Violence and the Embodiment of Inequality

Fernando De Maio

Paul Farmer is one of the most influential advocates for health equity in the world today. His analyses – rooted in both social science and medicine, owing to his training in anthropology and infectious disease – highlight the importance of the social determinants of health. His work has challenged existing orthodoxies in medicine and global health, including the belief – widely held in the 1990s – that treatment for HIV or multi-drug-resistant tuberculosis (MDRTB) was impossible in poor settings. Farmer has questioned the reliance on 'cost-effectiveness' as a decision-making process in healthcare delivery, arguing instead for the centrality of equity. At the same time, his work has critiqued medical anthropology, medical ethics, and related fields, including human rights, for ignoring the fundamental causes of global health inequities. Farmer's vision of 'geographically broad and historically deep' analysis offers a framework for a political economy of global health equity, a way of working that respects the tremendous benefits of biomedicine, yet highlights the social 'fault lines' that negate its discoveries for the majority of the world's poor.

Central to Farmer's work is the concept of *structural violence*, which he defines as:

> . . . social arrangements that put individuals and populations in harm's way . . . The arrangements are *structural* because they are embedded in the political and economic organisation of our social world; they are *violent* because they cause injury to people (Farmer et al. 2006:1686, emphasis added).

As a guiding concept, structural violence broadens and deepens our thinking about the causes of disease, explicitly linking our biology with global political economy. In this chapter, I use Farmer and the concept of structural violence as a way of understanding the embodiment of inequality. In particular, I explore how his ideas can be used in relation to the positivist research literature on income inequality and health. Farmer's perspective offers a more nuanced and global account of the pathogenic effects of inequality than is typically presented in public health and medical sociology.

Biography

Paul Farmer was born in Massachusetts in 1959 and raised in Florida. He studied medical anthropology at Duke University, and obtained his medical degree and PhD in anthropology from Harvard. He is currently the Koloktrones University Professor at Harvard and also serves as the Chief of the Division of Global Heath Equity at Brigham and the Women's Hospital in Boston, Massachusetts. He is the co-founder of Partners in Health (PIH) – one of the most important non-government organisations working in global health, with a significant presence in Haiti, Rwanda, Peru, Malawi, Russia and a host of other countries. PIH provides free care to impoverished populations, with expertise in HIV/AIDS, tuberculosis, cholera as well as cancer and other chronic diseases. They have also spearheaded a new movement in health services based on the use of community health workers.

His work developed at a unique time in global health. He saw first-hand the growth of the HIV/AIDS pandemic in the 1980s and 1990s, and owing to his dual role as a doctor in rural Haiti and in one of Boston's most well-equipped hospitals, he also saw the varying levels of care that could be offered to patients. He saw how politics and economics conspired to limit the poor's access to life-saving medicines. And he recognised this as an inequity: an inequality that is avoidable, unnecessary and unfair (Whitehead 1992; De Maio 2010).

Farmer's work

For many decades, health economists have integrated 'cost-effectiveness' analysis into health policy debates (Farmer et al. 2013). As a result, many medicines – including highly effective anti-retroviral therapy which essentially turned HIV from a death sentence to a manageable chronic disease in the 1990s – were deemed inappropriate technology for poor settings, effectively discarding the hope of the world's poorest people of benefiting from advances in biomedical and pharmacological innovation (Kovsted 2005; Hoen et al. 2011). Farmer has called his work a 'protest' against the social forces that foster inequities in health and a call for recognising the primacy of the right to health.

Farmer strongly critiqued the practice – widely accepted in the 1990s – of running HIV trials in sub-Saharan African countries which sought to observe the 'natural transmission' of the disease in treatment-naïve groups. He argued that such work, though approved by US-based ethics boards, exploited already marginalised populations, using their bodies for 'biovalue' and never sharing the direct benefits of the newly developed medications (Quinn et al. 2000; Farmer 2003). Throughout, Farmer's work shows a deep antagonism to inequity expressed through differential access to medical services. He and his colleagues in PIH have demonstrated the feasibility of providing advanced medical care in the poorest of places. In doing so, they have highlighted the real harm caused by the simplistic view that healthcare can be delivered under market mechanisms, writing ‘As a physician who has worked for much of my adult life among the poor of Haiti and the United States, I know that the laws of supply and demand will rarely serve the interests of my patients’ (Farmer 2003:5). Farmer’s writing – at times ethnographic, epidemiological and historical – emphasises the voice and needs of the poor.

His work displays a keen sense of global interconnectedness. Eschewing anachronistic divisions of the world into ‘developed’ and ‘developing’ countries, his analysis brings to the foreground the permeability of national boundaries to the flow of disease, and contrasts this with the erection of political, economic and cultural barriers that inhibit residents of affluent countries from recognising their position in a global web. Farmer observes, ‘the suffering of the world’s poor intrudes only rarely into the consciousness of the affluent, even when our affluence may be shown to have direct relation to their suffering’ (2003:31). Moreover, he writes:

> . . . to argue that human rights abuses occurring in Haiti, Guatemala, or Rwanda are unrelated to our surfeit in the rich world requires that we erase history and turn a blind eye to the pathologies of power that transcend all borders (Farmer 2003:245).

This perspective is rare in a field that has for many decades been grounded in *modernisation* and *development* theories (Cardoso 1972; Kay 1991; De Maio 2014). For many people, improving global health is still a matter of charity and the transfer of knowledge (in the form of high-tech medical services and/or policy ideas) from the ‘developed’ to the ‘developing’ world. Farmer’s perspective – with its clear ties to world-systems theory – challenges these notions.

In contrast to the more traditional ‘public health’ and ‘international health’ paradigms, Farmer’s work is indicative of the nascent ‘global health’ perspective (Koplan et al. 2009; Kruk 2012). The differences between these perspectives are beyond semantic; they alter how we might go about research and what kinds of solutions we seek to develop. Whereas international health in many ways is centred on health *out there*, in low- and middle-income countries, and while public health has historically been driven by a focus on populations and the idea of equity in health, neither of these perspectives adequately conceptualise the *interconnections* between policies and practices in the Global North and the Global South. Global health is increasingly not just about what happens *out there*, but is more concerned with how health/disease is shaped by global economic, political and cultural forces that transcend national boundaries.

This conceptualisation of global health runs throughout Farmer's writings. In his first book, *Aids and Accusations: Haiti and the Geography of Blame*, Farmer (1992) analyses the HIV/AIDS epidemic in Haiti, showing the deep connections between the rural health conditions on the island and global forces, including US military and development policy. His early work in Haiti is based in the impoverished central plateau, particularly the village of Cagne. With ethnographic richness, Farmer's analysis depicts the plight of his patients – their health, their understanding of disease, how they make sense of suffering – while highlighting the structural forces that have fostered both disease outbreaks and the poverty that prohibits their access to healthcare. Central to his analyses is the construction of a hydro-electric dam in the region which flooded the area's best agricultural land, forcing peasants to precarious living conditions. It is that act of US-aided 'development' that forms the core of Farmer's history of the region, although his work displays a keen appreciation of the importance of longer-term history as well (illustrated most clearly in *The Uses of Haiti* (Farmer 1994), his most detailed treatment of Haitian political economy).

Farmer's work is best described as blending ethnography and public health, and overall seeks to analyse the global politics of health such that we understand the lived experience of individuals while recognising the deep structural roots of their suffering. Farmer observes in a passage clearly reminiscent of Mills' (1959) *Sociological Imagination*: '...to explain suffering, one must embed individual biography in the larger matrix of culture, history, and political economy' (Farmer 2003:41). It is this perspective that makes Farmer such a noteworthy theorist in global health.

Farmer's work on structural violence and inequality as a fundamental determinant of health developed in *Infections and Inequalities* (Farmer 1999). He offers an historically rich ethnographic perspective on the relationship between inequality and health outcomes (particularly HIV/AIDS, tuberculosis and MDRTB), and advances our understanding of the issue in important ways. He calls for empirical research on the relationship between social inequality and the development of MDRTB, noting that in settings of shared wealth or poverty, MDRTB is unlikely to develop. In the first setting, access to efficacious treatment will control tuberculosis. In the second setting, few have access to drugs and therefore resistance to the drugs is unlikely to develop. However, Farmer argues, in settings of *inequality* – where poor and rich coexist – forces leading to MDRTB may actually be strengthened. This is because of the unequal access to treatment that is characteristic of such areas; some people will receive treatment, others will not, and some will receive treatment on a sporadic basis – and it is this third situation (sporadic treatment) that leads to drug-resistant strains of tuberculosis. Throughout his work, Farmer identifies inequality itself as a fundamental cause of illness.

His analysis of structural violence deepened in *Pathologies of Power* (Farmer 2003). It is this book, perhaps more than his others, where the strongest analysis of inequality as the fundamental cause of preventable disease and illness is presented. This book is an explicit critique of human rights and medical ethics for ignoring global health inequities and of social researchers for conflating 'culture' with poverty. Farmer's work takes on a truly global perspective – from the plight of Guatemalan orphans to the Zapatista rebellion in Mexico, to Russian prisoners fighting prison-acquired multi-drug-resistant tuberculosis. His work weaves these geographically disparate populations in a way that no other global health analyst has done to date.

Tracy Kidder's (2004) *Mountains Beyond Mountains* is currently the only published biographical work on Farmer. Kidder's account follows Farmer at a critical point in time – when Farmer's work in Haiti began to draw widespread attention in the popular press, and PIH emerged as a central player in global health, partly as a result of new-found funding from the Bill and Melinda Gates Foundation. Kidder offers a well-grounded and balanced perspective on Farmer – writing of admiring Farmer's unwavering commitment to providing high-quality healthcare to the poor as a matter of social justice while also fearing that he would disappoint him for being unable to match his concern for the poor. Kidder writes: 'I'd feel sorry that so many Haitian children still died of measles ... but I'd also feel I could never be sorry enough to satisfy him' (Kidder 2004:29). The book is an accessible account of Farmer's work in global health, with nuanced analysis of some of the most important concepts underpinning his theoretical and methodological positions.

Central concepts

Three interrelated concepts/frameworks are used throughout Farmer's work: (1) structural violence, (2) 'geographically broad and historically deep' analysis, and (3) liberation theology.

Structural violence

Structural violence is the core conceptual tool used in his work. It is used as both a descriptive term and an explanatory concept – the key building block in his theoretical arguments over the nature of health inequities. In *Pathologies of Power*, Farmer (2008:8) writes:

> For well over a decade, I have grappled, as have many others, with conditions that could only be described as violent – at least to those who must endure them. Since the misery in question need not involve bullets, knives, or implements of torture, this misery has often eluded those seeking to identify violence and its victims.

For Farmer, structural violence is a wide-ranging tool describing a 'host of offensives against human dignity', including poverty, racism and discrimination, gender inequality as well as 'the more spectacular forms of violence that are uncontestably human rights abuses, some of them punishment for efforts to escape structural violence' (Farmer 2003:8). Within this conceptualisation, structural violence is a multi-level idea, through which different 'axes' of oppression – based on economic inequality, patriarchy, racism, or other forms of discrimination – may intersect to generate preventable morbidity and premature mortality in marginalised populations.

Farmer uses the term as a critical realist *generative mechanism* (Scambler 2001) – something that cannot be directly measured with positivist methods, but can be theorised about, and can be understood through its effects on observable phenomena. Farmer (2003:50) notes:

> . . . today, the world's poor are the chief victims of structural violence – a violence that has thus far defied the analysis of many who seek to understand the nature and distribution of extreme suffering. Why might this be so? One answer is that the poor are not only more likely to suffer; they are also less likely to have their suffering noticed.

In particular, he criticises medical ethics and human rights discourses for ignoring structural violence, thus becoming tools for 'managing inequality' rather than overcoming it.

'Geographically broad and historically deep' analysis

'Geographically broad and historically deep' analysis is the salient characteristic of Farmer's methodological stance. The geographic scale is influenced by his conceptualisation of global health and global economic ties: 'the world as we know it is becoming increasingly interconnected. A corollary of this fact is that extreme suffering . . . is seldom divorced from the actions of the powerful' (Farmer 2003:42). Understanding the HIV/AIDS epidemic in Haiti, MDRTB in Peru, or maternal mortality in Rwanda requires analysis of not just what is happening in those countries but also of the global forces that influence (often by constraining) the actions that have been taken in those countries. From this perspective, to understand structural violence in one setting requires both a micro and macro analysis. Similarly, understanding these phenomena requires deep engagement with the history which manifests in contemporary power relations – for example, Farmer argues that understanding the HIV/AIDS epidemic in Haiti cannot be understood without analysis of the effects of decades-old development projects (the Peligre Dam) on the living conditions of rural peasants, nor without a longer-term view of the country's struggle for democracy over international interference.

Liberation theology

Liberation theology is described by Farmer as his 'moral compass', and throughout his work, takes the place usually afforded by researchers to a theoretical perspective. Arising from progressive Catholic theologians in Latin America in the 1950s and 1960s, liberation theology is firmly grounded in the lived experience of the poor. It is most closely associated with the work of Gustavo Gutiérrez, Leonardo Boff, Jon Sobrino, Óscar Romero and Juan Luis Segundo (Gutiérrez 1998). Its fundamental assertion is that social inequality is the product of 'structural sin'. Liberation theology applies Catholic social teachings to understanding socially and politically produced suffering (Boff and Boff 1987; Gutiérrez 1998), arguing that efforts to understand and alleviate poverty must be structural in nature – they must grapple with the political economy that generates poverty in the first place (Farmer 2014). Liberation theology offers a politically focused analysis of suffering – and its message has been influential in a range of Latin American social movements. It is closely associated with Marxist concepts of class struggle, class consciousness, alienation and exploitation, as well as ideas drawing on dependency theory explaining the *development of underdevelopment* in Latin America (Frank 1969; Dussel 2003).

Farmer takes liberation theology's Marxist core as his own, without explicitly aligning himself or being explicitly interested in academic Marxism. Farmer (2003:138) writes:

> . . . liberation theology has been one of my intellectual sources. Liberation theology, curiously enough, is the branch of theology most likely to turn to social theory, history, political economy. This would seem like an indirect way for an anthropologist to delve into the social sciences. But liberation theology adds something not found in any discipline: *how is this relevant to the suffering of the poor and to the relief of that suffering?* Thus, unlike most forms of social analysis, liberation theology seeks to yoke all of its reflection to the service of the poor.

Thus, liberation theology provides Farmer's theoretical perspective (a worldview in which poverty is *produced by* mechanisms of exploitation) as well as a guide for social action, placing utmost value on providing a 'preferential option for the poor'.

From liberation theology, Farmer (2003) derives what he describes as a 'simple methodology': *observe, judge, act*. Observation is described by Farmer as traditional scholarly analysis – critically important, but by itself insufficient. Farmer is clear in his work that it is not enough to study the suffering of the poor; that the task at hand is to change the world and reduce that suffering. In doing so, Farmer emphasises the second and third elements of liberation theology's methodology – judgement and action.

In his writing about judgement, Farmer explicitly challenges not only factors associated with structural violence but also our ways of thinking about them. He observes:

> Liberation theologians are among the few who have dared to underline, from the left, the deficiencies of the liberal human rights movement ... When children living in poverty die of measles, gastroenteritis, and malnutrition, and yet no party is judged guilty of a human rights violation, liberation theology finds fault with the entire notion of human rights as defined within liberal democracies (Farmer 2003:142).

Moreover, 'the goal of judging is not producing more publications or securing tenure in a university ... [the task is to] *change* the world' (Farmer 2003:144–5). Lastly, Farmer's position on *action* is particularly important. Throughout his work, it takes the form of 'pragmatic solidarity' with the poor. Drawing on the work of Paulo Freire, Farmer (2003:153) explicitly critiques traditional views of charity:

> Those who believe that charity is the answer to the world's problems often have the tendency – sometimes striking, sometimes subtle, and surely lurking in all of us – to regard those needing charity as intrinsically inferior. This is different from regarding the poor as powerless or impoverished because of historical processes and events ... There is an enormous difference between seeing people as the victims of innate shortcomings and seeing them as victims of structural violence.

Farmer thus places structural violence at the core of his theoretical gaze while also insisting – as did Marx in his *Theses on Feuerbach* – that our work must not only describe the world and its suffering, but must also seek to change it.

Scholarly lineage

Among the wide range of theorists who have written about health inequities, the strongest lineage is to be found in the ideas of Rudolph Virchow – the Prussian pathologist whose work on the links between living conditions, material deprivation and infectious disease is now acknowledged as a landmark in the social determinants of health literature (De Maio 2010). It is Virchow who famously concluded that 'disease is not something personal and special, but only a manifestation of life under (pathological) conditions ... Medicine is a social science and politics is nothing else but medicine on a large scale ...' (Virchow [1848] 1985) – an idea with clear echoes in Farmer's writings. Virchow taught us that the role of the physician is social and political, not merely scientific (Mackenbach 2009) – something which Farmer also reflects. Both Farmer and Virchow illustrate that the practice of medicine ought not to be separate from social activism and should work towards social justice.

Farmer's work also displays strong ties to the Latin American tradition of social medicine (Waitzkin et al. 2001; Barreto 2004). Although largely ignored in the English-language literature, it is the tradition of social medicine that has done the most to conceptualise disease as a product of both biological and socio-political processes. Its basic philosophy is radical, positing that a population's level of health cannot be understood – and thereby cannot be improved – without explicit engagement with its material conditions and its economic and political organisation. Moreover, the tradition is centred on social theory – calling for 'critical and ideological analysis of what is usually presented as purely technical knowledge' (Tajer 2003:2023). It is known as both a body of literature and as a political movement, one that values the articulation between theory and social change. All of these elements are fundamental to Farmer's work – which emphasises material conditions (framed as structural violence) and simultaneously critiques 'technical knowledge' (including inadequate regulations for treating MDRTB, unjust systems for pricing medicines, and uncritical formulations of 'health transition' in poor countries).

As well, a range of other theorists are also cited throughout Farmer's work – from Immanuel Wallerstein and *World Systems* to Arthur Kleinman and *Social Suffering* to Amartya Sen and *Capabilities*. All of these theorists contribute to Farmer's vision – one which centres on structural violence expressed through inequality as the fundamental cause of health inequities in the world today.

Pathogenic effects of inequality

Farmer's work is in many ways the qualitative/ethnographic counterpart to Richard Wilkinson's quantitative statement of the pathogenic effects of inequality. That area of work – which has grown exponentially since the publication of *Unhealthy Societies* (1996) – tests the basic idea that inequality (as a characteristic of the places in which we live) has direct influence on our health. The hypothesis has generated intense debates – with disagreements on methodological, theoretical and epistemological issues (Muntaner and Lynch 1999; Subramanian and Kawachi 2003; Coburn 2004; De Maio 2010). However, many central issues remain contested, and a consensus on the hypothesis is far from clear.

More than 200 statistical studies have examined the relationship between income inequality and population health, and approximately 90 per cent of these have found at least some support for the hypothesised relationship. However, once control variables are taken into account, this figure drops to approximately 40 per cent (Wilkinson and Pickett 2009b), with little agreement in the literature surrounding the distinction between confounders and mediators, the geographical level in which the hypothesis should be tested, the regions in the world where the hypothesis might apply (Lynch et al. 2003; Subramanian and Kawachi 2003; Lynch et al. 2004), and which health indicators should be used (De Maio 2007, 2008). Despite a large and growing body of research, agreement on the validity of the hypothesis, the mechanisms that underlie it, and the global forces that shape it has not been reached (Deaton 2002; Starfield and Birn 2007; Subramanian and Kawachi 2007; De Vogli et al. 2009; Bernburg 2010).

The bulk of literature suggests that income inequality is associated with poor health outcomes, at least in the United States (Ross et al. 2000; Backlund et al. 2007; Wilkinson and Pickett 2009a), with some contested exceptions (Deaton and Lubotsky 2003; Muntaner 2003; Subramanian and Kawachi 2007). The extent to which this model applies in within-country analyses in other parts of the world, including the relatively more equal countries of Scandinavia (Böckerman et al. 2009) and Central and Eastern Europe (Bobak et al. 2007) has been called into question. As well, non-significant findings have been published using data from other relatively equal countries, including Germany (Breckenkamp et al. 2007), Denmark (Osler et al. 2002, 2003), Canada (Veenstra 2002; Auger et al. 2009) and Japan (Shibuya et al. 2002).

Lending credence to the idea of a 'threshold' effect, wherein income inequality has a detectable effect on health but only at or above a certain level of inequality, significant effects have been detected in the relatively unequal countries of China (Pei and Rodriguez 2006), Italy (De Vogli et al. 2005), Brazil (Cavalini and de Leon 2008) and Chile (Subramanian et al. 2003), as well as in Argentina (De Maio 2008; De Maio et al. 2012). At the same time, recent multi-country analyses (Pickett et al. 2005; Moore 2006; Dorling et al. 2007; Pickett and Wilkinson 2007) have generated renewed support for the hypothesis, although this has been disputed in work using self-rated health measures (Jen et al. 2009). The net result of the empirical work in this area is deeply nuanced.

The core of the literature has been described by both friendly critics (Coburn 2000; Muntaner 2003) and hostile critics (Wainwright and Forbes 2000; Scambler 2001) as positivist, as it relies almost exclusively on statistical analysis of secondary data and looks to build a general theory from repeated observations of correlations between exposure (inequality) and effect (poor health). Most studies in this area have utilised some form of regression analysis. Some of the most intense debates in this field have been over measurement issues – the use of morbidity or mortality indicators, the geographical level at which to study the hypothesis, the operationalisation of income distribution, and the appropriateness of ecological versus multi-level statistical approaches. All of these are indicative of an epistemological approach that is guided by the idea that to 'measure is to know'. While never fully succumbing to the abstracted empiricism forcefully criticised by C. Wright Mills in the *Sociological Imagination* (1959), most of the studies in this area have largely ignored generative mechanisms (Scambler 2001) that are reflective of political economy. Income inequality has tended to be the starting point of the analysis, and the political/social determinants of that inequality have been neglected.

This has been perhaps the most important weakness of the scholarship on the income inequality – health hypothesis. A great deal of attention has been given to pathways that may link inequality to poor health, with insight drawing on psychosocial, social cohesion and neo-materialist traditions (De Maio 2010). Relatively few studies have focused on the mechanisms underlying patterns of income inequality, with the result being that a political economy of the health effects of income inequality is at best only preliminarily sketched out in the literature.

It is precisely this missing element that can be at least partly addressed by a closer consideration of Farmer's work, for structural violence is the generative mechanism that can manifest in high levels of economic inequality and poor population health indicators. Other scholars, including David Coburn, have expressed similar positions. Indeed, critical realist scholars like Coburn have called for an alternative approach, one that investigates the causes and not just the effects of income inequality. For Coburn, this represents 'a broader, more contextualised and more sociologically meaningful causal model' (2004:43; see also Coburn 2000). Coburn (2001:50) argues:

> . . . numerous researchers have explored methods of ameliorating the effects of poor social conditions on the health of the underprivileged . . . [but] hardly any have asked about the possible causes of inequality itself. Yet, examining the causes of social inequalities, and not simply their effects, changes our understanding of the causal sequences involved in the income inequality/health status relationship.

From this perspective, the health effects of income inequality are important but should be examined through the wider lens of political economy rather than epidemiology. Inequality, in other words, needs to be cast in a wider mould – as one aspect of structural violence.

One implication of this new approach is that future studies of the income inequality/heath relationship will need to overcome the tendency to be constrained by national boundaries. Following Farmer's 'geographically broad and historically deep' methodological stance, new studies in this area will need to incorporate a more nuanced globalist perspective. Taking the 'generative mechanisms' behind income inequality seriously will require grappling with international political economy. Farmer observes: 'Drawing on the work of many, I underline the pathogenic role of inequity ... societies riven by social inequality have poorer health indices than societies in which comparable levels of wealth are more evenly distributed' (2003:20). Yet Farmer (1999:281) critiques an important feature of the Wilkinson-derived literature, noting that:

> ... the cost of modern inequality is even greater than that calculated by Wilkinson and others who define 'societies' as nation-states. When he writes that 'it is clear that the main problems of poverty (at least within the developed world) are problems of relative poverty', Wilkinson misses the worst of it ... The sick of rural Haiti, urban Peru, and sub-Saharan Africa may be invisible to those tallying the victims of modern inequality, but they are, in many senses, casualties of the very same processes that have led to crime and decreased social cohesion 'at home'.

Farmer thereby offers a nuanced perspective on what the income inequality hypothesis may look like from a global health perspective – raising an important critique that one of the most debated hypotheses in social epidemiology and medical sociology has left out the bulk of the world's poor from its purview. When he argues that the Wilkinson-derived literature 'misses the worst of it', Farmer reminds us that the income inequality/health relationship must be understood from a global perspective. Farmer (2003:20) observes:

> ... it is important to sound a warning about the habit of conflating the notion of society with that of nation-state. We already live in a global society ... calls of a right to equity must necessarily contend with steep grades of inequality across as well as within international borders.

Farmer's observation raises a critical challenge for researchers who study the health effects of inequality: to take globalisation seriously, to incorporate – rather than ignore – the suffering of the world's poor, and perhaps most importantly, to not only observe, but judge and act upon our findings.

Conclusion

Farmer's perspective on global health is built, above all, on the concept of structural violence. And structural violence is, admittedly, a nebulous term – something that can describe gross violations of human rights to high levels of income inequality to complex international trade agreements that inhibit the generic production of medicine. For some, this represents a fundamental liability – for if structural violence can manifest in so many different ways, it ceases to be a useful explanatory force, becoming instead, a 'black box' (Janes and Corbett 2009). Moreover, structural violence cannot be measured in the same way that economic activity can be measured; we have no metric for structural violence that mirrors the specificity of gross domestic product per capita (the most common measure of a country's economic development) or the Gini coefficient (a commonly used measure of inequality). As such, the positivist disciplines of the social sciences (including epidemiology and quantitative sociology) have been hard pressed to incorporate the concept into their theories. And the interpretivist disciplines, including anthropology and qualitative sociology, may likewise avoid the concept, as it challenges ethnographic research to move from its traditional focus on the local and presents a stronger *determinism* than is usually welcomed in those disciplines.

Despite these drawbacks, Farmer urges us to give structural violence a central role in social science research on health. In particular, the concept of structural violence gives us a way of expanding the 'frame' of the income inequality hypothesis, moving beyond a traditional positivistic account of the pathogenic effects of inequality towards a more holistic analysis that models both the causes and effects of inequality. This is a critical difference – for if we fail to incorporate the causes of inequality into our analyses, we miss out on the generative mechanisms that lead to health inequities (Scambler 2001). The deep structural roots remain obscured, and our knowledge is limited as a result. More importantly, our capacity to think of, propose, and implement structural solutions is inhibited – leading to the continuation of avoidable, unnecessary and unjust patterns of disease in the world.

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