

Western Europe

Medical Sociology in Great Britain

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Medical sociology¹ is now firmly established as an academic discipline in Britain. In this chapter we reflect upon more than 30 years of scholarship, focusing upon the academic and policy issues that have concerned those working in the field. In particular, we consider the interplay of medical sociology's relationship with the theoretical concerns of its parent discipline of sociology and its strong empirical engagement with issues of health policy and practice. We argue that it is the shifting nature of this interplay, notably the ongoing tension between academic and practical policy concerns, that has defined the parameters of both theoretical and empirical research since the development of medical sociology in Britain in the late 1960s.

An enduring feature of medical sociology in Britain is that scholars work in diverse settings such as university social science departments (notably sociology and social policy), medical schools, departments of nursing, research units with very specific foci, and the National Health Service. This diversity enables the subdiscipline to respond very successfully to emerging policy agendas and to funding agencies (such as the Research Councils and the Department of Health). The subdiscipline, however, has been less successful in directing wider sociological debates, a concern which has exercised many commentators over the last three decades (e.g. Williams et al. 1998). However, its contribution in this respect has notably strengthened since the early 1990s, reflecting a heightened concern with health issues within both academic sociology and wider society. This concern is part of sociology's response to the large-scale shift from collectivism to individualism, which characterized the second half of twentieth-century Britain and continues into the new millennium. The impetus for this shift lies in changes in the economy, notably the decline in industrial production, the rise in service-sector employment, and the move away from the production of mass-market goods toward commodities tailored for highly specialized, and ever

changing, consumer markets. Related changes have taken place in the public sector which, increasingly, is directed less toward meeting mass universal need through monolithic bureaucratic structures and more toward responding to a diversity of need through “welfare pluralism, quasi-markets, reorganized welfare work and consumer-sovereignty” (F. Williams 1994: 49).

These shifts from collectivism to individualism at the structural level have occurred alongside fast-paced changes in what medical sociologists once rather simplistically called “the biomedical model,” such as the emergence of the “new genetics” and concerns about the health-related risks of living (e.g. Beck 1992). These changes have implications for both the social patterning of health and the experience of health and illness. Under these social conditions, a new sociological sensitivity has drawn attention away from a hitherto “disembodied” conceptualization of the rational individual bounded by collectivities such as social class, “race” and ethnicity, toward a self-reflexive individual making an array of life-style choices (e.g. in family formation, living arrangements, patterns of work and leisure). Since the body has been central to this new reflexivity (e.g. Giddens 1991), health concerns have begun to move, if not center stage, at least out of the wings and into the spotlight of wider sociology.

We begin the chapter with a discussion of the institutional context within which medical sociology developed in Britain and the research agenda of the early years. We then explore the shift from collectivism to individualism within British society, firstly as it is reflected within the National Health Service (NHS), and secondly in terms of its impact upon research in two areas of enduring interest to British medical sociology – health inequalities and the experience of illness.

THE DEVELOPMENT OF MEDICAL SOCIOLOGY IN BRITAIN

The Institutional Context

The development of medical sociology in Britain parallels that of sociology generally. Sociology was established as an academic discipline in the 1960s during a period of rapid expansion in higher education (HE) which lasted until the early 1970s. Over this period entrants to HE increased from around 60 percent of the 18–19 year-old population in 1961, to 14 percent in 1973 (CVCP 1997: 20). Three particular events mark the development of medical sociology during this period: the first conference gathering of around 60 medical sociologists in the city of York in 1969 which signalled the birth of the British Sociological Association’s (BSA) Medical Sociology Group;² the publication of the first edition of *Medical Sociology in Britain: A Register of Research and Teaching* in 1970 (hereafter referred to as the Register); and the publication of the Group’s newsletter, *Medical Sociology News*, in 1973. Despite these significant developments, the struggle of the fledgling subdiscipline to define its disciplinary boundaries was an enduring theme of the 1970s. Medical sociology’s “minority” relationship to medicine, the appropriate balance of the Medical Sociology Group’s academic and political activities, and the consequences of

the vagaries of funding and “changing fashions of what is worth being researched,” exercised the Group’s convenor in the late 1970s (Stimson 1978). When reflecting on the Group’s activities between 1974 and 1978 he raised what appears to have been an enduring concern since the late 1960s: “so each year one is inclined to ask – ‘how long can it last’ – yet each year the interest in the sociology of medicine continues” (Stimson 1978: xiv).

Concerns about the status of medical sociology persisted into the early 1980s, overlain with fears about financial cutbacks in HE in Britain (Murcott 1982) and their consequences for the employment of research and teaching staff in universities and polytechnics (Homans 1986). This echoed wider concerns as HE experienced a period of stagnation involving a retrenchment in employment, minimal growth in undergraduate student numbers, and the beginning of a downward spiral in public funding. The late 1980s were the beginning of a period of renewed growth, but in a context of fiscal constraint. There was a rapid upturn in undergraduate students from 1988 as government funding became more closely linked to student numbers even though funding per student continued to decline. By 1994, 34 percent of the 18–19 year-old population entered HE (CVCP 1997: 20).³ This expansion of the university sector from an elite to a mass system of higher education was accompanied by a change of status of the polytechnics which became universities in 1992.

Sociology matured during this period of significant change in HE and medical sociology grew rapidly to become the largest section of the BSA with an annual conference attracting well over 300 delegates. Its scholarship was consolidated through the UK-based journal *Sociology of Health and Illness*, first published in 1979 and now recognized as a major international journal in the field. By the end of the twentieth century the institutional foundations of medical sociology were firmly established and the discipline was confident in its contribution to both academic and policy debates. Medical sociologists who, like many of their contemporaries in other branches of sociology were first employed in the 1960s and early 1970s, began to attain senior academic positions. The Registers of the 1980s listed only ten full professors, by the mid-1990s this had risen to 38, and by the close of the decade, to 47 (Field et al. 1982; Field and Platt 1986; Field and Woodman 1990; Barbour and van Teijlingen 1994, 1998). Over this period, medical sociology/the sociology of health and illness became part of the curriculum of most sociology departments although then, as today, this was typically as an option for upper-level undergraduates rather than as a core course, or part of a core course, for those majoring in sociology. This perception of medical sociology as a specialist area is reflected in introductory sociology textbooks in Britain which have only very recently included health and illness as a topic.

In addition to expansion at undergraduate level, HE has seen a rapid growth in postgraduate students over the last 30 years, more than doubling as a percentage of total student numbers from just 6 percent in 1962/3 to 14 percent in 1995/6 (Burgess 1997; CVCP 1997: 19). Within medical sociology, a range of Masters programs has developed to accommodate both the training needs of contract researchers and students planning to register for a doctorate. In addition, the movement of nursing into HE (UKCC 1987) alongside a professionalizing

strategy within the professions allied to medicine which stressed research-based practice, has encouraged many senior health practitioners and nurse educators to pursue a Masters-level qualification with sociology as its basis.

The Research Agenda

The political context into which the subdiscipline was born, and within which it began to mature, significantly influenced the type of research that was undertaken. "Medico-centrism," that is, the tendency of sociologists to adopt their ideas of what is problematic, and thereby worthy of study, from medicine was high on the agenda in the 1970s (e.g. Murcott 1977). This echoed concerns voiced for some time in the United States, reflected, for example, in Straus's (1957) discussion of medical sociology as either *in* or *of* medicine. Concerns about medico-centrism also inaugurated a long-standing debate over whether the field should be titled "medical sociology" (which some see as medico-centric and constraining the research agenda) or whether the "sociology of health and illness" and related titles with a broader remit are more appropriate. In Britain worries about medico-centrism have been exacerbated not only by the exigencies of government funding, but also by the employment of a significant number of medical sociologists in medical schools and health service settings (for a recent discussion, see Jefferys 1996). Medical sociology became part of undergraduate medical education in Britain in the 1970s (Field 1988) and around one-fifth of people who placed entries in the Registers between 1978 and 1998 worked in medical school or related settings. A further quarter to almost one-third worked in a range of research centers, many with a strong health service focus, with others employed in various positions in the National Health Service, and to a lesser extent, nursing. Over the same period, between one-third to one-half of people worked in academic social science departments.⁴ The diversity which has characterized British medical sociology is therefore at the core of its relationship with medicine/the health service, and sociology. Horobin (1985: 95) captured this well, and signalled a clear power relationship when he referred to medical sociologists inhabiting the "interstices between the citadel of medicine and the suburb of sociology." Carrying these concerns into the 1990s, consecutive editors of the Registers remarked upon the very applied nature of many research projects and their lack of attention to wider sociological issues (Field and Woodman 1990; Barbour and van Teijlingen 1994).

The topic areas that have defined the field reflect very clearly British medical sociology's relationship with both academic sociology, medicine, and health policy. Although there have been ebbs and flows of interest and the particular foci and conceptual approaches to issues have changed considerably over the decades, there is an enduring core built around analyses of the experience of health and illness, health inequalities (notably as they relate to social class and, more recently, gender, "race," and age), and the provision of health care (both formal and informal). In each of these broad areas different issues came to the fore in response to developments within medical science, sociology, and social theory, new national policy agendas, and the emergence of new diseases and changes in the social patterning of health and illness characterized the 1990s (DOH 1997,

2000). For example, in terms of conceptual developments in social science, "risk" appears as a topic area for the first time in the 1994 Register (Barbour and van Teijlingen 1994). With respect to new disease patterns, research on AIDS and HIV was proliferate in the early 1990s accounting for the majority of all funding listed in the 1990 Register (Field and Woodman 1990). By 1994 its absolute level of funding remained the same, but its place in the league table of funded areas had been superseded by research into primary care/general practice and studies of chronic illness (Barbour and van Teijlingen 1994). The 1998 Register does not list AIDS/HIV as a separate category (Barbour and van Teijlingen 1998).

Research on genetics, though only commanding 3 percent of funding listed in the most recent 1998 Register (and listed as a topic area for the first time in the 1994 Register (Barbour and van Teijlingen 1994, 1998)), seems likely to move ever more to the fore in the new century (e.g. Conrad and Gabe 1999). Topic area rankings also provide an insight into the impact of government policy upon the nature of research. The increased prominence of health services research in recent years probably reflects the direction of funds toward evaluation of the national health service (NHS) from the mid-1990s following a virtual moratorium during the Conservative government's sweeping reforms of the early 1990s (DoH 1989). The specific attention to primary care undoubtedly reflects the intensification of moves toward a "primary care-led" health service that characterized the 1990s (DoH 1997).⁵

Even though broad areas of research have endured since the 1970s, emphases have changed and new research directions have emerged. Examples are legion, but by way of illustration, research on gender and health which was until the mid-1990s virtually synonymous with women's health, now gives increasing attention to the health of men. Here, and in other topic areas, theoretical developments within sociology have been crucial. Thus, developments in the sociology of gender and within feminism have sparked new approaches to the analysis of gender inequalities in health (Annandale and Hunt 2000) and the sociology of the body has had a major impact upon research on chronic illness (Bury 1997). Moreover, new empirical foci within the wider discipline, such as the increased emphasis upon the life course, have influenced medical sociologists' conceptualization of health issues. For example, child health developed significantly as a research area during the 1990s (Mayall 1998).

A final issue that needs to be raised in respect of topic areas that define medical sociology in Britain is what is excluded. Here the most problematic feature of the discipline is its parochialism. Although British medical sociologists have both drawn from and contributed to international debates on key empirical and conceptual issues (e.g. health inequalities and the sociology of the body), this has largely been used to inform domestic concerns with relatively little attention to comparative research. Moreover, many research areas to which medical sociology could make an important contribution such as the impact upon physical and mental health of ethno-nationalisms, violence, and warfare, remain largely unexplored. Not only is contemporary British medical sociology inward looking, but the previous emphasis upon historical sociology, which produced high-calibre work on the development of modern medicine (e.g. Jewson 1974; Waddington 1984) has virtually disappeared.

MEDICAL SOCIOLOGY FOR THE NEW CENTURY: THEMES AND ISSUES

At the beginning of the twenty-first century the anxieties of the 1970s about medical sociology's future, indeed if it even *had* a future, and where its allegiances should lie have been replaced by a new optimism about the subdiscipline's contribution to health policy and practice, and to academic sociology. We suggested earlier that this optimism reflects the increased prominence of health issues both within academic sociology and within society prompted by wider-scale changes in the economic and social structure of late modernity, summarized in the shift from a collectivist to an individualist social ethos. This section begins by discussing this shift through a consideration of British health policy, particularly in relation to the NHS. We then discuss two enduring themes of British medical sociology; research on health inequalities, and on the experience of illness, illustrating the increasingly symbiotic relationship between medical sociology and its parent discipline in the course of the discussion.

There is wide-scale recognition that, along with most other western societies, post-World War II Britain witnessed a significant period of economic and social restructuring. There are many competing theories about whether we are witnessing a maturing of modernity, albeit in a manner that is radically different from its traditional form (e.g. Bauman 1987; Giddens 1991; Beck 1992; Lash and Urry 1994), or whether this has been superseded by postmodernity (e.g. Baudrillard 1983; Lyotard 1986). These theories have a common interest in the declining relevance of the traditional structures of class, gender and, to a lesser extent, "race," for the actions of individuals. Differences in interpretation, simply put, turn upon whether new social parameters of late modernity such as risk and uncertainty invite, or even mandate, individuals to actively construct identities, or whether the postmodern condition signals a "loss of meaning," as the barrage of information that confronts individuals means that they are no longer able to grasp what is happening in society. Although to date postmodern perspectives have received little attention within British medical sociology (although see Fox 1993), writings which can be considered under the umbrella of theories of "late modernity" have been influential within both academic and political circles. Foremost in this regard has been the work of the sociologist Anthony Giddens who has both contributed to and intervened in center-left political debates (Driver and Martell 1998).

At the center of Giddens' project (e.g. 1994a, 1994b) is the premise that far from confirming the Enlightenment expectation that over time more and more areas of social life will become subject to prediction and control, late modernity has witnessed a contrary development – namely, a "run-away world" characterized by "dislocation and uncertainty" (Giddens 1994b: 21). Two related processes lie behind this. First, intensifying globalization which forces existing traditions, such as the gender order, into the open and makes them subject to ongoing justification. Second, an enhanced need for self-reflexivity which means that the self needs to be made "amid a puzzling diversity of options and possibilities" (Giddens 1991: 3).

This social reflexivity is now firmly embedded in contemporary British welfare politics. Giddens (1994b: 29) stresses that under conditions of “high reflexivity” people must “achieve a certain amount of autonomy” in order to “survive and forge a life.” Autonomy does not equate with egoism, but implies reciprocity and interdependence. Thus “reconciling autonomy and interdependence” is crucial to social life as reflected in Giddens’ proposed model of “positive welfare.” In contrast to the old welfare state of the postwar period which “picked up the pieces in the aftermath of misfortune,” this model “places much greater emphasis upon the mobilising of life-political measures, aimed . . . at connecting autonomy with personal and collective responsibilities” (Giddens 1994b: 35). Such intentions are very evident in the policies of the New Labor government (elected with a 179 seat majority in May 1997 after 18 years in political opposition). Characterized as enjoining democratic socialism and liberalism in a “third way” which moves beyond the Old political Left and New political Right (Blair 1998), New Labor policy “is simply that citizens have certain responsibilities toward their fellow citizens and that the state has a legitimate, indeed essential, role in cultivating the disposition to act on these obligations and, in some cases, in directly enforcing them” (White 1999: 167). As White explains, a doctrine of civic responsibility, that is, a balance of individual rights and responsibilities, is at the heart of New Labour. Current social policy agendas therefore construe the “reflexive” individual as the “responsible” individual. This vision of people making choices, while taking account of others and holding others to account is at the heart of changes in the British NHS (DoH 1997).

The NHS and the Welfare State

The NHS has been subject to major change and intense political debate over the last three decades following a period of relative consensus during the 1950s and 1960s (Baggott 1998). As one commentator put it, the NHS is “an institution which is constantly reinventing itself [like] a car that is being re-engineered even while it is roaring round the test track” (Klein 1995, quoted in Ranade 1998: 117). The early 1990s saw the replacement of a centralized health service system with the introduction of an internal market. “Purchasers” (general practitioners⁶ and health authorities) placed contracts to buy care for their patients from a range of “providers” such as community care services and hospitals which had taken on self-governing trust status (see DoH 1989). Criticisms were made about transaction costs, the impact of contracting upon the health care workforce (e.g. short-term contracts for nurses and the increased use of agency staff), and the emergence of a two-tier system of care which favored the patients of general practices which held their own funds (fundholders) (Audit Commission 1996). Moreover, it was argued that the “contract culture” was fostering a climate of low trust both between health care providers and between providers and their patients (e.g. Flynn et al. 1996). However, despite strong initial criticism from the Labor party in opposition and later in government, there is now a moving political consensus in health care (Baggott 1998; Ranade 1998) and the main elements of the Conservative government reforms, namely the purchaser-provider split, contracts, public-private partnerships, NHS trusts,

the emphasis on primary care and “evidence-based medicine” remain (Ranade 1998: 116). Thus, the internal market is intact despite a rhetoric of its abolition (DoH 1997: 12), as the division between fundholding and non-fundholding general practices is replaced by local Primary Care Groups consisting of local networks of GPs and community nurses (which commission most of the services for their patients on a longer term basis from a delegated share of health authority budgets (DoH 1997)).

These changes in the NHS reflect those in society generally. Quasi-contractual relationships between individuals dominate the provision of care in the context of a public no longer so ready to passively accept what is offered to them. The consumerist ethos which began in the 1970s was fostered by the Patient’s Charter (first introduced in 1992 and in existence in revised form today) and active encouragement of health authorities by government to take the views of local people into account (NHSME 1992; NHSE 1995; Milewa et al. 1999). Medical sociologists have made a significant contribution to analyses of the ethos of individualism embedded in contract culture (e.g. Flynn et al.’s (1996) study of community care) and the consumerist mood in health care (e.g. Allsop and Mulcahy’s (1996) consideration of professional regulation in analyses of the health care system).

One contribution of social science to health policy and practice that requires special mention is research on informal or unwaged carers. From the 1980s, British feminists have pointed to the ways in which patterns of informal care reflect and reinforce gender divisions in society (e.g. Graham 1993; Thomas 1993). Alongside this, empirical work (e.g. Parker and Lawton 1990) has documented just how common informal care in the community is in Britain. Some 3.7 million people report that they are the main carers for relatives, friends, and neighbors who are sick, disabled, or elderly. Crucially, 1.7 million people provide an average of 20 hours unpaid work a week (ONS 1998), a figure which exceeds the whole NHS workforce (James 1998), providing a resource worth between £15 billion to £24 billion to the state (N. Kohner 1993 cited in Barnes 1997).

In the context of our discussion of the shift from collectivism to individualism as reflected in health policy, governmental recognition of the existence of large numbers of informal carers and their incorporation into health care policy underscores the ethos of individual and family responsibility and self-care (Barnes 1997; James 1998). Taking this point further in the wider context of welfare provision, Bauman argues that the *universal* (collectivist) founding principles of the NHS (in 1946) – a free, comprehensive, and equitable service for all citizens – are out of tune with a culture which elevates *selective* values of difference and choice. Consumerism and the welfare state are at cross-purposes, and, since a universal welfare state cannot deliver true consumer choice, its existence is under threat as selective practices (such as means-tested benefits) are increasingly accepted by a self-reliant “contented majority” confident that they can control their own lives (Bauman 1998).

Health Status and Health Inequalities

Evidence of the “new individualism” can also be found within wider public health policy. Expectations of individual responsibility for health which have been part of both government and public consciousness since the 1970s, have taken on a new dimension in recent years. For example, exercise and dietary practices and advances in medical science (such as plastic surgery, transplantation and genetic engineering) have expanded what were once seen as the limits of the corporeal body (Williams et al. 1998). Sociologists have conceptualized this in terms of the emphasis on the body as a social project to be made and remade (Turner 1984, 1992) which is drawn ever more into the reflexive organization of social life (Giddens 1991: 98). However, this stress upon the individual as the orchestrator of her or his own health exists alongside an enduring concern for the wider social patterning of health within Britain.

Interest in the social patterning of health and illness dates back to the mid-1880s and Engels’ (1993 [1845]) writing on the conditions of the English working class. It gained particular momentum in the 1980s after the publication of *The Black Report* in 1979 (Townsend and Davidson 1988). This drew together existing evidence within a sociologically informed explanatory framework which stressed the significant role of socioeconomic factors in explaining the relatively poor health of working-class people. The recent *Independent Inquiry into Inequalities in Health* (Acheson 1998) which was overseen by a five-member Scientific Advisory Group, three of whom were leading British social scientists, also strongly argues that “the weight of scientific evidence supports a socioeconomic explanation of health inequalities.” The Report highlights that even though average death rates have fallen and life expectancy has risen, health inequalities between social class groups have widened in Britain. For example, using the Registrar General’s Classification of social class based on occupation, “in the late 1970s, death rates were 53 percent higher among men in classes IV and V compared with those in classes I and II. In the late 1980s, they were 68 percent higher. Among women, the differential increased from 50 to 55 percent” (Acheson 1998: 11). Moreover, despite increases in life expectancy, there is little evidence that the physical and mental health of the nation has improved over the last 10 to 20 years and, again, class gradients are evident. These class differences in health have been accompanied by widening differentials in the economic circumstances of Britons. Despite a period of substantial economic growth since the 1980s, income differentials have widened “to a degree not seen since the World War II” (Acheson 1998: 32).

Government enquiries into matters of health take place within a highly politicized arena. For example, it seems likely that during the late 1970s, the authors of the Black Report felt it expedient to present cultural/behavioral, health selection, artefact, and material/economic explanations as alternative rather than as interacting explanations for health inequalities in order that the first three could not be used to “explain away” the fourth, and preferred, economic explanation (Macintyre 1997). The Acheson Report (1998) still seems sensitive to the political context even though it is able to welcome the

current government's concern to improve the health of the worse off in society and to narrow the health gap (as expressed in *Our Healthier Nation* (DoH 1998)). Social scientists, however, appear to have felt freer to explore the interacting role of a range of socioeconomic and lifestyle factors as well as to consider the combined effects of class, "race," gender, and age upon health (e.g. Macintyre 1997; Bartley et al. 1998; Marmot and Wilkinson 1999; Annandale and Hunt 2000).⁷

As well as a strong empirical research agenda, British sociologists have recently begun to raise questions about the theoretical underpinnings of health inequalities research. It has been argued that researchers have stuck rather steadfastly to conventional approaches to social divisions of class, "race," and gender, failing to appreciate that the social changes of late modernity that we outlined earlier invite new theoretical and methodological approaches to inequality (Annandale 1998; Bartley et al. 1998; Scambler and Higgs 1999; Popay and Groves 2000). There is a need to reflect more critically upon sociologically constructed social positions to take account of human agency in the construction of social class, ethnic, gender, and age-related identities and their significance for health status. In contrast to most research on health inequalities, work on the experience of illness which we now turn to consider, has given significant attention to the active construction of self-identity both in and through illness.

The Experience of Illness

Along with other areas of sociology, such as crime and deviance (e.g. Taylor 1971; Young 1971), the initial theoretical underpinnings of research on the experience of illness derive from the growing interest in action theories, particularly symbolic interactionism, in Britain during the 1960s. Certainly, the concerns with self and reflexivity which we have discussed can be traced back to this strand of research work and interest. However, as we will see in the course of the discussion, recent developments in social theory, such as the sociology of the body, the sociology of emotions, and Foucauldian social constructionism, have fostered different approaches to the self and the experience of illness. In the 1970s, British work was strongly influenced by the work of US interactionists such as Davis (1963), Goffman (1963), Roth (1963), and Zola (1966, 1973) as can be clearly seen in the early textbooks produced by British medical sociologists (e.g. Robinson 1973; Field 1976). Early research informed by this seminal work tended to focus upon the crisis created by chronic illness or major disability and the fundamental alteration of the meaning of social life and personal identities. Examples of such work are Locker's (1981) analysis of the lay construction of the symptoms and meaning of chronic illness and Voysey's (1975) research on the difficult reconstitution of social life by parents of disabled children.

Research on chronic illness was complemented by the development of a broader body of work on lay perceptions and constructions of illness. For example, Cornwell's (1984) influential ethnographic study of "Eastenders" in London, explored the ways in which health beliefs and illness behaviors were

firmly embedded within working-class age and gender relations, limited autonomy and control over life, and “fatalistic” beliefs and attitudes. During the 1980s researchers also began for the first time to consider the relationship between ethnicity and health within a qualitative framework, for example Donovan’s (1988) study of Afro-Caribbeans and South Asians in London (see Kelleher and Hillier (eds.) 1996 for more recent work). Interactionism also influenced studies of health behavior during the mid-to-late 1970s and early 1980s (Dingwall 1976; Morgan et al. 1985: ch. 3) which mounted a forceful critique of earlier research which tended to ignore the active role of individuals in interpreting and responding to symptoms. Finally, interactionism provided the foundation for a large body of research on the interaction of patients and health care providers and the social construction of illness in various formal health care settings (e.g. Stimson and Webb 1975; McIntosh 1976; Strong 1979; A. Davis 1982).

This early work set a firm foundation for a substantial and growing body of research on the experience of illness. From the mid-1980s data on morbidity (rather than simply mortality) became more readily available as a resource for researchers working in the area of health status and the experience of illness. This shows, as noted earlier, that there is little evidence of general improvement in morbidity in Britain in recent years, despite increases in life expectancy. The prevalence of limiting long-standing illness, which is often used as a measure of disability, fluctuated over the 1980s and 1990s. Between 1980 and 1994 approximately 17 to 22 percent of British women and 16 to 19 percent of British men reported a limited long-standing illness (OPCS 1995). By the early 1990s this body of information as well as the many criticisms that were being levied against interactionism and new theoretical developments in European social theory led to new directions in work on the experience of illness. Critical debates arose about the tendency of much early research to ignore the impact of economic and political realities upon the experience of illness and disability. Sociologists of the body and of the emotions also highlighted the “cognitive bias” of work in the field. Together, these criticisms (e.g. Freund 1990; S. Williams and Bendelow 1996) prompted researchers to develop stronger conceptualizations of the relationship between the individual and society, and between self and body, in illness.

As we discussed in the context of health inequalities, the politics of health and illness have been central to British medical sociology. Perhaps because of the long-recognized neglect of issues of power in interactionism, early research tended to gloss over the impact of relations of domination and subordination upon the experience of illness. These were brought strongly to the fore in the late 1980s through the work of disability activists (e.g. Oliver 1990) and feminists (e.g. Morris 1991). Most recently, this realist approach to power has been contested by social scientists influenced by postmodern approaches to the body (e.g. Seymour 1998). Gareth Williams (1999) uses the metaphor of a battlefield to depict the contesting approaches within British social science to disability at present:

while body theorists emphasize, and often celebrate, differentiation in embodied experience by impairment, gender, sexuality, and race, disability theorists are more likely to stress the common factors disabled people face in a world built by and for

people with able bodies – two hostile camps facing each other: oppressor and oppressed, able-bodied and disabled. (1999: 243)

The nature and experience of health and illness has also become highly contested as the interactionist orthodoxy of the 1970s and 1980s has given way to a range of competing approaches. By the late 1990s, realist (e.g. Kelly and Field 1996), social constructionist (e.g. Petersen and Bunton 1997) and, to a lesser extent, postmodern (Fox 1993) approaches existed side by side. Within this corpus of research and conceptualization, the body has been a central theme. Significantly influenced by social constructionism and the groundbreaking work of Turner (1984), the sociology of the body has been a major resource for British medical sociologists seeking theoretically to locate the relationship between self and society in the context of illness. In this regard Simon Williams and Bendelow (1996, 1998) argue that taking account of emotions in illness provides a link between self and society, mind and body. This link has been explored through an increasing body of international work which draws upon the narrative method (e.g. Kleinman 1988; Frank 1995). Building upon this and earlier British work on “biographical disruption” (Bury 1982) and “narrative reconstruction” (Williams, G. 1984), narrative accounts of illness “illuminate the subjectively experienced relationship between identity (people’s sense of who they are), agency (an individual’s capacity for action) and social structures (macro mechanisms and processes by which power and control are socially distributed and utilized) which impinge on the ways in which individuals negotiate their lives” (Popay and Groves 2000: 76).

CONCLUSION

In this chapter we have outlined the development of medical sociology in Britain from its early and uncertain beginnings in the 1960s to its present status of a self-assured and substantial subdiscipline within British sociology. We have attempted to locate this development within the wider context of British society, especially with reference to the move from collectivism toward the individualistic ethos of “late modern” Britain. We have also sketched in the varying influences of conceptual developments within sociology as a discipline and the practical concerns of health policy and attempted to indicate new trends and emerging topics. At the start of the twenty-first century, as in the 1960s, British medical sociologists remain strongly influenced by the sometimes competing demands of applied research driven by policy agendas and the desire to contribute to the development of more adequate sociological conceptualizations of health and illness.

Notes

- 1 We use the term “medical sociology” throughout the chapter. However, in Britain, as elsewhere, there has been a long-standing debate over whether more inclusive definitions of the field, such as the sociology of health and illness, are more appropriate.

- 2 Further details on the current activities of the BSA Medical Sociology Group can be found on its website: <http://medsocbsa.swan.ac.uk>. The Group's archives for 1969–1982 are deposited in The Modern Records Center, University of Warwick, Coventry CV4 7AL, UK.
- 3 It should also be noted that the 1980s and early 1990s also saw a significant increase in the entry of mature applicants (i.e. those over the age of 21) to higher education, many studying part-time.
- 4 Despite some fluctuations, these divisions have remained fairly stable over the 1978 to 1998 period. We cannot necessarily assume that these figures accurately represent the employment of medical sociologists in Britain since they include only those who chose to place an entry in the various Registers (the number of entrants ranges from between just under 200 to almost 300 at various points over the period).
- 5 It needs to be borne in mind that data on funding from the Medical Sociology Registers are simply based on information provided by researchers. Although the national picture is likely to be similar, we do not assume that the data presented here are representative.
- 6 Within the NHS in Britain, 95 percent of the population are registered with general practitioners who act as gatekeepers to a range of services.
- 7 The ESRC (Economic and Social Research Council) has funded the Health Variations Programme, details of which can be found at <http://www.lancs.ac.uk/users/apsocsci/hvp.htm>

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