Health, Medicine and Society
Key Theories, Future Agendas
edited by Simon J. Williams, Jonathan Gabe and Michael Calnan

Also available as a printed book
see title verso for ISBN details
Health, medicine and society

Taking as its point of departure recent developments in health and social theory, *Health, Medicine and Society* brings together twenty eminent, international scholars to debate the key issues at the turn of the century. Contributors draw upon a range of contemporary theories, both modernist and postmodernist, in order to illustrate these issues and provide a fresh critical analysis. The four main themes of the book are health and social structure, the contested nature of the body, the salience of consumption and risk, and the challenge of emotions both inside and outside the formal health care arena.

*Health, Medicine and Society* provides a ‘state-of-the-art’ assessment of health-related issues at the millennium and a cogent set of arguments for the centrality of health to contemporary social theory. Written in a clear, accessible style it will be ideal reading for students and researchers in medical sociology, health studies, public health, medicine and nursing.

**Simon J. Williams** is Senior Lecturer in Sociology at the University of Warwick; **Jonathan Gabe** is Senior Research Fellow at Royal Holloway, University of London; **Michael Calnan** is Professor of Sociology of Health Studies, University of Kent.

The book contains contributions from Ellen Annandale, Mildred Blaxter, Michael Bury, Helen Busby, Michael Calnan, Simon Carter, Judith Clark, Robert Crawford, Nick Crossley, Nick Fox, Jonathan Gabe, Graham Hart, Deborah Lupton, Emily Martin, Virginia Olesen, Lindsay Prior, Alan Prout, Chris Smaje, Deborah Lynn Steinberg, Gareth Williams, and Simon Williams.
In memory of Winsome Gabe who died while this book was being prepared
# Contents

*List of contributors*  

**Introduction—Health, medicine and society: key theories, future agendas**  

SIMON J. WILLIAMS, JONATHAN GABE AND MICHAEL CALNAN  

Rethinking social structure and health  4  

The body  8  

Risk and consumption  11  

Emotions  15  

## PART I  

**Rethinking social structure and health**  

1 **Class, time and biography**  

MILDRED BLAXTER  

*Class*  28  

*Time*  37  

*Biography*  41  

*Conclusion*  45  

2 **Gender, postmodernism and health**  

ELLEN ANNANDALE AND JUDITH CLARK  

*Introduction*  51  

Beginnings: the class and gender debate  53  

Class and gender in transition  54  

Ludic and resistance postmodern feminism  56  

New order, new problems  58  

*Conclusion*  64
3 A place for race? Medical sociology and the critique of racial ideology
CHRIS SMAJE

Introduction 67
Race, medical sociology and the critique of ideology 68
Pierre Bourdieu: habitus, capital and meta-theory 73
A research programme: health status and health care utilisation 77
Conclusion 82

4 Health, ageing and the lifecourse
MICHAEL BURY

Introduction 87
Changing boundaries across the lifecourse: the optimistic perspective 90
Inequalities across the lifecourse: the pessimistic perspective 96
Conclusion 100

PART II
The Body

5 Childhood bodies: social construction and translation
ALAN PROUT

Introduction 109
Foundationalist and anti-foundationalist accounts of the body 110
Childhood bodies 111
The body unfinished 114
The body translated 117
Conclusion 120

6 Flexible bodies: science and a new culture of health in the US
EMILY MARTIN

Healthy bodies 125
Bodies as complex systems 128
Immunising (educating and training) the body 132
Working bodies 135
Post-Darwinism 138
Conclusion 142

7 ‘Recombinant bodies’: narrative, metaphor and the gene 146
DEBORAH LYNN STEINBERG

Introduction 146
Narrative, metaphor and the gene 147
Science, narration and embodiment: a critical standpoint 148
Genes and genre 149
Of monads and machines: Yanchinski’s industrial utopia 151
Dark continents: genetics as colonial conquest 154
Making the world safe for genetics: Kitcher’s diagnostic democracy 160
Conclusion 166

8 The politics of ‘disabled’ bodies 169
GARETH WILLIAMS AND HELEN BUSBY

Introduction 169
The medical model 170
Chronic illness and disability: sociological perspectives 172
The politics of disability and disability theory 175
Situated knowledge 177
Towards an understanding of living in bodies in places 180

9 Reflections on the ‘mortal’ body in late modernity 186
LINDSAY PRIOR

Death, disease and the body in the modern world 189
The certainty of mortality is transformed into a personal risk 195
Conclusion 199
PART III
Risk and consumption

10 Food, risk and subjectivity
DEBORAH LUPTON

Introduction 205
Food and health risks in the ‘risk society’ 206
Breaching boundaries: food, risk and cultural transgression 210
The risks of the ‘uncivilised’ body 213
Conclusion 216

11 The ritual of health promotion
ROBERT CRAWFORD

Pleasure or denial: the ritualisation of ambivalence 225
Conclusion 231

12 Drugs and risk: developing a sociology of HIV risk behaviour
GRAHAM HART AND SIMON CARTER

Introduction 236
Current paradigms of non-medical drug consumption 237
Understanding drug use: the example of Ecstasy 240
Macro-social analyses 241
Meso-social considerations 244
Micro-social accounts 246
From the micro to the macro: pleasure, risk and health 249
Conclusion 250

13 Health care and consumption
JONATHAN GABE AND MICHAEL CALNAN

Introduction 255
Warde’s model of production/consumption cycles 256
The internal market 257
The new managerialism 259
Promoting welfare pluralism 264
Conclusion 268
PART IV
Emotions

14 Emotions, psychiatry and social order: a Habermasian approach
NICK CROSSLEY

Reason and emotion 278
Rational emotion 279
Emotion and the three validity claims 280
Irrational emotion, social order and psychiatry 281
System and lifeworld 285
The colonisation of the lifeworld and cultural impoverishment 287
The emotion industry 289
Conclusion: the colonisation of emotional life 292

15 Emotions, social structure and health: rethinking the class inequalities debate
SIMON J.WILLIAMS

Introduction 296
The sociology of emotions 297
Emotional ‘capital’ and the psychosocial pathways to disease 300
Emotions, health and ‘distributive justice’ 306
Discussion and concluding remarks 308

16 Emotions and gender in US health care contexts: implications for change and stasis in the division of labour
VIRGINIA OLESEN

Emotions in changing organisations 317
Rationalisation in US health care contexts 318
Gender, occupational and emotional stratification 320
Emotion and gender 321
‘Deviant’ emotions 322
The individual in the social 323
Sociology of emotions and the sociology of health care 325
17 The ethics and politics of caring: postmodern reflections 333
NIck Fox

Introduction 333
The vigilance of the carer 335
Resisting the vigil: the gift of care 337
Care and nomadic subjectivity 339
Nomadology for carers and recipients of care 341
Conclusion 345

Notes 351
Index 359
List of Contributors

Ellen Annandale is a Senior Lecturer in Sociology at the University of Leicester. She has been involved in research on issues of gender, health and inequalities for a number of years, and has published widely in these areas, including *The Sociology of Health and Medicine* (Polity Press, 1998), a forthcoming book *Feminist Theory and the Sociology of Health and Illness* (Routledge) and a co-edited volume (with Kate Hunt) *Gender Inequalities in Health* (Open University Press).

Mildred Blaxter is Honorary Professor of Sociology in the School of Health Policy and Practice, University of East Anglia, and Senior Editor of the Journal *Social Science and Medicine*. She has published widely in the fields of inequality in health and lay attitudes to health.

Michael Bury is Professor of Sociology and Head of the Department of Social and Political Science, at Royal Holloway, University of London. His research interests cover social dimensions of chronic illness and disability, ageing, and cultural dimensions of health and medical treatment. He has published widely in all of these fields. His latest book *Health and Illness in a Changing Society* was published by Routledge in 1997. Currently he teaches on the M.Sc. in Medical Sociology at Royal Holloway and is co-editor of the journal *Sociology of Health and Illness*.

Helen Busby is an anthropologist. She is currently a Research Fellow at the National Primary Care R & D Centre at Salford University. In addition to her current work about musculoskeletal disorders and primary care, her research interests include the relationship between paid work and illness; the place of labour in contemporary sociological theory; and the social and policy responses to health needs.

Michael Calnan is Professor of the Sociology of Health Studies and Director of the Centre for Health Services Studies (CHSS) at the University of Kent. His current research interests focus on the sociology of dentistry and general practice, and the sociology of comparative health care systems.
Simon Carter is a Research Fellow at the MRC Social and Public Health Sciences Unit, University of Glasgow, where he has been studying the ways in which risk and danger are understood. He is currently examining lay and expert understandings of the biomedical sciences.

Judith Clark teaches in the Department of Sociology, University of Warwick, with a long-standing involvement in the development of the MA Sociological Research in Health Care. Her research interests include the sociology of human reproduction, women’s health and literature, and recently the division of labour in medicine and nursing.

Robert Crawford is on faculty at the University of Washington, Tacoma, USA, where he teaches an interdisciplinary arts and science programme. In 1996, he received the University’s Distinguished Teaching Award. He has written in the area of health, culture and ideology since the late 1970s.

Nick Crossley is a lecturer in sociology at the University of Manchester. He has published two books, The Politics of Subjectivity: between Foucault and Merleau-Ponty (Averbury, 1994) and Intersubjectivity: the Fabric of Social Becoming (Sage, 1997), in addition to a number of papers. He is currently working on an ESRC funded project concerning social movements in mental health in postwar Britain, and a book on ‘embodied sociology’.

Nick Fox is Senior Lecturer in Sociology at the University of Sheffield, and is author of The Social Meaning of Surgery (Open University Press, 1992), Postmodernism, Sociology and Health (Open University Press, 1993) and Beyond Health (Free Association Books, 1999). His research interests include postmodern social theory, perceptions of care and the use of the Internet in education.

Jonathan Gabe is Senior Research Fellow in the Department of Social and Political Science at Royal Holloway, University of London. He has published widely in the areas of mental health, health care professions, health policy, the mass media and health and health risks. He is the editor or author of a number of books, including Sociological Perspectives on the New Genetics (edited with Peter Conrad), (Basil Blackwell, 1999). He is co-editor of the journal Sociology of Health and Illness.

Graham Hart is a Professor and Associate Director of the MRC Social and Public Health Sciences Unit at the University of Glasgow. He heads the Unit’s programme of research on sexual and reproductive health, and has published widely on sexual and drug related risk behaviour. He is joint editor of AIDS Care (Carfax), co-editor of The Social Aspects of AIDS series (Taylor and Francis) and General Editor of the book series Health, Risk and Society (UCL Press).

Emily Martin is Professor of Anthropology at Princeton University. Her research over the years has led her in many different directions, including the shaping of medical language through gender stereotypes, and the interplay between scientific and popular conceptions of the immune system. These studies yielded two major books, *The Woman in the Body: a Cultural Analysis of Reproduction* (Beacon Press, 1987)—which won the Eileen Basker Memorial Prize of the Society for Medical Anthropology—and *Flexible Bodies: Tracking Immunity in American Culture from the Days of Polio to the Age of AIDS* (Beacon Press, 1994). Her present work is on theories of normalisation and the evolving constitution of self-hood in contemporary society.

Virginia Olesen, Professor Emerita of Sociology at the University of California, San Francisco, teaches feminism and qualitative research and seminars on the body and emotions. She is co-author with S. Ruzek and A. Clarke of *Women’s Health: Complexities and Differences*, (Ohio State University Press, 1997), and with A. Clarke of *Re/Visioning Women’s Health: Perspectives from Science Studies, Cultural Studies and Feminist Theory*, (Routledge, 1998). She continues to pursue her interests in emotions in rationalising health care contexts.

Lindsay Prior holds a joint Cardiff University/University of Wales College of Medicine post as Research Director for a Health and Risk programme. His previous published work has focused on the sociology of death and the sociology of mental illness.

Alan Prout is Director of the ESRC Children 5–16 Programme and Professor of Sociology at the University of Stirling. He previously held posts at the Universities of Hull, Keele and Cambridge. He has worked on interdisciplinary research projects concerning children’s health beliefs, parenthood education, children and medicine use and childhood asthma. A sociologist of childhood, he is co-author of *Theorizing Childhood* (Polity Press, 1998) and co-editor of *Constructing and Reconstructing Childhood* published as a second, revised edition, by Falmer Press in 1997. He is currently editing a book *Childhood and the Body* for Macmillan.
Chris Smaje is a lecturer in the Department of Sociology at the University of Surrey. He has published widely on issues relating to the health and health care of minority ethnic groups, including a book—*Health, Race and Ethnicity: Making Sense of the Evidence* (King’s Fund, 1995). He has also written on sociological theories of race and ethnicity, and is currently working on issues in the historical sociology of race and colonialism, the topic of a forthcoming book *Natural Hierarchies: The Historical Sociology of Race and Caste* (Blackwell, 2000).

Deborah Lynn Steinberg is a senior lecturer teaching feminist and cultural theory at Warwick University. She has written widely on the topics of science, popular culture, narrative and embodiment. Recent publications include: *Bodies in Glass: Genetics, Eugenics, Embryo Ethics* (Manchester University Press, 1997) and *Border Patrols: Policing the Boundaries of Heterosexuality* (Cassell, 1997), co-edited with Debbie Epstein and Richard Johnson.

Gareth Williams is Professorial Fellow in the School of Social Sciences, Cardiff University. He has published widely in academic and professional journals, and is co-author of: *Markets and Networks: Contracting in Community Health Services* (Open University Press, 1996), and *Understanding Rheumatoid Arthritis* (Routledge, 1996). He is currently one of the principal researchers on an ESRC-funded study of health inequalities.

Simon J. Williams is a Senior Lecturer/Warwick Research Fellow in the Department of Sociology, University of Warwick, and co-Director of the new Centre for Research in Health, Medicine and Society. He has published widely in the fields of chronic illness and disability, class, health and lifestyles, health promotion, and the lay evaluation of modern medicine. His current research interests centre on the relationship between social theory and the sociology of health and illness, with particular reference to issues of emotions, embodiment and the need to re-think the ‘biological’ in non-reductionist terms. Recent books include *Modern Medicine: Lay Perspectives and Experiences* (with M.Calnan, UCL Press, 1996), *Emotions in Social Life: Critical Themes and Contemporary Issues* (with G.Bendelow, Routledge, 1998), *The Lived Body: Sociological Themes, Embodied Issues* (with G.Bendelow, Routledge, 1998), *Emotions and Social Theory* (Sage), and a forthcoming text, *Medicine, Emotions and the Body* (Sage).
Introduction—Health, medicine and society: Key theories, future agendas

Simon J. Williams, Jonathan Gabe and Michael Calnan

What is the relationship between sociological theory and medical sociology? How are we to theorise recent developments in health, medicine and society? And what does this tell us about the nature of the sociological enterprise and the future development of medical sociology at the turn of the century? These are some of the issues which this volume seeks to address.

Debates as to the nature and status of medical sociology have been an abiding theme since its inception. It is not, however, our intention to rehearse them again here. Suffice it to say that the charge of an atheoretical, policy-driven discipline, in-the-service-of medicine, has now been largely dispensed with. Ideas about health and illness, as Gerhardt (1989) notes, have played a central role in the development of general sociological theory since the Second World War, including issues of order and control, ‘deviance’ and ‘normality’. Contemporary work encompasses a variety of perspectives, from phenomenology to constructionism, and despite various ‘border skirmishes’ and ‘internal disputes’ (Strong 1979; Bury 1986), the sociology of health and illness remains a flourishing sub-discipline, both theoretically and empirically.

Not only is qualitative sociological research—formerly the ‘poor relation’ of social epidemiology—increasingly valued in medical circles (Green 1998; Blaxter 1996; Pope and Mays 1995; Black 1994), but debates as to the relevance of theory itself, including the advent of so-called ‘narrative based medicine’ (Greenhalgh and Hurwitz 1998), are now appearing in such hallowed places as the British Medical Journal (Alderson 1998). Tensions nonetheless remain, not simply concerning this eclectic theoretical base, but also regarding various funding crises, institutional dilemmas and the push towards more evaluative health service research (HSR), including ‘evidence based’ medicine and ‘quality assurance’ initiatives. Should medical sociologists, given these pressures, remain true to their trade, both theoretically and empirically (i.e. the autonomous, ‘outsider’ solution); or should they ‘toil’ instead under the banner of public health, HSR or some
other such title in the hope of promoting ‘change from within’ (i.e. the ‘pragmatic’, insider solution)? These, to be sure, are familiar concerns, including the dilemma of ‘sociological imperialism’ itself (Strong 1979). We are all, moreover, given the vicissitudes of funding and institutional constraints, called upon to be ‘double-agents’ at times. What has changed, however, both inside and outside the academy, are the reflexive parameters within which these and other debates are currently taking place: a dynamism in which the ‘limits’ of expertise, whatever its source, are increasingly exposed.

A key question here concerns whether or not we are living in a postmodern society? For some theorists the modern project—linked as it is to processes of rationality, discipline and control—is all but over (Lyotard 1984; Baudrillard 1988). Modernist notions of causality, identity, the subject and truth should, it is claimed, be abandoned in favour of a more destabilised, desedimented position which celebrates indeterminacy, contingency and flux: a postmodern carnival in which surface substitutes for depth, time dissipates into a series of ephemeral presents, the subject becomes de-centred and reality itself becomes ‘hyper-real’.

Others, however, dismiss these claims as rash and hasty, preferring instead to reconsider the nature of modernity itself. Giddens (1990, 1991), for example, sees reflexivity as a constant (i.e. chronic) feature in the history of modernity; a trend which he claims has been exacerbated in contemporary Western society through the disembedding mechanisms of globalisation and the internally referential nature of contemporary social life. Seen in these terms, we are not living in a postmodern era, but one in which the consequences of modernity are only now becoming fully realised (see also Habermas 1992; Gellner 1992). Despite tying itself to the ‘certainties’ of science and rationality, modernity has always been an ambivalent, ambiguous order, involving both liberty and discipline (Wagner 1994), certainty and doubt, the Apollonian (i.e. control) and the Dionysian (i.e. chaos) (Rojek 1994). The Renaissance and the Enlightenment, as Durkheim reminds us, were both periods of excessive anomie, the latter involving both science and irrationality, higher rights and brutal oppression, cosmopolitanism and nationalism. Seen from this angle, the Enlightenment ‘project’, like the civilising process, has a certain ‘counterfeit’ quality or feel to it; one which displays an ‘irrational passion for dispassionate rationality’ and a betrayal—from witch-hunts, colonialism and slavery to the Holocaust and beyond—of its bloody roots and barbaric foundations (Mestrovic 1993, 1997).

In a similar vein, Bauman has suggested that postmodernity, properly interpreted, is really ‘modernity looking at itself at a distance rather than from inside, making a full inventory of its gains and issues, psychoanalysing itself’ (1991:272). (See also Berman 1982 and Touraine 1995). Taken together, these critiques, alongside the emergence of critical realism as a dominant new force and promising alternative in contemporary social theory
(Archer et al 1998; Bhaskar 1989a, 1989b), suggest that the notion of ‘postmodernity’ is highly problematic, thereby encouraging the alternative view, endorsed by many contributors to this particular volume, that ‘contemporary social changes are best understood as the increased dominance of certain aspects of modernity over others, rather than as indicators of a radical break with modernity as such’ (Mellor and Shilling 1997:188). To the extent that so-called ‘postmodern’ perspectives have shaken the foundations of rational thought, destabilised seemingly ossified conceptual forms, and opened up new (ethical) questions and ways of being and caring for each other, they are to be welcomed. To see this as the ‘death of modernity’ however, to say the very least, is premature. Rather, processes of rationality, including ongoing advances in science and technology and a resurgence of biological explanations (Benton 1991), continue to hold sway over large tracts of society, at one and the same time as new forms of sociality, emotionality and communality begin to emerge (Maffesoli 1995, 1996).

It is within this context that the rationale for the present volume is located, the central aim of which is to address explicitly the relationship between mainstream sociological theory and medical sociology in the light of a number of key issues within the field of health at the turn of the century. Whilst, as we have argued, medical sociology has never been an atheoretical discipline, it nonetheless remains the case, particularly in the current economic and political climate with its emphasis on evaluation and cost-effectiveness, that bridges between mainstream theory and the sociology of health and illness need to be continually built if an instructive and mutually informing dialogue is to occur. Four key themes, we suggest, are central here both to current mainstream theorising and contemporary research within the sociology of health and illness. Re-thinking of social structure, the first of these, raises a series of issues, from debates over the future of class, to the blurring of traditional categories and distinctions concerning gender, ‘race’ and ‘ageing’ in the late/postmodern era. The body, our second theme, is also becoming increasingly ‘contested’ and ‘uncertain’ at the turn of the century, both inside and outside the academy. What sense are we to make of these corporeal developments, and in what ways do the embodied dilemmas of health and medicine help clarify the issues at stake? Consumption and risk, our third key theme, mesh closely with these arguments, from the ‘rituals’ of health promotion in the ‘epidemiological clinic’ of late modernity (Bunton and Burrows 1995), to the commodification of health care in the ‘marketised’ state. Emotions are equally central here, partly through this upsurge of interest in the body, consumption and risk, and partly through the broader debates, postmodern or otherwise, they engender concerning the project of rationality itself. How should we see emotions in this context, and what role do they play in the health arena? These and other issues, as we shall see, are as central to health as they are to mainstream theory. The lines
of influence, in other words—from the sick role to the clinical gaze and beyond—flow both ways. Medical sociology, in short, for the first time in its history perhaps, may become a ‘leading edge’ of contemporary social theory (Turner 1992). It is to a fuller exposition of these themes, and the chapters which follow, that we now turn.

**Rethinking social structure and health**

Within medical sociology the debate about the relationship between social structure and health has focused, at least until recently, on the inverse relationship between social class position, health status and longevity—the so-called ‘inequality in health’ debate. Social class position, in this respect, has tended to be conceptualised ‘atheoretically’, measured as it is through occupational class. Much of this research has been empirical in nature (mainly from a social epidemiological perspective), including the identification and description of more or less ‘patterned’ statistical relationships between indicators of occupational class, indicators of ill health and mortality and factors that might mediate between the two.

A central issue here has been the extent to which the relationship between occupational social class and ill health can be explained by social selection or by structural (material) factors. The catalyst for this debate was the Black Report of 1980. As MacIntyre (1997) points out in her review of developments since the report’s publication, the debate has tended to become polarised, confusing what she sees as the ‘hard’ and ‘soft’ versions of the four different explanations proposed: artefact, natural/social selection, cultural/behavioural and materialist/structuralist. The Black Report accepted the hard version of a materialist/structuralist explanation (i.e. material, physical conditions of life associated with the class structure are the complete explanation for class gradients in health), but rejected the explanatory power of hard versions of the other three. It did not, however, reject the soft versions of these three explanations, and there now appears to be some consensus that these explanations are not necessarily alternatives. As MacIntyre states:

> The ‘selection versus causation’, ‘artefact versus real differences’ and ‘behaviour versus material circumstances’ distinctions can thus be seen to be politically and conceptually important but are becoming false antitheses if treated as being mutually exclusive: the same applies to new distinctions, such as those between material and psychosocial factors, and between early life and adult life influences on inequalities.

(1997:740)

One of the newer (and perhaps more sociological) explanations that MacIntyre refers to is that proposed by Wilkinson (1996). He argues that it
is income inequality rather than low income which is the key determinant of poor health, in that relative income is more important than absolute income in rich, developed countries. For Wilkinson income inequalities influence national mortality rates primarily by determining the strength of impact of relative deprivation on health. Narrowing health inequalities give rise to faster improvements in national mortality rates. Thus a nation’s health reflects the way resources are distributed and not simply the existence of different levels of income between socio-economic groups. Relative differences in income are said to undermine social cohesion in different societies by increasing the stress of the disadvantaged and damaging their self-esteem. Thus emphasis is placed on the role of psychosocial factors rather than the physical effects of poverty (see Chapter 15 by Williams).

However, this overall approach has been criticised, at least from a sociological point of view, as being atheoretical and divorced from mainstream sociological debates about class. As Mildred Blaxter points out in Chapter 1, not only have critics focused on the sociological limitations of the operationalisation of the concepts of social class and health used in these debates, they have also pointed out the neglect of broader questions about changes in the meaning of class and in the significance of occupation, suggesting that the notion of occupational social class depicted in these debates is now outmoded.

Medical sociology, Blaxter suggests, has responded positively to such criticisms, taking cognisance of contemporary debates about class and responding creatively to them. The key explanatory concept for Blaxter is time (social, calendar and personal). Her analysis begins by showing how current debates about the concept of class manifest themselves in medical sociological research. She shows, for example, how new sociological forms of occupational classification have begun to be used to explore class as an explanatory (as opposed to a descriptive) factor in health. This has manifested itself in research exploring the relations between social structure and health and the way resources associated with different social positions enable differential management and control of risks to health and ontological insecurity. The approach builds on the work of Beck (1992) who claims that we are no longer primarily divided by access to wealth, but by our relative vulnerability to risk. This argument is illustrated by research on stress, control and the social distribution of risk which is found in studies examining job insecurity, unemployment and health.

For Blaxter, however, time is the key to explaining the relationship between the development of social capital over an individual’s lifecourse (or even in the generation before) and the link with health. A distinction is drawn here between social time, calendar time and personal time; the latter being of central relevance to biography. Individuals have their own definitions of biotemporal orderliness which provide structure to life and death. For example, one of the features for those living in deprivation is that
time accelerates the perceived ageing process and makes those in such circumstances feel they are deprived of time. More importantly Blaxter suggests that the process of individualisation which has undermined hierarchical models of social class stratification has led to biographies tending to be private and ahistorical, with people no longer being aware of their parents’ life circumstances.

In these and many other ways, Blaxter moves these class related debates on, both theoretically and empirically, relating the ‘private’ realm of personal troubles, *qua* biography, to broader ‘public’ issues of social structure and temporality, itself the defining hallmark of the ‘sociological imagination’ (Mills 1959). Moreover, it also suggests some promising new linkages between traditional concerns within the sociology of chronic illness centred on notions of ‘biographical disruption’ (Bury 1982) and ongoing inequalities and life-events research.

Social class also features in Ellen Annandale and Judith Clark’s chapter on gender, postmodernism and health. They consider the changing nature of class and gender and argue that the contemporary debate about class allows for the conceptualisation of gender as part of and integrated within the restructuring of the ‘economic base’ of society. However, they claim that the effects of the mutuality of class and gender have been neglected by mainstream medical sociology.

Drawing on Ebert’s (1996) ‘resistance’ postmodern feminism, they analyse contemporary relationships between gender and health focusing specifically on health-related behaviours. They note that postmodern feminists reject the grounding of ‘modernist’ feminism in terms of a difference between men and women and agree with Ebert ‘that the fragmentation of gender is a “reality” of late twentieth century society, itself thrown up by the metamorphosis of capital’.

Annandale and Clark then go on to explore these ideas in the context of gender, health and illness, taking health related behaviour, and more specifically tobacco consumption, to illustrate their analytical approach. They argue that changes in health related behaviour have accompanied the ‘loosening of gender prescriptions’ and that products that were once marketed as ‘male’ activities are now also marketed at women and vice versa. The authors argue that gender and health related practices reflect both the ‘opening up’ of gender, in terms of marketing fitness products, and the maintenance of gender differences, but in reverse form, as illustrated by patterns of cigarette smoking. Anorexia nervosa is also used to illustrate the point that the ‘dual demands’ of gender (i.e. the dual demands of ‘female domesticity’ and ‘male mastery’ that are placed on women) affect women more than men.

Turning to race and health, Chris Smaje, in his chapter on the way medical sociology has engaged with sociological arguments about race and ethnicity, suggests that while the latter’s influence is evident in medical
sociology there is a tension between these two fields. On the one hand, medical sociology has examined aspects of the health of groups in the population defined according to some notion of their race or ethnicity. In doing so, it has produced a diverse and intriguing body of empirical findings. On the other, medical sociology has used sociological arguments to critique the basis upon which categories like race and ethnicity have come to be defined. Smaje, however, is critical of what he sees as a negative critique of racial categories and argues that it is both necessary and possible to theorise race in such a way that it is neither a secondary extension of some other analytical category, or constructed as a ‘natural’ fact.

Smaje’s theoretical perspective on race and health draws on the writings of Bourdieu and, in particular, his ‘theory of practice’ and the concepts of ‘habitus’ and ‘capital’. Smaje sets out a research programme in two areas: the racial patterning of health status, and health service use by people from racialised minority groups. For example, he suggests that Bourdieu’s approach to the genesis of social groups and their embodied practices might provide a useful basis for understanding evidence of a relationship between the structure and organisation of a community and health. He also draws on Bourdieu’s approach to capital (social/cultural) to explain the ‘over-utilisation’ of GP services but relatively low use of hospital outpatient services by several racialised minority groups. In doing so, he suggests that the ability to mobilise the social capital required to conduct a consultation with ‘apparent’ competence may vary according to racialised identity.

In the final chapter in this part (Chapter 4) Michael Bury focuses on health and ageing. Like Blaxter, he emphasises the importance of locating sociological analysis in the context of the concept of the ‘lifecourse’. His analysis focuses on two main contemporary perspectives, one of which identifies a more ‘optimistic’ approach and the other a more traditional ‘negative’ or pessimistic approach to ageing.

The ‘optimistic’ approach draws on Laslett’s (1989) ‘Theory of the Third Age’ and ‘postmodern’ forms of sociological writing on ageing. The basic idea is that ill health and disability will be prevalent over a shorter period (the fourth one) in later life, thus allowing for a more positive and successful form of ageing to occur. The shifting position of the elderly is in part due to the changing meaning of work and the increasing importance of consumerism and leisure. Also age related boundaries have become more permeable and modes of behaviour and experience are less tied to chronological stages of a ‘lifecycle’.

In parallel with this ‘celebratory’ perspective on ageing is a more pessimistic perspective which emphasises inequalities around the lifecourse and particularly the impact of maternal deprivation and the consequences of dependency. For example, Bury notes that there is an increasing body of evidence suggesting that disadvantages in early life shape experiences in later life. In conclusion, Bury suggests that these two perspectives have tended to
operate in isolation. He argues for a more integrated perspective which requires a closer and more realistic understanding of problem oriented research by the ‘optimists’ and a greater recognition of social discontinuity and change among the ‘pessimists’.

The body

Recent years have witnessed a veritable explosion of body-centred sociological discourse. Indeed, currently the body is both everywhere and nowhere: an elusive victim of its own success (Williams and Bendelow 1998). Fortunately, however, this deafening chorus of cries to ‘bring the body back in’ is now being replaced by a new, more critical call; one which seeks to ‘question’ the body, re-open debates about the role of biology, and move towards a more ‘integrative’ phase of social theorising. Here the emphasis is not simply on re-reading old sociological themes in a new corporeal light, but on mapping out new ways of thinking and research agendas which challenge previous dualistic positions; positions which have sought to divorce mind from body, biology from society and reason from emotion. To this, we may add the growing body of empirical research on the body in everyday life, research which is providing a much needed counterweight to the predominantly theoretical nature of these corporeal debates to date (Nettleton and Watson 1998).

The body, as Frank (1991a) suggests, is ‘constituted’, sociologically speaking, at the intersection of an equilateral triangle composed of institutions, discourses and corporeality (i.e. the flesh as an ‘obdurate fact’). From this perspective, bodies are the foundation of both discourse and institutions as well as being their products. Discourses, in other words, are embodied, and social institutions cannot be understood apart from the real, lived experiences and actions of bodies; including the embodied actions of sociological practitioners themselves. What is required, therefore, is not so much a sociology of the body as an embodied sociology (Williams and Bendelow 1998): a position which mirrors recent debates over a sociology of postmodernity versus a postmodern sociology (Bauman 1992). The basis of social theory must, in short, be the body’s consciousness of itself (Frank 1991a:91). Only on this basis can theory put the mind back in the body, the body back in society and society back in the body (Williams and Bendelow 1998).

Certainly, the sociology of health and illness—dealing as it does with issues of pain and sickness, disability and death—provides a fertile terrain upon which to fashion some of these evolving debates on human embodiment, including the need to work at the ‘interface’ between materialism and constructionism, experience and representation, culture and the flesh. Indeed, underlying questions of human embodiment constitute what is perhaps one of the core problematics of medical sociology: the
contingencies of the flesh and the search for meaning and identity in an ambivalent, health-conscious, age.

These issues are taken up in Chapter 5 by Alan Prout. He adopts Turner’s (1992) analytical distinction between foundationalist and anti-foundationalist accounts of the body—i.e. the body as founded beyond or within the social—to illustrate these different positions with examples drawn from the literature on childhood. Shilling’s (1993) notion of the body as a biologically and socially ‘unfinished’ entity is seen as a useful way forward in this respect, but one which overemphasises children’s passivity in social life and underemphasises their specificity as social actors. What is missing here, as Prout rightly argues, is a sense of childhood as a being as well as a becoming; childhood as staged and children as active, creative performers. Within this formulation the possibility arises that childhood itself is created through, perhaps even requires, certain kinds of bodily performance; performances which themselves exhibit difference at the level of bodily conduct. More generally, it suggests that bodies, as resource and constraint, both shape and are shaped, at one and the same time, by social relations.

These issues are taken further by Prout through his advocacy of the sociology of translation as an alternative framework for discussing children’s bodies. Such an approach not only draws into play bodies as a constituent of sociality conceived in heterogeneous terms, but also the part played by artefacts, those other materialised hybrids of nature and culture. Seen in these terms, childhoods and bodies, like all other phenomena, are constituted not only from human minds and their interactions; not only from human bodies and their interactions; but also through an ‘unending mutually constituting set of interactions of a vast array of material and non-material resources’. The upshot of these arguments is clear. Attention to childhoods and children’s bodies serves as a litmus paper test of the broader claims which currently circulate both in sociological discourse on the body in general, and the sociology of health and illness in particular.

In Chapter 6, Emily Martin discusses a new, emerging conception of the body in the US which, she suggests, has the potential to lead to new forms of discipline and control. From this perspective the body is seen not as a collection of mechanical parts, but as a complex, fluid, non-linear system in constant motion. As Martin notes, this has, in part, occurred through an ever increasing cultural emphasis on the body’s immune system, something which is central to organising the ways in which people think about health and work, life and leisure. This new, ever changing body, exists in a delicate relationship to its environment, including late capitalist imperatives for a flexible, post-Fordist workforce. For Martin, this cultural shift signifies the emergence of a new post-Darwinian conception of ‘fitness’ in which some will ‘survive’ and others will ‘perish’. Such flexibility, on closer inspection, turns out to be both highly constrained and morally suspect.
If immunological discourse is one site in which bodies are (rapidly) being transformed in contemporary Western society, then the new genetics is another. In Chapter 7, Deborah Lynn Steinberg takes up these issues through the cultural analysis of a selection of ‘genetics advocacy’ literature located within the wider genre of ‘high culture’, popular science. Taking as her point of departure Sontag’s (1978) early work on illness as metaphor, together with other more recent writings on scientific narratives and narrative theory more generally, Steinberg examines three texts, all of which, in their different ways, make a case for a widening practice of ‘recombinant genetics’ (i.e. genetic engineering). In the first, Stephanie Yanchinski’s (1985) *Setting Genes to Work*, Steinberg identifies what she terms a ‘libertarian, free market, individual utopian’ discourse in which capitalist metaphors and narratives dominate the text. In contrast, Steve Jones and Borin Van Loon’s (1993) *Genetics for Beginners* presents what might be termed an ‘imperialist liberal utopia’ characterised by colonial metaphors and narratives. Finally, in Philip Kitcher’s (1996) text, *The Lives to Come*, a quintessentially ‘American social conscience, liberal utopia’ of genetics is presented; one involving narratives of quests and journeys of the Bunyan variety. Within this latter discourse, Kitcher, at one and the same time, locates science within/disaggregates it from social hierarchy and practice. For Steinberg, it is this narrative frame of reference which makes it possible for ‘dystopian’ dimensions of the new genetics revolution to be acknowledged, embattled and ultimately ‘saved’.

Discussion of genetics and the human genome project, in turn raises a broader set of issues about the biological and social constitution of so-called ‘disabled’ bodies. As Williams and Busby note in Chapter 8, disability has become a ‘hotly contested’ issue in recent years. Indeed, the language of disability itself has become the object of political analysis and dispute. Finding terms to describe chronic illness and disability in an ‘innocent way’ therefore becomes increasingly difficult. On the one hand, it is argued—both inside and outside the disability movement—that too close a focus on impairment deflects attention from the systematic way in which the environment excludes people from participation in civil society (i.e. disability as ‘social oppression’). On the other hand, focusing too closely on subjective experience is said to lead the investigator into a ‘bottomless pit’ of phenomenological analysis where the structures which underpin or destroy identities and the disabling barriers which deny access and participation in society are lost sight of.

The question therefore becomes how impairment can be ‘brought back in’ without re-entering the embrace of biomedicine? More generally, it concerns how we are to reconcile the ‘politics of exclusion’ with the real effects of different impairments and the complex, ‘negotiated’ aspects of everyday life. It is with these thorny questions in mind that Williams and Busby’s chapter proceeds. In many ways, as they note, disability is fundamentally a
‘representational’ problem: there is no ‘untainted’ language within which adequately to discuss it. The language and categories we use influence both its definition and measurement, and there is a continuing dispute as to who are the legitimate representatives of the experience and reality of disability in contemporary Western society. Whilst some may find this situation itself ‘disabling’, Williams and Busby stress instead that it is still possible to be politically committed without being sociologically one-dimensional. They also suggest that a multi-dimensional understanding of disability is required if ways are to be found of making disability less oppressive for people with many different bodies, experiences and circumstances.

Moving from disability to death, Lindsay Prior, in the final chapter (Chapter 9) of Part 2, offers a series of reflections on the ‘mortal’ body in late modernity. In doing so, he draws a useful distinction between the sociology of mortality as an examination of structures, patterns and causes of death in populations, and the sociology of death as an examination of the meanings and experiences of death for individuals. Prior then proceeds to explore more fully the calculability and predictability of death in the modern world, including the sequestration and deconstruction of death itself (i.e. the privatisation of death and the reduction of death to its diseases). Central issues here concern the ‘risks’ of dying, risks for collectivities and for individuals alike. This, in turn, enables Prior to conclude with a broader set of reflections on the relationship between death, risk and the everyday world, including narratives of disaster and consumer oriented death in late/postmodernity. Again we glimpse, through this insightful chapter, how arguments within the sociology of health and illness mesh, more or less closely, with ongoing debates, corporeally focused or otherwise, within mainstream theory itself.

**Risk and consumption**

Sociologists have come relatively late to issues of risk and consumption. As regards risk, they only really started to make a mark during the 1980s, by focusing on environmental risks such as hazardous nuclear waste, landfill sites or the use of herbicides, the differing risk assessments of regulatory authorities and public distrust in risk experts (Jasanoff 1987; Wynne 1980, 1982, 1989). This in turn has become part and parcel of a wider analysis of the problems of calculating risk in a ‘risk society’ faced with ecological mega hazards (Beck 1992; Giddens 1990, 1991). From this perspective risk has become a defining feature of late modern societies as a result of these societies’ growing vulnerability to major socio-technical dislocations and their ever-increasing interdependence in a global marketplace. In the face of such risks old class-based inequalities collapse to be replaced by new ones based on differences in ability to deal with insecurity and risk (Beck 1992).
It is against this background that the sociology of health and illness has started to make its own distinctive contribution. Taking as its starting point that risks are socially constructed or framed and collectively perceived, medical sociologists have concentrated on the cultural factors shaping risk perceptions of hazards to health and their management, and the role of material factors and social interests in shaping responses to health risks. Consideration has thus been given to the ways in which perception of health risks and risk behaviour are contextually dependent or socially situated and may also be influenced by social interaction, behavioural norms, habit and the distribution of power (Rhodes 1997). In addition a distinction has been drawn between risks from the environment and from an individual’s lifestyle and embodied or corporeal risks. While environmental risks happen to people and lifestyle risks stem from what people do or do not do, embodied risks are located within the bodies of individuals and say something about what a person is (Kavanagh and Broom 1998).

Consumption has also only been a source of interest for sociologists in recent times (Campbell 1995). Two broad approaches have been taken (Warde 1990). The first has focused on consumption sector cleavages and the extent to which they have replaced production-based cleavages as the major fault line in social relations. Much of the work in this area has concentrated on public sector services such as housing and water and whether increasing private ownership has altered political alignments (e.g. Saunders and Harris 1990, Savage et al. 1990). In the health field such arguments have been taken up by Busfield (1990) and Calnan et al. (1993) who have considered the consequences of the increased consumption of private medicine for sectoral divisions.

The second approach has focused on the growth of a consumer culture in late modernity and the consequences of the construction of divergent lifestyles for the self (Featherstone 1991). In the health field this focus has been taken up by those interested in studying health promotion, with attention being paid to the way in which the consumption of goods and services such as alcohol, fashion, fitness, food and leisure activities contribute to an individual’s body image and sense of health (Bunton and Burrows 1995; Lupton 1994).

Chapter 10 takes up some of these issues in relation to the risks associated with food consumption as they are represented and perceived, negotiated and experienced in contemporary western society. As Deborah Lupton notes, hardly a day goes by without a report in the news media either on the linking of a food substance with illness, or a claim that a particular food is protective against disease. The link between health status and food consumption is, in other words, constantly made across the commercial advertising/health promotion divide. As a consequence, food has become ‘profoundly medicalised’ in its association with health, illness and disease. Risks associated with food consumption also involve
challenges to the self, including the maintenance of self-autonomy and control, the shape and size of the body, as well as broader issues of social group membership.

In discussing these dimensions of risk and food consumption, Lupton examines three major theoretical perspectives. In the first, ‘risk society’ perspective (e.g. Giddens 1991 and Beck 1992), attention is drawn to macro issues and political aspects of risk discourse, locating the major cause of current anxiety within broader concerns about the negative outcomes of modernisation and industrialisation. Concern about risk, from this perspective, is a rational (i.e. cognitive) response to individuals’ perceptions of the uncertainties and growing hazards of life in late (i.e. reflexive) modernity. The ‘cultural’ approach, in contrast, directs attention to more latent meanings underpinning concerns about food. Exponents of this perspective (e.g. Douglas 1966/1980 and Kristeva 1982), highlight the symbolic role that food plays in passing across (i.e. ‘transgressing’) cultural boundaries, and the risks that are integral to this act of incorporation of ‘other’ into ‘self’. Finally, within the third, ‘civility’ perspective (e.g. Elias 1978), the consumption of food is seen as being surrounded by the ‘social’ risks of embarrassment, shame or humiliation through ‘inappropriate’ (i.e. ‘uncivilised’) eating practices or in demonstrating to oneself and others one’s lack of discipline and self-control (i.e. the ‘grotesque’ body).

Whilst these perspectives address the topic of food consumption and risk at differing levels of analysis, and with more or less conceptual depth, they are nonetheless, as Lupton notes, insightful in underlining that notions of risk are integral to notions of the body, selfhood and social relations. Seen in these terms, the risks associated with eating extend far beyond the biological effects of poisonous, indigestible or carcinogenic food substances. Rather, their ‘danger’ is founded far more on the social norms and cultural conventions associated with the need for individuals or social groups to ‘maintain some sense of certainty and order, preserve self-integrity, present themselves as “civilised” and defend their bodily and symbolic boundaries against transgression’. Risk, in short, is a sociocultural issue through and through.

The relationship between transgression, risk and taboo is also taken up and elegantly addressed by Robert Crawford in Chapter 11. Building on his previous work on the cultural contradictions of health in contemporary (American) society, Crawford considers health promotion—both popular and professional—as a ‘ritual’: one which opens a ‘window’ on the symbolic practices undertaken in its name. Health promotion, in other words, is both a professionally mediated and popular ritual which provides a symbolic repertoire for making sense of and morally managing ‘matter out of place’—i.e. the contradictory demands and internalised mandates for ‘control’ and ‘release’ as they are meaningfully experienced in the current era.
Metaphorically homologous with economic experience, health promotion serves as an ‘emotionally resonant’ expression and commentary on the ‘conflict-generating’ logic of economic restructuring. Seen in these terms, health promotion can profitably be understood as a ‘displacement onto the medicalised body’ of the middle classes’ ambivalence about discipline and pleasure; a highly stylised blend of discursive practices for managing and moralising this very ambivalence. In adopting this stance, Crawford deepens Martin’s analysis of ‘flexible’ bodies (Chapter 6) within contemporary American society, noting how the current emphasis on balance and flexibility will not, in all likelihood, be easily achieved. Some ‘matter’, in short, will always remain ‘out of place’, for better or worse.

These issues, in turn, raise a broader series of questions, currently under debate, concerning the relationship between health and illness, transgression and taboo. Previously thought of, in Parsonian (1951) terms, as ‘conformity’ to the ‘norm’, could it be that health itself, particularly through its ‘release’ modality, harbours these ‘deviant’ qualities: attributes previously seen as the sole province of illness (Williams 1998; Frank 1991b; Pflanz and Rohde 1970)?

In the next chapter, Graham Hart and Simon Carter discuss the differing social perspectives which have been used to understand the risks associated with intravenous (IV) drug use and HIV, and the extent to which there exists a sufficiently cohesive body of literature to review present progress within these areas and inform future research. The chapter begins with an example of how a recent drug scare raises a range of issues which are important for an understanding of drug use. Having done so, Hart and Carter then proceed to develop a sociological analysis of drug culture at three interrelated levels, namely: the macro or supra-structural; the mid or meso-structural; and, finally, the micro-social level. Previously used to understand sexual risk behaviour and HIV infection, they suggest this approach can also contribute to our understanding of the relationship between drug use and risk.

From this more sociological perspective, it is the links shared by and connecting social actors, and the contexts within which actions occur, which are significant (i.e. risk as situated between people rather than residing within their individual cognition). Within this context, issues of pleasure associated with bodies, risk and consumption come to the fore. More generally, in contrast to previous epidemiological and (social) psychological models, the sociology of HIV risk behaviours demonstrates that broader socio-structural factors should be the starting point rather than end point of any adequate study of the social dynamics of risk.

In the final chapter of Part 3 (Chapter 13), Jonathan Gabe and Michael Calnan consider the relevance of sociological debates about consumption for understanding the changing experience of health care by users of the British National Health Service (NHS). Starting with the observation that
sociologists have generally employed a rather loose consumerist perspective to frame their discussions, they turn to Warde’s (1990) model of production/consumption cycles to see what light it can throw on the consumption of health care. The model represents a rare attempt to link production with consumption and identifies four modes of provision—market, state, household and communal—which are said to have potential consequences for social relations governing access, the manner of delivery and the experience of consumption.

Gabe and Calnan focus on market and state modes of provision as they relate to the NHS and ask whether this distinction can be sustained in the 1990s. They also assess the consequences of the changing mode of provision for the users of health care and for citizenship rights, enquiring whether users have been empowered by the changes or whether social divisions have been enhanced. These questions are addressed as they assess the impact of three changes to the structure of NHS provision during the 1980s and 1990s, namely: the implementation of the internal market, the introduction of new managerialism and the development of welfare pluralism. They suggest that Warde’s model never adequately portrayed the complex nature of the production and consumption of health care in the NHS, but that since the 1980s the distinction has been harder to maintain. Indeed, they argue that it would be more accurate to describe the current mode of provision as that of the ‘marketised state’. This new set of arrangements has in turn helped to an extent to undermine social rights to equity and justice while social divisions have, if anything, worsened as a result of these changes.

**Emotions**

In the final part of the volume, we take up the problem of emotions in social life through the lens of health. Like the body to which they are so closely tied, emotions, historically speaking, have tended to enjoy a rather ‘ethereal existence’, lurking in the shadows or banished to the margins of (malestream) sociological thought and practice. Certainly, it is possible to trace implicit if not explicit emotional themes in the work of classical sociological thinkers, from Marx’s writings on alienation to Durkheim’s discussion of collective effervescence, and from Weber’s analysis of asceticism and the charismatic leader to Simmel’s observations on the sociological significance of the senses and the vicissitudes of mental life in the metropolis. Nonetheless, it is really only since the 1980s that a distinct ‘corpus’ of work, mostly American in origin, has begun to emerge on the sociology of emotions.5

Emotions lie at the juncture of a number of fundamental dualisms in western thought such as mind/body, nature/culture, public/private. A major strength of the sociological study of emotion lies, therefore, in its ability to
transcend many of these former dichotomous ways of thinking; divisions
which serve to limit social thought and scientific investigation in
unnecessary, self-perpetuating ways. Certainly many of those in the field of
emotions are actively engaged with or contesting divisions such as the
biological versus the social, the micro versus the macro, quantitative versus
qualitative, positivism versus naturalism, managing versus accounting for
emotions, prediction versus description, and so on (see, for example, Kemper
1990, and more recently, Bendelow and Williams 1998). Again, work within
the sociology of health and illness is proving central to this enterprise.

Whilst debates continue to rage as to what, precisely, emotions are,\textsuperscript{b} it is
perhaps most profitable to view them as multi-faceted, embodied phenomena
which are irreducible to any one domain or discourse. Emotions, in other
words, are thinking, moving, feeling ‘complexes’ which, sociologically
speaking, are relational in nature; i.e. communicative, intercorporeal and
intersubjective. This, in turn, offers us a way of moving beyond more micro-
oriented sociological concerns with issues of emotional experience and
expression, to broader, more macro-oriented concerns such as the
commercialisation/commodification of human feeling, and the relationship
between the private realm of ‘personal troubles’ and broader ‘public issues’
of social structure, conflict and control (Bendelow and Williams 1998; Mills
1959).

At first glance, the work of Habermas (1986, 1988, 1992) may seem to
offer little to sociologists interested in emotions and health. In a critical
reworking of the Habermasian programme, however, Nick Crossley (Chapter
14) provides us with a paradigmatic example of the insights which can be
gained from a return to his \textit{Theory of Communicative Action} (1986, 1988)
and deliberations on the rationalisation of society/colonisation of the
lifeworld. Taking as his point of departure a re-thinking of the very notion of
reason—one which comprises mutual understandability, accountability and
the possibility for critical, argumentative discourse—Crossley shows how
emotions can themselves be seen as communicatively rational in this re-
worked sense of the word. Having done so, he then proceeds to consider the
emotion-psychiatry-order nexus from both a systems and a lifeworld
perspective, charting the growth during the postwar era of the ‘emotion
industry’—from pharmaceutical companies to public sector psychiatry, and
from psychotherapy to the booming sales of psychologically oriented self-
help manuals. Not only does this enable us to question the dividing line
drawn, by psychiatry and other disciplines, between ‘reasonable’ and
‘irrational’ emotions. It also allows us to cast the technology of emotions
offered by the emotion industry more generally in a new Habermasian light,
contrast it with a viable alternative; namely, the rational regulation of
emotion in the lifeworld. The Habermasian programme, therefore, as
Crossley rightly argues, provides us with some interesting new hypotheses
for future sociological work within these and related domains.
Complementing this Habermasian focus on the relationship between system and lifeworld, Simon Williams, in Chapter 15, takes up the related problem of micro-macro linkages in health through a critical analysis of the role of emotions in bridging this traditional sociological divide. Taking as his point of departure the ‘epidemiological transition’ and the shift from direct material to indirect psychosocial pathways to disease in the western world, Williams explores the centrality of emotions to the relationship between class, health and society. In doing so, he brings the health inequalities and the life-events literature into a new theoretical alignment through a focus on ‘emotional capital’ and the links this provides between ‘distressful’ feelings and the emotionally expressive body. Following Gerhardt (1979), a key analytical distinction is drawn here between ‘psycho-neuro-immunological adaptation’, ‘psycho-social coping’ and ‘socio-political praxis’: responses linked to different types of life-events and difficulties. These issues are then related, in the final section of Williams’s chapter, to a broader set of reflections on emotions, health and ‘distributive justice’, and a reconsideration of the role of the ‘biological’ in social explanation (i.e. the need for a non-reductionist, socially ‘pliable’ biology and a critical realist ontology of the body).

Building on these emotional themes and micro-macro linkages, Virginia Olesen, in the next chapter (Chapter 16), considers the relationship between emotions and gender in contemporary US health care contexts. In particular, she argues that changes currently taking place within this field serve as a microcosm for the interplay between gender, emotions and rationalisation. In many other contexts too, such as the law, education, business and the church, gendered differences in emotion—interactive and being done—are crucially and obdurately embedded in the occupational and gender stratification systems, with potential for insuring stability or change. Looking at differences in health care contexts and their relation to wider institutional change therefore provides fruitful leads as to how these changes may ‘play out’ differentially in other areas unrelated to health. More generally, Olesen argues, the analysis of gender, emotions and changing health care contexts integrates the sociology of health and the discipline of sociology in ways which enlarge and expand each one’s theoretical possibilities. In doing so, one is able to attend to the enduring problems of a sociology of ‘humane health care’: one which demands that the theoretical and empirical enterprise does not founder in the ‘thicket of abstractions’ or ‘waves of objectified data’, thereby losing sight of the interactive, affective, subjective and relational elements in organisations.

This notion of a new, more ‘humane’, approach to health is also taken up and critically explored by Nick Fox in the last chapter (Chapter 17) of the volume. In addressing these issues Fox wishes to consider, in a more explicitly postmodern vein than previous chapters, what recent social theories can contribute to the understanding of human engagements in
Williams, Gabe and Calnan

‘caring’ relationships. His exploration starts, therefore, from the poststructuralist feminist position of Hélène Cixous and others, and their notion of a ‘gift’ relationship—as opposed to the masculine ‘proper’. Unlike Maussian ‘gifts’ (which assume reciprocity), the ‘true gift’ is one which the giver is unaware of giving. This postmodern reading of gift relations, in turn, leads Fox onto an exploration of the connection with Deleuze and Guattari’s (1984) ideas of ‘nomadic subjectivity’ (i.e. the ‘becoming other’ of the subject). Relating these philosophical explorations to certain concrete episodes of caring, Fox is able to engage in a series of postmodern reflections on difference and diversity as a starting point for ethical and political engagement with those with whom we interact, including those for whom we care. In taking this line, Fox returns to and deepens his earlier insights concerning the pursuit of so-called ‘arche-health’ (i.e. a ‘becoming different which is potentially emancipatory’). For Fox, the celebration of ‘difference’ entails the abandonment of tried and trusted formulae—any such formula would simply offer yet another new discourse on ‘how to do caring’. The message, in short, is that resistance is always possible, that anything we do is potentially a ‘gift’, and that things can and should be different: a new ethics of existence in a supposedly pluralised, ‘postmodern’ world.

This, in turn, keys in to broader claims by writers such as Michel Maffesoli (1996), that we are now living at a decisive moment in the history of modernity: one in which the ‘rationalization of the world’ is being displaced if not replaced by a parallel ‘re-enchantment of the world’ and a resurgence of more emotional forms of sociality—i.e. Durkheimian ‘collective effervescence’ and the rise of ‘neo-tribalism’, a shift captured in the move from Promethean to Dionysian values. From astrology to macrobiotic food, ecological movements to alternative therapies, the ‘keep your distance’ mentality, common to western epistemologies and social practices alike, is, Maffesoli claims, giving way to more ‘participatory’ modes of being: a ‘fusional realm’ or ‘communalized empathy’, constituting all those forms of ‘being together’ which, for the past few decades, have been steadily transforming society.

Here we return to some of the debates discussed above concerning the modernity/postmodernity question. Modernity, as we have argued, is a complex network of mixed possibilities involving a constant dialectic between order and chaos, the subject and reason, (scientific) instrumentality and (emotional) expressivity. Seen in this light, whilst writers such as Fox and Maffesoli may be somewhat over-optimistic, they nonetheless point to the central role which health is playing, on the one hand, in the resurgence of the emotions and, on the other hand, in the re-evaluation of morality, ethics and what it is to be ‘human’ at the start of the new millennium. Things could indeed, as Foucault rightly suggests, ‘be otherwise’, and health, in all probability, is a central currency within which these potential
changes and transformations are likely to be forged (Williams 1998; Frank 1991b).

Taken together, the chapters contained in this volume suggest a promising future, both theoretically and empirically, for the sociology of health and illness. To be sure, there are pressures, both inside and outside the academy, which point towards a fragmentation of the discipline and its dispersal within a variety of other fields such as epidemiology, public health and community medicine. To this we may add the weight of research funding priorities—what Turner (1992) refers to as the commercialisation or ‘McDonaldization’ (cf. Ritzer 1993; Smart 1999) of social science research alongside the commercialisation of medicine itself—whereby only those projects which contribute directly or indirectly to economic productivity, or the evaluation of service provision, are likely to be funded, whilst other less applied, more theory driven, types of research are starved of economic support. Whatever its future prospects, one thing remains clear; without an adequate theoretical base, the identity and disciplinary integrity of medical sociology will surely suffer. A theoretically informed defence of medical sociology is therefore both timely and necessary. The very fact that bridge building exercises of this nature are possible, and that a volume of this nature has been compiled, offers us more than a glimmer of theoretical hope for the future. The lines of influence between mainstream theory and the sociology of health and illness, in short, are mutually reinforcing: a ritual point of contact in an ‘ambivalent’ age?

References

clinic of late modern medicine’, in R.Bunton, S.Nettleton and R.Burrows (eds) The
Illness 4:167–82.
Health Care, Buckingham: Open University Press.
Clarke, J. (1981) ‘A multiple paradigm approach to the sociology of medicine, health
London: Athlone.
Ebert, T. (1996) Ludic Feminism and After: Postmodernism, Desire and Labor in Late
Capitalism, Ann Arbor: University of Michigan.
Blackwell.
M.Hepworth and B.S.Turner (eds) The Body: Social Processes and Cultural
Foucault, M. (1973) The Birth of the Clinic: an Archaeology of Medical Perception,
London: Tavistock.
Fox, N. (1993) Postmodernism, Sociology and Health, Milton Keynes: Open
University Press.
Frank, A.W. (1991a) ‘For a sociology of the body: an analytical review’, in
M.Featherstone, M.Hepworth and B.S.Turner (eds) The Body: Social Process and
——(1991b) ‘From sick role to health role: deconstructing Parsons’, in R. Robertson
Original Essays and Research Papers, Greenwich, CT: JAI Press.
Gerhardt, U. (1979) ‘Coping as social action: theoretical reconstruction of the life-
——(1989) Ideas About Illness: an Intellectual and Political History of Medical
Introduction


