Coming out: exposing social theory in medical geography

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The debate about the role of theory in human geography has now spanned two decades. This debate has largely bypassed medial geography which has remained, with one or two exceptions, largely atheoretical. This, we argue, is merely an appearance because no social science is atheoretical when theory is understood as a way of understanding the world. The aim of this paper is to present the three broad groups of theory which can be found (explicitly and implicitly) in medical geography. In addition to presenting the basic concepts of these theories, how they are used within health-related research and medical geography in particular is also explored. The paper concludes by presenting a conceptual framework to illustrate how medical geography can develop in order to meet one of its newest challenges—theory generation.

Keywords: social theory, medical geography, theory generation

Introduction

The debate about the role of theory in human geography has now spanned two decades. It was initially influenced by the growing recognition by geographers such as Gregory (1981), Massey (1973) and Thrift (1983) that the central concerns of geography arise from the relationships between human beings and nature with space being the outcome (in part) of social processes (Urry, 1989). This debate has largely bypassed medical geography, which has remained, with one or two exceptions, atheoretical. In doing so, medical geography as reported by McGlashan (1972), has remained simply as a tool of bio-medicine.

Medical geography is a tool and not rarely an end itself. It is the application of geographical methods and skills to medical problems. One may consider geographical evidence on medical hypotheses. It would be improper to claim that geography provides proof.

We assert that the atheoretical nature of medical geography is merely an appearance. It has in fact been largely influenced by a positivist philosophy. Indeed no social science is atheoretical when theory is understood as a way of understanding the world. It is, therefore, a matter of revealing the implicit theoretical underpinnings of medical geography. This, we advance, is central in the development of medical geography so it can meet one of its newest challenges—theory generation. In trying to meet this challenge, medical geography will also face the current debate over how space and place are to be defined and treated. In most medical geographical analysis, space and place are viewed as containers of things (geometric view) or as attributes of other social phenomena (Eyles, 1993). However, explicit theorizing will result in seeing these concepts relationally, thus moving them from the sidelines of the research problem to the centre stage. Consequently it is through theory use and theory generation that medical geography moves ‘out’ of bio-medicine and assists in understanding and explaining the social world.

In this paper, we argue that theory is already present in medical geography. Even ‘traditional’ medical geography, which has viewed itself primarily as epidemiologic, is implicitly informed by a particular view of the world. We shall explore this traditional framework as well as examine the different theoretical constructs found—usually implicitly—in medical geography. It is our contention that different social theories influence different types of medical geography. Table 1 reveals that medical geography, even that which is considered to be more traditional (Mayer and Meade, 1994), has always been theory informed. The framework is thus intended to demonstrate
the basic concepts of three grand theories and how they are used within health-related research and medical geography in particular. Lastly we provide a conceptual framework which will illustrate our ideas about how, by combining the different approaches, medical geography can move towards becoming theory generating. In this way medical geography becomes like all social geography and all social science, and not merely empirical backwater.

The role of theory

Sayer (1992) argues that all research in the social sciences is theory laden. Facts, as a goal of observation, are also theory laden (Eyles, 1985). In fact, Kuhn (1962) contends that what we see depends on what we look at as well as what our previous (visual-perceptual-conceptual) experiences have taught us to see. What we say we see is presupposed by a particular view of the world (a theory). Consequently, unacknowledged theoretical criteria shape our search for and classification of observable phenomena and the relationships between them. Theoretical systems are not, however, established and then ‘proven’ by observation. Nor does theory determine what we ultimately find (Sayer, 1992). Theory and observation inform one another. Theory thus shapes observation—the way in which data are ‘produced’—and thus the whole scientific enterprise.

In order to understand and explain social phenomena, we gather data which are ‘re-conceptualized’ because we cannot have perceptions without concepts. We are used to thinking in terms of particular sets of concepts, yet we rarely openly recognize their influence or presence. Thus the social world is socially produced and all ‘facts’ are social constructions. Subsequently, changes in specific concepts have an impact on and produce changes in societies ‘objective’ form. Yet there is potential to alter the ‘facts’.

Investigation of social phenomena entails that we critically evaluate them. Therefore, in selecting what to measure and what not to measure, we are making a theory-laden decision as evaluation is a purposive and normative activity. This cannot be avoided and any attempt to analyze and explain social phenomena involves the researcher making this critical evaluation. Medical geographers, by not recognizing those theory-informed decisions, appear to be measuring observations just for the sake of doing so (Cicourel, 1964). They appear to avoid the issue that all data about social phenomena are concept dependent and thus commit the error of empiricism.

But as Sayer states, ‘knowledge . . . never develops in a vacuum but is always embedded in social practices and we can more fully understand the former if we understand the latter’ (Sayer, 1992, p.45). Along these lines, in making our assumptions explicit—in coming out—we move forward in our understanding of social phenomena by laying bare the bases of understanding. Moreover, to understand the practice of science (including medical geography) through revealing its theoretical underpinnings, is to understand the practice of social institutions and the embedding of science within them. Thus, through theory, science and practice are connected and the apparent objectivity of science is denied.

Theory, consequently, plays a much greater role than simply providing a conceptual framework to derive relationships for empirical testing (see Taylor et al., 1986; Elliott et al., 1993). It is through theory that the conceptualization of all our observations, even the so-called value-free ones are negotiated. The former conceptualization of the role of theory is a traditional or natural ‘scientific’ one where theory is viewed as a set of interrelated propositions that allow for the systematization of knowledge, explanation and the prediction of social life, and the generation of new research hypotheses (Faiia, in Ritze, 1992). In medical geography, this ‘normal’ scientific view of theory has evolved from the strong links it has with positivistic ‘sciences’ such as epidemiology, economics and behavioural sciences (Eyles, 1993).

By recognizing that there is more to medical geography, to any social science, than isolating the relationships between phenomena, a broader definition of theory emerges. The relationships between particular phenomena with society in general must be understood if we want to be able to understand why phenomena are related to each other in the ways that they are. Theories of society, therefore, not only act as frameworks. They represent a wide ranging system of ideas
demonstrating the centrally important issues of social life (Ritzer, 1992). Theory represents how we perceive and, consequently, how we construct the social world.

The scope of medical geography

Medical geography addresses the tensions between the natural and social science in that it deals with both the physical and human elements, which combined, can affect the physical and mental health of human populations (Eyles, 1993). Because of its traditional focus on the relationships between biomedical phenomena and the role of the environment (Eyles and Woods, 1983; Mayer and Mead, 1994), it is closely related to epidemiology in both subject matter and approach. But there are two distinctive elements to medical geography: the geography of disease/ill-health and the geography of health care. The geography of disease/ill-health involves both descriptive research, looking at the frequency of disease or illness occurrence, who is and who is not suffering from it, and where and when it occurs, and analytic research in that it seeks to test ideas about what determines whether or not a person or population will become affected. Descriptively and analytically, the geography of disease and ill-health focuses on the correlates of diseases and disease distribution in addition to possible and actual environmental associations.

The other distinctive element of medical geography, the geography of health care, has focused primarily on facility location, accessibility and utilization. The geography of health care has employed modelling techniques drawn from location theory and/or quantitative survey design in examining service provision and location (e.g. Halseth and Rosenberg, 1988; Joseph and Bantock, 1982), as well as consumer/patient behaviour patterns (e.g. Ross et al., 1994; Joseph and Pinhey, 1984). Thus the geography of health care exemplifies spatial analysis in which geographic tools (i.e. correlation and regression analyses, location-allocation modelling) are used. However, this research does not limit itself to isolating patterns of health care delivery, but has also looked at the relationships between the distribution and the characteristics of the containing areas, otherwise referred to as ecological analyses.

These two aspects of medical geography, the geography of disease/ill-health and the geography of health care, both utilize similar methodologies deriving them from epidemiology, economics, and behavioural research. These methods allow the conversion of all dimensions of health problems to measurable, quantifiable characteristics—referred to as ‘facts’. In recent years, there has been some dissatisfaction with such approaches and methods, mirroring what has occurred in social geography and social theory in general (Moon, 1990; Kears, 1993). New approaches have been added to reconceptualize the content of medical geography through explicit theorization. These approaches are informed by a social constructionist rather than a biomedical or ecological view of the world (Eyles and Woods, 1983; Baxter et al., 1992; Eyles et al., 1993b; Gesler, 1990; Laws, 1989; Kears and Joseph, 1992; Litva and Eyles, 1994). We still assert that through its relationships to epidemiology and location-allocation modelling, as well as its subject matter—illness distribution and facility location—medical geography has remained largely, usually implicitly, embedded in a positive stance.

It is because of this positivist stance that the geography of disease/ill-health with its use of epidemiology, and the geography of health care with its use of location-allocation modelling, rests upon structural functionalist theory. Both types of medical geography use social facts, a central component of structural functionalist theory, in disease mapping and facility location analysis. We discuss this relationship in much greater detail in the next section.

Structural functionalism

Structural functionalist theory has its roots in the work of Comte and Spencer, but is especially influenced by Durkheim. The terms structural and functional constitute the elements which characterize structural functionalism although they are not necessarily conjoined. Structural features are the patterned ways in which social institutions are integrated to make up and stabilize society. Functions are the processes that maintain necessary integration or solidarity (i.e. norms and values). The level of analysis is society, its functions and dysfunctions (i.e. the ways in which society is (is not) integrated to form a coherent and consistent whole). The social system is viewed as being composed of parts—the family, the economy, the polity, military, health care— which are seen as being interrelated. These subsystems operate interdependently to ensure the continued functioning of society. Structural functionalism is particularly concerned with what happens when problems (i.e. illness/disease) arise and threaten the working order in society (see Parsons, 1951).

The focus of this theoretical approach may be seen as the study of social facts (Durkheim, 1964). Social facts are conceptualized as 'things' in their own right (sui generis), objectively real and external to the individual, and which can shape human behaviour and thought. They are derived from society, not from the individual.
Thus they are products of group living and may be manifested in values, attitudes and beliefs. They cannot, however, be deduced from psychological facts. They 'emerge' from several distinctive elements which combine to form new phenomena with properties different from the original elements.

Social facts are found in the different aspects of the social structure, such as the norms which guide behaviour (moral codes), in social institutions (i.e. family, religions), in social behaviours (such as those in relationships between genders or in marriage), as well as in social currents (trends in a population). Because human behaviour is seen as being shaped by social facts, humans are predictable and controllable through the manipulation of social facts, as in social engineering. Indeed much health promotion/disease prevention policy is predicated on a structural functionalist view in that desired outcomes can be 'engineered' with due attention to 'facts' presented as rational arguments (see Noble Tesh, 1990). But in order to understand the nature and influence of social facts upon human behaviour, the causal relationships between them must be isolated because all of the different parts of society are inextricably linked together to form a system/structure.

Structural functionalism uses a positivist approach (Durkheim, 1964), although positivism must not be equated with structural functionalism (except perhaps in medical geography). Positivism uses 'objective' (quantitative) methods in order to obtain 'facts' about the social world. Indeed, it is one of the defining tenets of positivism, namely empiricism. The aim is then to be able to describe social phenomena in a series of 'scientific laws' thus creating a probabilistic or deterministic explanation of relationships in the social world. Following the writings of Durkheim (1964), social scientists must also be objective and value-free while observing and interpreting social phenomena. Durkheim asserted that it is especially important during the early phases of research to focus on the most objectively verifiable, externally visible characteristics: the brute facts. Individual context is not felt to be important to the understanding of social facts because they are a collective phenomenon not an individual one. Thus, what is happening around the phenomenon of interest is seen as irrelevant to understanding the nature of objects or things and the relationships between them (Rosenberg et al., 1987).

Since structural functionalists must treat social facts as 'real' and external to the individual, quantitative methods are the preferred methods for data collection. The search for generalizability is not compromised by the 'irrelevance' of the individual's context. The individual is seen as an aggregate of attributes and further data are consequently analyzed and organized to reflect the probability of the occurrence of certain behaviours among a certain aggregate or group of individuals.

In health and health care investigations, epidemiology may be seen as positivistic and structural functionalist. To the extent that epidemiology is a way to understand disease patterns in order to understand and explain their effects on populations, it is not related to structural functionalism. To the extent that social facts such as norms, social structures, and social behaviour—treated as social phenomena—are considered relevant subjects for the analysis of disease incidence and prevalence, epidemiology is informed by the structural functionalist perspective (Clarke, 1990). This type of epidemiologic research examines the effects of such attributes as sex, class, educational level, family type, marital status, rural–urban background, culture, religion on such (dependent) variables as health experience and health care utilization. It may also focus on the impact of the experience of health status on such structural dimensions as socio-economic status, education level, and rural/urban background.

There are a number of examples of medical geographic research which is informed by the structural functionalist approach. McGlashan (1972) examined food contamination and oesophageal cancer in central Africa. In addition to collecting data on the number of patients with oesophageal cancer, he also collected data on local customs and diet behaviours to determine that a home-distilled spirit was being consumed by the residents living in high prevalence areas, which were associated with a known carcinogen, dimethyl-N-nitrosamine (DMN). Thus, in order to understand the causal link between location and oesophageal cancer, McGlashan used customs and diet behaviours as aggregate attributes, as social facts, as the independent variables. In other words, existing patterned ways of thinking and behaving were used to examine the relationship between diet, drinking and culture and a particular form of death.

Anderson's (1968) model of utilization has been greatly influential to the geography of health care. This conditional model isolates individual characteristics that regulate the volume of services used. Three sets of factors are identified; those which predispose people to utilization (i.e. social structure, martial status, family composition); those that enable use to occur (i.e. income, available services); and those that stimulate need (i.e. need factors). Need has been found to be the most significant factor in determining use of health care (see Joseph and Phillips, 1984). But other factors (social facts) influence use of different types of services. Aday and Anderson (1974)
elaborated this model, focusing upon the system (structure) as well as individual characteristics. But these aggregate level models seldom explain more than 20% of individual health care utilization (Powell, 1987). They are poor predictors of behaviour suggesting that such approaches are limited for an explanation of health-seeking behaviour. The patterned, aggregate approach tells only part of the story.

Thus, medical geographers using deterministic and probabilistic causal modelling are essentially seeking the causal relationships between social facts as aggregate characteristics. Elliott et al. (1993), in examining the effects of exposure to solid waste facilities, used an epidemiologic survey which is based upon a conceptual model that portrays psychosocial effects as being influenced by characteristics of individuals, social networks, exposure, and the wider community system. Social networks were found to be important in determining concern and action outcomes. But because of the nature of the analysis, social networks are treated as abstract social phenomena as a patterned way of behaving, a social given rather than a dynamic, organizational structure, the relevance of which ebbs and flows. While this does not detract from the study’s findings, it suggests that the theory implicit in the study is structural functionalism which by definition examines the relationships in particular ways and limits the interpretations of the data that can be offered and put forward.

While this particular theory has recently been viewed as limited in its scope and applicability, it has been too readily dismissed (see Ritzer, 1992). It emphasizes the large-scale systemic aspects of social existence which have essentially disappeared from current forms of action theory (Craib, 1984). Above all else it potentially provides an understanding of one realm of social existence. Therefore, this theory deserves continued explicit examination by medical geography especially for answering specific types of research questions (i.e. those that are oriented towards the study of aggregate behaviours to patterned responses or social facts). This will help in the recognition of the limitations of these conceptualizations. While structural functionalism analysis allows the detailed descriptions of observed patterns of relations and the discovered linkages (see Radcliffe-Brown, 1952), it denies much significance to the role of human actions and meanings and the messy, conflictual nature of much social reality.

The conflict theory approach

Like structural functionalism, the unit of analysis for conflict theory is the social system. However, conflict theory provides a critique of the economic and social arrangements found in society. Unlike structural functionalists, conflict theorists believe that not being explicit about world views contributes to social injustice. Research topics, methodological approaches, and commitment to the use of findings are all seen as reflecting the political and economic interests of the researcher. There can then be no claims to neutrality or objectivity. Consequently, medical geographers who have been informed by this theory have a particular agenda with regards to exposing injustice in all types of society.

Fundamentally this approach is based upon the work of Marx who asserted that human thought and behaviour are the result of socio-economic relations, and that both thought and behaviour are alterable for human and social betterment. While structural functionalism views society as being held together by norms, values, and a common morality, conflict theorists see social order in society as stemming from the coercion of some members by those with greater (economic) power. Thus conflict theorists emphasize the role of power in maintaining order in society. In recent years, the notion of power has been extended from power to control the means of production to that involving civil society (Gramsci, 1971) and also that which enables the definition of what exists, is possible and is seen positively (Herbert, 1980; Foucault, 1968). Like structural functionalism, conflict theory sees the function of power as integrative, thus ensuring compliance where there are reversed sets of norms and values in society. However, conflict theory diverts from structural functionalism in that power is seen as exploitive and potentially divisive, not integrative. Power engenders conflicting interests and role expectations. Power and authority are in themselves scarce resources and ensure access to other scarce resources. Those who hold them, like medical care, have an interest in maintaining the status quo whereas those who do not, have an interest in their redistribution. Thus the social world is structured into potentially conflicting groups. For some conflict theorists (i.e. Marxists, feminists) the groups involved are rather more clearly defined and the pattern of conflict is usually determined by particular social relations, namely those based on social class/gender and power.

Conflict theory propounds that all social arrangements, all social theories (seen as normative statements or ideologies), as well as all methods, have political/economic bases and consequences. Conflict theory’s approach to research is that the purpose of social research is the documentation and analysis of injustice resulting from such factors as class, race, gender, and power. Conflict theory also surfac is that knowledge never be objective because it is depen-
dent on social, material, and historical contexts. Therefore, there are no ‘brute facts’. Harding (1987) has raised this question regarding who can be a ‘knower’; what is the role of subjective ‘truths’ and experiences as knowledge; what is objective; what shapes the relations between the researcher and his/her subjects? Consequently, understanding conflict in social and economic relations is essential for understanding all other conditions of social life.

When conflict theorists, who are influenced by the Marxist argument, speak of health they often assert that capitalism requires a sufficiently healthy and disciplined workforce to ensure that production takes place in an uninterrupted manner (Navarro, 1980; Gough, 1979). Health is seen as a resource necessary for both maintaining oneself and for living in a capitalist society. Often people must work in conditions which are hazardous to their health in order to earn a living. The Marxist dimension of conflict theory sees disease and illness striking at particular ‘targets’. Health is patterned within society with some groups coming out consistently better than others no matter how health is measured. Health, therefore, is a commodity and illness is the result of unequal distribution of resources or unequal exchanges (Gerhardt, 1989). Smith (1981) has described the controversy that surrounded the identification of black lung disease as an occupational health hazard among coal miners. She found that workers in this sickening occupational environment were frequently faced with political and legal resistance to their claims for medical or economic assistance. Smith’s study reveals that what constitutes disease is transformed in relation to changing society.

The feminist dimension of conflict theory argues that women’s physical and mental health is used as a device for suppression. While there are variations within feminist thought, there is some consensus regarding how women’s health is jeopardized by patriarchal structures. Oakley (1993), a feminist medical sociologist, argues that women’s normal reproductive functions have recently become a frontier by which the medical community, inherently patriarchal because of its male dominance, have re-erected the present position that women hold in society. By medicalizing normal body functions (i.e. childbirth, pre-menstruation, menstruation, menopause) women’s bodies become to be seen as being inherently unhealthy. Thus, women are kept in a constant state of ‘sickness’ and remain at a constant disadvantage. Power in society relies not only on repression and suppression, but also exists in the ability to define that which is acceptable and appropriate and correct. Thus the power to define what it means to be ‘ill’ and ‘mad’ has led to the social and spatial separation and isolation of different groups of people in different ways at different times (Foucault, 1965).

While structural functionalists seek to make causal explanations about health and health care, conflict theorists often employ the medicalization thesis to explain the tendency for increasingly more arenas of people’s behaviour, and life in general, to become subject to medical definition and intervention (Gerhardt, 1989; Clarke, 1990). Medicalization is the process whereby the medical profession extends its domain to a wide range of human phenomena. Illich (1976) explains that the increasing medical technology has resulted in a dependence upon healing technology in addition to reducing people’s own ability to take care of themselves. The medical community uses its special position in society to dominate those of lesser power. Eyles and Donovan (1990) found very similar attitudes to health and health care amongst working-class populations in different areas of England with different traditions. They argue that this may be explained by medicine having a globalizing tendency to act as an institute of social control/influence.

Further, Zola (1972) describes medicine as an institution of social control since increasingly legally or religiously defined norms have come under the jurisdiction of medicine (i.e. alcoholism, homosexuality). Medicine has acquired an aura of scientifically grounded neutrality while being deeply political without knowing it (Gerhardt, 1989). Conrad and Schneider (1980) support this idea and demonstrate that through medicalization of social control (redefining deviance from ‘badness to sickness’), medicine has acquired a political and ideological role in shaping social and spatial practices.

The conflict theory perspective has been used by several medical geographers in particular to look at health care systems. Eyles and Woods (1983) argue that medicine and health are embedded in the social system with the shape of that system influencing how health is defined and how health care is provided. For example, Eyles and Woods found in examining the UK health care system that medicine and other institutional health care policy-makers determine the relative importance of particular sectors of health care. The results are inequalities in health care provision with mental health and geriatric service and the non-metropolitan regions being potentially disadvantaged. Therefore, they conclude that in order to understand health problems, research must incorporate the economic, social and political processes which create them.

Mohan (1980) argues that in Britain, the centralization of secondary care facilities has had a profound effect on inequality. Mohan and Woods (1985) have found that, in the UK, there has been a major growth in private hospitals and private
insurance such that there has been a restructuring of the health care service from one planned on social need to one which is more conducive to capital accumulation (Navarro, 1980). This tendency has been documented for several Western nations (see Scarpaci, 1989).

Conflict theory may also be seen to underlie some real theoretical development in medical geography because it has encouraged some medical geographers to re-think how they go about studying health and illness. Jones and Moon's (1987) concept of a critical epidemiological approach reflects this while still using an epidemiological design. Unlike clinical epidemiology, which rests upon the assumption that disease is a generic, reified concept, a critical epidemiologic approach takes into account that illness and disease are social productions moulded by the changing power relations in society. It also takes into account that different power relations in society affect those with different access to resources in significantly different ways. Diseases, Jones and Moon insist, are not natural immutable categories. Disease must be examined as contingent and historically specific strategies over who provides the definition and makes the diagnosis (see Smith, 1981). In many ways Smith's (1981) study of the changing definitions of 'black lung' joins together a critical epidemiologic perspective with an emphasis on the implications of the power to define, which in this case determined treatment and compensation for Appalachian coal miners.

It is interesting to note that while there are feminists doing medical geography, there is no feminist medical geography. In addition to this, few medical geographers have attempted to use a medicalization thesis to explain why differences in power affect health and, most importantly, what this all means. The next section describes a theoretical approach which takes a micro approach to understanding the social world. Like conflict theories, context is seen as an essential feature for understanding the nature of relations but in this case specifically in terms of how meanings arise. Unlike structural functionalism and conflict theory, symbolic interactionist 'approaches' do not see structures as wholes. Instead they see them as a set of interacting parts all contributing to a whole. Symbolic interactionism has only recently been taken up by medical geographers but certainly holds great potential for providing new grounds for theoretically informed research.

**Symbolic interactionism**

Influenced by the writing of Blumer (1962) and Mead (1962), the symbolic interactionist approach emphasizes how subjective definitions of social reality are constructed and how this reality is experienced, negotiated, and described by different social actors. It uses a micro approach, as opposed to the macro-scale analyses of the structural functionalists and conflict theorists. The unit of analysis then is not the system but rather the individual and the social structure is viewed as being made up of interacting individuals. There are three components which characterize the symbolic interactionist perspective. First, people act towards things based upon the meaning that these things hold for them. Second, meanings arise out of and are modified through social interactions with other people. Finally, this interpretive process is used by people in dealing with all things that they encounter.

From a symbolic interactionist perspective, the world-views and meanings given to reality are the primary objects of exploration (Blumer, 1962).

The methods employed have to be able to capture the world views of actors and draw out very descriptive and richly complex data—which after analysis and interpretation results in thick description (Geertz, 1973). Qualitative methods such as in-depth interviewing, focus groups, participant observation, are used to collect these data.

The interactionist perspective on health and health care tends to focus primarily on the processes by which people come to understand themselves as being healthy, anxious, or at risk. According to interactionist theory, people actively construct understandings of themselves using the evidence which comes from their interactions and negotiations with others (Cooley, 1964). Some of these interactions may lead them to believe that they are healthy, unwell, or whatever. So research interest lies in the subjective aspects of health (and related ideas) and how these conceptions are developed.

In any social setting in which communication takes place, a negotiated order develops between the actors involved (Strauss et al., 1963; Hall and Spencer-Hall, 1982). This negotiated order contributes to the definition of the situation—the set of assumptions about the nature of the circumstances in which the action is taking place. Often, the definitions of the situation arises from mutual agreement between participants. Sometimes situations can be defined without the actor's explicit agreement. Through negotiated order, the role of power may be recognized in an interactionist perspective. This often happens in the health field when medical definitions may be imposed upon individuals. Thus interactionists often investigate how different labels arise and how being labelled with them influences our behaviour.

Labelling (theory) is one explanation used by symbolic interactionists when examining health and health care. It acknowledges that there are a
number of different positions and viewpoints in the construction and labelling of an illness. All players have a stake in whether or not something becomes labelled as an illness. The construction of illness is not necessarily done with malicious intent but is done to insist on the importance of a particular treatment regime, such as isolation (Waxler, 1988). Labelling, however, often leads to the stigmatization of those who are being labelled. This may happen not only to individuals but also to communities, such as those that live near toxic contaminants (Edelstein, 1988).

Health is not the only concept that may be seen as socially constructed. In environmental health, risk may be similarly viewed (see Eyles, 1993). Appraisal and management of risk are determined by people’s places in the world and how they see and act in the world (Eyles, 1985). Ideas about the world are rooted in individual experiences but the different forms of social organization and their underlying value system influence risk perception and in turn link those perceptions to core values and life domains such as security, future health, children and so on (Eyles et al., 1993). Our assessments about what is risky is informed as much on the basis of what we value as it is on what we know. So too is our assessment of illness. Clinical definitions of illness are often seen as irrelevant if “normal” functioning and personal worth are maintained (Donovan, 1986; Eyles and Donovan, 1990; Litva and Eyles, 1994). Thus health and illness, risk and anxiety, are not conceived as any one ‘thing’ because they are not static or stable concepts. Each concept varies according to each individual and their individual contexts.

Conclusions

In some ways, our review of theories in medical geography seems old-fashioned. It is old-fashioned insofar that the concerns addressed by social science and social geography (in the 1970s and 1980s) have not been tackled in this subdiscipline. Thus we have discussed the three main bodies of social theory which already informs a large part of existing medical geography (see Table 1). There is some attention to the cultural theories and notion of difference found in the post-modern stance (Dorn and Laws, 1994), itself now some 20 years old. There is little if any attention to the irrelevance of theory as a priori posturing which is said to obfuscate our understanding of the particular (Strohmayer, 1993).

We do not follow these paths. We see theory as necessary, indeed inevitable, as scientists never examine society without ideas. We turn rather in conclusion to the linkages between these three apparently separate bodies of theory, not to create a metatheory but to see if particular integrations lead to better understanding and explanation of medical geography subject matter. It is for that reason that theory development is important.

What do we mean, then, by theory development? Different theories essentially provide the concepts for describing the same world but in different ways. Which theory we use should largely depend upon the type of research question we ask. There is no contest as to which theory describes the social world better. It is an inappropriate quest unless we adopt ideological positions. It is rather a matter of which is most appropriate for the task at hand. Theory generation is when we decide to seek new ways of describing the same old world. In order to do so, we suggest doing a little ontological gerrymandering (see Woolgar and Pawluch, 1985). In other words, medical geographers must seek to challenge the boundaries set by existing theories, and seek new ways of thinking about and exploring social phenomena. So we have developed a model (Figure 1) which removes any ‘walls’ between theories with the intention of demonstrating how medical geography can move towards theory generation. Here we see no boundaries and no borders, only continuous circles which illustrate how we feel medical geographers should attempt to think about theory. By drawing linkages or overlapping theories, new ideas about how the world works, as well as innovative ways of studying social phenomena, emerge. At the very least, geographers can contribute to existing bodies of theory by ‘adding space’ thus contributing to the development of their analytic power.

There is already evidence of medical geographers seeking to challenge existing theories and the results are both surprising and inspiring. For example, the notion of a critical epidemiology, developed by Jones and Moon (1987), begins to transcend the boundary between structural functionalism and conflict theory. It adopts a standpoint that considers dynamic relationships between social people rather than static relationships between natural objects. Disease must be examined as contingent and historically specific struggles over who defines and makes diagnosis and for what reasons. Cornwell (1984) uses the medicalization thesis in her study of working-class perceptions of health in East London. She partially rejects the notion that medicine is an institution of social control stating that this is ‘idealist’. Medicine, she asserts, does not have complete ideological sway over everything associated with health and illness because it does not determine people’s responses (i.e. they don’t always seek treatment). These responses are negotiated. What is unique about this medicalization explanation is that Cornwell has adapted the medicalization thesis to incorporate an interactionist perspective thus indicating the possibility for overlap.
between conflict and interactionist theory within the medicalization thesis. Litva and Eyles (1994), in examining the concept of health, began with an interactionist perspective but found components of Parsons' (1951) structural functionalism to be useful for providing an explanation in their study of lay perceptions of health. Health was found to be a resource so important for living in our society that people often negotiate illness away in order to not be seen as ill (and consequently as deviant). So the challenge of becoming theory generating is simply realizing that theory does not act simply as a template or 'framework' for doing research but is a launching pad for exploring all the different aspects of our world.

To take its place in the world of human geography and social science, medical geography must first become comfortable with theory in general and with the fact that all research is theory informed. The best theory construction is done by those who are comfortable with a variety of theoretical strategies (see Stinchcombe, 1986). Medical geographers must also learn to be more comfortable with doing theoretically driven research as well as policy driven research (Jones and Moon, 1993). While policy research is vital for a discipline that is applied or a mere tool (see Earickson et al., 1989; McGlashan, 1972), theory is paramount for the development, growth and maturation of the subject itself. We have not tried to present one theory as the best. Instead, our goal has been to demonstrate the potential that all social theories provide for the future of medical geography. This framework is developed to encourage medical geographers to 'do theory' although the quest for theoretically informed 'partial truths' (Clifford, 1986)—as nothing is complete or for ever—is important for innovative development. But in recognizing that all research is theoretically informed and by coming out and acknowledging the theories which inform our research we shall notice that in our exposing ourselves, we are just like everyone else. Difference enriches and theories inform. Without this recognition, we remain in an empirical backwater in disciplinary development.

References

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