

Variations of the social: some reflections on public health, social research and the health-society relation¹

Variaciones de lo social: algunas reflexiones sobre salud pública, investigación social y la relación salud-sociedad

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Abstract

The idea of a social dimension of health is widely accepted as unavoidable and relevant for public health. This article proposes a reflection around the notion of the social examining some of the manifold ways in which it might be inherited by researchers, professionals, administrative staff and material settings involved in the practices of public health care. It will be argued that this inheritance has deep consequences for efforts of care inasmuch these different versions of the social characterise, circumscribe and reframe the health-society relation, modifying the scope under which public health issues are tackled or dismissed. To ground this seemingly abstract discussion I will work considering a specific public health problem: the case of frequent attenders in public health. Drawing on two approaches from the Sociology of Health (i.e. illness-behaviour and the user-professional relation) and the field of Science and Technology Studies, I will show how these ways of framing the study of frequent attenders assume and simultaneously promote three different versions of the social. The article aims to explore how social research in these traditions participate in the achievement and promotion of specific health-society relations, in which certain notions of the social operate helping or limiting research and care efforts by creating richer or poorer possibilities for posing, examining and facing the problems of public health. **Keywords:** Social Research; Public Health; Sociology of Health; Science and Technology Studies; Frequent Attenders.

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Resumen

La idea de una dimensión social de la salud ha sido ampliamente aceptada como inevitable y relevante para la salud pública. Este artículo propone una reflexión en torno a la noción de lo social examinando algunas de las muchas formas en que ésta puede ser heredada por los investigadores, profesionales, personal administrativo y contextos materiales involucrados en las prácticas sanitarias. Se propondrá que esta herencia tiene consecuencias importantes para los esfuerzos de atención en la medida en que distintas versiones de lo social caracterizan, circunscriben y replantean la relación salud-sociedad, modificando el alcance bajo el cual se enfrentan o descartan los problemas de salud pública. Para situar esta discusión, aparentemente abstracta, se trabajará a partir de un problema específico de salud pública: el caso de los pacientes policonsultantes. Tomando elementos de dos aproximaciones de la Sociología de la Salud (el comportamiento de enfermedad y la relación usuario-profesional) y del campo de los Estudios de Ciencia, Tecnología y Sociedad, mostraré cómo estas maneras de dar forma al estudio de los policonsultantes asumen y simultáneamente promueven tres versiones distintas de lo social. El artículo busca explorar cómo la investigación social situada en estas tradiciones participa en el logro y promoción de relaciones específicas entre salud y sociedad, en las cuales ciertas nociones de lo social operan ayudando o limitando los esfuerzos de cuidado e investigación, creando posibilidades más ricas o pobres para plantear, examinar y enfrentar los problemas de la salud pública.

Palabras clave: Investigación social; Salud Pública; Sociología de la Salud; Estudios de ciencia, Tecnología y sociedad; Policonsultantes.

Introduction

What do we do when we inherit a concept? This article reflects around this matter focusing on a notion whose relevant presence in the field of public health has become unavoidable: 'the social'. In the following pages I will argue that the different ways in which the social has been conceptualised and put into action in relation to health by different traditions of social research have had at least two significant consequences: First, they have informed some of public health's assumptions in relation to the existence of a set of social dimensions of health. Second, they have fostered distinct versions of what we have come to understand as the relationship between health and society.

Why take the time to reflect upon this seemingly abstract matter, especially considering that public health not only welcomes but also foregrounds the 'socialities' involved in the population's disease and distress? It is my contention that it is precisely the ubiquity of this openness to 'the social' what makes urgent to reflect upon what we are doing on its behalf². In this sense, this article argues that concepts do not operate only as passive representations; they are things born from experience and that lead back to it, affirming certain possibilities in the world while foreclosing others. The ways in which conceptual abstractions such as the idea of the social work do not determine but catalyse the creation of differences in our understandings, practices and relations (James, 2000).

This article does not seek to propose a thorough examination of the social in relation to public health. That would imply giving a detailed account on this concept's turbulent past and an equally troubled present. In fact, the social has no substantial, unified definition, and even the most naïve attempts to approach it are forced to admit that it does not refer to a specific, stable set of objects in the world. Likewise, since its use begun in the nineteenth century, the notions of the social and society seem to operate as an abstraction ambivalently and recurrently invoked

² This openness does not mean that the encounter between public health and the social sciences -in Latin America or elsewhere- has not been epistemologically, ontologically, methodologically and politically problematic. This is stressed by Cohn (2013) and the dossier about knowledge production at the interface between the social sciences and public health has been recently published in this journal (Ianni; Barreto Jr.; Martins, 2013).

only to be dismissed (or made disappear) as unsustainable (Wagner, 2000). Rather than attempting to take position in this discussion and its eventual ramifications into the health field, I will limit my analysis to three specific versions of the social in order to foreground the richer or poorer social and material worlds they help to cultivate for healthcare issues. To achieve this purpose, I will consider three research areas that have fostered influential ways in which the social has been understood, shaped and achieved in public health. Rather than just proposing a dubious and overarching overview of these traditions and the notions of the social they entertain, my aim is to show how thinking and working with them contributes to reshape the way in which we might deal with public health issues. In order to do this I will reflect on the challenges and pitfalls that have emerged in my attempts to research a specific public health issue: the case of frequent attenders.

In the following sections I will think about (or rather with) frequent attendance and, relying on its problematic and ambiguous status as an issue that cuts across medicine, management, mental health, etc., I will highlight how research efforts in the areas of health users' illness-behaviour, the professional-user relationship, and the socio-material enactments of public health and biomedical entities foster three different notions and uses of the social that have or might impinge in public health practices. What follows is, then, a theoretical reflection grounded in the nuances of an elusive public health problem. It is not a research's data or results report, but rather a specific case to draw on, a complex issue that I propose to the reader as an incitement to both circumscribe this article's discussion and, hopefully, spark her curiosity in relation to what we do and what we let ourselves be part of when we assume (and help to achieve) a certain version of what the social is, does and might become.

Caring about frequent attenders: the social in the health sciences' approach

I will briefly begin by outlining the issue that will guide my reflections in relation to the social and the health-society relation, i.e. frequent attendance.

There is no sociological literature that explicitly and systematically tackles this problem in public health. There is, however, a small and heterogeneous body of literature across different disciplines that has studied this elusive object. In this section I will review how this literature has circumscribed and studied frequent attendance, and the notion of the social that implicitly operates in it.

The simplest way in which health professionals and managers describe frequent attendance is as a regular and excessive use of human and material resources of the health care system by certain users, through a high demand of consultations, exams and procedures (Fagalde et al., 2011). This definition does not frame frequent attendance as a mere medical issue; instead, the category is made to inhabit a space that crosses the boundaries between the health sciences and public health management, where public policy deals with the problems of health care demands, resources and organisation. It is not merely a 'managerial' category either, since the users considered to be frequent attenders do bring something of the order of health and disease to their consultations. The mobile character of the category and the phenomenon it tries to name becomes problematic in a twofold way: First, as it turns frequent attendance into something that ambiguously moves -or is pushed- between a public (health) issue and a personal health problem. Secondly, it creates difficulties inasmuch no code or protocol exists that clearly states which symptoms, pathologies and/or patterns of illness behaviour should be understood under the category of frequent attendance. This raises difficulties for attempts to calculate the resources involved in its handling and treatment, since there is no specific set of actions -or even general guideline- to deal with the group of users identified as frequent attenders.

To deal with this situation, medical and public health approaches respond mainly by trying to define what frequent attendance is. This is done by binding the category to specific statistical figures, exploring the difficulties to tackle it in a cost-effective way, and even wondering about the need of using 'frequent attender' as a special status in health care or not (Gomes et al., 2013; Luciano et al., 2010; Morriss et al., 2012; Vested et al., 2002; Vested et al., 2004; Vested;

Christensen, 2005). The most significant conclusion that this body of work provides is that there is no clear definition of frequent attendance and no clear figures of user consultation. There is a recurrent call to face this problem, since different definitions and the absence of a common norm regarding which amount of consultations in a particular lapse of time will be considered as frequent attendance make the problem difficult to handle both medically and financially. There are cases, like in Chilean literature, where the category is not even referred to explicitly, circulating in a descriptive way as an unfavourable outcome or result in the context of a wider discussion about the problems of workload in public health services (Borlando; Jeria, 2007; Chile, 1996, 2005a, 2005b; Chile, 2007).

This body of literature seeks to tackle frequent attendance in two levels: as a public health issue and/or as an individual problem of the user. This opens two broad explanatory directions. The first frames this phenomenon as a medico-managerial issue. Here, the demand of explaining what frequent attendance 'really is' is grounded in a call to produce a general account that could acceptably define it, so more efficient and satisfactory interventions and management decisions could be developed. At the same time frequent attendance is targeted as an individual problem of certain users, one characterised by something that becomes of relevance when professionals deal with them in practice: they become associated with misuse, lack of adjustment to the system and problematic behaviours. What is it exactly that is wrong with these users is a question with no clear answers. Different explanations stress a myriad of problems such as the distance between certain users' perception of urgency when they look for consultations and the actual lack of medical urgency thereof (Galaz et al., 2004), or the existence of certain patients that exhibit "consult practices with medically appropriate problems such as injuries at the same rate as other patients of the same age and gender but they consult more often for other problems such as functional somatic symptoms, and mental disorder such as depressive and anxiety episodes" (Morriss et al., 2012, p. 7).

This quotation exemplifies what perhaps is the key concern of the literature that frames frequent

attendance as a personal problem: Where to draw the blurry line that separates 'normal' consultations from the misuse associated to frequent attenders? To answer this question a set of analyses -clinical, psychological, statistical- examines certain pathological, clinical, subjective and/or (psycho)social conditions that entail unexpected consequences in health seeking behaviour (Fagalde et al., 2011; Florenzano et al., 2002; Fullerton; Fiorenzano; Acuña, 2000; Smits et al., 2013). One of them would be certain users' excessive consultations and troublesome behaviour in relation to health agents and services. This is the point where mental health enters the discussion, for this literature tries to make the case for the inclusion of the psychological, psychiatric and social dimensions of illness and distress into both health care professionals' and policy makers' concerns. Diagnostic and clinical issues like somatisation disorders, hypochondria, psychosomatic diseases, borderline personality disorder, medically unexplained symptoms and depression are under the spotlight, and frequent attenders are considered to be one of their possible effects (Ferrari et al., 2008; Morriss et al., 2012; Norton et al., 2012.) What these conditions have in common is that they introduce disagreement and ambiguity into both the study of frequent attenders and the everyday practices involved in their care.

Up to this point, and even though implicit, the idea of 'the social' is at play at least in two ways in relation to frequent attendance. On the one hand, it is assumed as part of the larger problem of the determinant factors of certain users' behaviours and (mental) health conditions, a counterpart of the medical dimension. On the other, if frequent attenders are those who make a regular and/or excessive use of a public health network, there is an implicit idea of the social as the constant movement of bodies and information through consultations, referrals and interventions across different settings, territories, buildings, and medical technologies. The problem here is that medical and public health oriented literature deals with frequent attendance often avoiding this latter implicit version of the social, i.e. this issue's practical complexities -as health professionals and staff are forced to do in the day to day realities of health care centres. Instead,

the literature tends to work with conceptual tools and categories that inherit an impoverished and over-simplified version of the social. In other words, they tend to privilege an idea of the social as a set of discrete, determinant factors that generally determine individual conducts. In the next section I will try to show how this impoverishment has been, at least partially, inherited from popular trends in the sociology of health³ that have fed public health ideas about the relationship between health and society.

Sociology of Health's gifts: two understandings of the social

Speaking about the sociology of health poses a formidable challenge given that, as Turner (1992) noticed, historically this sub-discipline has no obvious "specific integrating theme or powerful theoretical structure, which is able to give the field some coherence and direction" (p. 163). This heterogeneous character precludes any attempt to provide a general account of what understandings and enactments of 'the social' have been fostered by sociology in the field of public health. I will, however, turn this limitation into a possibility for reflection departing, once again, from the problem of frequent attendance. My suggestion is that attempts to deal with this issue inherit versions of the social coming from at least two substantive bodies of research in the sociology of health: illness-behaviour and the user-professional relationship. I will examine them making explicit the way in which they frame the health-society relationship and foregrounding their possibilities and limits.

Illness-behaviour

Perhaps sociology of health's most widespread contributions to the traditional understanding of the social dimension of health is that which emerged under the concept of illness-behaviour. The latter can be defined as the way in which "symptoms are differentially perceived, evaluated and acted upon (or not acted upon) by different kinds of people

in different social situations" (Mechanic, 1968, p. 116). In other words, it is the study of: 1) the way in which an individual recognises a certain experience or symptom as a potential illness; 2) her/his help-seeking behaviours and 3) her/his reaction to illness and treatment. Sociological interest in this topic has been related with researching the social 'factors' that influence the way people define illness, decide or not to attend to and use health care services, and undertake activities to look for help or engage in activities of self-care (Cockerham; Glasser, 2001). Therefore, all socio-economic variables that have an impact in an individual's use of health services become of interest, and so do all the patterns of behaviour related to health. Different models have been created to formalise these factors and turn them into mappings of individual decision-making and the way illness-behaviour varies among socio-demographic groups (Blaxter, 2010). The factors considered to be relevant vary significantly. For example, Mechanic (1968) counted among them the visibility and recognisability of the symptoms, their perceived seriousness, their frequency and persistence, the extent to which they disrupted work, family and social life, the availability of information and costs, and so on. It is not hard to link this concept with a possible understanding of health and society in relation to frequent-attenders. In fact, and to a significant degree, the way in which they are currently being addressed by health professionals, managers and policy-makers frames them precisely as a problem of an inadequate use of the health care network, i.e. an inadequate illness-behaviour. Thus, frequent attendance would be seen as the misconceptions that a certain group of users has in relation to their symptoms, which lead to an exaggerated attempt to seek for help both in frequency and in perceived urgency, and eventually to a refractory behaviour in terms of adherence and compliance to medical diagnosis and intervention. Under this framework, mental health conditions such as somatisation, depression and anxiety could be considered explicative factors, since they would stimulate this

³ For the sake of clarity I will speak generally of sociology of health, avoiding the debate around the use of this term against others such as 'medical sociology' or 'sociology of health and illness/disease'. Cf. Timmermans (2013) for a cogent discussion about the positions/tasks sociology can assume in relation to the health field.

lack of calibration between bodily sensations, the perception of the suffering they entail, and the magnitude of help-seeking reactions that brings the user to the health care centre.

Under this scope, the social is made to be a myriad of factors that operate as a complement of the biomedical groundings of disease. Moreover, the social appears as that what triggers certain ways of looking for or rejecting the need of health care in a given place and time. Social research contributions to public health would be then the assistance in the compilation of factors that determine the 'what', 'when', and 'how' of illness. For the specific public health case of this article that would mean to establish the way in which they create frequent attendance as a specific pattern of illness-behaviour.

The problems with this still widely popular version of the place of the social in relation to health have been extensively documented. Following Bury (1997), I suggest that illness-behaviour is a concept that reinforces a simplistic view that both sociologists and some practitioners may have about public health users, disavowing complex and troublesome patterns of behaviour as irrational. In Bury's words: "Doctors routinely complained that patients both delayed seeking help and presented with trivial complaints, especially to GP [general practitioners] surgeries. These paradoxical injunctions can still be heard emanating from the medical profession today" (p. 22). From this perspective, frequent attenders could be understood as users who present trivial motives for consultation and, instead of delaying help-seeking behaviours, exaggerate them with an irrational and misleading sense of urgency. This paradox can be taken a little bit further if we consider illness-behaviour's underlying assumption of an ideal user: well-educated in issues of health care, active and attentive enough to consult (but only when necessary), and completely docile in medical settings and when following medical prescriptions (Bloor; Horobin, 1975). Moreover, this assumed ideal patient seems to rest on a notion of the individual that has been widely criticised by sociology, that is to

say: eminently cognitive, clear-bounded, determined from an 'outside' (Craib, 1998) and thus, I would add, susceptible of medical education in a relatively straightforward way.

The individual and 'psychological' models that illness-behaviour gave rise to have thus been a target for sustained sociological criticism due to their tendency to act in a deterministic way, isolated from social systems, culturally biased and unable to deal with social complexity (Blaxter, 2010). However, the simple conceptualisation of the social as a backdrop and aggregate of factors that ultimately express themselves in individual behaviour in a rather direct way has become popular in public health and disciplines as health psychology⁴. This is not the place to follow the nuances of this debate⁵. Instead, I would like to ask what alternative versions of frequent attendance could be contributed by the sociology of health? What different understandings of health-society can we prompt? As I stated above, the notion of illness-behaviour tends to make us think that conflicts in health care have to do with a clash of individuals -the patient versus the professional-, disregarding a more complex approach. But, even under this scope, where is frequent attendance established? Is it an individual property of the patient? A judgement of the doctor? A product of their interaction? A managerial statement based on statistical measures? A consequence of the interplay between certain bodily sensations and mental distress? A matter of cultural attitudes towards illness and disease? An entanglement of all the aforementioned?

I propose that the latter is the most adequate option to address a shifting and unclear entity as frequent attendance. Instead of focusing on individuals and the 'external' factors that influence their patterns of consultation, as illness-behaviour and most of the literature reviewed so far does, I will propose that the 'where' of frequent attendance is a very complex matter, a production of the different forms of relationality to be found in health care practices. Reducing it to an individual's irrationality is a comfortable but unjustified generalisation that

4 Although this is usually done in a more nuanced way in contemporary research efforts (cf. Belon et al., 2014 for a recent example and discussion on 'environment' and individual behaviour).

5 A concise account on this can be found in Blaxter (2010, chapter 4). It also animates some of the contributions to a special issue of the journal 'Sociology of Health and Illness' (2014) devoted to health practices.

puts both social research and public health under the risk of forgetting about more subtle ways in which the social and material conditions of health care might play a part in this and other phenomena.

The lay-professional relationship

One of social research key contributions to a more complex understanding of the relation between health and society has been the critical examination of the user-professional relationship. In this section I will stress how this line of work in the sociology of health has amassed a rich set of theoretical and empirical hypotheses that may help to think with the problem of frequent attendance, mobilising more complex versions of the social.

Initially devoted to the doctor-patient relationship, this area of research focuses now on a wider conception of both professionals and users, expressing public health's increasingly interdisciplinary and bio-psycho-social character (Bury, 1997).

Social research of the lay-professional relationship's key contribution is threesome: Firstly, it has denounced the excesses of medical authority and its social role in the control of the population. Secondly, it has highlighted the key role that health care users can and want to play in their processes of attention. Thirdly, it has fostered the study of the effects that the quality of the lay-professional interaction has in the outcomes of health care in terms of satisfaction and recovery (Nettleton, 2013).

Following Bury (1997), at least three broad conceptualisations of the lay-professional relationship can be found. First, there is a 'consensus model' that follows the structural functionalism of the 'father' of medical sociology, Talcott Parsons (1951). This suggests that, for maintaining the social order, the system allows certain roles and values that reconcile differences in power and knowledge. Thus, a 'sick role' and a 'physician role' can be found. The second one demands neutrality and a collective orientation, that is, to take care of the ill person and return her/him as soon as possible to her/his usual social functions. In turn, the sick role demands the patient to cooperate voluntarily with the doctor, to behave in relation to illness as an undesirable state, and to follow the professional's indications both in the consultation room and outside. However, Parsons'

model has been widely criticized in the sociology of health. For example, socio-demographic changes in the population (like extended life periods) have led to an increase of the prevalence of chronic disease, whereas Parson's sick role was established under the model of acute conditions (Blaxter, 2010; Bury, 1997). Moreover, it has been accused of ignoring other ways of dealing with illness, since sociological research has revealed that actually only a very small portion of people's bodily discomfort and suffering leads to consult to the physician (Zola, 1973). Under this first model, the problem of frequent attenders could be understood as a mere inadequate use of Parson's sick role, since these users are perceived to attend to health care services constantly and not always complying with health professionals' instructions. However, this explains nothing about the specificities of frequent attender's lack of compliance or its relations with the explicit and implicit ideal uses of health care services and resources.

We could look for those explanations in a second model for the lay-professional relationship, one that emerged as a critical reaction to Parson's proposal. The 'conflict model' states that a clash of perspectives is to be found at the heart of the lay-professional division (Bury, 1997). Hence, conflict would be a structural problem and not a result of a result of specific inadequate performances of the sick and physician role. Since patients and professionals inhabit different socio-economic coordinates, there is an inescapable asymmetry between them. Doctors and care institutions like hospitals reinforce class ideology, capitalist forms of rationality and male gender domination, not being able to realise that their expectations in relation to the patients' assessment of their illnesses ignore or simply reject patient's beliefs (Bloor; Horobin, 1975; Freidson, 1970; Nettleton, 2013). Thus, different forms of critical analysis have stressed the wider coordinates of inequalities and struggles in gender and sexism, class and ideology, and the knowledge and power relations fostered by medicine and its associated industries and institutions under specific socio-historical conditions and forms of government of the population, unveiling the structural conditions that fuel and determine the frictions at the lay-professional encounter (for exemplary contributions cf. Ehrenreich;

English, 2005; Waitzkin, 2000, Petersen; Bunton, 1997; for more recent case studies cf. Barker, 2011; Scambler; Scambler; Speed, 2014). Thus, the conflict model stresses a notion of the social as those forces or structures which arrange the conditions of possibility and perpetuation of certain arrangements of dominance, inequality and domination that become manifest in the nuances of public health. Under this version of the social, frequent attenders can be understood as a particular symptom of this struggle, giving an account of the power, gender and class differences that determine frequent attendance as a conflictive entity in Chilean health care. This body of work has certainly enriched the way we frame the health-society relationship, stripping it of its innocence as a mere scientific or technical matter, and highlighting the ethico-political concerns necessarily involved in a comprehensive understanding of health that is more sensitive to equality, difference and plurality. However, along with these potentials this model presents two difficulties that make me follow a different direction to keep thinking with frequent attendance. First, this perspective tends to downplay the crucial cooperative and shared dimensions of health care. Recognising differences between professionals and patients does not exempt social research from giving an account on how they are -at least partially- collaboratively intertwined in the enactment of health care practices (Mol, 2008). Secondly, it proposes a sort of mechanistic top-down determinism, where general structural categories define unidirectionally the quality and character of the professional-frequent attender relationship.

My idea here is not to say that gender, class or power are not relevant dimensions of analysis, but to point out the fact that using these categories as ready-made explanations of everything can lead to an erasure of the specificity of any public health phenomenon. In other words, an exaggeration of this way of enacting the social can turn any phenomenon into an epiphenomenon of social forces, a thing to dismantle with critical suspicion, or 'just a case' to illustrate the wider human interests and affairs behind it (Puig de la Bellacasa, 2011, p. 89).

But a third model has tried to incorporate both consensus and conflict, i.e. the 'negotiation model' (Bury, 1997). This poses the professional-user re-

lationship as "the result of a bargaining process between the individuals concerned" (Bury, 1997, p. 80). Studies in this area recognise structural differences, but at the same time allow considering the patient an active actor in the shaping of the medical encounter, despite professionals usually having the upper hand in the interaction. This body of research has been crucial in fostering the study and value of lay people's experiences and life perspectives and incorporating the patient's view into consideration. Hence, it represents departure from concepts that were popular in sociology of health's literature, like illness-behaviour, that promoted a simplistic understanding of the lay-professional interaction in terms of individual conducts and the doctors' division of patients between those who follow instructions and those who do not. Illness-behaviour -still popular in public health research and some sociological efforts today- underlines doctors' explanation of non-compliance to their instructions "in terms of patient error, ignorance or misunderstanding. Actions which are not consistent with medical advice are seen as illogical or deviant" (Blaxter, 2010, p. 84). Instead, this third model focuses on concordance rather than compliance, stressing the patient's course of action in relation to health care as the result of an exchange where lay beliefs and the patient's (psycho)social situation play an important role. This opens the door for the study of a less hierarchical version of the lay-professional relationship, where the patient's efforts of self-management and resistance have to be taken into account. At the same time, it makes possible a different study of the patient-doctor interaction, one that does not rely exclusively in the hypothesis of the supremacy of a biomedical model that is imposed onto individuals as means of domination, control and normalisation.

This model allows examining the lay-professional relationship as something where no particular outcome is assured, since it depends on the specificities of the actors and specific institutions involved in health care interactions. For an understanding of frequent attendance, for example, it would mean reconstructing the problem through the ways in which it is negotiated. The tactics that frequent attenders put into play can be mapped, and so can its consequences for patients and professionals. This

path also provides the chance to elude the moralising stance of an illness-behaviour approach, the difficulties of a consensus model to deal with the clashes that frequent attendance enacts, and the use of total explanations through which the conflict model prevents research from dealing with the specificities of frequent attenders and the professionals involved in their health care.

This approach leads to a different health-society relationship, where the latter is not the only determinant of the former but rather is part of the myriad of conditions in which everyday health care is practised, disputed and agreed between different actors. However, this way of framing the relation still lacks a key protagonist of the organisation and provision of health care for the population. A negotiation model is strongly committed to a topic that has been central in the sociology of health: rescuing patients' (and sometimes, also professionals') perspectives in relation to illness (Conrad; Barker, 2010). This important task has had, however, an unexpected consequence: it has prompted an idea that the social dimension of health is exclusively a human affair, relinquishing the materiality of disease as a biomedical issue. As Timmermans and Haas (2008) state: "social scientists have become mainly interested in the experience, culture and social structuring of illnesses while bracketing the biological bedrock of disease" (p. 660). Interestingly enough, these authors relate this division between illness (experiential, subjective, and cultural) and disease (material and biological) to Parsons' (1951) refusal to reduce disease to its medico-physiological features and his gesture of claiming for a social dimension of analysis thereof. Following this path, sociologists of health -since the 1970s- have downplayed the patho-physiological worlds of disease (Timmermans; Hass, 2008).

Once again, frequent attendance can act as a concrete problem that might show the specific consequences of these apparently only theoretical considerations. As I stated above, usual ways of tackling the challenges posed by frequent attenders attempt to stabilise the nature of their problematic and 'inadequate' use of the health care network. They do so by framing that misuse as a problem of the individual -an inadequate behaviour whose

origin is to be sought in a number of social factors or (usually mental) health conditions. Some of those efforts are even willing to concede that the social dimension of health care must be considered in terms of the social determinants of the conflictive interaction between user and health professionals. Sociological research can reinforce this trend by making us think that the best way to frame the study of frequent attenders should be the careful description, understanding and/or interpretation of the human dynamics at play in the interactions that turn them into a problem for health care. Let us consider a concrete way in which this could be done today by examining the problem of frequent attendance in Chile under the light provided by an area of social research that currently receives a lot of attention, that which highlights the interactional nuances of the diagnostic process as a socially situated, practical achievement. Under this scope, diagnosis operates not only as a major medical classification tool but also as that which "validates what counts as disease; offers explanations and coheres patient's symptoms; legitimates illness, enabling access to the sick role; provides a means to access resources and facilitates their allocation; and forms the foundation of medical authority" (Jutel; Nettleton, 2011, p. 793; Jutel, 2009).

This direction can prompt us to examine the figure of the frequent attender against the backdrop of a number of conditions that have sparked a rich body of research focused in various complex and problematic health care entities recognised as 'contested' conditions (Nettleton, 2006, p. 1168). These include a series of medical problems and public health issues characterised by their uncertainty (Dumit, 2005), appearance of disease in which there is no disease (Kleinman, 1988), and the demarcation of a gap between symptoms (usually framed as the patient's account on her/his bodily distress) and signs (what is reported by medical or professional observation) (Whelan, 2007). This way, frequent attendance could be related to what Dumit (2005) calls 'emergent' and 'uncertain' illnesses "in the sense that they are researched, discussed, and reported on, but no aspect of them is settled medically, legally, or popularly" (p. 578). Frequent attendance seems to fit even more in this category when he goes further by

characterising these illnesses as being: 1) chronic conditions, 2) biomenal entities where there is no clarity regarding their mental, psychiatric and/or biological aetiology and nature, 3) therapeutically diverse, 4) fuzzily bounded with other conditions and emergent illnesses, and 5) legally explosive. This could be a welcome input on the social dimension of frequent attendance as a health care problem, and a welcome contribution by sociology, since it could give an account on the nature of the encounters and interactions that enact the uncertainty and ambiguity that produce frequent attendance as a problem.

However, to analyse the problem of frequent attendance solely as a matter of human interaction risks to be insufficient, for even though it satisfactorily articulates most of social research's powerful contributions to problematize the health-society relation it can ignore key specific issues that largely contribute to produce this entity as a problem for health care. Frequent attendance is not just an illness. As I already mentioned, it is a hybrid category where both medical issues and the practicalities of certain health care network become intertwined creating an ambiguous phenomenon. Thus, frequent attendance is not just diagnostic or medical category decided in a human bargaining process, although it involves the situated dramas of a number of individuals moving in and out of public health services. Two additional dimensions should be considered: Firstly, the material dimension of the specific medical conditions suffered by the frequent attender, since frequent attendance is not limited to 'mental' conditions (opposed to 'physical' ones) causing constant consultations. Frequent attenders can emerge in relation to various medical problems including complications in relation to chronic diseases such as diabetes, hypertension, chronic obstructive pulmonary disease and, indeed and sometimes, mental health conditions. Secondly, frequent attenders only become problematic in relation to these and other conditions inasmuch they exercise specific 'inadequacies' in relation to other form of materiality: that of the arrangements that organise a particular provision of health care in a given time and space. Therefore, the division between responsible regular consultations and problematic frequent attendance only

makes sense in relation to a vast array of formal and informal socio-technical devices -policies, plans, programmes, protocols, administrative directions- and the entities that embody them such as territorial infrastructures, pharmaceuticals, medical tools, etc.

Perhaps this kind of considerations has prompted social researchers to recognise that the tactical repertoire used by the human actors involved in health care and its outcomes cannot be isolated from the non-human dimensions involved thereof. Diagnostic practices, for instance, are entangled with different technologies and material arrangements that allow (or foreclose) multiple forms of relation, kinaesthesia and knowledge, transforming the diagnostic process and generating a myriad of different openings for 'acceptable', 'contested' and/or 'uncertain' illnesses, diseases or conditions (Dumit, 2005; Jutel; Nettleton, 2011; cf. Greco, 2012 for an analysis of the problems that emerge from the intricacies of the interaction of social research and healthcare practices when tackling diagnostic and categorisation issues). Can social research take this non-only-human world into account and put it into play in a different understating of how the social and health are related? The increasing attention that the field of science and technology studies (from now on STS) has drawn might suggest a source for further reflection.

Science and technology studies: socio-material enactments of public health and biomedical entities

In this section, I will outline a different set of possibilities for studying both frequent attendance and the health-society relationship by tackling some of the contributions of STS. The heterogeneity of this field makes impossible for me to deal with it as a whole. However, I will tackle some of its key inputs to social research through an examination of the work of Annemarie Mol (1999, 2002, 2006, 2008, 2010; Mol; Law, 2004). Her research presents the advantage of being both widely influential in the STS arena, and suggesting a provocative approach

to the question about the role of socio-materialities in the enactments of health.

Mol's (2002) most provocative contribution for this article is her proposal to move away from the problem of the representation of disease to focus on the specific ways through which disease is done in practice. This change of direction has deep consequences for social research. Mol's (1999) claim is that instead of insisting in attempts to unify biomedical entities under a single representation, we can rather entertain the hypothesis that reality is multiple, that is, that various versions of an object or entity can be performed. This proposal challenges both naive positivist ideas of a simple correspondence between entities and a single, stable reality 'out there', and the perspectivism that underlies many constructionist approaches in the social sciences. Rather than the many perspectives through which we can look into a single object, Mol's idea of multiple ontologies seeks to show how different versions of the object are enacted through everyday care practices. Mol's (1999, 2002; Mol; Law, 2004) suggestion is then to move away from attempts to find the universal "is" of an object, focusing instead in the careful study of how entities are mundanely enacted in everyday realities where "to be is to be related" with certain objects and practices (Mol, 2002, p. 54). In other words, it is an invitation to unbracket the practicalities that are usually invisibilised, purified and eliminated from our accounts in order to achieve single and clean representations. Thus, the "is" of the entities fostered by Mol is not universal; it is local and requires a determinate spatial set of specifications.

The clearest way to examine this proposal is to pay attention to the consequences it had in Mol's own empirical studies, for instance, her ethnography of practices through which atherosclerosis was performed in a Dutch hospital. In this case study, Mol (2002) patiently shows how different versions of atherosclerosis can be enacted by talking in the clinic (atherosclerosis as a patient's pain and complaints about difficulties when walking), or by the imaging technologies a technician can produce and decipher in the laboratory (atherosclerosis as certain visual representation of the leg's vessels). The way to trace these and other versions is to describe the way in

which their visibilities and existences are done by a range of human and non-human actors through different methods and interventions. For, as Mol (2002) claims, disease is never alone: "it depends on everything and everyone that is active while it is being practised" (p. 32). Mol's research supports the wider claim of the field of STS which states that medical technologies -understood widely as "the drugs, devices, and medical and surgical procedures used in medical care, and the organizational and supportive systems within which such care is provided" (Behney, 1989 in Timmermans; Berg, 2003, p. 99)- operate as a key materiality in the enactment of health care entities. It is not a matter of considering technology as unilaterally determining health care, or, as the opposite view might suggest, as a passive, dumb element that is only alive when in hands of human actors (Timmermans & Berg, 2003). Technology can do things, it is an actor among many others in shifting socio-technical configurations, favouring or limiting different forms of enactment of medical entities and health care issues (Mol, 2002).

Mol's call for a pluralization -of both the actors involved in and the versions enacted through everyday human and non-human practices- suggests that in practice sociality and materiality intertwine until they become almost indistinguishable. This was also illustrated in Mol's studies regarding hypoglycaemia and diabetes. Through an exploration of the ways in which the body acted and was made to act in the different enactments of such medical conditions, she showed how hypoglycaemia entangled bodies that watched (for example that of the pathologist), touched (in a clinical examination), ate and chewed (in order to look out for certain blood sugar levels), or manipulated and pricked (using machines to measure those blood sugar levels, getting blood samples) (Mol, 2006, 2008; Mol; Law, 2004). A cluster of heterogeneous actors -human and non-human- participated in this, in the midst of a creative calibration of elements that made up situations, performed diagnosis, enacted treatments and tried different solutions (Mol, 2008). As this process unfolded, bodies in health care interacted with each other and with machinery, incorporating them to their actions, and excorporating their own actions well beyond their boundaries. A machine for patients

to measure their own blood levels could, for instance, become part of their lives, creating contingent and novel forms of agency through which a 'diabetic' body was enacted (Mol, 2008; Mol; Law, 2004). Thus, different medical practices and technologies acted as mediators and mediations that perform not only different biomedical and health care entities, but also different kinds of self-body relations or body awareness (Mol; Law; cf. Akrich; Bernike, 2004 for a different relevant case study).

From this perspective, the hybrid character of the entities that are made to circulate through medical and public health and care networks challenge any attempt to simplify them since, in practice, illness and disease, human actions and medical technologies, infrastructures and policy regulations, are entangled and constantly put into action through particular connections that draw them together (or apart) in relation to specific interventions. At the same time, the idea that different assemblages of actants and specific practices enact different versions of phenomena challenges any attempt to consider the entities we research as something unified -from bodily suffering to disciplines, from knowledge to interventions, from personal problems to public issues. Even medicine itself is reframed:

It is not unity. It is, rather, an amalgam of thoughts, a mixture of habits, and an assemblage of techniques. Medicine is a heterogeneous coalition of ways of handling bodies, studying pictures, making numbers, conducting conversations. Wherever you look, in hospitals, in clinics, in laboratories, in general practitioner's offices - there is multiplicity. There is multiplicity even inside medicine's biomedical "core". (Mol; Berg, 1998, p. 3)

But, how is this multiplicity enacted and with which consequences? Mol (1999, 2002) suggests us to be cautious: reality might be multiple, but this does not mean that it is totally fragmented. Different enactments and versions are connected. Drawing data from her ethnographic case studies she shows how anaemia, for example, can be performed in three different ways that relate to different assemblages, sites and methods of diagnosis and intervention -a clinical, a laboratory/statistical and a pathophysiological one. However, she says that they do not nec-

essarily overlap: "this does not lead to big debates, to attempts to seek consensus or even concern. It is simply how it is" (Mol, 1999, p. 78). But how do different versions of an entity co-exist or relate? This is precisely what must be examined case to case, in practice. Thus, for a certain enactment of an object or entity, its singularity, its temporary unity, is an accomplishment, a collaborative, contingent effort (Mol 2002, 2008).

If we are inspired by STS' theoretical and methodological tools, we can let go the effort -shared by most of the literature reviewed so far- of determining the single, particular, stable entity that frequent attenders 'really are'. Instead, we can attempt an understanding that frames this problematic category in a processual way, i.e. as an entity with a situated on-going emergence whose character is shaped by a multitude of exigencies and specific configurations of material and cultural elements (Michael; Rosengarten., 2012, 2013). The idea would be to deal with, instead of avoiding, the messiness of the multiple everyday enactments of this issue, taking into account its varying relationalities to other entities and their distributions through primary care. The interest in frequent attenders moves therefore to the way the activities of nurses, doctors, technicians, patients and technologies shape the lives and bodies of the people and beings -human and beyond- involved in health care (Mol; Berg, 1998). This change of emphasis opens novel and interesting possibilities to conceptualize and engage empirically with a number of day to day practical situations that otherwise would possibly be overlooked. For example, during my fieldwork researching frequent attendance in Chile, professionals and administrators consider an immense amount of factors involved in the problematic circulation of frequent attenders throughout the care system. In open interviews and informal conversations they have talked about money, the number of available doctors, the presence or absence of methods of intervention and infrastructure. In turn, health care users talked about waiting rooms of hospitals and primary care centres, staff training, the behaviour of professionals, the ambiguity of the criteria for referrals, the role of pharmaceuticals, the way the doctors' intervention

changed according to specific social and technical milieus. What is taken for granted also plays its part. Through users' and professionals' accounts, actions and trajectories I could appreciate the ways in which policy organises Chilean health care and how every decision -for instance, a focus on an acute or chronic model of attention, or a public health system oriented towards families and territories versus one focused towards urgencies and hospitalisation- rearrange the mundane, quotidian realities of the human and non-human actors involved inside and beyond the actual physical spaces formally devoted to the promotion and provision of health care. Medical entities -illnesses and diseases- like depression, anxiety, somatisation, but also diabetes, hypertension, recurrent flus or the consequences of failed surgeries mingled with the aforementioned objects to produce different versions of frequent attendance in specific ways.

Thus, STS emphasis in the social as a contingent socio-material arrangement highlights frequent attendance as a 'patchwork singularity', a composite entity where different forms of connection between enactments, spatialization of practices, localization and quantification of interventions, and forms of materiality, sociality and awareness of the body perform themselves and, at the same time, are constantly intervened upon and contested (Law; Mol, 1995; Mol, 1999, 2002; Gardner et al., 2011). Frequent attenders become bodies in action, opening a space of problematization that shows these users as something else than individuals who have single bounded, self-contained bodies with fixed and problematic identities. It prompts an approach that considers their bodies as open and semi-permeable to both its environment and its own materialities, and their identities as complex health care users inseparable from a myriad of -sometimes successful, sometimes failed- shared efforts of coordination and interruption only understandable in relation to fragile, local rationalities and coherences practically achieved. Instead of the social as a set of discrete or fragmentary factors that determine health and/or individual behaviours, the health and society relationship becomes something to look for in a dynamic collective composition where sociality and materiality subtly intertwine.

Certainly, STS challenge usual understandings of the social in provocative and fertile ways. However, they are not a panacea. To this field's internal discussion of what might be the real scope of science studies' turn to ontology -and its associated idea of a multiplicity of socio-material enactments done in practice- (Woolgar; Lezaun, 2013), one might add a reflection about the consequences that this area's concern with the rescue of materiality and the non-humans have. Sometimes framed (and deservedly celebrated) as an attempt to finally include non-human entities into democracy (Latour, 2004a; Puig de la Bellacasa, 2011), what other effects might this ideal have when we research and intervene on the human dimensions of health care? STS' rejection of a separation between a human world of subjectivity, beliefs and power from a natural, physical world of pure facts acts as a promising direction for novel conceptualisations and research of health care issues (Latour, 2004a, p. 69; 2004b). But, is this emphasis on the non-human going to be understood as an incentive to look for the complex ways in which humans and non-humans, materiality and sociality articulate in a complex manner? Or is it going to be considered an authorization to simplify 'the human' and, paradoxically reduce it through a dilution of the experiences, beliefs and subjectivities that many forms of critical social and public health research have struggled for?

By way of conclusion: on variations, versions, and our care and research practices

Inheriting something can be an opportunity or a damnation. Our inheritance of certain version of a concept such as 'the social' is not innocuous. Versions attract or reject other versions (Despret, 2004), sensitizing or anaesthetising our practices. Even in the case of concepts we should be attentive to the fact that, if they actually have truth effects, that is if they are to make a difference in our lives, then there is "no difference anywhere that doesn't make a difference elsewhere -no difference in abstract truth that doesn't express itself in a difference in concrete fact and in conduct consequent upon that

fact, imposed on somebody, somehow, somewhere, and somewhen” (James, 2000, p. 27).

Throughout this article I have tried to characterise three versions of the social that are frequently inherited in public health, namely, the social as discrete factors determining singular health behaviours, as impersonal human over-arching forces determining the local realities of the exercise of medicine and public health, and as an amalgam of local socio-material arrangements that entail emergent compositions of both redundancy and creativity. The idea has not been to suggest a progression; instead, I attempted to show how these versions expand on, challenge, cooperate with or dismiss not only other notions of the social, but also our versions of what health, suffering, professional expertise, patienthood, care and their relations are. I examined how these three varieties of the social were originated in specific spaces of research and concern, eventually gaining certain autonomy, circulating through public health and our common sense assumptions of what the social dimension of health is and how does it matter.

I tried to suggest that in order to enrich the possibilities of the phenomena and entities we face in the field of public health, we would do well in examining what happens when we make ourselves part of a certain version of the social. I did so by reflecting on the specific problem of frequent attendance in public health: How do we engage with this issue and what notions of the social are put in play by the ways in which we research or intervene it? The answers to these questions, I stressed, varied greatly inasmuch different assumptions of the social dimension of the problem entailed different possibilities to think of frequent attendance through a diverse health-society relationship, fostering different duties, goals, scopes and chances of cooperation or confrontation not only for social research and public health promotion, prevention and intervention schemes, but also for frequent attenders themselves. This is not an abstract reflection, it is rather an ethical concern: For a long time public health has been a crucial point of intersection of a series of practices and beings that contribute to shape (better) lives. For years it has also welcomed the promise that the social brings to the composition of a more complex, difficult, but eventually more rewarding and effective notion of

health. If that promise will be fulfilled or not it depends closely on public health and social research's capacity to operate with the simplified perceptions needed to intervene and succeed in their day to day actions, but also on their cultivation of a capacity to dwell into fecund moments of hesitation (Connolly, 2011) when a better negotiation of the ways in which they are involved in their contemporary predicaments can be achieved.

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